

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Determination

by

Sheriff Andrew Christie Normand, Sheriff of Glasgow and Strathkelvin

in the Fatal Accident Inquiry into the deaths of

Mhairi Samantha Convy and Laura Catherine Linda Stewart

Glasgow, 14 November 2014

The Sheriff, having heard evidence and having resumed consideration of the cause, finds and determines that

1. In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

Mhairi Samantha Convy, whose date of birth was 4 January 1992, and who resided at 4 Lennox Road, Lennoxtown, died at the Royal Infirmary, Glasgow at 11.25 a.m. on 17 December 2010.

Laura Catherine Linda Stewart, whose date of birth was 10 November 1990, and who resided at 26 Woodhead Grove, Cumbernauld died at the Royal Infirmary, Glasgow at 11.30 a.m. on 17 December 2010.

An accident resulting in the deaths of Mhairi Samantha Convy and Laura Catherine Linda Stewart occurred at about 10.56 a.m. on 17 December 2010 on North Hanover Street at

Killermont Street, Glasgow, when Mhairi Samantha Convy and Laura Catherine Linda Stewart were struck by motor vehicle registered number H18HEX.

2. In terms of section 6(1)(b) of the Act:

The cause of the death of Mhairi Samantha Convy was:

1a Head and chest injuries

due to

1b Road Accident (pedestrian)

The cause of the death of Laura Catherine Linda Stewart was:

1a Chest and abdominal injuries

due to

1b Road Accident (pedestrian)

The cause of the accident resulting in the deaths of Mhairi Samantha Convy and Laura Catherine Linda Stewart was the loss of control of the motor vehicle registered number H18HEX by its driver, William Payne, while driving said vehicle on North Hanover Street, Glasgow, as a result of which the said vehicle mounted the pavement on North Hanover Street at Killermont Street, Glasgow and collided with Mhairi Samantha Convy and Laura Catherine Linda Stewart. The loss of control of the vehicle was caused by a vasovagal episode which caused William Payne to lose consciousness temporarily and rendered him unable to control the movement and direction of the vehicle.

3. In terms of section 6(1)(c) of the Act:

The deaths resulted from an accident. The reasonable precautions whereby the accident resulting in the deaths might have been avoided were:

1. For William Payne to have notified the Driver and Vehicle Licensing Agency (DVLA) about his blackouts after his loss of consciousness on 5 June 2009, which was the fourth occasion on which he had suffered an episode or episodes of blackout in the period since 25 December 2007.

2. For William Payne to have attended the appointment made for him with a Consultant at Stobhill Hospital, Glasgow on 17 September 2009 for further examination about blackouts, or to have made and attended a rescheduled appointment if he was unable to attend that appointment.
3. For William Payne at a medical examination on 2 July 2010 in connection with an application for renewal of his Group 2 (HGV) driving licence to have disclosed and provided accurate and complete information about his history of blackouts to the medical practitioner who examined him and in the driving licence renewal application form.
4. For the Consultant who saw William Payne at Stobhill Hospital on 13 January 2009 at a follow-up consultation after Mr Payne's admission to Stobhill Hospital on 6 October 2008 as a result of episodes of loss of consciousness that day, to have arranged for further, appropriate tests to be carried out in relation to Mr Payne's episodes of loss of consciousness, and to have advised Mr Payne not to drive and to notify DVLA of his blackouts.
5. For the General Practitioner at William Payne's GP practice at Possilpark Health Centre, who wrote a jury excusal letter for William Payne on 3 July 2009 and saw William Payne on 10 July 2009, to have advised William Payne not to drive and to notify DVLA of his blackouts, pending his further consultation with the Consultant at Stobhill Hospital to whom the GP referred him.

4. In terms of section 6(1)(d) of the Act:

There is no determination about defects in any system of working which contributed to the deaths or any accident resulting in the death.

5. In terms of section 6(1)(e):

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

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Representation at the Inquiry:

For the Crown: James Graham, Senior Procurator Fiscal Depute

For the family of Mhairi Samantha Convy and the family of Laura Catherine Linda Stewart: Dorothy R Bain Q.C.

For the Driver and Vehicle Licensing Agency: Hugh J Olson, Advocate

For William Payne: Brian J Fitzpatrick, Solicitor

For Dr Alistair Ireland and Dr Stephen Cleland: Laura V M Ceresa, Solicitor

For Dr Petra Sambale, Dr Claire Keatley, Dr Natasha Cox, Dr Katie Padgham: James Stewart, Solicitor

For Glasgow City Council: Catherine Dowdalls, QC

Understandably the deaths of the two young women, Mhairi Convy and Laura Stewart, has had a profound effect on their families. The love, respect and loyalty of the families was demonstrated by the attendance of family members throughout the court hearings. The family members conducted themselves throughout with composure, patience, and dignity and I pay tribute to them in that regard. I expressed the condolences of the court to the Convy and Stewart families at the Inquiry and I repeat here that expression of sympathy on the tragic and immensely sad loss of their much-loved daughters, Mhairi and Laura.

Part 1. General Legal Framework

1.1 This was an Inquiry held under section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, on the ground, stated in the Application of the Procurator Fiscal, that “it appears to the Lord Advocate to be expedient in the public interest that an inquiry under the said Act should be held into the circumstances of said death”. Section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides for the holding of an inquiry under the Act where “it appears to the Lord Advocate to be expedient in the public interest...that an inquiry under this Act should be held into the circumstances of the death on the ground that it was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern.”

1.2 Fatal Accident Inquiries, and the procedure to be followed in the conduct of such Inquiries, are governed by the provisions of the 1976 Act and the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977 made under section 7(1) of the Act.

1.3 Subject to the provisions of the Act and the Rules, the rules of evidence and procedure are to be “as nearly as possible those applicable in an ordinary civil cause brought before the sheriff sitting alone” (section 4(7) of the Act). The normal civil standard of proof (the balance of probabilities) applies (section 4(7)) and corroboration is not required (section 6(2)). Hearsay evidence is admissible (section 2(1) of the Civil Evidence (Scotland) Act 1988),

as is affidavit evidence (Rule 10 of the 1977 Rules), and evidence may be agreed by joint Minute of Agreement.

1.4 The purpose of an Inquiry held in terms of the 1976 Act is for the Sheriff to make a determination setting out the following circumstances of the death, so far as they have been established to his 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 may 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;
- (e) any other facts which are relevant to the circumstances of the death

- all in terms of Section 6(1) of the Act.

1.5 The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and any other party if so advised. Any determination by the sheriff must be based on the evidence presented at the Inquiry and is limited to the matters defined in Section 6(1) of the Act.

1.6 As has been stated in many Fatal Accident Inquiry ("FAI") Determinations, consideration of Section 6(1)(c) involves an exercise of retrospective consideration of matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the Inquiry. (See for example, Sheriff Principal Lockhart's Determination in the "Rosepark Inquiry", 20 April 2011 [at para. 7], in which he referred to his Determination in the Newton rail crash Inquiry in 1993.) A finding under sub-paragraph (c) requires not a probability but a "real and lively possibility" that the death might have been avoided by the reasonable precaution (Carmichael, *Sudden Deaths and Fatal Accident Inquiries* 3rd Ed at para. 5-75, using Sheriff Kearney's expression in his Determination in the FAI in relation to the death of James McAlpine, issued on 17 January 1986.) It is not necessary for the court to be satisfied that the precaution would in fact have avoided the accident or death, only that it might have done, but the court must, as well as being satisfied that the precaution might

have prevented the accident or death, be satisfied that the precaution was a reasonable one (Sheriff Kearney in his above-mentioned Determination, referred to in Carmichael at para. 8-99 and in countless other Determinations.)

1.7 Section 6(3) of the Act sets out that the determination of the sheriff shall not be admissible in evidence or be founded on in any judicial proceedings, of whatever nature, arising out of the death or out of any accident resulting in the death. While this prohibition is intended to encourage a full and open exploration of the circumstances of a death it also reflects the position that an FAI is not a forum designed to establish legal fault. Nor does the sheriff have any power to make such a finding. The position was authoritatively stated in the routinely quoted opinion of Lord President Hope in *Black v Scott Lithgow Limited* 1990 SC 322, at page 327: *"There is no power in this section to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident."* That position was more recently confirmed by Lord President Hamilton in *Global Santa Fe Drilling v Lord Advocate* 2009 SLT 597 where at page 604 para. 28 he observed under reference to *Black v Scott Lithgow* that although the sheriff presiding at a Fatal Accident Inquiry has judicial duties he does not sit to determine the rights or obligations of parties. Thus a Fatal Accident Inquiry is more concerned with fact-finding, than fault-finding (Carmichael para. 5-63).

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. In the words of Carmichael (at para. 5-76.):

"[W]here the evidence is sufficiently compelling, the responsibility of exposing and finding fault should be accepted. The whole object of impartial public inquiry is to get at the truth, to expose fault where fault is proven to exist, and in all case to see to it so far as is humanly possible that the same mistake, when it arise through fault or any other reason, is not made in the future. The public interest, in whose name inquiries are held, requires and deserves no less."

Such a position was recognised by Lord Cullen in the course of his review of fatal accident inquiries:

"It is true that the investigation into the circumstances of a death in an FAI may disclose grounds of criticism from which a basis for alleging fault may be inferred. That may be unavoidable if the FAI is to fulfil its function of investigating the circumstances of a death." (Report of the Review of Fatal Accident Inquiry Legislation (2009) at para.3.23.)

Part 2. Particular Legal Issues

2.1 In this Inquiry particular legal issues arose in connection with the circumstances of the application by the Lord Advocate for the holding of an Inquiry and one of the provisions of the 1976 Act.

2.2 As I have noted above, this was an Inquiry held under section 1(1)(b) of the 1976 Act, on the ground, stated in the Application of the Procurator Fiscal, that “it appears to the Lord Advocate to be expedient in the public interest that an inquiry under the said Act should be held into the circumstances of said death”. The decision to apply for the holding of a Fatal Accident Inquiry on the above ground was a matter entirely for the Lord Advocate. The Lord Advocate’s specific reason for making an application for the holding of an FAI does not require to be stated and was not stated in the application in this case.

2.3 However, it appeared from information provided at an early stage of these proceedings that the Lord Advocate had considered it to be expedient in the public interest that an FAI should be held in this case because the deaths had occurred “in circumstances such as to give rise to serious public concern” (Section 1(b)). It also became clear that the background to the Lord Advocate’s decision to apply for the holding of an FAI in this case was the position of the Crown in relation to undertaking any criminal prosecution of William Payne for possible criminal offences relating to the circumstances of the deaths of Mhairi Convy and Laura Stewart.

2.4 In connection with an issue that arose in the course of the Inquiry (explained below) there was produced by Ms Bain for the families (as the Families’ Production 21) a copy of a letter dated 29 October 2013 from the Solicitor General for Scotland to a Member of the Scottish Parliament, Mr Jamie Hepburn MSP, in which the Crown’s position was stated. The letter referred to the Crown’s decision not to take criminal proceedings and included the statement that the decision “*was taken by Crown Counsel only after the most thorough and*

extensive enquiry had established that there was insufficient admissible evidence to establish any crime had been committed". The letter immediately went on to say: "The Fatal Accident Inquiry will allow further exploration of all of the evidence in the case and the judicial determination on the circumstances in order that lessons can be learned and everything possible can be done to prevent a similar tragedy in the future."

2.5 That background affected the conduct of the proceedings. It led to a debate about the application of section 5(2) of the 1976 Act and the resultant unavailability to the Inquiry of relevant evidence. It also resulted in certain submissions on behalf of some of the parties to the Inquiry.

2.6 I shall deal first with the section 5(2) matter. This arose when the Crown called as a witness William Payne, who was the driver of the vehicle involved in the fatal accident. The circumstances of this Inquiry suggested that a warning required to be administered to Mr Payne in terms of section 5(2) of the 1976 Act, which provides: "No witness at the inquiry shall be compellable to answer any question tending to show that he is guilty of any crime or offence."

2.7 However, in a motion that she made when Mr Payne was called by the PF to give evidence, Ms Bain QC for the families invited me to rule that this statutory protection did not apply in the present Inquiry, as there had been an unequivocal renunciation by the Crown of the right to prosecute Mr Payne and further the Inquiry would not be ECHR compliant if Mr Payne was allowed to refuse to answer questions, as the Article 2 rights of the families would be infringed. In support of her motion Ms Bain referred *inter alia* to the letter mentioned in paragraph 2.4 above. Her motion was opposed by the Crown and by Mr Fitzpatrick, for Mr Payne, who both argued that there had been no such unequivocal renunciation by the Crown of the right to prosecute Mr Payne. The PF further argued that there was no authority for the proposition that the sheriff may make a finding in an FAI that there has been an unequivocal renunciation by the Crown of the right to prosecute. It was expressly stated that the Crown reserved the right to prosecute and this was said to have been the Crown's position throughout, whatever statements about proceedings may have been made in meetings or correspondence with those representing the families, including an MSP.

2.8 Mr Fitzpatrick confirmed that no unequivocal renunciation by the Crown of the right to prosecute had been received by Mr Payne or himself. No public statement to that effect had been made by any Law Officer. In opposing Ms Bain's motion Mr Fitzpatrick also referred to Mr Payne's Article 6 rights.

2.9 In those circumstances I refused Ms Bain's motion and decided that it was necessary to administer a warning to Mr Payne in terms of section 5(2) of the 1976 Act that he was not compelled to answer any question tending to show that he is guilty of any crime or offence. In the event Mr Payne declined to answer most of the questions that were asked of him by the PF and Ms Bain.

2.10 As regards the background to the FAI, Mr Fitzpatrick on behalf of William Payne drew my attention to certain comments made by Sheriff Principal Dunlop in his Determination in the FAI into the death of Colin Marr, dated 21 April 2011. In his Determination Sheriff Principal Dunlop observed (at paragraph 1.3) that the central issue in that Inquiry was an unusual issue to be raised in the context of FAI proceedings. That issue was whether a wound was self-inflicted by the deceased or inflicted by another person, who was a witness in the Inquiry. The Sheriff Principal (at paragraph 2.7) expressed considerable reservations about whether such a stark issue ought to be considered at an Inquiry under the 1976 Act. He pointed out:

"Although this Inquiry is not about guilt or innocence of a crime, the way that the central issue has been framed invites a determination which in the minds of the public may well be indistinguishable from a finding of guilt or innocence and that on a balance of probabilities only. We have a system of criminal justice which is intended to deal with such questions. In that system the Crown has the responsibility for determining whether or not criminal proceedings are instituted and a key component of any such decision is the question whether there is sufficient evidence to prove guilt beyond reasonable doubt."

While recognising that it was a matter for the Lord Advocate, the Sheriff Principal expressed concern if the request for an Inquiry in that case indicated an emerging inclination to ask the court to adjudicate on issues which ought more appropriately to be considered within the context of the criminal justice system, in which suspects are presumed innocent until proved guilty beyond reasonable doubt and the Crown has a particular responsibility for deciding whether there is a sufficient basis in evidence to demonstrate such guilt.

2.11 In his submissions Mr Fitzpatrick invited me “to make no unauthorised findings which may be interpreted as attributing fault to William Payne or making any findings on the balance of probabilities which in the words of Sheriff Principal Dunlop ‘in the minds of the public may well be indistinguishable from a finding of guilt or innocence’”. He further invited me to make no findings “which would impinge on the presumption of innocence”.

2.12 By contrast with Mr Fitzpatrick’s submissions in this regard Ms Bain’s submission for the families invited me to make a finding in my Determination that William Payne had, in effect, committed a serious driving offence and a recommendation that the Solicitor General and the Crown Office should reconsider matters in relation to prosecution of William Payne.

2.13 I fully recognize, of course, that this Inquiry is not a criminal court. It is a *sui generis* form of statutory public inquiry. As already noted, the procedures are generally those of a civil court, corroboration is not required for the sheriff to be entitled to be satisfied about any of the circumstances on which he may make a determination in terms of section 6(1) of the Act and the standard of proof is the civil standard of the balance of probabilities.

2.14 I do not consider that it is necessary, appropriate or competent in this Inquiry for me to make a finding in my Determination that a person has been guilty of a criminal offence. That is a decision for a criminal court – and indeed for a jury, not a judge, so far as the most serious potentially relevant offence is concerned. However, Parliament in enacting the 1976 Act appears to have envisaged circumstances in which conduct which may amount to a crime or offence may fall within the proper scope of an Inquiry under the Act – hence the provisions of section 5 of the Act. Consequently, while noting Sheriff Principal Dunlop’s comments, I consider that it is competent to deal with such circumstances in an FAI and I have no difficulty in doing so, to the extent that that is necessary to comply with the requirements of section 6 of the 1976 Act.

Part 3. The Proceedings

3.1 The Inquiry took place over thirteen (non-consecutive) days in February, March and June 2014, during which evidence was heard on 11 days.

3.2 Parties' written submissions were circulated among the parties, as a result of which supplementary written submissions were lodged by the Crown and by Mr Fitzpatrick on behalf of William Payne. The hearing on submissions was on 14 August 2014. Some of the submissions were lengthy and in total the written submissions extended to about 150 pages. I do not rehearse all the submissions in detail, although I refer to particular submissions where appropriate. I should state that I have given all the parties' submissions full and careful consideration, even where there is no specific reference or comment in the relevant part of my Determination.

Part 4. Witnesses/Evidence

4.1 Evidence was led principally by the Senior Depute Procurator Fiscal, Mr Graham, in accordance with the duty under section 4(1) of the 1976 Act. Evidence was also led on behalf of the families and there was evidence for Glasgow City Council. Six joint minutes of agreement were entered into by the parties and received by the Inquiry.

4.2 The witnesses are listed in Annex 1 in the order in which they gave evidence, with the exception of the families' witness, Dr Northcote, whose evidence was taken for convenience before the completion of the Crown evidence. Also listed are witnesses whose evidence was agreed in the joint minutes or given by affidavit.

Part 5. The Quality and Adequacy of the Evidence

5.1 This Inquiry started just over three years after the deaths of Mhairi Convy and Laura Stewart and the Inquiry has taken nine months to complete - to the stage of the issue of my Determination.

5.2 As noted above, during the period prior to the holding of the Inquiry the circumstances of the deaths of Mhairi Convy and Laura Stewart were being investigated by the Crown and consideration was being given to possible criminal proceedings. However, the period explored in the course of evidence in the Inquiry did not just cover the date of the fatal accident, but extended back several years before the deaths of Mhairi Convy and Laura Stewart in December 2010. Consequently recollections of some witnesses to the Inquiry were understandably affected by the passage of time, although the extent to which that applied was not always clear.

5.3 As regards medical witnesses and their evidence about dealings with William Payne, the passage of time meant that there was inevitably substantial reliance on medical records for evidence, with some witnesses relying largely or entirely on the records in giving their evidence and stating that they had little recollection of the relevant consultations now. There was also a question about the completeness of some medical records and it appeared that organisational changes had resulted in some records not being available at the relevant time or at time of the Inquiry. Not all of the medical practitioners who dealt with William Payne in the period of three years before the fatal accident were called as witnesses at the Inquiry. This did not give rise to any substantial difficulty, but it did mean that some medical witnesses were asked to consider and interpret medical records prepared by other doctors who were not witnesses. It might have been helpful to have heard from one or two of those doctors, had they been identifiable and available.

5.4 I have kept in mind difficulties faced by witnesses in giving evidence in relation to consultations or events that happened several years ago, particularly when subjected to detailed questioning. It appeared to me that the witnesses who gave evidence to the Inquiry were generally attempting to do so the best of their ability, having regard to the passage of time and any consequent difficulty of recollection.

5.5 I have described above the particular issue about giving full and accurate evidence which arose in relation to the witness, William Payne. As I have noted, after I administered a warning to Mr Payne in terms of section 5(2) of the 1976 Act that he was not compelled to answer any question tending to show that he is guilty of any crime or offence, Mr Payne declined to answer most of the questions that were asked of him by the PF and Ms Bain. The Inquiry did not therefore hear evidence from Mr Payne about the circumstances of the fatal accident (or his medical history).

5.6 The Inquiry did hear evidence of what William Payne told the police in a tape-recorded police interview under caution in the presence of his lawyer on 5 May 2011. (Production 1) That was not, of course, evidence on oath and cross examination of Mr Payne on what he told the police on that occasion was constrained by the operation of section 5(2).

Part 6. The Young Women into whose deaths the Inquiry was held

6.1 Mhairi Samantha Convy was 18 years of age. She was a student at Glasgow College of Commerce. She resided at 4 Lennox Road, Lennoxtown with her family. She had no medical history that was of any significance to the Inquiry.

6.2 Laura Catherine Linda Stewart was 20 years of age. She was a student at Glasgow College of Commerce. She resided at 26 Woodhead Grove, Cumbernauld with her family. She had no significant medical history.

Part 7. Summary of Evidence

7.1 In this section I set out the factual circumstances as I found them to be established by the evidence I heard and saw. I shall summarise the circumstances of the fatal accident and related matters.

The Road Accident:

7.2 As noted, Mhairi Convy and Laura Stewart were students at Glasgow College of Commerce. The college is located in Glasgow city centre. Shortly before 11 o'clock on the morning of 17 December 2010 Mhairi Convy and Laura Stewart were pedestrians in a street close to the college, North Hanover Street. They were on the footpath on the east side of North Hanover Street, near to its junction with Killermont Street, Glasgow.

7.2 Just before 10.56am Range Rover H18 HEX, driven by William Payne, stopped at a red traffic light in North Hanover Street, near to the junction with Cowcaddens Road. The vehicle was in the outer lane of the southbound carriageway (lane two). Several other vehicles were stopped at this junction, including a car driven by the witness Mark Harrison which was stopped in the inside lane (lane one).

7.3 The traffic signal changed to green and the car driven by Mr Harrison in lane one moved off. Vehicles in lane two behind the Range Rover were briefly held up as the Range Rover did not immediately move off. The Range Rover remained stationary for a short time before moving forward southward on North Hanover Street. It caught up with Mr Harrison's car, which was in lane one and collided with the offside of that car, pushing it into the nearside kerb where it came to a stop. The Range Rover did not slow down or stop. It continued moving forward to its nearside and mounted the footpath. It continued along the footpath

before striking a road sign mounted on two metal poles on the footpath. The road sign was lifted out of the ground by the force of the collision and propelled forward for a distance of approximately 15-20 metres. The Range Rover continued south on the footpath towards a pedestrian, Mark Hopwood. The vehicle struck him, causing him to fall to the ground and injuring him.

7.4 The Range Rover continued on its path and struck a metal refuse bin which then became lodged under the vehicle, which still did not come to a halt. The Range Rover then collided with a lamp post, ripping it from the pavement. The upper section of the lamp post twisted over the top of the vehicle. The vehicle continued moving on the footpath, dragging the lamp post with it.

7.5 The Range Rover then ran into Mhairi Convy and Laura Stewart as they walked on the footpath. They were both thrown from the footpath by the force of the collision and landed on separate parts of the roadway.

7.6 The Range Rover continued south on the footpath for a short distance before coming to a halt on the nearside embankment. The engine continued to operate and the wheels continued to turn. The engine was switched off by a passer-by who had witnessed the collision. William Payne was in the driving seat. He appeared dazed and initially unresponsive.

7.7 Mhairi Convy and Laura Stewart did not regain consciousness. They were taken by ambulance to Glasgow Royal Infirmary where they died soon after.

7.8 The driver, William Payne, was taken to the Western Infirmary, Glasgow.

The Locus:

7.9 North Hanover Street is a single carriageway with two lanes in each direction and it extends generally north to south and is unclassified. Killermont Street runs generally west to east forming a T junction with North Hanover Street at its eastern most point. This junction is controlled by traffic lights, which are single phased with a pedestrian phasing.

7.10 At this locus the carriageways are separated by normal central lane markings. The carriageway is bordered east and west by pedestrian footpaths. Buchanan Street Bus Station

is adjacent to the west footpath and the exit for buses from the station is onto Killermont Street. The east footpath of North Hanover Street has a small raised area of grass/shrubbery separating it from St Mungo Avenue.

7.11 Drivers travelling south on North Hanover Street have an unobstructed view of the road ahead from the junction with Cowcaddens Road, which is the junction to the north of the junction with Killermont Street. The road runs slightly downhill and drivers have a clear and unobstructed view along this section of road. At the time of the incident there were no stationary vehicles on the carriageway. The flow of vehicular traffic was moderate. There were numerous pedestrians in the area. It was daylight. Weather conditions were dry and visibility was good.

7.12 A site examination of the locus by qualified police officers and council officials found that there was nothing in the road infrastructure or layout that was a cause for concern on road safety grounds.

The Vehicle:

7.13 The Range Rover H18HEX was found on examination by a qualified vehicle examiner to have minor defects, but these were not a contributory factor to the accident.

The Driver:

7.14 At the time of the fatal accident William Payne suffered a temporary loss of consciousness ("blackout"). At the time of the fatal accident William Payne was suffering from a medical condition which made it unsafe for him to drive. This condition was discovered in the course of medical investigations carried out after the accident when a particular test was performed on 22 December 2010 - a "Tilt Table" test. This is a test which involves a patient lying on a table, which is tilted upwards from a horizontal position to a vertical position while the patient's blood pressure, pulse and symptoms are monitored. A further Tilt Table test which was carried out in June 2011 after a pacemaker had been fitted in January 2011 resulted in a medical diagnosis that William Payne was suffering from a malignant form of vasodepressor syncope syndrome. There is no treatment for this and as it cannot be guaranteed that there will not be another episode it is likely that Mr Payne will not be able to drive again. His licences to drive have been withdrawn.

7.15 During the period of three years before the fatal accident episodes of loss of consciousness (“blackouts”) by William Payne occurred on six occasions on four different dates and William Payne was seen by several doctors in connection with those episodes. None of the doctors diagnosed that Mr Payne was suffering from a condition that made it unsafe for him to drive. Medical examinations and tests during the period did not include a “Tilt Table” test. Such a test would have disclosed the existence of the condition that made it unsafe for Mr Payne to drive. None of the doctors advised Mr Payne not to drive or to notify the Driver and Vehicle Licensing Agency (DVLA).

7.16 William Payne did not himself notify DVLA or choose to stop driving during the period between 25 December 2007 and 17 December 2010. Mr Payne did not seek advice about driving from any doctor seen by him between 25 December 2007 and 17 December 2010.

7.17 In July 2009 William Payne requested and obtained from his GP a letter to enable him to be excused from jury service because he had had “several episodes of unexplained dizziness and collapse over the last year”.

7.18 In July 2010 in connection with an application to DVLA for renewal of his Group 2 (“HGV”) driving licence William Payne failed to disclose his history of blackouts to the doctor who was examining him and falsely stated in the relevant application form that he had not suffered from “blackouts” or impaired consciousness within the previous 5 years.

7.19 Reporting to the DVLA of William Payne’s history of blackouts would have been likely to have resulted in tests being carried out which would have revealed Mr Payne’s medical condition, leading to the revocation of Mr Payne’s driving licence before 17 December 2010.

Part 8. Section 6(1)(a)

Where and when the deaths took place –

8.1 Mhairi Samantha Convy, whose date of birth was 4 January 1992, and who resided at 4 Lennox Road, Lennoxtown, died at the Royal Infirmary, Glasgow at 11.25 a.m. on 17 December 2010.

8.2 Laura Catherine Linda Stewart, whose date of birth was 10 November 1990 and who resided at 26 Woodhead Grove, Westfield, Cumbernauld died at the Royal Infirmary, Glasgow at 11.30 a.m. on 17 December 2010.

8.3 A Joint Minute of Agreement between the parties covered the above circumstances, which were also set out in post mortem reports (Crown productions 14 and 16) of examinations on 23 December 2010 by forensic pathologists, Dr John Clark and Dr Julia Bell, which reports were agreed to be a true and accurate record of the pathologists' findings.

Where and when the accident resulting in the deaths took place –

8.4 It was established by evidence from several eye-witnesses at the Inquiry that an accident resulting in the deaths of Mhairi Samantha Convy and Laura Catherine Linda Stewart occurred at about 10.56 a.m. on 17 December 2010 on North Hanover Street at Killermont Street, Glasgow, when Mhairi Samantha Convy and Laura Catherine Linda Stewart were struck by motor vehicle registered number H18HEX. The evidence is outlined in greater detail below.

Part 9. Section 6(1)(b)

The cause of the deaths –

9.1 In terms of the said Joint Minute of Agreement between the parties it was agreed that Mhairi Convy and Laura Stewart died as a result of severe injuries sustained as a result of being struck by Range Rover motor car registered number H18HEX, then being driven by William Payne (whose address was stated in the Joint Minute).

9.2 As noted, the Joint Minute also agreed that the post mortem reports of examinations carried out on 23 December 2010 by forensic pathologists, Dr John Clark and Dr Julia Bell were a true and accurate record of the pathologists' findings. In terms of the post mortem report, the examination of Mhairi Convy showed that she died from severe head and chest injuries, entirely consistent with her having been involved in a road traffic accident as described. The cause of death of Mhairi Samantha Convy was certified as:

1a Head and chest injuries

due to

1b Road Accident (pedestrian)

9.3 In terms of the post mortem report, the examination of Laura Catherine Linda Stewart showed that she died as the result of severe injuries to her chest and abdomen, entirely in

keeping with her having been involved in a road traffic accident as described. The cause of the death of Laura Catherine Linda Stewart was certified as:

1a Chest and abdominal injuries

due to

1b Road Accident (pedestrian)

9.4 There was a separate submission for the families in relation to the Determination under section 6(1)(b) in the following terms:

“Laura and Mhairi sustained fatal injuries as a result of being struck by the Range Rover motor vehicle registered number H18 HEX then being driven by Mr William Payne. Mr Payne caused both Laura’s and Mhairi’s death by driving his Range Rover vehicle dangerously. On 17 December 2010, he drove his Range Rover vehicle in the face of an obvious and material danger that he was fully aware of; he knew that he suffered from a medical condition that made it unsafe for him to drive.”

I deal with this below, as it is necessary to consider the accident and the cause of the accident in that context.

The cause of the accident resulting in the deaths –

9.5 The cause of the accident that resulted in the deaths of Mhairi Samantha Convy and Laura Catherine Linda Stewart was not a matter of formal agreement between the parties. Only the Crown submission specifically addressed the questions of “accident” and cause thereof.

9.6 It is necessary to refer to the relevant evidence. It should also be noted that that evidence did not include evidence from the driver of the vehicle involved in the fatal road accident, William Payne. In terms of section 5(2) of the 1976 Act Mr Payne chose to decline to answer questions about the circumstances of the accident, as previously noted.

9.7 There was a considerable amount of evidence from members of the public who witnessed the event, including Mark Hopwood who was struck and injured, other pedestrians and also drivers of other vehicles. A CCTV recording was shown, which had been recovered from a National Express coach that had travelled behind William Payne’s Range Rover on the approach to the traffic lights at North Hanover Street. The recording, which was covered by a Joint Minute of Agreement, showed the view looking forward from

the front of the bus. It showed the Range Rover being driven in normal, safe fashion in the flow of traffic and stopping at the red traffic light signal on North Hanover Street at Cowcaddens. The recording then showed the traffic lights changing to green and the Range Rover accelerating away from the traffic lights and colliding with the car driven by the witness Mark Harrison. It could then be seen to mount the footpath and knock over a road sign before coming to rest near to the junction of Killermont Street. Due to the distances involved, the speed of the Range Rover and the image quality the collisions with the three pedestrians could not be seen from the recording. However, these collisions were spoken to by a number of credible and reliable eye-witnesses who were at or close to the scene and who also, to varying extents, described the passage of the Range Rover and the way in which it travelled.

9.8 Descriptions of the speed of the vehicle ranged from 50 to 60 m.p.h. and “a ridiculous speed” to 30 m.p.h. A witness, Philip Docherty, had been driving a taxi behind the Range Rover for some distance before the junction of Cowcaddens and North Hanover Street, during which time there was nothing untoward about the manner in which the vehicle was driven. The taxi having then travelled ahead of the Range Rover to the junction with Killermont Street, where it stopped, the witness Docherty stated that the Range Rover passed him on the pavement “going about 50m.p.h. at least” before it “ploughed into two girls”. The witness could not see anything to account for this as the driving up to then had been fine. The pedestrian who was struck by the Range Rover and injured – Mark Hopwood – stated that the car that hit him was going about 50 or 60m.p.h. Another witness, Brian McCabe, was the driver of a car that was stopped directly behind the Range Rover at the traffic lights at the junction of Cowcaddens and North Hanover Street. He observed the Range Rover taking off from the lights and then travelling down North Hanover Street onto the pavement without deviation or braking, picking up speed all the way to a speed he estimated from some distance behind as 30 to 35 m.p.h. This witness did not speak to having seen the collision with the young women.

9.9 From the evidence about the manner of travel of the Range Rover, the collisions, the damage and injury caused, and from what is shown in the CCTV recording I think it probable that the higher estimates of speed are accurate.

9.10 The witness McCabe gave evidence that he had suggested to the police at the time that the driver of the Range Rover may have passed out. That suggestion was made because there was no indication that the driver was in control of the vehicle – there was no braking or deviation. Mr McCabe stated that when stopped behind the Range Rover at the traffic lights at the junction of Cowcaddens and North Hanover Street he saw that the driver of the Range Rover “stuck his head out of the car window and seemed to spit or take a breath, then his head went back in the car”. When the lights changed the car did not move for 6 to 8 seconds and then it took off and proceeded down North Hanover Street in the manner described.

9.11 No other witnesses gave evidence about observing the driver as the Range Rover travelled from the junction of Cowcaddens and North Hanover Street to where it came to a halt on the nearside embankment on the east side of North Hanover Street after colliding with Mhairi Convy and Laura Stewart. One witness, Darren Bell, from a position on the other side of the road near the junction with Killermont Street, saw the vehicle just as it came to a halt after the collision. His evidence was that he saw the male driver with one hand on the steering wheel – “like trying to keep himself in the car as the embankment pushed him over”. The witness also thought it was like the male “was trying to control the steering wheel”.

9.12 A number of witnesses gave evidence about the state of the driver, William Payne, immediately after the Range Rover came to a halt. They went to the vehicle and some of them spoke to William Payne. When the witness John Hutchison went over to the Range Rover the engine was still running and he turned it off. It looked as if the driver was slumped back in the seat. He was not saying anything, but when the police came over he said he was not well. The witness agreed he had said in a statement given to the police at time that the driver “looked ashen faced” and that he didn’t know if the driver “had taken a bad turn”. Witness Gary McGinley spoke to the driver and got no response from him. His eyes were fixed staring ahead. He had a pale expression and was in shock. The witness asked the driver if he was okay and got no response. Another witness, John Anderson, also said that the driver was very pale and dazed, staring straight ahead. Witness David Toner saw a man in the driver’s seat who looked dazed but conscious. He was sitting semiconscious. Mr Toner agreed that a statement he gave on 18 December 2010 accurately

recorded that when asked for an opinion about what happened he said to the police that there was an involuntary loss of control or mechanical failure.

9.13 The first police officer to arrive, P C Gary O'Connell, found William Payne to be very pale and ashen. He was conscious and gave his name. When the officer spoke to Mr Payne at the Western Infirmary shortly after arrival there Mr Payne told him that he had been treated at Stobhill for blackouts 3 years before. P C Gordon McIntyre thought William Payne looked pale and in shock. Mr Payne said he did not know what had happened. A breath test was administered which was negative.

9.14 William Payne was examined by William Tullett, Accident and Emergency Consultant, at the Western Infirmary on 17 December 2010. According to Mr Tullett's notes Mr Payne stated that he did not remember anything from sitting at the traffic lights to a person speaking to him when the car stopped again.

9.15 Mr Payne repeated that account during a tape-recorded police interview under caution in the presence of his lawyer on 5 May 2011, when he said: *"I was driving my vehicle eh I got to a set, a second set of lights in North Hanover Street, there was a car in front of me I went to pull my handbrake on and it's the last thing I can remember eh and then the next thing I remember is an off duty police woman speaking to me..."*. (Production 1 at page 3)

9.16 William Payne had a collapse at the Western Infirmary on 17 December 2010. As was disclosed in evidence and explored in detail and at length in the Inquiry, Mr Payne had a history of recorded "blackouts" or losses of consciousness over a period of at least three years before that date (as described and discussed in a subsequent section of the Determination).

9.17 In the tape-recorded police interview on 5 May 2011, Mr Payne was asked if he would put the road traffic crash on 17 December down to one of the blackouts that he'd had, to which he replied: "Yes". (Production 1 at page 24)

9.18 On the basis of the evidence as just outlined, I am satisfied that the event was an "accident" for purposes of section 6 of the 1976 Act.

9.19 As regards the cause of the accident, the expert witness led by the Crown, Dr Neil Grubb, Consultant in Cardiology, gave as his opinion in his report (Production 29) after

reviewing records and statements: “ *Vasovagal syndrome provides a good explanation for Mr Payne’s loss of control at the wheel of his car...It is entirely possible that Mr Payne was conscious as he drove off from the traffic lights, but that he abruptly lost consciousness at this time because of a pause in his heart rhythm similar to that demonstrated during the first tilt test.*” (There is further reference to Dr Grubb’s evidence in the section on expert evidence below at page 64.) The expert witness for the families, Dr Northcote, who had also reviewed the medical records and statements, stated in evidence that “on 17 December 2010 Mr Payne must be assumed to have had a loss of consciousness”. (Dr Northcote’s evidence is also dealt with more fully in the subsequent section on expert evidence.)

Submissions

9.20 The Crown’s submission was that:

“The accident was caused by William Payne suffering a vasovagal episode at the wheel of the motor vehicle H18 HEX then being driven by him in North Hanover Street, Glasgow as a result of which he lost control of said vehicle causing it to mount the pavement and there collide with both now deceased causing injuries from which they died.”

9.21 There was also a supplementary submission from the Crown about the families’ submission noted below. The Crown argued that this submission suggested fault on the part of William Payne and implied that he may have committed a criminal offence. As a finding or determination to this effect would be incompetent and irrelevant, the supplementary Crown submission was: “*The function of a Fatal Accident Inquiry not being to find fault, no finding should be made in terms of section 6(1)(b) of the 1976 Act suggesting fault on the part of William Payne, or that a criminal offence was committed.*”

9.22 As mentioned above the submission for the families in relation to the Determination under section 6(1)(b) was:

““Laura and Mhairi sustained fatal injuries as a result of being struck by the Range Rover motor vehicle registered number H18 HEX then being driven by Mr William Payne. Mr Payne caused both Laura’s and Mhairi’s death by driving his Range Rover vehicle dangerously. On 17 December 2010, he drove his Range Rover vehicle in the face of an obvious and material danger that he was fully aware of; he knew that he suffered from a medical condition that made it unsafe for him to drive.”

9.23 There were no specific submissions in this connection on behalf of the other parties, apart from a supplementary submission for William Payne that a determination such as was sought by the families would be incompetent.

Determination

9.24 My view of the relevant evidence at the Inquiry is that the evidence showed that the cause of the accident was the loss of control of the motor vehicle registered number H18HEX by its driver, William Payne, while driving the vehicle on North Hanover Street, Glasgow, as a result of which the vehicle mounted the pavement on North Hanover Street at Killermont Street, Glasgow and collided with Mhairi Convy and Laura Stewart. Further, the evidence showed that the loss of control of the vehicle was caused by a vasovagal episode which caused William Payne to lose consciousness temporarily and rendered him unable to control the movement and direction of the vehicle.

9.25 I consider a finding and determination in the above terms to be appropriate – based on the evidence and the inferences that can properly be drawn from it.

9.26 So far as the submission for the families is concerned, as has been noted the cause of the deaths of Mhairi Convy and Laura Stewart was agreed in a Joint Minute of Agreement agreed by all the parties. In any event I do not consider that a finding and determination in the terms proposed on behalf of the families would be appropriate or competent. A finding and determination in those terms would suggest legal fault and imply guilt of a crime on the part of William Payne. It is not the function of this Inquiry to make a finding as to fault or to determine civil or criminal liability. (I refer to what I have said above at page 11.)

Part 10. Section 6(1)(c)

The reasonable precautions, if any, whereby the deaths and any accident resulting in the deaths might have been avoided -

10.1 For convenience I include here a list of the various topic headings and related subheadings in this part of my Determination:

Page 25 Road Safety - locus etc.

Page 28 Reasonable precautions concerning the driver, William Payne:

Page 28 - William Payne's Medical History

Page 34 - Medical examination, testing, treatment following the accident
Page 35 - The total number of blackouts
Page 37 - Fitness to drive – statutory provision and DVLA guidance
Page 41 - The consequences of DVLA being informed about blackouts
Page 43 - William Payne’s actions and explanations in relation to his fitness to drive
Page 46 - Submissions regarding William Payne
Page 48 - Discussion and determination regarding William Payne
Page 52 - The likely effect of medical advice to William Payne not to drive/to report to DVLA
Page 54 - Evidence of treating/examining doctors about their dealings with William Payne
Page 64 - Expert and opinion medical evidence
Page 69 – Submissions regarding treating/examining doctors
Page 77 – Discussion and determination regarding treating/examining doctors
Page 87 DVLA

10.2 There is no determination specifically about reasonable precautions whereby the deaths as such might have been avoided. The deaths were caused by an accident. There were no supervening events or other factors affecting the fatal outcome of that accident. Self-evidently the deaths would have been avoided if the accident that resulted in them had been avoided. The deaths might have been avoided by any reasonable precautions whereby the accident resulting in the deaths might have been avoided.

10.3 The main focus of the Inquiry was the issue of whether there were reasonable precautions that might have prevented the accident (and thereby the deaths) by preventing William Payne from driving at the relevant time, having regard to Mr Payne’s medical history, relevant statutory provision and DVLA guidance. However, the Inquiry also investigated the question of whether there were any road safety issues relevant to the accident and deaths and I propose to deal with that matter first.

Road Safety – locus etc.

10.4 There was evidence before the Inquiry about the locus and the particular matter of roadside barriers or “guardrailing”. Having regard to the established cause of the accident, as stated above, it seems clear that the way in which the vehicle travelled out of control would have resulted in a collision and therefore an accident of some kind in any case. However, road safety matters may be relevant to whether the accident would have been an accident which resulted in the deaths. I shall deal here with the evidence about the road safety matters which were the responsibility of Glasgow City Council (“GCC”). In summarising the relevant evidence I draw on the outline of evidence helpfully provided by Ms Dowdalls QC, Counsel for Glasgow City Council. I should also say that the evidence in question was not in dispute and some of it was formally agreed.

10.5 There was evidence from Police Constable Alan Stewart, who was the author of the Crash Investigation Report dated 23 December 2010 and the later, undated, Supplementary Collision Investigation Report (both Crown Production 18). Referring to his main report, PC Stewart described a number of “points of impact” as the vehicle travelled on North Hanover Street, mounting the pavement and eventually coming to rest on the grass verge. By reference to a scale plan of the locus which he had prepared (GCC Production 10) he was able to confirm that the vehicle had travelled 70 metres along the footpath before striking Mhairi and Laura, who were standing at the pedestrian crossing. He said that there was no evidence from which to calculate the speed at which the vehicle was travelling. In the supplementary report, he concluded that it was unlikely that the low metal barrier located between an area of shrubbery and the east footway on North Hanover Street significantly changed the course of the Range Rover vehicle driven by Mr Payne.

10.6 Inspector Bryan McGeogh was the officer in charge of the inquiry into the accident on 17 December 2010. He confirmed that, as is customary when there is a fatal road accident in Glasgow, a site visit took place at the locus at which police and officers from Glasgow City Council were present. He confirmed in his evidence that there was nothing in the road infrastructure or layout that was a cause for concern on road safety grounds.

10.7 Paul Little, the Principal of City of Glasgow College, where Mhairi Convy and Laura Stewart were students, gave evidence that following their deaths he had “lobbied” GCC to install barriers at the lights where Mhairi and Laura were standing when they were struck

by Mr Payne's vehicle. He had not previously contacted GCC about the installation of safety barriers. Shown photographs of pedestrian guardrails in Crown production 10, he confirmed that these were the guardrails which were installed following his approach to GCC. He said that he was impressed by the extent of the barriers that had been erected and by the "responsiveness of the council and their concerns for road safety in the area."

10.8 The evidence of James Rodden, currently Group Manager Traffic and Road Safety, GCC Land and Environmental Services and previously in 2010 Group Manager Traffic Operations, was given by affidavit. In his current role Mr Rodden has responsibility, *inter alia*, for Accident Investigation and Prevention. He explained the statutory duties of local authorities in relation to road safety matters in terms of section 39 of the Road Traffic Act 1988. He confirmed that, as was customary in the event of a fatal accident on a GCC publicly adopted road, a site investigation was undertaken jointly by GCC officers and police following the accident on 17 December 2010. He further confirmed that from his knowledge the conclusion of the site visit was that there were no factors in the layout of the road that contributed to the accident.

10.9 Mr Rodden described the circumstances in which vehicle safety barriers, commonly described as "crash barriers", would be required on local authority roads, by reference to the relevant guidance manual. His evidence was that vehicle safety barriers would not have been considered at the accident locus, because "the accident was not caused or contributed to by speed or geometry at the site".

10.10 Mr Rodden provided further information about pedestrian guardrailing, in which he explained that it is not used as a vehicle safety barrier and has no vehicle restraint properties. It is used to direct pedestrians towards pedestrian crossings and to discourage them from walking out on to the road. Referring to the correspondence (Crown production 33) between GCC and Mr Little from January to July 2011 Mr Rodden confirmed that a decision was taken to put guardrailing in place and he had implemented that decision, with the installation of the guardrailing being completed by August 2011. Mr Rodden's evidence was that there was no road safety requirement for the installation of pedestrian guardrail at the locus of the accident.

10.11 The evidence of Peter Smith, a Senior Road Safety Consultant and independent expert in road safety related matters, was agreed by joint minute. He was instructed as an expert witness on behalf of GCC. Mr Smith's evidence was contained in GCC productions 5 and 6, being his report dated 3 March 2014 and supplementary report dated 17 March 2014. Mr Smith's conclusion, having had regard to the productions referred to in his reports, the published guidance also referred to and his inspection of the accident locus on 25 February 2014 was that the road safety provision at the locus was "*adequate, appropriate and consistent with all relevant best practice and guidance*", and that "*there were no additional road safety measures that [GCC] might have reasonably implemented that could have any bearing on the collision subject of this inquiry and that the subsequent installation of pedestrian guard rail was not justified on road safety grounds*". Mr Smith's conclusion, expressed in the report, GCC production 5, was unaltered by his consideration of the further production (Crown Production 40) and the identical data contained in Crown Production 32 (produced by a Police Scotland statistician, the witness John Santarossa) mentioned in his supplementary report (GCC production 6).

10.12 On the basis of the foregoing evidence about road safety matters, which was agreed or not in dispute, I accept the submission by Ms Dowdalls QC on behalf of Glasgow City Council that the evidence available to the Inquiry supports the proposition that there were no reasonable precautions that could have been taken by GCC whereby the deaths of Mhairi Convy and Laura Stewart might have been avoided.

Reasonable precautions concerning the driver, William Payne

10.13 As I have said, the main focus of the Inquiry was the issue of whether there were reasonable precautions that might have prevented the accident (and the deaths) by preventing William Payne from driving at the relevant time, having regard to Mr Payne's medical history, relevant statutory provision and DVLA guidance.

10.14 Consideration of that issue requires examination of whether particular actions by William Payne or the various doctors who examined or treated him "might" have avoided the fatal accident and whether such actions would have been "reasonable" precautions.

10.15 Questions could potentially arise also in relation to the DVLA guidance. I comment on that at page 87 below.

10.16 I set out in some detail below the relevant evidence and submissions, as well as discussion and findings. It is necessary to describe William Payne's medical history in the relevant period, including his various consultations with doctors and episodes of losses of consciousness.

William Payne's Medical History:

10.17 There was documented evidence that William Payne suffered episodes of loss of consciousness ("blackouts") on 6 occasions on four dates prior to 17 December 2010, starting from 25 December 2007. William Payne's medical history is summarised below – in particular the episodes of loss of consciousness. The evidence in this regard came largely from the medical records (which were Productions 6 and 7), spoken to by a number of medical practitioners.

2007:

10.18 On **25 December 2007**, William Payne sustained a sudden loss of consciousness and collapsed at home while walking to the bathroom. He attended Stobhill Hospital A&E department. While being examined, he had a further loss of consciousness. On this occasion he was supine. He was admitted to the ward for tests. There does not seem to have been any specific investigation of these episodes, such as an echocardiogram, ambulatory electrocardiogram or brain scans. Mr Payne was diagnosed as suffering from a viral infection and then discharged after 24 hours. Mr Payne contacted his GP surgery a few days later to update his GP and at that time stated he was feeling much better.

10.19 In the period prior to 25 December 2007 William Payne had attended at his GP surgery, Keppoch Medical Practice, Possilpark Health Centre, 85 Denmark Street, Glasgow on 22 October, 14 November and 22 November 2007, complaining each time of a sore throat and cough, which were treated with antibiotics, the diagnosis of the locum doctor on 22 November being a lower respiratory tract infection. Mr Payne had a chest x-ray on 29 November, which was normal. He had a health check on 18 December 2007 and all results were normal.

2008:

10.20 On **30 April 2008** Mr Payne suddenly collapsed at the office of an insurance broker whilst standing at the counter there. According to the witness Claire Wotherspoon, who

was an employee at the office, Mr Payne collapsed without warning while speaking to her and lost consciousness for a period. According to GP practice records Mr Payne stated he had felt warm and light-headed prior to the collapse. Mr Payne attended at Stobhill Hospital A&E department. At Stobhill Hospital observations, an ECG and a glucose test were all normal and no medication was prescribed. Mr Payne attended his GP surgery on 2 May and again spoke with a locum (not a witness), who noted that Mr Payne had had a vagal response prior to the collapse and to consider a referral "if it happens again".

10.21 In the period before that episode William Payne was seen at the surgery by a registrar and a locum (not witnesses) on 7 and 29 January 2008, again complaining of a sore throat, cough, breathlessness and chest pain. He reported that his symptoms had now lasted over four months. The locum advised him that his chest x-ray, blood tests and throat swab were all clear. He was referred to the Ear, Nose and Throat Clinic at Stobhill Hospital. He was seen at that clinic on 20 February. He was given a chest x-ray, an abdominal x-ray and an ECG. All results were normal.

10.22 After the 30 April episode Mr Payne was next seen at the GP surgery on 27 May 2008, by a locum (who was not a witness). He complained of a sore throat, low mood, anxiety and panic attacks. He was seen by Dr Rigg (not a witness) at the surgery on 16 June when his recurrent sore throat was discussed and he was advised that there had been no abnormal developments and that his blood tests were normal.

10.23 The witness Dr Claire Keatley saw William Payne at the GP surgery on 4 September 2008. At that time he stated that he had had a sore throat for 4 days and was concerned since his previous collapses had occurred when he had a sore throat. He told Dr Keatley that he had been diagnosed with viral infections when he collapsed in the past. He said he sometimes felt dizzy when he stood up. He was prescribed paracetamol and dispersible aspirin.

10.24 On **6 October 2008** Mr Payne had another episode of loss of consciousness when he attended a physiotherapist to be given a cortisone injection in his shoulder. The physiotherapist, the witness Helen Little, explained in her evidence that before she administered the injection she went through Mr Payne's medical history and at this stage he did not disclose that he had lost consciousness on prior occasions or that he had viral

infections. He showed no sign of being anxious about the injection and the procedure she performed was not painful. The injection was administered whilst Mr Payne was seated. After the injection was finished and about 1 – 2 minutes later, he collapsed and lost consciousness.

10.25 Despite Mr Payne's reluctance, he was taken to the A&E department at Stobhill Hospital. At the hospital while the consultant, Dr Alistair Ireland (witness), was examining Mr Payne he had another episode, when he became very pale and lost consciousness. Mr Payne was probably in a semi-recumbent position on a trolley at the time. Dr Ireland admitted him for tests and observations to determine the cause of the collapses. He ordered cardiology tests to be carried out. At Stobhill Hospital various tests were carried out, including CT scan and ECG and there was cardiac monitoring. He was also tested for diabetes. All of these tests gave normal results.

10.26 Mr Payne was discharged and it was arranged that his case would be reviewed as a new patient in the hospital's medical clinic in 2 or 3 months. In the discharge letter to Mr Payne's GP dictated on 7 October 2008 Dr Nick Barwell, the Specialist Registrar, wrote that Mr Payne *"had had an episode of loss of consciousness preceded by vasovagal symptoms. There was no clear trigger to this and in fact he had further episodes in A & E. ... He will be reviewed as a new patient at our medical clinic in the next 2-3 months"*. (Production 7 pg. 5) A "Final Discharge Letter" sent to Mr Payne's GP on 30 October contained comments by Dr J W Davie, Consultant Physician, in which he referred to Mr Payne having presented to A & E *"with four episodes of collapse in the last year"* and went on to say *"These episodes are likely to be vasovagal in origin as there is no underlying pathology that may be giving rise to these episodes."* (Production 7 page 3). Neither Dr Davie nor Dr Barwell was a witness.

2009:

10.27 On 13 January 2009 the witness Dr Stephen Cleland, Consultant Physician, saw William Payne for a review in his clinic at Stobhill Hospital. Dr Cleland did not have a full set of case notes when he saw Mr Payne. He had the "admission bundle" and he referred to the notes of the doctors who saw Mr Payne when he was admitted to Stobhill Hospital in October 2008. The medical records produced at the Inquiry included no handwritten record for Dr Cleland, the explanation being given that the notes were lost. Dr Cleland's letter to

Mr Payne's GP dated 22/1/2009 was all that was available (Production 7 page 6). At the consultation Mr Payne informed Dr Cleland that he had not had any collapses since his last admission (in October 2008) although he sometimes felt faint when he stood up. Dr Cleland was not aware of Mr Payne's loss of consciousness in April of 2008. On 13 January 2009 Dr Cleland dictated the letter mentioned above (which was sent to Mr Payne's GP on 22 January), in which he said: *"Given the fact that he has no concerning ongoing symptoms and no further episodes of syncope for the past 3 months, I think we should call a halt to investigations for now...If he starts having unexplained syncopal episodes I would be happy to hear from you and we will reappoint him for further investigations at the clinic."* Mr Payne had a routine check-up at the GP surgery with the Practice Nurse on 5 February 2009 which showed up no problems.

10.28 On **5 June 2009** William Payne collapsed and lost consciousness whilst at the Vet's surgery with his dog. He then attended at the GP surgery and was seen by a registrar (not a witness). He stated that he was in the Vet and fainted. He stated that he had recovered quickly following the collapse and described it as being exactly the same as previous episodes. The GP registrar recorded: *"was unsure what had caused it although was anxious about what was going to happen to his dog – wonders if this was it"*. (Production 6 page 8) Mr Payne stated that he had felt a bit run down over the previous few days and was coughing up green/brown spit. He did not have a temperature, headache, runny nose, palpitations or chest pain although his throat was red. The GP registrar diagnosed a simple faint and discussed Mr Payne's options. Mr Payne asked to be prescribed antibiotics since this had helped following earlier collapses. He was advised that if his symptoms continued, he might need further investigation.

10.29 On 3 July, William Payne spoke by telephone with the witness Dr Natasha Cox at the surgery and asked the doctor to give him a letter to enable him to be excused from jury duty. Dr Cox wrote the letter which was posted to Mr Payne. The letter was in the following terms: *"Mr Payne has had several episodes of unexplained dizziness and collapse over the past year. On occasion he has been admitted to hospital because of these. He feels worse when he is under stress and he is very concerned he may become dizzy and collapse if he has to attend for service."* (Production 6 page 41)

10.30 Dr Cox saw William Payne at the surgery on 10 July. Mr Payne stated that his health had not been right for two years and it was decided that he would be referred to Dr Cleland's clinic at Stobhill. A referral letter was sent to Dr Cleland's clinic in which Dr Cox stated: "*.. I believe he had quite a lot of investigations under your care and was discharged with no specific diagnosis.... He continues to feel unwell and had a vasovagal episode on 5/6/09. He could not identify a particular trigger but was at the vets and feeling a little anxious about what was going to happen to his dog. ... He feels for the last 2 and a half years that he has felt unwell....*". (Production 6 page 47) Mr Payne was sent an appointment for 17 September.

10.31 Mr Payne was seen at the surgery on 12 August by Dr Cox, at which time he reported that he had had no further faints. He confirmed that he had a clinic appointment in September.

10.32 On 17 September Mr Payne did not attend the appointment at Dr Cleland's clinic at Stobhill. This was one matter about which Mr Payne was prepared to give evidence when called as a witness at the Inquiry. His explanation for his failure to attend the appointment was that on arriving at the hospital he was sick in the car park and the receptionist told him not to come in. He gave evidence that he did not get another appointment or inquire about getting one.

10.33 On 6 October 2009 Mr Payne attended at the GP surgery when he confirmed that he had recently been seen by an out of hours GP who had prescribed antibiotics for a chest infection. He felt it had not cleared the infection and said that he had a sore throat and a cough. He was prescribed antibiotics and analgesics. There is no record that Mr Payne informed the GP that he had not attended the appointment with Dr Cleland and any reason for this or that he asked for another appointment to be made.

2010:

10.34 On 2 February 2010 Mr Payne was seen at the surgery by a registrar (not a witness). He complained of a cough and dark spit, saying he had had it for 4 days. He stated that when he had this previously he had collapsed. The registrar diagnosed an upper respiratory tract infection and prescribed a low dose antibiotic. He also recorded regarding Mr Payne: "*He is currently undergoing investigation for collapse*". Mr Payne did not then return to the surgery until 4 November 2010 at which time he was seen by the witness Dr Katy Padgham.

He stated that he had had a cough for the preceding 4 weeks which was not improving. The diagnosis was lower respiratory tract infection and he was prescribed antibiotics. This was Mr Payne's last medical intervention prior to the fatal road traffic accident.

10.35 There was nothing in the medical records or the evidence of any of the medical witnesses to suggest that William Payne was told by any of the doctors at the GP surgery or any of the consultants he saw that he should stop driving or report his condition to DVLA. I understood it not to be in dispute that at no time was William Payne told by any of the doctors he saw that he should stop driving or report his condition to DVLA. There was no evidence that Mr Payne himself asked for advice about driving from any doctor he saw.

Medical examination, testing and treatment following the accident on 17 December 2010

10.36 On 17 December 2010, immediately following the fatal accident, William Payne was taken by ambulance to the Accident and Emergency Department at the Western Infirmary, where he was seen by the witness Dr William Tullett, Consultant in A & E, who noted that he had no significant physical injuries, although he complained of back pain. His back was x-rayed and it was normal. A CT scan was carried out which proved inconclusive so an MRI (magnetic resonance imaging) scan was instructed. However, before it could be carried out Mr Payne became pale, sweaty and unresponsive and collapsed. He subsequently had a variety of investigations including the MRI scan. Cardiology and neurology consultations were arranged. He was seen by Dr Piotr Sonecki, Consultant Cardiologist (not a witness), who arranged for him to have a Tilt Table test. As previously noted, this test involves a patient being placed horizontal on a table, then the table being tilted upwards by degrees to a vertical position, while the patient is monitored. It was performed on Mr Payne on 22 December and demonstrated a profound bradycardic response with a prolonged asystolic pause in the cardiac rhythm (referred to as sinus arrest, i.e. temporary dysfunction of the heart's own pacemaker called the sinus node with resultant loss of cardiac output).

10.37 The severity of the Tilt Table test response prompted the implantation of a dual chamber permanent pacemaker, which was performed on 12 January 2011. In June 2011 a further Tilt Table test was carried out with the pacemaker in situ. During this test, William Payne suffered a loss of consciousness and his blood pressure dropped severely. His pacemaker took over. The result of the test showed that Mr Payne had a mixed response of

bradycardia (slow heart beat) and hypotension (low blood pressure), which in combination cause loss of consciousness but independently can also result in loss of consciousness. Mr Payne was diagnosed with a malignant form of vasodepressor syncope syndrome which manifests in an exaggerated reflex response which causes him to faint more than is usual. There is no treatment for this and it is likely that Mr Payne will not be able to drive again, since it cannot be guaranteed that he will never have another episode.

10.38 The history of blackouts given by William Payne to various doctors who saw him at the Western Infirmary varied as regards the number of such episodes reported by Mr Payne. In medical notes recorded at 12.10 pm on 17 December by Mr Tullett (Production 8 at page 12) it was noted: *"Blackout 2 years ago secondary to viral infection – none since"*. The medical notes recorded at 3.15 pm by Dr Frances McManus (witness) (page 14) are, *"PMH Previous 1x at Stobhill for LOC. Felt to be vagal."* At 18.10pm, the witness Dr Sandeep Bawa's record relating to past medical history is: *"1 x collapse 3 years ago taken to Stobhill ?viral ok -1 x collapse 1 year ago at GP surgery"*. (page 16) On 22 December Mr Payne gave a version of his past history of blackouts to Dr John Leach (witness) (see page 36). He told Dr Leach he had a blackout history of four years and that he had had about 3 blackouts in the year before 17 December 2010 and other blackouts between 2006 and 2009 – "about 9 episodes by his account", according to Dr Leach.

The total number of blackouts

10.39 The question of the total number of blackouts suffered by Mr Payne was explored in evidence and featured in certain submissions.

10.40 On the basis of medical records and eyewitness evidence blackouts occurred on 6 occasions prior to the fatal accident of 17 December 2010:

25 December 2007 – two occasions, one at home, the second at Stobhill Hospital

30 April 2008 – at the office of Andrew Yule insurance, Bishopbriggs

6 October 2008 – two occasions, the first at the Springburn Health Centre after a cortisone injection, then later at Stobhill Hospital.

5 June 2009 – at the Vet's surgery.

10.41 In layman's terms there were six recorded collapses involving loss of consciousness, these occurring on four different dates. The witness Dr Cleland in his evidence did not

accept that the two collapses on 25 December 2007 were discrete episodes. He saw them as a single cluster of events. He also referred to the two collapses on 6 October 2008 as a cluster of events. The witness Dr Hanley gave evidence that the DVLA approach is to view two faints in a 24 hour period as a single episode.

10.42 In addition to what was recorded and witnessed in relation to blackouts there was some evidence about what William Payne himself said to various persons – witnesses and others. Some of these statements have been interpreted as suggesting not only that there were more blackouts than are recorded in medical records, but that one of these occurred only 3 months before the examination of Mr Payne by Dr Gordon Duff on 2 July 2010.

10.43 The submission for the families (at page 9) states that on Mr Payne's admission to Stobhill Hospital at 19.20 on 25 December 2007 *"the patient profile records that he had 3 prior episodes of collapse"*. I have no note that any relevant witness spoke to the particular entry in the medical records (Production 7 page 32) and the person who made the entry was not a witness. The entry reads – *"47 year old man admitted today with cough, sore throat, collapse x 3"*. The meaning of the reference to *"collapse x 3"* in the context is a matter of interpretation, but it would seem likely that it includes one or both of the collapses on 25 December that resulted in Mr Payne's admission to hospital.

10.44 More significance is attached in the submission to the proposition that Mr Payne had a blackout about 3 months before the examination by Dr Duff and the related allegation that Mr Payne failed to tell Dr Duff about this. This proposition was based on an interpretation of something said by Mr Payne in the course of the interview under caution by the police on 5 May 2011.

10.45 Towards the end of the interview the witness Police Sergeant Bryan McGeogh asked Mr Payne when the previous episode was before 17 December 2010. Mr Payne's recorded reply was: *"I think it may be, I'm not very good with dates I'm awfully sorry I think it might have been 8 months, 9 months something like that, maybe even longer."* He went on immediately to say: *"Eh but I think all the, the answers will be on the paperwork there..Em I just, I don't know the exact date."* (Production 1 page 25).

10.46 I do not consider that to be a very firm basis for the proposition that Mr Payne suffered an apparently unrecorded blackout in 2010 about 3 months before the examination by Dr

Duff, although I note that the proposition also rested to some extent on Dr Leach's evidence to which I have referred above. However, it is clear from the full record of what Mr Payne said to the police that he was suggesting that all blackouts would have been recorded and the relevant information would be in the paperwork held by the police.

10.47 Mr Payne declined to answer questions at the Inquiry about his history of blackouts. Mr Fitzpatrick submitted on his behalf that *"there is no evidence that there were any instances of collapse other than those documented in the medical records. The evidence was that William Payne sought assistance from his doctors on each occasion of collapse. He was anxious for his health problems to be identified and treated"*.

10.48 I do not consider that it was conclusively established that the total number of blackouts suffered by Mr Payne was higher than the six recorded and/or witnessed or that there was a blackout in the period between 5 June 2009 and 17 December 2010, only a few months before William Payne's examination by Dr Duff. However, that possibility – raised by what Mr Payne said himself - cannot be entirely excluded.

Fitness to drive – statutory provision and DVLA guidance

10.49 The Inquiry heard evidence about statutory provision and Driver and Vehicle Licensing Agency (DVLA) guidance about fitness to drive. The evidence about the system came principally from the witness Dr J G G Hanley, a medical officer with the DVLA, but his evidence was supplemented by statement evidence from Dr Michael Griffith, a Consultant Cardiologist who is Chairman of the Cardiovascular Panel and Medical Advisory Group for the DVLA and Professor Anthony Marson, Professor of Neurology at the University of Liverpool and honorary Consultant Neurologist, who is a member of the DVLA Advisory Panel for neurological conditions. (Dr Griffith and Professor Marson did not give evidence in person and there was consequently no cross examination, their statements having been agreed by joint minute.) The matter was also explored in the examination of other medical witnesses as regards the application of the legislation and guidance in relation to William Payne.

10.50 The Road Traffic Act 1988 imposes a duty on holders of a driving licence to notify the Secretary of State (for Transport) of any medical condition from which the licence holder is

suffering that may affect safe driving. Section 94 of the 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, ...

the licence holder must forthwith notify the Secretary of State in writing of the nature and extent of his disability.

10.51 Guidance in relation to Class (Group) 1 driving licences is contained in a Driver and Vehicle Licensing Agency (DVLA) information leaflet D100 (Families Production 14). It contains a clear direction: “You **must** tell us if you have ever had or currently have ...fits and blackouts”. Licence holders are advised to consult their doctor for advice.

10.52 Guidance is issued by the DVLA for Medical Practitioners in the form of an “At a glance Guide to the current Medical Standards of Fitness to Drive”. The February 2008 Guide was Production 36 at the Inquiry and the February 2010 version was also produced (Production 24a). In substance these were the same as the current May 2014 version. The top of each page of the Guide carries the message: “**The applicant or licence holder must notify DVLA unless otherwise stated in the text**”.

10.53 Page 4 begins by setting out at “Notification to the DVLA” the duty of the licence holder to notify the DVLA of any medical condition, which may affect safe driving. It then sets out the GMC guidelines on when a doctor may be under a duty to notify the DVLA. It continues at “Application of the Medical Standards” by explaining how the medical standards will be applied. In particular it informs the reader that there may be a relatively lengthy process to obtain all necessary reports before a decision can be made by the DVLA. During that period the licence holder normally retains legal entitlement to drive.

“However, by reference to this booklet, the doctor in charge of their care should be able to advise the driver whether or not it is appropriate for them to continue to drive during this period...”

If doctors require any further advice the At a Glance Guide advises them on page 5 that they can write to, or telephone, a medical advisor (at the DVLA).

10.54 Chapter 1 of the Guide deals with “Neurological Disorders”. The chapter begins by setting out the position in relation to Epilepsy and Provoked Seizures (page 6). It then deals with loss of consciousness/loss of or altered awareness. It states:-

“A full history is imperative to include the pre-morbid history, prodromal symptoms, period of time unconscious, degree of amnesia and confusion on recovery.”

10.55 If a neurological or cardiac cause is identified the relevant DVLA guidelines for that condition will apply. The Guide goes on to state that the remaining cases can be classified under five categories, which are then set out in a table at page 7 of the Guide. The relevant part of the guidance, dealing with simple faint/reflex vasovagal syncope, is in the first category in the table, which is set out below:

<i>“1. Simple faint</i>	<i>Group 1 and 2</i>
<i>Definite provocational factors with</i>	<i>No driving restrictions.</i>
<i>associated prodromal symptoms and</i>	
<i>which are unlikely to occur whilst</i>	
<i>sitting or lying.</i>	
<i>Benign in nature.</i>	
<i>If recurrent will need to check the “3</i>	<i>DVLA need not be notified</i>
<i>P’s” apply on each occasion</i>	
<i>(provocation/prodrome/postural)</i>	
<i>(If not see Number 3 below)”</i>	

10.56 It is only if category 1 applies (including that if recurrent the “3Ps” have been checked and found to apply on each occasion) that there are no driving restrictions and the DVLA need not be notified. If category 1 does not apply then all the other boxes (including box number 3 mentioned above, to which reference was made by some witnesses) have driving restrictions and require the DVLA to be notified. If a doctor has a patient who suffers from temporary loss of consciousness or altered awareness, unless category 1 applies the patient should not drive and the DVLA should be notified. If the patient does not fall into category

1 the question of which other category the patient does in fact fall into is only relevant to the issue of what is the likely outcome once the DVLA have completed their inquiries. It is of interest to the doctor and the patient as indicating what the future may hold for the patient. It does not affect the decision that the patient should not drive and the DVLA should be notified.

10.57 The meaning and relevance of the “3Ps” (provocation/prodrome/posture) was explained and commented on by a number of the witnesses. In common with other medical witnesses, Professor Marson in his statement (Families’ Production 45) explained “provocation” as *“the trigger”* and *“The thing that caused the faint”*, and “prodrome” as *“the symptoms that a person will experience before they black out.”* In his statement (Families’ Production 44) Dr Griffith expressed the opinion that “prodrome” is the single most important factor, drawing attention (as did other medical witnesses) to the significance of adequate warning to enable a driver to take avoiding action.

10.58 In his evidence the Crown’s expert witness, Dr Neil Grubb, also explained the relevance of prodrome in the context of driving as being that if a driver experiences warning symptoms “he has time to slow down, pull over, keep control.” He said that a doctor is more likely to advise a patient not to drive if they have sudden blackouts without warning. The view Professor Marson expressed in his statement was *“that if you do not have prodromal symptoms then it cannot be a simple faint”*. In relation to “posture” Professor Marson stated: *“it is not possible for someone to suffer from a simple faint if they are lying down”*. Dr Hanley shared that view. Dr Griffith commented in his statement that vasovagal syncope *“very rarely occurs when someone is lying down”*. Also in relation to the aspect of posture there was general consensus that fainting while sitting is unusual and, as Professor Marson put it: *“you have to be more careful in your diagnosis”*. Dr Hanley’s opinion in his evidence was that if loss of consciousness happens when the person is sitting “that is not a benign form” and that should be regarded as a “red flag” (danger sign).

10.59 Explaining the meaning of “recurrent” Dr Hanley said that it means more than one, there is no time frame and the “faints” could be years apart. Professor Marson stated: *“A faint will be recurrent if it happens more than once.”* He did not think that time is relevant. Dr Griffith’s position was that recurrent *“simply means more than one”*. If there were multiple

faints over a period of time such as five years he would consider that to be recurrent. Professor Marson explained “benign” as meaning that there was no serious cause.

10.60 All three medical witnesses associated with the DVLA were emphatic in their evidence about the operation of the DVLA guidance. Professor Marson considered that the guidelines are very clear, that they are written in “*a very prescriptive manner*” and in his understanding they are “*intended to be applied in a very rigid way*”. Dr Griffith described the guidance as “*unequivocal*” and stated that it is very clear that the DVLA “*have taken a strict approach to the guidance*”. Dr Hanley, Professor Marson and Dr Griffith all emphasised that if faints are recurrent the doctor must consider the “3Ps” on each and every occasion and the “3Ps” must be present on each and every occasion for box 1 to apply. If not the DVLA require to be notified and there are driving restrictions.

10.61 In the evidence from the families’ witness Dr Robin Northcote (see further below at page 65) reference was made to clinical guidelines about “Transient loss of consciousness (‘blackouts’) management in adults and young people” issued by the National Institute for Health and Care Excellence (NICE) (Annex to Families’ Production 43). The submission on behalf of the DVLA pointed out that the DVLA category 1 guidance mirrors the position in the NICE Clinical Guidelines.

10.62 For completeness it should also be mentioned that there was evidence that if a doctor becomes aware that a patient has ignored the doctor’s advice not to drive the doctor should notify the DVLA, in accordance with GMC guidance, which is set out in the “At a glance Guide” (at page 4). Dr Hanley gave evidence that there are many such calls.

The consequences of DVLA being informed about blackouts

10.63 A matter that was also explored in evidence was the position in relation to restriction on driving in the case of a person who has had to notify the DVLA in accordance with section 94 of the Road Traffic Act 1988 or in terms of the guidance that has just been discussed – and in particular the possible position in relation to William Payne. This was relevant to the question whether notification to the DVLA by William Payne (or any of the doctors who dealt with him) “might” have avoided the fatal accident. Although other

witnesses gave evidence about this I considered that the most authoritative witness on this topic was Dr Hanley, a DVLA medical officer, who had revoked Mr Payne's licences.

10.64 Reference was made to the sections of the "At a glance Guide" dealing with loss of consciousness in which periods of driving restriction are set out. Dr Hanley explained that carrying out medical checks considered appropriate after notification to DVLA may be a long process that may take months. Recurrent episodes would almost certainly be referred to cardiac experts. The stated periods of revocation of a driving licence are minimum periods and restoration is dependent on the DVLA being satisfied by medical enquiry that restoration is appropriate. The expiry of the periods stated in the guidance would not automatically result in the restoration of a licence. Satisfactory medical enquiry is necessary.

10.65 In relation to William Payne, Dr Hanley's evidence was that if DVLA had been notified in April 2008 or in July 2009 about Mr Payne's losses of consciousness medical enquiries would have been instructed which could have led to the revocation of Mr Payne's licence, following either such notification. Asked if the timescale for enquiry about Mr Payne and related examination would have meant that Mr Payne would not have been driving in December 2010, Dr Hanley replied – "I can't guarantee that, but it's quite likely." He also stated that if notification had been made to DVLA in April 2008 it was "probable" that Mr Payne would not have been driving in December 2010.

10.66 For the reason I have stated above, relating to Dr Hanley's experience and expertise, I prefer his evidence on the potential operation of the DVLA system in relation William Payne to the evidence of the witness Dr Neil Grubb, who at one point suggested that even if William Payne's licence had been revoked following the episode in June 2009 he would probably have been able to drive in December 2010 because any period of revocation would only have been for 12 months from the last episode.

10.67 Dr Hanley stated in evidence that if William Payne had in July 2010 disclosed his history of blackouts in the Medical Examination form (Production 21) in connection with his application for renewal of his HGV (Group 2) licence enquiry would have been carried out by the DVLA and it was probable that Mr Payne would not have been driving in December 2010. The disclosure in the application for renewal of Mr Payne's HGV licence would have had such consequences for driving generally and not just renewal of the HGV licence.

10.68 Dr Hanley also confirmed in his evidence that revocation of a driving licence by the DVLA may be implemented as a matter of urgency – as happened following the medical tests on William Payne after the fatal accident on 17 December 2010.

10.69 It is reasonable to conclude that if there had been notification of William Payne's losses of consciousness ("blackouts") to the DVLA by William Payne (or one of the doctors who examined or treated him) or by disclosure of the history of losses of consciousness in the DVLA form for renewal of Mr Payne's HGV (Group 2) licence, revocation of Mr Payne's driving licence may have been in operation as at 17 December 2010, Mr Payne may not have been driving and the fatal accident might have been avoided.

William Payne's actions and explanations in relation to his fitness to drive

10.70 When William Payne appeared as a witness at the Inquiry he declined to answer questions about his medical history, his fitness to drive, his acting as the holder of a driving licence, as well as about the fatal accident. He was entitled to do so in terms of section 5(2) of the 1976 Act.

10.71 Mr Payne did answer questions in this connection when interviewed by the police under caution on 5 May 2011. In that interview he stated that, as appeared from other evidence, he did not report his "blackouts" to the DVLA before 17 December 2010. He also confirmed the evidence of the witness Dr Gordon Duff that on 2 July 2010 he failed to disclose his history of blackouts in the course of a medical examination and completion of the relevant DVLA form in connection with his application to renew his HGV (Group 2) licence.

10.72 Dr Gordon Duff is an occupational physician who carries out DVLA examinations at Ritchie's Training Centre, Glasgow. He gave evidence about his examination of William Payne and the completion of DVLA Form D4 (Production 21) in connection with Mr Payne's application to renew his HGV (or Group 2) driving licence on 2 July 2010. Dr Duff did not know Mr Payne and did not have access to his medical records. Dr Duff confirmed that he carried out the normal procedure of going through the form with Mr Payne. In relation to a question in the form - "Is there a history of blackout or impaired consciousness within the last 5 years", Mr Payne answered "No" and the "No" box was ticked in the form. Had the

question been answered "Yes" further information would have required to be provided in another section of the form (Section 7) and the DVLA would have carried out investigation as necessary. I understood Dr Duff's evidence to be that he would have told Mr Payne not to drive while DVLA investigations were carried out. Dr Duff confirmed that at the end of the procedure William Payne signed the form, which includes a declaration that the details he has given are correct to the best of his knowledge and belief. The relevant forms were submitted to DVLA and the licence renewed.

10.73 Mr Payne gave an explanation for his failure to disclose his history of blackouts at the examination by Dr Duff and completion of the form and for his general failure to notify the DVLA in the course of his police interview on 5 May 2011, to which I now turn. (The recording was played at the Inquiry and the transcript is Production 1.)

10.74 Early in that interview Mr Payne was asked about his general health. He did not initially mention a history of blackouts. He replied that his health was fine apart from what happened on 17 December 2010. Asked if he had been attending his doctor for any specific conditions he said *"No..nothing at all, I had things what they called a viral infection..that I've had for the last 3 or 4 years."* Asked when was the first time the form of viral infection that he suffered from happened he said he thought it was on Christmas Day 2007 when he ended up in Stobhill Hospital, where they told him it was a viral infection and when they were going to let him go home he *"collapsed on top of the doctor"*. He did not specifically explain that the reason for ending up in Stobhill Hospital was a blackout at home.

10.75 When Mr Payne was then asked if he had any other periods of collapse from Christmas 2007 he said that this had happened several times and every time he was taken to the hospital. Asked about the number of episodes he said that there had been maybe 7 or 8, up to December 2010, maybe less maybe more. Asked if the periods of collapse were preceded by any symptoms or anything like that he said *"...they just come and I black out."*

10.76 He went on to describe the Christmas Day 2007 episode and other blackout episodes, including that at the insurance company which he thought was just when he got the Range Rover. In that connection he was asked if he ever notified his insurance company that he was having episodes of blackout, to which he replied: *"No, because it was always put down to a viral infection."* That was also the explanation that he gave when asked about ticking the

“no” box in answer to a question “Is there a history of blackout or impaired consciousness within the last 5 years?” in the relevant part of the DVLA form D4 for renewal of his HGV licence in 2010. Again that was his explanation when he admitted not having notified DVLA of his condition and once again when he answered in the negative a question about whether he had any concerns that he might have a blackout at the wheel.

10.77 Later in the interview Mr Payne was asked about being excused jury duty. Immediately before that he confirmed that he had attended his doctor’s surgery on a number of occasions since Christmas Day 2007 in relation to fainting/blackout episodes and said that he had been told on each occasion that it was down to a viral infection. Asked then if he felt that his blackouts were triggered by anything at all he answered: *“No, I didn’t at the time”*. He confirmed that he had been excused jury duty in July 2009. His explanation for being excused jury duty was: *“my wife was going through a really hard time of it as I say I’m a carer for her and I felt as if I’d been away too long that was the only reason.”* Asked immediately after that if he thought his blackout episodes were stress related, Mr Payne said *“No”*.

10.78 Towards the end of the interview the senior interviewing officer summarised Mr Payne’s position as revealed in his answers to questions as being that he had had a series of blackouts since Christmas Day 2007, that he had attended at his doctor and hospital on a number of occasions in relation to these, that each time they were explained as being as a result of a viral infection, that he was never told they were anything else, that he never took any action in relation to them, and he never informed DVLA or his insurance company about the blackouts. Mr Payne confirmed that summary of the position, saying: *“Cause it’s the same answer they kept telling me they gie me antibiotics, takes the viral infection away and then I don’t collapse for whatever amount of time, I don’t know how long a period”*.

10.79 Asked when the previous episode of blackout before 17 December 2010 was Mr Payne said he was not very good with dates: *“ I think it might have been 8 months, 9 months something like that, maybe even longer”*. He suggested the answer would be in the paperwork that the police had.

10.80 In relation to the excusal from jury duty on 3 July 2009, there was a conflict between what Mr Payne told the police and the evidence of Dr Natasha Cox. Dr Cox’s evidence is reviewed in greater detail below, but for present purposes it suffices to draw attention to the

evidence noted below. The letter that Dr Cox wrote for Mr Payne was in the following terms:

“Mr Payne has had several episodes of unexplained dizziness and collapse over the past year. On occasion he has been admitted to hospital because of these. He feels worse when he is under stress and he is very concerned he may become dizzy and collapse if he has to attend for service.” (Production 6 page 41)

10.81 Dr Cox’s recollection was that this resulted from a five minute telephone conversation she had with Mr Payne about his citation for jury service in which he said he was concerned he might feel faint or collapse. The reference in the letter to stress resulted from a discussion about stress in the telephone call and was what Mr Payne told Dr Cox. Dr Cox confirmed that she had reflected in the content of the letter what the patient reported to her and such medical records as she had time to consult. In the practice records (Production 6 page 8) Dr Cox’s record of this call on 3 July 2009 states: *“letter to excuse for jury service – feels collapsing/fainting episodes worse when stressed”*. According to my notes of evidence Mr Payne’s different account to the police of his reason for asking for the jury excusal letter was not put to Dr Cox in cross examination on behalf of Mr Payne. The closest the cross examination came to that was when Dr Cox agreed on being referred to the medical records that Mr Payne had said at the consultation on 12 August 2009 that his wife also had her own life stresses. (Production 6 page 7)

10.82 Mr Payne’s explanation to the police about the reason for requesting a letter for jury excusal clearly did not accord with what Dr Cox recollected and what was recorded in the medical records as his explanation to her.

10.83 To summarise - the evidence at the Inquiry established that the series of blackouts suffered by William Payne did not cause him to give up driving, or to ask any doctor for advice about driving, or to report his condition to DVLA, and further that in a driving licence renewal examination and application a few months before the fatal accident he failed to disclose his history of blackouts.

Submissions regarding William Payne

10.84 **Crown** - The Procurator Fiscal's submission for the Crown was that a determination under section 6(1)(c) should be made in respect of William Payne that *"The deaths and accident might have been prevented if William Payne had ceased driving after the episode in June 2009 and until he had been examined by a specialist. That would likely have accelerated the ultimate medical findings, leading to revocation of his licence."*

10.85 That submission was supported by reference to the following points: *"This [the June 2009 episode] was Mr Payne's fourth episode, two of the previous ones were attributed to viral infections and the third provoked by an injection. On this occasion he told the GP that he was unsure what had caused it but he had been anxious about what was going to happen to his dog. He continued to suffer infections. He attended his GP for these in October 2009, February 2010 and November 2010. Given that the periods between previous episodes of blackout were approximately 4, 6 and 8 months apart it would not have been unreasonable to assume that a further blackout might occur with or without obvious provocation in the foreseeable future which, of course, it did with tragic results."*

10.86 The Procurator Fiscal also made a submission concerning William Payne in relation to section 6(1)(e), (any other facts which are relevant to the deaths) which I think it appropriate to consider here. The PF submitted that another fact which was relevant to the deaths was that as the accident was caused by the witness William Payne losing control of his motor vehicle following a vasovagal episode, given his medical condition he should not have been driving a motor vehicle on the road. *"He would not have been the holder of a valid licence at the time of the fatal accident if he had acted upon DVLA recommendations to drivers and had acted honestly and responsibly."* Referring to the obligation on licence holders under Section 94 of the Road Traffic Act 1988 to inform the Secretary of State of any relevant disability of which they become aware, the PF noted: *"Despite the existence of the requirements to notify DVLA of fainting or blackouts William Payne made no attempt to do so"*, although he had had blackouts in December 2007, April 2008, October 2008 and June 2009. The PF submitted that the failure to declare his blackouts to Dr Duff and his insurers together with his omission in January 2009 to advise Dr Cleland of his episode in April 2008 of which the latter was unaware and his failure to attend the appointment with Dr Cleland in September 2009 *"do not suggest that he was honest and responsible in respect of his medical condition"*.

10.87 The Procurator Fiscal also commented on the families' submission noted below, to the effect that it implicitly attributes fault to William Payne and any such finding or

determination would be incompetent. A related supplementary submission for the Crown in this regard was: *"The function of a Fatal Accident Inquiry not being to find fault, no finding should be made in terms of section 6(1)(c) of the 1976 Act suggesting fault on the part of William Payne, or that a criminal offence was committed."*

10.88 Families – The submission for the families was in the following terms: *"The families consider that the following reasonable precautions, if taken by Mr William Payne, would have avoided the accident and deaths of Laura and Mhairi;- (a) compliance with the statutory duties incumbent upon him in terms of the Road Traffic Act 1988 ("RTA 1988"), (b) following the guidance readily available to all drivers as provided by the DVLA, (c) telling Dr Gordon Duff the truth about his medical history at the DVLA medical assessment in July 2010 and (d) attending the appointment, or making a rescheduled appointment with Dr Clelland (sic) in September 2009."* Those submissions were based essentially on evidence that I have outlined above, particularly in the section dealing with William Payne's actions and explanations in relation to his fitness to drive. I do not think it necessary to repeat that here. The families' submissions also commented with approval on some of the Crown submissions, noted above, about William Payne's failure to act honestly and responsibly in relation to his obligations regarding reporting of his medical condition.

10.89 William Payne - The general submission for William Payne was that *"it is not for an Inquiry to make any finding of fault or to apportion blame between any persons whose actions or omissions may have contributed to the accident. The court is respectfully invited to make no unauthorised findings which may be interpreted as attributing fault to William Payne or making any findings on the balance of probabilities which in the words of Sheriff Principal Dunlop 'in the minds of the public may well be indistinguishable from a finding of guilt or innocence.'* The court is invited to make no findings which would impinge on the presumption of innocence." A further submission, contained in a note of supplementary submissions, was that a determination such as was sought by the families would be incompetent.

10.90 Mr Fitzpatrick also made a submission about the discrepancy in evidence about the jury excusal letter, stating: *"it is clear from the medical records that at about the time of the telephone call requesting the letter William Payne had health problems, as did his wife for whom he was the carer."*

Discussion and determination regarding William Payne

10.91 My ability to assess Mr Payne's position was, of course, hampered by the lack of direct evidence from him at the Inquiry. It was necessary to refer to his answers to police questioning in the police interview on 5 May 2011. In one of his submissions for William Payne Mr Fitzpatrick stated that in the police interview "there was no attempt to conceal anything" by Mr Payne. My analysis of his interview led me a less favourable view, in that parts at least of Mr Payne's answers to the police appeared to be less than entirely frank, self-serving and lacking in credibility.

10.92 Mr Payne's explanation for failing to disclose his history of blackouts to the DVLA, in particular in connection with his application for renewal of his Group 2 driving licence, was not credible, in my view, and his failure to do so was not justified.

10.93 The wording of the relevant question in the DVLA form D4 is clear, unambiguous, unqualified and allows of no exceptions. There is no room for uncertainty or confusion. The clear evidence is that Mr Payne knew well that he had suffered blackouts in the relevant period. There is nothing in the form to suggest that what Mr Payne claimed to be his circumstances entitled him to refrain from disclosing that he had a history of blackouts.

10.94 Even on Mr Payne's explanation he knew that he frequently suffered from viral infections and he was aware of the occurrence and consequent risk of blackouts when suffering from a viral infection. For example, when he consulted his GP, Dr Kearney, in September 2008 about a sore throat he was concerned because his previous collapses had occurred when he had had a sore throat. When he was seen at the surgery by a registrar on 2 February 2010, complaining of a cough and dark spit, he stated that when he had this previously he had collapsed.

10.95 Mr Payne's position to the police that the only explanation that was ever given each time he attended a medical practitioner, namely that the blackouts were as a result of a viral infection, does not accord with the evidence. The doctor who saw Mr Payne after the 6 October 2008 episode following the cortisone injection by the physiotherapist was not a witness, but there is nothing in the records to suggest the blackout was explained as being a

result of a viral infection. In relation to the collapse at the Vet's on 5 June 2009 what is recorded in the practice record was that Mr Payne "*was unsure what had caused it although was anxious about what was going to happen to his dog – wonders if that was it*". Also, it is clear that he told Dr Cox on 3 July 2009 that he felt worse when under stress and it appears that he may also have told Dr Cox that his several episodes of dizziness and collapse over the past year were "unexplained".

10.96 I have noted above Mr Fitzpatrick's submission about Mr Payne's explanation to the police of the reason for his request for a jury duty excusal letter. That explanation, in my view, is an example of Mr Payne being less than frank with the police and apparently attempting to conceal the true circumstances, which I consider were as set out in Dr Cox's evidence, the letter itself and the medical record. Mr Payne's request to Dr Cox for a letter to enable him to be excused from jury service followed a loss of consciousness on 5 June 2009 which was the fourth occasion on which Mr Payne suffered a blackout or blackouts in a period of eighteen months. Mr Payne was sufficiently concerned about the risk of further blackouts that he contacted his GP to ask for a jury duty excusal letter. Dr Cox's note of the consultation that followed that phone call records: "*worried by further vasovagal episode that occurred last month*" (Production 6 page 8). Yet Mr Payne took no action to report his blackouts to DVLA.

10.97 So far as concerned the medical examination by Dr Duff and the completion of the form for licence renewal on 2 July 2010, the evidence supports the conclusion that Mr Payne knowingly chose to give an incorrect answer to the question about blackouts and to withhold information about his history of blackouts. His most recent blackout had been about a year earlier and all his blackouts had occurred in the 5 year period covered by the question in the form.

10.98 I have noted the point made by Mr Fitzpatrick that none of the doctors who saw Mr Payne discussed driving with him or advised him that he should not be driving. However, the responsibility for reporting his blackouts to the DVLA rested with Mr Payne himself. Also, it is one thing to fail to report blackouts to the DVLA in the absence of advice from any doctor, it is quite another knowingly to fail to report blackouts and give an untruthful

answer when specifically asked during a medical examination and in a DVLA form in connection with the renewal of a driving licence.

10.99 Turning to the submissions - the Crown submission that Mr Payne should have (voluntarily) ceased driving focused on the time when Mr Payne had had blackouts on four different dates within a period of just over 18 months – namely after the June 2009 episode. There may be some force in the Crown submission that Mr Payne should have stopped driving, having regard to the number and circumstances of the blackouts. However, at that stage no medical advice had been given to Mr Payne to stop driving pending further medical examination and no medical advice about driving had apparently been sought by Mr Payne. It is not known what medical advice would have been given if he had sought such advice at the time.

10.100 The families' submission focused on the statutory duty to report medical conditions, on following the relevant guidance, and on telling the examining doctor the truth at the medical assessment for driving licence renewal in July 2010, as well also as attending the appointment with Dr Cleland or making a rescheduled appointment.

10.101 Both submissions contained reference to the appointment with Dr Cleland. The Crown submission in relation to section 6(1)(e) covered points that were similar to other parts of the families' submission section 6(1)(c).

10.102 Although I understand the reason for the Crown submission under section 6(1)(c), it seems to me that the approach in the part of the families' submission relating to notification by William Payne to the DVLA and disclosure to Dr Duff and also the Crown submission in relation to section 6(1)(e) fit better with the actual circumstances and are to be preferred to the Crown submission about Mr Payne giving up driving. As I understood the evidence it was that the statutory responsibility that applied to Mr Payne after the June 2009 blackout was to report to the DVLA, not to stop driving.

10.103 The evidence suggests that had William Payne disclosed his history of blackouts to the DVLA in June/July 2009 or to the DVLA and Dr Duff in July 2010 that would have been likely to result in him being advised or required to stop driving and that within a time-frame that might well have meant he was not driving in December 2010. Consequently, in my

view reasonable precautions whereby the accident resulting in the deaths might have been avoided would have been for William Payne to have notified the DVLA about his blackouts after the June 2009 episode and to have disclosed his history of blackouts to Dr Duff and in the DVLA form D4 on 2 July 2010.

10.104 Referring again to the Crown submission, I take the reference to ceasing driving until Mr Payne had been examined by a “specialist” to refer to the appointment with Dr Cleland. The families’ submission also included an element relating to Mr Payne attending that appointment or making and attending a rescheduled appointment. Mr Payne gave evidence about this appointment and provided his reason for not attending it. I am not persuaded that Mr Payne deliberately gave untruthful evidence on oath about this, although I find it somewhat surprising that he took no action about a re-arranged appointment if his position generally was that he was trying to resolve his health problems.

10.105 Dr Cleland’s evidence (covered in more detail below) suggested he would have told Mr Payne not to drive, carried out more tests and seen him again if Mr Payne had attended the September 2009 appointment and told him of another episode. Noting that both the Crown and the families made submissions about the missed appointment with Dr Cleland in September 2009, I am prepared to make a determination in that regard - namely that a reasonable precaution would have been for Mr Payne to have attended the appointment with Dr Cleland on September 2009, or to have made and attended a rescheduled appointment.

10.106 In making these determinations and wording them in the above terms I have had regard to the submissions made on behalf of William Payne to which I have referred, including the general submission about the presumption of innocence. I have not made any finding that any offence may have been committed by Mr Payne, but to the extent that any criticism of Mr Payne’s acts or omissions may be implied from the foregoing discussion and determinations I consider my comments, conclusions and determinations to be appropriate and legitimate in the circumstances of this Inquiry.

The likely effect of medical advice to William Payne not to drive/to report to DVLA

10.107 Before turning from consideration of the position of William Payne to consideration of the various contacts that medical practitioners had with William Payne, there is another matter relating to Mr Payne that could usefully be dealt with here.

10.108 In an earlier section of this Determination the likely consequences of notification to the DVLA of William Payne's losses of consciousness were discussed. That was relevant to the question of whether a precaution might have avoided the accident and deaths – that is whether there was “a real and lively possibility” that a precaution might have avoided the accident and deaths.

10.109 In their submissions on behalf of the medical practitioners both Ms Ceresa and Mr Stewart raised the point that, having regard in particular to William Payne's failure to disclose his history of blackouts to Dr Duff when completing the DVLA form for renewal of his HGV licence, even if doctors had advised him not to drive “*it is probable that William Payne would not have told DVLA and the deaths accordingly would not have been prevented*”, as Ms Ceresa put it, or as Mr Stewart submitted: “*there must be a genuine doubt that Mr Payne would cease to drive even if so advised*”. Mr Stewart also suggested that it must be doubtful if Mr Payne would actually have reported his history of blackouts to DVLA if advised to do so by a doctor.

10.110 Ms Bain in her submissions on behalf of the families commented that whether Mr Payne would have accepted advice from one of his GPs not to drive and to report his condition to the DVLA “*is difficult to answer given his subsequent conduct towards Dr Duff in July 2010.*” As Ms Ceresa commented, there was no evidence from William Payne himself about whether he would have notified DVLA (and stopped driving) if advised by a doctor to do so. However, so far as I recall and am able to tell from my notes of the evidence this was not something that Mr Payne was asked about and given an opportunity to answer.

10.111 Mr Fitzpatrick's submission about this on behalf of William Payne was that there was no evidence to support the proposition that William Payne would have ignored medical advice.

10.112 A further circumstance that was suggested by Mr Stewart as being relevant to the doubt about whether William Payne would have followed advice not to drive was the

decision by Mr Payne not to attend his own doctor for his HGV licence renewal. This, it was suggested by Mr Stewart and by Ms Bain, was a deliberate decision by Mr Payne intended to prevent disclosure of Mr Payne's history of blackouts, in order that Mr Payne could retain his licence to drive. Mr Payne's explanation (in his police interview) was that it was only because it was £50 cheaper that he went to Ritchie's (where he saw Dr Duff) instead of his GP.

10.113 There was no evidence that Mr Payne did not otherwise respect and follow the advice of doctors. Mr Payne was a frequent visitor to the GP surgery and it appears that he requested the referral back to Dr Cleland in July 2009. Mr Payne gave evidence about the reason for him not attending the resultant appointment in September 2009. While the explanation was plainly self-serving, as I have said I am not persuaded that Mr Payne gave untruthful evidence on oath about this. The explanation for going to Ritchie's instead of his GP for the licence renewal examination was plausible.

10.114 In addressing whether Mr Payne would have followed advice I have also considered what regard should be had to the DVLA/GMC guidance to doctors about reporting to DVLA themselves if a driver who has been advised to stop driving fails to do so. However, the possibility of this situation arising in William Payne's case was not explored in evidence and no clear assessment can be made of the likely position in that regard.

10.115 It could be suggested that a conclusion that William Payne would not have followed medical advice not to drive and/or to report to DVLA would render it unnecessary and irrelevant to consider the question of whether it would have been a reasonable precaution for any of the many examining or treating doctors who saw him during the period from 2007 to 2010 to have advised him not to drive and/or to report to DVLA.

10.116 However, I think it is appropriate to give consideration to that question, and indeed a related question about further medical examination that may have revealed Mr Payne's medical condition and led to advice not to drive and revocation of his licence. The postulated response of Mr Payne to advice or direction not to drive and/or to report to the DVLA is speculative. Against a background of Mr Payne apparently following medical advice the evidence does not in my view support a conclusion that he would not have followed medical advice to stop driving or report to the DVLA if such advice had been

given. I am prepared to accept that there would have been a real possibility that he would have followed advice.

Evidence of treating/examining doctors about their dealings with William Payne

10.117 Much of the Inquiry was taken up with the questioning by parties of the doctors who examined or treated William Payne about whether any advice was given or action taken by them about Mr Payne driving or reporting to DVLA and about the application of the DVLA guidance to his case.

10.118 As noted above, the evidence suggests that none of the doctors who examined and/or treated William Payne in the period from 2007 to 17 December 2010 advised him not to drive, and/or to report his blackouts to DVLA. No doctor who saw Mr Payne in that period apparently sought advice from DVLA.

10.119 There was no clear evidence that the doctors who examined or treated William Payne had specifically given consideration to the application of the DVLA guidance and the question of driving at the time they saw William Payne, although as will be seen there were suggestions in some of the evidence that this had been done. The entries in the medical records by doctors who dealt with Mr Payne but who were not witnesses contain nothing to indicate that such consideration was given. The position in relation to the medical witnesses who gave evidence is discussed below.

10.120 William Payne was seen by GPs at the Keppoch Practice at Possilpark Health Centre, Glasgow and by consultants at Stobhill Hospital, Glasgow. The order in which medical witnesses gave evidence at the Inquiry was mixed. The representation of doctors and the questioning of witnesses involved the consultants preceding the GPs and that was also the order of submissions. Accordingly I shall deal first with the consultants.

10.121 Two consultants who had respectively dealt with Mr Payne at Stobhill Hospital on admission in October 2008 and review in January 2009 were called as witnesses. They were Dr Alistair Ireland and Dr Stephen Cleland. I should observe in passing that the doctors who were responsible for William Payne after his admission to Stobhill Hospital were not witnesses.

10.122 Dr Alistair Ireland was the Accident and Emergency Consultant who examined William Payne and admitted him to Stobhill Hospital on 6 October 2008 after his loss of consciousness at the GP surgery that day. He spoke to relevant parts of the medical records (Production 7), including page 49, to which reference is made below. He also gave evidence about Mr Payne's collapse at Stobhill Hospital, which he thought he had seen, but did not recall. It was probable that Mr Payne was semi-recumbent on a trolley at the time. Asked to comment on the reference in a Stobhill Hospital discharge letter to the GP on 15 October 2008 to there being "no clear trigger" for the losses of consciousness on 6 October his opinion was that there was an element of trigger in relation to the initial collapse, namely the injection, but not for the second collapse in the hospital. As Dr Ireland's concern was to work out what was wrong with Mr Payne and to admit him to hospital giving him advice about driving was not in his mind.

10.123 Dr Stephen Cleland is an experienced Consultant Physician, who in January 2009 was working at Stobhill Hospital, Glasgow. As outlined above on 13 January 2009 Dr Cleland saw William Payne for a review in his clinic at Stobhill Hospital, following Mr Payne's admission to Stobhill in October 2008. After that review Dr Cleland sent a letter to Mr Payne's GP dated 22/1/2009 in which he said (in summary) that he thought that a halt should be called to investigations for now and if Mr Payne started to have unexplained syncopal episodes he would reappoint him for further investigations at the clinic (see page 31 above).

10.124 Following Mr Payne's consultation with Dr Cox on 10 July 2009 an appointment was made for Dr Cleland to see Mr Payne again in September 2009 after the June 2009 blackout. However, Dr Cleland did not have an opportunity to examine Mr Payne again in September (or thereafter) because Mr Payne did not attend the appointment that had been made for him and there was no further appointment arranged.

10.125 In relation to that matter Dr Cleland stated in evidence that if Mr Payne had attended the September 2009 appointment and told him of another episode he would have told him not to drive for a period of 4 weeks or until further tests had been carried out. He further stated that had he known about the full picture of episodes in December 2007, April 2008,

October 2008 and June 2009 he would have advised Mr Payne not to drive and seen him again.

10.126 Dr Cleland was questioned in particular about his decision to call a halt to investigations in January 2009 and his awareness, interpretation and application of the DVLA guidelines in the context of Mr Payne's case. I do not propose to rehearse all that evidence here, but I shall make reference to what I consider to be important aspects of it. I note here that Dr Cleland's overall position was he disputed the suggestion made to him by Ms Bain for the families that because of his "superficial examination an opportunity was missed".

10.127 Dr Cleland's evidence was that he was aware of the episodes of loss of consciousness in December 2007 and October 2008, but he was not aware of the loss of consciousness that Mr Payne suffered on 30 April 2008. He said that he may not have had full records or case notes when he saw Mr Payne. He had the "admission bundle" and he would have read the notes, including the Accident and Emergency doctor's entries, when Mr Payne was admitted to Stobhill Hospital in October 2008. He said that the 30 April 2008 admission was not part of the history. Mr Payne did not "volunteer" information about the April 2008 episode. Dr Cleland's evidence was that had he been aware of that episode that would have affected his approach and "might have changed things".

10.128 Mr Fitzpatrick, for Mr Payne, drew Dr Cleland's attention to Dr Ireland's note of October 2008 in the medical records (Production 7 page 49) which stated that there had been *"2 similar collapses this year resulting in brief hospitalisations"*. Mr Fitzpatrick questioned Dr Cleland about this and suggested that Dr Ireland's recorded history showed that the admission to Stobhill on 6 October 2008 was the third time that William Payne had been at hospital following collapses. Dr Cleland agreed that the records containing this note were in the "admission bundle" that he had available to him on 13 January 2009. His reply to Mr Fitzpatrick was: "I didn't read this. I saw '2 collapses' and may have thought that was December 2007." He went on to say that he was not asking questions about previous collapses. There was no evidence to contradict Dr Cleland's evidence that Mr Payne did not tell him about the April 2008 episode. Dr Cleland did not seek clarification from Mr Payne of the reference in the notes to *"2 similar collapses this year resulting in brief hospitalisations"*.

10.129 During cross examination by counsel for the families Dr Cleland said that at the time he did not go into details of earlier incidents and symptoms because there were no further episodes since October 2008. His remit, he said, was “to ask about any incidents in the three month period since Mr Payne’s October admission”. In direct examination Dr Cleland’s evidence was that his remit was twofold – firstly, to ascertain if there had been any further blackouts, such as caused Mr Payne’s admission in October 2008, and secondly, to check the outcome of urine test results which had not been available on discharge. Dr Cleland described the main purpose of the consultation as being to check if there had been any more episodes and if so what warning factors there had been. Mr Payne reported that there had been no incidents. In her submission on behalf of Dr Cleland Ms Ceresa noted that Dr Cleland “*had a limited remit for reviewing William Payne*”.

10.130 Dr Cleland confirmed in his evidence that he was aware of the DVLA guidance. He explained his understanding of the “3Ps” and gave evidence about them in relation to Mr Payne’s episodes of loss of consciousness of which he was aware. As I have noted, he stated that at the time he did not go into details of earlier incidents and symptoms because there were no further episodes since October 2008 and his remit was limited. At one point in direct examination he stated: “the crucial thing was that he had not had any events since October.” Dr Cleland said he did know about the provoking circumstances in relation to the December 2007 and October 2008 episodes.

10.131 In cross examination by counsel for the families he was taken through the medical records, asked about and commented on the presence of the “3Ps” in relation to the episodes of which he had been aware. Dr Cleland inferred from Dr Davie’s diagnosis about the admission in October 2008, recorded in the hospital records, that the “3Ps” were all present in relation to that episode. Dr Cleland’s position was that he had no reason to “unpick” senior colleagues’ decisions in October. Although he accepted that a particular trigger was not recorded in the notes he suggested that Dr Barnwell, who sent a Stobhill Hospital discharge letter to the GP on 15 October 2008, had “made a mistake” in stating that there was no clear trigger to the loss of consciousness on 6 October, as that did not match what was in the records. The final discharge letter, sent under authority of Dr Davie, noted that the episodes “are likely to be vasovagal in origin” (Production 7, page 3). As already noted, the doctor concerned was not a witness at the Inquiry.

10.132 At various points during his evidence Dr Cleland referred to his decisions having been made in the exercise of his clinical judgment. At one point he said that the October 2008 and earlier incidents had explaining factors, so he used his clinical judgment to decide on no further investigation. At the time he saw Mr Payne, he said “my clinical judgment was that he was not high risk and so no lifestyle restriction was appropriate, but I qualified that by saying that *‘If he starts having unexplained syncopal episodes I would be happy to hear from you and we will reappoint him for further investigations at the clinic.’*” In what appeared to be a statement about his general practice, Dr Cleland said: “You have to make a global, clinical judgment and if there is unexplained syncope you think about lifestyle advice.”

10.133 During cross examination by Ms Bain, in the course of an exchange about the “3Ps”, which started with a suggestion that the position about the postural element of the “3Ps” was not known as regards the loss of consciousness by Mr Payne at Stobhill Hospital, Dr Cleland was asked about the need to check that the “3Ps” apply on each occasion of recurrent blackouts. He said: “Yes, but you need to use clinical judgment.” When it was then suggested that he did not know if there was a trigger for what was described as the second incident (i.e. in the hospital) Dr Cleland replied “I don’t know, but that doesn’t stop me from applying clinical judgment.” Referring to box 3 in the DVLA guide his position was that the key thing is that you only interpret as “high risk” if the syncope is unexplained, the key word being “unexplained”. He went on to say that in relation to the application of the DVLA guidance: “It is not as simple as applying three things. It is a helpful guide, but clinical judgment is necessary.”

10.134 In answer to questions by his solicitor, Ms Ceresa, about the application of the DVLA guidance Dr Cleland’s position was that you do not follow the guidelines “word for word”, you take them in the clinical context of your patient. He agreed with the suggestion put to him by Ms Ceresa that his position was that in his clinical judgment the clinical context of Mr Payne’s case was that it fell squarely in box 1 of the DVLA guidance.

10.135 Dr Cleland’s position was that if he had known about the full picture of losses of consciousness in December 2007, April and October 2008 and June 2009 that may have changed things. He would have advised Mr Payne not to drive and seen him again.

10.136 I note and discuss below the expert witnesses' comments and parties' submissions in respect of Dr Cleland and his involvement with William Payne and my view of his evidence.

10.137 The two main GP witnesses from the Keppoch Practice at Possilpark Health Centre, where William Payne was a patient, were Dr Claire Keatley and Dr Natasha Cox. There was also evidence from other GPs, to whom brief reference will be made.

10.138 Dr Claire Keatley was a GP at the GP practice where Mr Payne was a patient. This was a large, busy, practice in a deprived urban area with several doctors, which was also regularly using locums during the relevant period. During that period between 2007 and 2010 Dr Keatley personally examined William Payne twice - on 22 October 2007 and 4 September 2008.

10.139 Dr Keatley was taken through the practice medical records for William Payne (Production 6) including the two occasions when she saw him. Her evidence was that she did not think any advice had been given to him about driving. Asked if it should have been, she said there was a good reason for each collapse, but she agreed she had said in her statement to the police that on the basis of Mr Payne collapsing he should have been told not to drive. She was further questioned about this and her position on whether that comment was correct varied somewhat depending on who was questioning her. During examination by Ms Bain for the families she said at one point that she wished Mr Payne had been told not to drive, but asked if he should have been she said "not necessarily with what he presented with, although it could be argued the other way." In the course of examination by Mr Stewart, who was representing her, she agreed that her "gut reaction" to the history of fainting was that Mr Payne should have been told not to drive. She also agreed with the proposition that she had now had time to consider the records and the DVLA guidance, that there had been no reason to consider the guidance at the time and the decisions now seemed reasonable. She further agreed that the fact that secondary care doctors had discharged Mr Payne on a number of occasions without follow-ups reassured her.

10.140 Dr Keatley acknowledged in re-examination by the Procurator Fiscal that she had not been aware of the details of DVLA guidelines at time, as she had not had time to read them in a busy practice. In response to questioning by the court she confirmed that she had not

been familiar with the guidance at box 1 of page 7 of the DVLA guidance, which contains reference to the “3Ps”.

10.141 Dr Natasha Cox was also a GP in the Keppoch Practice in 2009. Her involvement with William Payne as a patient was limited, but included the significant matter of Mr Payne’s request for a letter to enable him to be excused from jury duty. Dr Cox was questioned in particular about the letter which she wrote for William Payne on 3 July 2009 in response to that request made in a telephone call from Mr Payne. Dr Cox was also examined about her consultation with William Payne at the surgery on 10 July, which resulted in her referring Mr Payne to Dr Cleland’s clinic again.

10.142 As has already been noted, the jury excusal letter was in the following terms: *“Mr Payne has had several episodes of unexplained dizziness and collapse over the past year. On occasion he has been admitted to hospital because of these. He feels worse when he is under stress and he is very concerned he may become dizzy and collapse if he has to attend for service.”* (Production 6 page 41)

10.143 Dr Cox accepted in her evidence that jury service is an important civic duty, to be undertaken unless a prospective juror suffers from a genuine medical condition. She agreed with Ms Bain for the families that she would take care about a letter about excusal from jury service, saying “I would take care to phrase it appropriately.” She agreed that in preparing the letter for Mr Payne on her professional responsibility she had based it on information from the patient and the medical records. When she was asked about the use of the word “unexplained” in her letter, she said that she had not had time to check every record and this had resulted in an “unintended inaccuracy”. The reference to “unexplained” may be inaccurate, she said. It was her “best interpretation of the records at the time.” She could not now say if that statement was an accurate reflection of what William Payne reported to her.

10.144 Dr Cox denied the suggestion by Ms Bain for the families that she wanted to re-interpret the jury excusal letter because she now knew what the DVLA guidance says and had she applied it at the time she would have known that there was a big problem with William Payne driving. In the course of her evidence Dr Cox stated that she was aware of the DVLA guidelines, that she knew how to access them, but had not memorised them.

10.145 Explaining her jury excusal letter further Dr Cox said that she “would have wanted to ensure the patient could safely serve on a jury without disturbing the case or causing a problem to him.” Her purpose was “safeguarding his health and avoiding disrupting the court process”.

10.146 The Procurator Fiscal asked Dr Cox if the question of William Payne driving was ever raised. Her reply was that he (Mr Payne) never raised it. When the PF then asked if she thought to raise it Dr Cox did not give a direct answer to that question, but said she knew that Mr Payne had been through hospital checks and to her knowledge you did not need to raise it if it was vasovagal. She had never assessed Mr Payne after a faint. Expanding her answer to a follow-up question from the PF about her awareness of the DVLA guidelines, Dr Cox said: “My thought was he'd be seen by the hospital again.” “I felt he had been assessed by Dr Cleland. I was hoping Dr Cleland could review him. I was not specifically asking for advice about driving.” The simple vasovagal episode recorded by her colleague had occurred about nine months after the previous episode and was not, she said, “an episode I would regard as needing advice and he had been examined by the hospital.” She would rely on hospital colleagues and would “expect them to tell the patient not to drive.”

10.147 When asked by Ms Bain for the families if she had ever considered whether if Mr Payne was not fit for jury service he was not fit to drive, Dr Cox did not directly answer that question, but responded with the statement that these are “entirely different situations”. She expanded on that by referring to jury service being very stressful, in a stuffy environment and a court setting where the patient might faint, unlike an everyday activity like driving. In response to Ms Bain’s suggestion that driving may be very stressful, Dr Cox replied that jury service is very stressful to patients in her experience and is quite different from driving.

10.148 Dr Cox said that nothing at the time of the jury excusal letter made her think about the inappropriateness of driving. “At the time of writing the jury letter I did not have information to make me think Mr Payne should not be driving”, she said. She could not remember if she had thought about driving. She did not document advice about driving. To a further question about whether she had considered it she said: “I always have that as a thought process. I did not have information that caused me to look at DVLA guidance.” She said she would not have gone through the “3Ps”. She would have trusted colleagues,

knowing that Mr Payne went through hospital too. She said: "I would have considered that there was no driving restriction by the hospital and no restriction by my colleague in June". She was worried about collapse in the context of jury service. Dr Cox rejected Ms Bain's suggestion that it did not make sense that a patient is unfit for jury service, but fit to drive.

10.149 In her evidence about the consultation on 10 July 2009, Dr Cox made the point that Mr Payne was not attending following a fainting episode. Several symptoms were noted. Dr Cox was aware that Mr Payne had been assessed in relation to fainting by Dr Cleland. She had seen Dr Cleland's letter and was thinking about it and what he said. She said the letter placed the practice under instruction to refer Mr Payne back if there was any further unexplained episode. She stated that because of Mr Payne's concerns she decided to refer him again to Dr Cleland's clinic at Stobhill. A referral letter was sent to Dr Cleland's clinic in which Dr Cox stated: "*.. I believe he had quite a lot of investigations under your care and was discharged with no specific diagnosis.... He continues to feel unwell and had a vasovagal episode on 5/6/09. He could not identify a particular trigger but was at the vets and feeling a little anxious about what was going to happen to his dog. ... He feels for the last 2 and a half years that he has felt unwell....*". (Production 6 page 47)

10.150 When Dr Cox saw Mr Payne at the surgery again on 12 August 2009 he reported that he had had no further faints and he confirmed that he had a clinic appointment in September. Dr Cox did not see Mr Payne again after his failure to attend that appointment. She was not asked about and did not offer comment on the significance, if any, of that failure having regard to her evidence about the reliance that she placed on the consultant.

10.151 In examination by her solicitor, Mr Stewart, Dr Cox agreed with the summary of her position that he suggested to her - namely that she did not look behind her colleague's diagnosis that the 5 June 2009 episode was a simple faint that seemed to be triggered by a visit to the Vet, that she did not look behind the hospital letter (Dr Cleland's letter) and that she followed Dr Cleland's advice and referred Mr Payne back.

10.152 I note and discuss below the expert witnesses' comments and parties' submissions in respect of Dr Cox and her involvement with William Payne, as well as my view of her evidence.

10.153 Two other doctors at the GP practice were witnesses - Dr Katy Padgham and Dr Petra Sambale. The evidence of the latter was more relevant to another subsection of section 6 of the Act and will be dealt with there. Other doctors who dealt with William Payne at the practice were not witnesses. It might have been of assistance to the Inquiry to have heard from the registrar at the GP practice who saw Mr Payne after his collapse at the Vets' practice on 5 June 2009.

10.154 Dr Katy Padgham examined William Payne on 4 January when he presented with a cough. Mr Payne made no mention of his history of collapse or of driving. Dr Padgham stated that she gave no advice about driving. She was dealing with the cough. She was aware that Mr Payne had been investigated at hospital and that no instruction had been given not to drive. Dr Padgham was aware of the DVLA guidance.

Expert and opinion medical evidence

10.155 The Inquiry heard expert medical evidence from two Consultant Cardiologists - Dr Neil Grubb, who was led by the Crown, and Dr Robin Northcote, who was called as a witness by the families. Both witnesses spoke to their reports, which were productions – Production 29 and Families' Production 43, respectively.

10.156 Precognition Statements of Dr Michael Griffith, Consultant Cardiologist and Professor Anthony Marson, Consultant Neurologist, were also lodged on behalf of the Families (Families Productions 44 and 45). It was agreed by Joint Minute that they were true and accurate accounts of the answers of Dr Griffith and Professor Marson to questions at precognition and that they were "equivalent to the whole evidence" of the respective consultants. I have referred to this evidence above in relation to the DVLA guidance regarding fitness to drive.

10.157 Dr Neil Grubb is a Consultant Cardiologist (Electrophysiology) at the Royal Infirmary of Edinburgh and a Fellow of the Royal College of Physicians of Edinburgh. He had examined medical records and witness statements. During his evidence it became clear that there was other information of which he was not aware from that examination. The additional information caused him to modify his opinion previously stated in his report.

10.158 In particular, in light of further information given to him in court Dr Grubb gave as his opinion that William Payne would have fallen into the DVLA risk category in 2008. Dr Grubb would have considered a Tilt Table test after the April 2008 loss of consciousness, which was the second episode of loss of consciousness and the appropriate stage for initiating further investigations, in Dr Grubb's view. It would have been reasonable to advise Mr Payne to stop driving and to carry out further tests. In answer to a question in re-examination by the Procurator Fiscal he stated that he would have arranged a Tilt Table test of William Payne after the loss of consciousness in October 2008. His interpretation of all the information now available to him was that these were unheralded episodes. He considered the application of the "3Ps" test in that connection. He stated that he would have expected the result of a Tilt Table test in 2008 to be positive, with the same result as in December 2010 being possible. The Tilt Table test result would probably have been quite dramatic, if not as dramatic as in December 2010. If so he would have stopped Mr Payne driving. He would also have been concerned about the June 2009 episode. He agreed with the position stated by Dr Cleland in his evidence that Dr Cleland would have advised Mr Payne not to drive if he had been aware of the June 2009 episode. He agreed with the proposition on behalf of the families that by the stage of the letter from Dr Cox (in July 2009) about excusal from jury duty Mr Payne should have been told not to drive and DVLA should have been informed. Again, it would have been appropriate to carry out a Tilt Table test if that had not already been done – with the likely same result.

10.159 Dr Grubb's position as outlined above contrasted with conclusions in his report in which he stated his opinion that it was a reasonable decision, based on the history and information available prior to the fatal accident, that Mr Payne was not advised to cease driving. As stated above, Dr Grubb made clear in his evidence that he had modified his opinion based on information he had been given in court, which included information about the circumstances of the June 2009 blackout, the terms of the jury excusal letter and what was said by Mr Payne in his police interview.

10.160 Dr Robin Northcote is a Consultant Cardiologist at the Victoria Infirmary in Glasgow and a Fellow (and currently Registrar) of the Royal College of Physicians and Surgeons of Glasgow. He spoke to his report, which was Families' Production 43, and referred to two further documents which he produced as annexes to his report – "Guidelines for the

diagnosis and management of syncope (version 2009)” produced by the Task Force of the European Society of Cardiology (Annex1) and National Institute for Health and Care excellence clinical guideline on “Transient loss of consciousness (‘blackouts’) management in adults and young people” (August 2010) (Annex 2). These guidelines, it was suggested, supported Dr Northcote’s position in evidence and validated his own clinical practice. This did not appear to be disputed.

10.161 Dr Northcote had prepared his report following review of medical records and witnesses’ statements. His overall opinion as stated in his report and in evidence was: “Throughout the clinical assessment of Mr Payne there appears to have been a lack of urgency in determining the underlying cause of his episodes of loss of consciousness.” In his report Dr Northcote commented that *“While every effort was made to investigate and manage Mr Payne’s recurring sore throats and respiratory tract infections I do not feel that the episodes of loss of consciousness were adequately investigated.”* His position was developed in the course of his evidence.

10.162 Dr Northcote recorded the following opinion in his report and spoke to it in evidence: *“It is my opinion that the episodes of loss of consciousness were related to vasodepressor syncope syndrome resulting in loss of consciousness. It is also my opinion that the diagnosis of “simple faint” tends to underestimate the severity and potential consequences of a more malignant variety of vasodepressor syncope syndrome, which Mr Payne undoubtedly suffers from. I believe that a more thorough clinical evaluation should have occurred for Mr Payne at an earlier stage, in the form of continuous ECG event monitoring, an Echocardiogram and Tilt Table Testing. Given the findings of the Tilt Table Testing in December 2010, I would be extremely surprised if this investigation, had it been performed earlier, would not have confirmed a similar pattern which would have necessitated pacemaker deployment and also prompted attending doctors to advise Mr Payne to stop driving.”* Dr Northcote emphasised the importance of the Tilt Table test in his report and his evidence. In his evidence he confirmed that if a Tilt Table test had been carried out in 2007 or 2008 or 2009 with the same result as in 2010 – which he would have expected – Mr Payne would have been advised to stop driving.

10.163 In his evidence Dr Northcote laid stress on the point that the development of loss of consciousness in a man in his forties is very unusual and requires to be investigated. As he

had stated in his report, there is a danger of assuming a “simple faint” diagnosis. In his opinion, “Over 40 any loss of consciousness should not be regarded as a simple faint”.

10.164 Even in December 2007 the two losses of consciousness in a short time, one of them while lying flat, should have been investigated in greater detail, including by a Tilt Table test. Such investigation would most likely have revealed what was eventually discovered in 2010. There was also a missed opportunity to investigate after the April 2008 collapse, when in Dr Northcote’s assessment the collapse was largely ignored. Again in relation to the losses of consciousness on 6 October 2008 he commented that the occurrence of four losses of consciousness in a year was highly unusual and he would have investigated using various tests, such as ambulatory electrocardiography, echocardiography and a Tilt Table test. In his opinion what was missing was the basic investigations set out in the European Society of Cardiology guidelines (Annex 1 to his report) and “these guidelines indicate that these tests should have taken place”. However, Dr Northcote did state that he would not have expected practitioners necessarily to be familiar with the guidelines, which were produced by a specialist body.

10.165 Asked about Dr Cleland’s assessment in January 2009 and shown his letter to Mr Payne’s GP calling a halt to investigations (Production 7 page 6), Dr Northcote felt that Dr Cleland had been “guilty of undervaluing the whole fainting aspect” and that there were opportunities missed with regard to the above-mentioned tests.

10.166 In cross examination by Ms Ceresa for Dr Cleland, Dr Northcote was asked whether if the doctor concerned (Dr Cleland) was presented with a limited amount of information his opinion might be different from Dr Northcote’s opinion. Dr Northcote’s first answer was that that depended on the amount of information. However, he accepted that if information was incomplete that influences the doctor’s decision. Asked whether if there was evidence that Dr Cleland did not have all the paperwork and those were the circumstances in which the letter to the GP resulted Dr Cleland was entitled to a different clinical opinion, Dr Northcote replied: “Of course he is.”

10.167 In his report and in his evidence Dr Northcote gave his views about the DVLA guidance in relation to Mr Payne’s case, including application of the “3Ps” to the various episodes of loss of consciousness. Having reviewed the information about those episodes of

loss of consciousness, Dr Northcote considered that advice should have been given to Mr Payne not to drive.

10.168 There was some discussion in his evidence about the jury service excusal letter provided by Dr Cox in July 2009 (Production 7 page 11). Dr Northcote commended Dr Cox's grasp of the situation as abnormal when she decided to refer Mr Payne back to Dr Cleland. Dr Northcote would have told Mr Payne to stop driving. Although he commented that it was difficult to criticise Dr Cox for not doing so as the letter was not a clinical record, he expressed the view that based on what the GP had written she should have advised the patient to stop driving.

10.169 In summary, in Dr Northcote's opinion a number of opportunities arose between 2007 and 2010 when William Payne could have been advised to stop driving.

10.170 Opinion evidence was also elicited from the witness Dr Gordon Duff, principally by counsel for the families, about Mr Payne's medical history and whether at particular times he should have been advised to report his losses of consciousness to DVLA. Dr Duff offered his opinion about what his advice would have been in relation to blackout episodes in 2008 and 2009, if he had been fully informed about those. However, he did not lay any claim to expertise in this area and his evidence about this was inconsistent in some respects. More relevant, in my view, was his evidence about his direct involvement with Mr Payne in July 2010 and what his attitude and approach would have been had William Payne disclosed his history of blackouts to him then. As I have noted above (at paragraph 10.72), I understood Dr Duff's position to be that if Mr Payne had at that time disclosed his history of blackouts he would have advised him not to drive.

10.171 I considered that the evidence of Dr J G G Hanley, to whom reference has already been made, was more relevant and persuasive as regards the application of the DVLA guidance to the circumstances of William Payne's medical history. Dr Hanley confirmed that he had spent time going through the medical records. He expressed the view that it was "very difficult to identify the "3Ps" on each occasion". In relation specifically to the April 2008 episode his assessment was that the box 1 ("3Ps") test was not satisfied and Mr Payne should have been advised not to drive. As regards Dr Cox's jury service excusal letter, Dr Hanley noted the significance of the reference in the letter to several episodes of

“unexplained” dizziness and collapse. There had been another recent episode without explanation and the GP was sufficiently concerned about further collapses to write the excusal letter. In Dr Hanley’s view the doctor should have told Mr Payne not to drive.

10.172 There was also questioning of Professor Kenneth McColl, a Consultant Physician at Gartnavel Hospital, who saw William Payne on 21 December 2010 after his admission to the Western Infirmary, about his opinion about Mr Payne driving having regard to his collapses. I do not consider his evidence in that regard to be of any substantial value. Professor McColl was not an expert witness and he said in terms that faints were not his area of expertise and that he organised other appropriate experts to assess William Payne. Although he had originally stated in a police statement which was put to him that there was no reason for Mr Payne not to drive, he himself gave Mr Payne advice not to drive, and under questioning he qualified and revised the position he had stated to the police, agreeing that more information was available to other colleagues. Professor McColl also gave evidence about practice at out-patient consultations in which he highlighted the limited time available for looking at detailed written notes in medical records, saying that access to written notes is limited by availability and time.

Submissions regarding treating/examining doctors

10.173 Detailed submissions were offered by a number of the parties in relation to the medical practitioners. I do not propose to set out the full content of each such submission. I shall mention what I consider to be the most important points raised and arguments advanced. I have, of course, given careful consideration to all the submissions, whether or not they are repeated in detail here.

10.174 **Crown** - There were no Crown submissions under section 6(1)(c) about reasonable precautions specifically involving medical practitioners. However, as in relation to William Payne, the Crown submissions under section 6(1)(e) (any other facts which are relevant to the deaths) included submissions that related to medical practitioners. I think it appropriate to mention and consider these here in the context of section 6(1)(c). They were that William Payne “*would not have been the holder of a valid licence at the time of the fatal accident if :-... (b) DVLA guidelines for medical practitioners had been properly followed. (c) William Payne’s condition had been properly diagnosed.*”

10.175 In relation to the proposed determination under section 6(1)(e) about following DVLA guidelines, having summarised the circumstances of the series of episodes of blackouts from December 2007 to June 2009, the Crown submitted that *"given the DVLA guidelines William Payne should have been further investigated and advised not to drive, but neither was done"*. It was submitted in relation to Mr Payne's consultation with Dr Cox that *"(t)here having been a recurrent vasovagal episode the 3P's should have been examined and the matter reported to DVLA"*. Dr Cox should have appreciated that the June 2009 episode was a new unexplained event and the appropriate steps should have been taken. Dr Cox was aware that the matter now required further investigation and referred Mr Payne him back to Dr Cleland. In the submission of the Crown *"Dr Cox should in July 2009 have advised William Payne not to drive and to report his condition to DVLA."*

10.176 The section of the Crown submission concerning the DVLA guidelines for medical practitioners then makes reference to the fact that William Payne was seen on a further three occasions at the GP practice all in connection with his ongoing chest problems. On the penultimate visit on 2 February 2010 he advised the GP that these were the same symptoms he had before he collapsed previously. The submission comments: *"On each visit little regard seems to have been made to the possibility of a further blackout especially when he was suffering symptoms which, on the basis of past experience, might possibly provoke this and the question of continuing to drive was never raised. This apparent lack of awareness of the importance of the guidelines is reflected in the fact that Dr Keatley, a partner in the GP practice, admitted in evidence that she had never actually read them."*

10.177 As regards proper diagnosis of William Payne's condition, the Crown submission drew attention to the fact that the DVLA guidelines state that in box 3 cases ambulatory ECG and echocardiography tests should be considered after referral for specialist opinion and that the evidence before the Inquiry suggested that had these tests been carried out they would likely have been followed up by a Tilt Table test. William Payne's first "recurrent" episode was in April 2008. *"Fuller hospital investigation by ambulatory ECG, echocardiography and tilt table testing would have, according to cardiologist specialist witnesses at the inquiry, revealed the true extent of William Payne's condition even at that stage"*.

10.178 The Crown submission then argued that William Payne would not have passed the posture test on at least the first episode in October 2008, but the situation *"was confused due to*

the fact that Dr Cleland, when he saw him in January 2009, was not aware of the April 2008 incident.” It was submitted: “An ambulatory ECG and tilt table test carried out at this stage would have been appropriate”.

10.179 It was further submitted that the fourth episode at the Vet “*clearly called for immediate further investigation*”, as there was no evidence that the “3Ps” test was met. “*Unfortunately the relatively junior Doctor whom William Payne saw on the day of the blackout decided to take no further action when, in fact, he should have referred him for specialist assessment.*”

10.180 **Families** – The second and third submissions for the families under section 6(1)(c) related to medical examination and treatment:

“(SECOND) The families consider that the following reasonable precautions could have been taken by the treating clinicians at Stobhill Hospital in the period 2007 to 2009. Had the treating clinicians at Stobhill Hospital conducted a more thorough evaluation of Mr William Payne’s presenting complaints of loss of consciousness from 2007, by taking and recording a full [history?], by conducting, ECG event monitoring, Echocardiogram and Tilt Table testing then this would have resulted in the identification of his underlying condition of vasodepressor syncope syndrome. Consequently, this would have resulted in the deployment of a pacemaker and instruction that Mr Payne was not medically fit to drive. In so acting, the treating clinicians would have been acting in accordance with the guidelines issued by the European Cardiologist Society. If they had acted accordingly Laura’s and Mhairi’s death might have been avoided.

(THIRD) The families consider that the General Practitioners treating Mr William Payne from April 2008 onwards could have taken the following reasonable precaution. The treating General Practitioners should have had specific regard to, and consulted, the DVLA guidelines available to medical practitioners and advised Mr Payne not to drive. If they had acted accordingly Laura’s and Mhairi’s death might have been avoided.”

10.181 The propositions in the families’ submission about the medical treatment of William Payne placed reliance on the evidence of Dr Duff, Dr Grubb and Dr Northcote. I have referred to Dr Grubb’s and Dr Northcote’s evidence in some detail in the section on expert and opinion evidence above, where I have also considered Dr Duff’s evidence,. The families’ submission contains reference to fairly substantial passages of Dr Northcote’s

evidence, which I have outlined in large part in the said section and which I do not propose to repeat here. Dr Northcote's opinion on which the families relied was summarised in part in the statement in the submission: *"Dr Northcote criticised both the treating clinicians at Stobhill Hospital and the General Practitioners for failing to implement the DVLA 'at a glance guidance'."* The submission directed attention to those criticisms, which I have noted.

10.182 The submission also placed emphasis on Dr Northcote's statement during his evidence, when shown Dr Cleland's letter of 21 January 2009 calling a halt to investigations: *"I feel that Dr Cleland has been guilty of undervaluing the whole fainting aspect. I disagree with this simple faint situation. I think there were opportunities missed with regards to the simple tests of the ambulatory electrocardiography, echocardiography and a Tilt Table test"*.

10.183 In relation to examination and treatment of William Payne by GPs the submission for the families was that in July 2009 Dr Cox should have advised Mr Payne not to drive and to report his condition to DVLA. The argument advanced was similar to the Crown's submission in relation to a suggested section 6(1)(e) finding that is outlined above. In the families' submission: *"Dr Cox knew that Mr Payne had been through recent hospital test in October 2008 and was reassured by these. However, the June 2009 collapse was a new unexplained event. This should have been appreciated by her and the appropriate steps taken – examination and direction to inform the DVLA. Dr Cox was aware that Mr Payne now required further investigation and the manner in which she characterised Mr Payne's presenting history (the referral letter and jury service letter) showed a man with a very concerning history who should on any view not be driving. Dr Cox's suggestion that you could be unfit for jury service through unexplained collapse but fit for driving does not withstand any logical or reasoned analysis."*

10.184 Noting that William Payne was seen on a further seven occasions at the GP practice after seeing Dr Cox, including on 2 February 2010 when he advised the GP that he was suffering from symptoms that had previously caused him to collapse, the families' submission stated: *"On each visit no regard has been had to the possibility of a further blackout."* The comment made in that regard was: *"The fact that this continued to be the position after June 2009 simply serves to underline the point being advanced by the family; the GP practice had a lack of awareness of the DVLA guidance. (If Mr Payne had collapsed in the past with certain symptoms and he returned with these very same symptoms then there is a further and foreseeable risk of future*

collapse.)”

10.185 **William Payne** – There were no submissions on behalf of Mr Payne as to any particular findings or determinations regarding medical practitioners. However, Mr Fitzpatrick did draw attention in his submission for Mr Payne to the fact that Mr Payne attended his GP practice on approximately twelve occasions and at Stobhill Hospital on three occasions “seeking assistance” throughout the period from the first incident in December 2007. He was treated by a number of GPs, hospital consultants, registrars and junior doctors - at least twelve in total. The submission continued: *“While different Doctors in their evidence took different views regarding interpretation of the DVLA guidelines what is not in dispute is that none of the Doctors either in the GP practice or in Stobhill Hospital discussed with William Payne the issue of driving and none certainly advised him that he should not be driving.”*

10.186 **Doctor Alistair Ireland and Dr Stephen Cleland** – In relation to Dr Ireland, Ms Ceresa’s submission was that Dr Ireland’s actions were reasonable, no witness criticised him and no findings should be made in relation to him.

10.187 Ms Ceresa’s submissions were principally concerned with Dr Stephen Cleland, albeit some were framed as applying to both doctors.

10.188 In relation to Dr Cleland Ms Ceresa submitted that *“there are two potential circumstances which justify the making of a Section 6 (1) (c) finding in a case such as this – (1) Where the medical witness concerned has conceded that a different course of action ought to have been taken, or (2) where the Court has accepted the evidence of an expert witness who has stated that a different course of action ought to have been taken”* and *“in the absence of either of these two criteria being met, the Court has no evidential basis to justify a Section 6 (1) (c) finding”*. She argued that no findings should be made under this section because Dr Cleland made no concession that he ought to have taken a different course of action and the expert witness who otherwise criticised Dr Cleland accepted that he was entitled to a different clinical opinion if his state of knowledge was limited.

10.189 Ms Ceresa’s proposition was that if I believed Dr Cleland’s evidence that he was unaware of William Payne’s episode of collapse in April 2008 there was no reasonable precaution that Dr Cleland ought to have taken whereby the deaths might have been

avoided. Ms Ceresa invited me to accept Dr Cleland's evidence in that regard.

10.190 Ms Ceresa's submissions also contained an assertion that "*Hindsight has no place in this Inquiry*". She cited judicial statements in support of that proposition – principally by Sheriff Stephen in her Determination in the FAI into the death of Lynsy Myles, February 2004, but also by Sheriff Braid in the Fatal Accident Inquiry into the death of Marion Bellfield, March 2011. I do not set out here all the references to what was said in those Determinations, although I have noted and considered them all as well as the related arguments advanced. However, one particular passage in Sheriff Stephen's Determination on which Ms Ceresa relied was:

"It is for obvious reasons that hindsight has been described as "the cruel handmaiden of history" and, whereas it is a matter of necessity that Inquiries are conducted in hindsight, it is my view that hindsight has no relevance to the issues which are raised in the context of a medical Fatal Accident Inquiry in assessing the proper approach to the Section 6(1)(c) test namely "reasonable precautions". That test is redundant unless it takes account of the precautions which are reasonable in the context of the circumstances of the treatment [of] the patients and the actions of the treating doctors, all as pertained at the time the treatment was given and the clinical judgements made."

10.191 Ms Ceresa suggested that support for Dr Cleland's position about calling a halt to investigation could be found in the evidence and report of the expert medical witness Dr Grubb. She also argued that Dr Northcote made a "crucial" concession in his evidence when he accepted that in circumstances presented to him by Ms Ceresa about Dr Cleland's limited knowledge of William Payne's history, Dr Cleland was entitled to come to a different clinical opinion. Consequently, in her submission it was not open to the Inquiry to make a section 6(1)(c) finding in relation to Dr Cleland.

10.192 Ms Ceresa's submission included the further point in relation to Dr Northcote's evidence that the guidelines to which Dr Northcote referred and which indicated that particular investigations and tests should be carried out were the guidelines of the European Cardiology Society. Dr Cleland is not a cardiologist.

10.193 Reference was made by Ms Ceresa to the evidence of the witness Professor Kenneth McColl, a Consultant Physician at Gartnavel Hospital, about his opinion about Mr Payne driving, having regard to his collapses, and about the limited time available for looking at detailed written notes at out-patient consultations. Ms Ceresa referred to the latter matter to meet any criticism that might be made to the effect that Dr Cleland did not take a sufficiently

detailed history from William Payne at the consultation on 13 January 2009.

10.194 **Dr Petra Sambale, Dr Claire Keatley, Dr Natasha Cox and Dr Katie Padgham** – Mr Stewart’s submission on behalf of all four GPs invited me to make no findings in relation to any of the doctors in terms of section 6(1)(c), (d), or (e) – and if I wished to make any observations in respect of any doctor to do so in the Notes section of my determination. Mr Stewart’s position was summarised towards the end of his submission when he stated: *“In conclusion I submit on behalf of all four GPs that they were reasonable in their dealings with Mr Payne and there is nothing they should have done that may form a reasonable precaution. It would not be reasonable to tell an individual to stop driving when he has already been diagnosed with a simple faint by another doctor. It would also not be reasonable to doubt the judgement of that doctor without good reason, or embark on a detailed examination of medical history when there is no good reason to do so. I submit that in relation to the four GPs no such reason was present at the time they dealt with Mr Payne.”*

10.195 As regards Dr Keatley, Mr Stewart submitted that her only relevant consultation with Mr Payne was on 4 September 2008, *“her actions were entirely reasonable and there was nothing further she should have done at or following the consultation.”* That submission was made with reference to the following factors: *“First and foremost Mr Payne was not before her in relation to an episode of fainting. He was there due to a sore throat. Whilst he was concerned that he had fainted previously when he had a sore throat that was not the presenting complaint. The most recent episode of fainting had occurred some four months earlier and Mr Payne had attended hospital directly following that. The discharge letter at page 24 confirms the patient was discharged with no treatment or follow up. It was clear that the hospital did not consider this incident to be concerning so why should Dr Keatley four months later when there has been no reoccurrence of the problem? Dr Keatley had no valid reason to doubt the hospital doctor’s judgement or investigate matters further.”*

10.196 Mr Stewart stated Dr Keatley’s position as being *“that whilst Mr Payne should have been told not to drive, she could not identify with any confidence who should have told him that, as on a closer examination of matters the actions of the clinicians all appeared reasonable in the circumstances.”* He went on to suggest that there is nothing inherently contradictory or surprising about such a view. *“We would all wish that Mr Payne was not driving that day, it is another thing altogether to identify an individual to tell him not to do so.”*

10.197 Mr Stewart dealt at greater length with Dr Cox, anticipating that *“she is perhaps the Keppoch Practice GP the inquiry may perhaps be most interested in given her letter re jury duty, her consultation with Mr Payne and her referral back to Mr Cleland”*. He advanced a number of arguments in support of his submission that *“there were no further precautions that Dr Cox should have taken in her dealings with Mr Payne.”* I have outlined some of these below. I have, of course, considered all the arguments adduced, whether detailed here or not.

10.198 The arguments advanced included an argument that no independent GP experts were called to give evidence dealing with the appropriateness of the actions of Dr Cox, and consequently the evidence of secondary care consultants must be *“somewhat irrelevant”* – with the exception of Dr Northcote, whose experience included training as a GP. Mr Stewart suggested that this very point was recognised by Dr Northcote in that whilst he suggested more should have been done to investigate Mr Payne’s condition, his view was that by the time Dr Cox wrote the letter of referral to Dr Cleland the matter was *“beyond the GPs”*.

10.199 Reference was made by Mr Stewart to Dr Northcote’s comment that *“Dr Cox had a good grasp of the situation, she had requested help from secondary care and she had asked for further investigation.”* In relation to advising Mr Payne not to drive, Mr Stewart suggested that Dr Northcote said he found it difficult to criticise the GP and Mr Stewart further asserted that *“crucially”* Dr Northcote did not proceed to do so. Although Dr Northcote stated that personally he would have given a different response, Mr Stewart suggested it was significant that Dr Northcote also noted that GPs have less experience with these problems. Mr Stewart submitted that it was clear from the foregoing *“that Dr Northcote was recognising that different standards apply to different medical professionals based on their background and their experience.”* Mr Stewart’s submission commended that approach to the Court and further submitted in light of Dr Northcote’s comments that I should *“find it a reasonable decision for Dr Cox to have acted as she did when referring Mr Payne to the hospital not advising him re driving”*.

10.200 Mr Stewart further submitted that Dr Northcote declined to criticise Dr Cox in relation to the letter that Dr Cox had written regarding jury service. He referred to Dr Cox’s explanation of the letter, her position that she accepted that stating in the letter that the episodes were *“unexplained”* was inaccurate, and her strong denial of any suggestion that

she was changing her position in relation to the letter due to now understanding the DVLA guidance. In Mr Stewart's submission there was no reason to doubt Dr Cox's credibility or reliability on this point.

10.201 Mr Stewart concluded by reminding me that Dr Cox was never actually assessing Mr Payne in relation to a collapse or faint. He suggested that the referral to Dr Cleland reflects well on Dr Cox, as she was in effect complying with the instructions in Dr Cleland's letter of 21 January 2009, which letter would have had a reassuring effect on Dr Cox and any other GP when it stated that Dr Cleland was calling a halt to investigations. .

10.202 As regards Dr Katy Padgham, Mr Stewart submitted that Dr Padgham's actions were entirely reasonable in the circumstances. He pointed out that *"by the time Mr Payne consults with her he has not had a fainting episode for 17 months and he was not there in relation to collapses, but instead with a troublesome cough. Further, Dr Padgham could see from the records that he was apparently under investigation for collapse."* Given this, he submitted that there was no need for Dr Padgham to address or consider (what were by then) historical incidents of fainting.

10.203 I should at this point note that Mr Stewart made submissions about Dr Petra Sambale, but I consider her limited evidence to be more relevant to section 6(1)(e) and so I shall deal with this there.

Discussion and determination regarding treating/examining doctors

10.204 Regarding my approach to considering a determination under section 6(1)(c) in relation to the involvement of medical practitioners with William Payne, it is necessary to refer back to an earlier section of this Determination, in which I dealt with legal matters. I referred there to the frequently-stated approach to section 6(1)(c) that it involves an exercise of retrospective consideration of matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the Inquiry. I made reference to what Sheriff Principal Lockhart said in his Determination in the "Rosepark Inquiry", 20 April 2011, and his reference there (at paragraph 7) to what he said in his Determination in the Newton Rail Crash Inquiry in 1993 about the approach to be taken, including the application of hindsight.

10.205 Sheriff Principal Lockhart expressed the opinion that *“a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight.”* He went on to say:

“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.”

The approach described by Sheriff Principal Lockhart is one that in my experience is commonly followed in Fatal Accident Inquiries.

10.206 I mention this matter again here because in her submission concerning Dr Cleland Ms Ceresa argued that hindsight has no place in this Inquiry. I take that to be a proposition made in the particular context of the matters which she was addressing in her submission. In particular I note that the statement is made in a paragraph which is about issues which arise in Fatal Accident Inquiries “which involve medical matters”.

10.207 I have considered the judicial statements in FAI Determinations adduced by Ms Ceresa in support of her proposition. These statements are, of course, not binding on me, but they may be persuasive where the Inquiry is into sufficiently similar circumstances. In that regard I note that Sheriff Stephen’s statements about hindsight in her Determination in the FAI into the death of Lynsy Myles related to an “Inquiry into a death while undergoing medical treatment” (emphasis added). Sheriff Braid’s statement quoted by Ms Ceresa also appears to have been made in a Determination in an Inquiry into a death that followed medical intervention. The context in this Inquiry is different. It is not an Inquiry into a death while undergoing medical treatment. It involves not only questions about medical examination and testing, but also about the application of guidelines – in relation to a person other than the person whose death is the subject of the Inquiry. Also, it is an Inquiry into an accident.

10.208 I do not consider it necessary to express a concluded view as to the correctness of the approach taken and statements made by Sheriff Stephen and Sheriff Braid. I do not, however, understand their approach to be one that is followed in all Inquiries into deaths while undergoing medical treatment. I note the statement in the Determination (dated 7 April 2010) of my learned colleague Sheriff Ruxton in the FAI into the death of Gordon

Ewing, which occurred during anaesthetic procedure, where she said (at paragraph 118): *“It seems to me clear that having regard to the purpose of a fatal accident inquiry, the court is afforded a wide discretion to consider these issues with the benefit of hindsight.”*

10.209 Ms Ceresa’s was the only submission that hindsight has no place in this Inquiry. Mr Stewart, in his submission on behalf of other medical practitioners, stated that he accepted that hindsight *“can and will inform your Lordship’s determination”*, although he argued that such hindsight *“should not be applied 20/20”*. I do not accept Ms Ceresa’s submission as a correct statement of the position as regards the place of hindsight in this Inquiry. In the circumstances of this case I consider it to be appropriate and in accordance with law to apply hindsight to consideration of reasonable precautions in the context of doctors’ dealings with William Payne.

10.210 I propose to consider that matter by dealing first with the consultants at Stobhill Hospital and then the General Practitioners. However, before proceeding to consider the relevant evidence and submissions about the consultants, there is a point that relates both to them and the GPs that I believe it is appropriate to mention here.

10.211 I note that the submission for the families invites a determination under section 6(1)(c) in relation to *“the treating clinicians at Stobhill Hospital in the period 2007 to 2009”* and in relation to *“the General Practitioners treating Mr William Payne from April 2008 onwards”*. I am mindful of the comment made by Mr Stewart in his submission – *“We would all wish that Mr Payne was not driving that day, it is another thing altogether to identify an individual to tell him not to do so.”* The families’ submission does not, of course, identify and specify any particular individual doctor. I shall take this point into account in approaching the question of whether there should be a determination under this section in respect of the medical examination and treatment of the driver, William Payne, and if so what its terms should be.

10.212 In that connection I require to take account of the evidence of witnesses presented as expert witness and of witnesses, who were not experts, but whose opinions were sought on matters relating to the history of Mr Payne’s medical examination and treatment, which were not matters in which they had been personally involved. I note, for example, that the propositions in the families’ submission about the medical treatment of William Payne placed reliance on the evidence of Dr Duff, as well as Dr Grubb and Dr Northcote. I have

referred to Dr Grubb's and Dr Northcote's evidence in some detail in the section on expert and opinion evidence above. I considered their evidence, and that of Dr Hanley, to be more authoritative and persuasive than Dr Duff's opinion evidence about Mr Payne's medical history and whether at particular times he should have been advised to report his losses of consciousness to DVLA and stop driving and I attached greater weight to their evidence. Ms Ceresa's submission referred to the evidence of Professor McColl. He was not an expert witness and I have set out my view of the weight to be attached to his evidence above.

10.213 Dealing now with the first of the consultants at Stobhill, Dr Alistair Ireland, I have noted that no issue was taken with Dr Ireland's evidence that his concern was to work out what was wrong with Mr Payne and to admit him to hospital and that giving him advice about driving was not in his mind. I accept his position. I accept Ms Ceresa's submission that Dr Ireland's actions were reasonable, no witness criticised him and no findings should be made in relation to him. I do not consider it appropriate to make any section 6(1)(c) determination that relates to Dr Ireland.

10.214 Turning to Dr Cleland, his position was summarised by Ms Ceresa in a statement that she put to him, with which he agreed - namely, that in his clinical judgment the clinical context of Mr Payne's case was that it fell squarely in box 1 of the DVLA guidance. However, I was uncertain whether that statement of his position reflected a process of assessment which Dr Cleland carried out at the time he dealt with Mr Payne or retrospectively.

10.215 It was not clear to me how much detailed recollection Dr Cleland had of the case, the examination in question having taken place over five years before he gave evidence. As Ms Ceresa stated in her submission for Dr Cleland, "*Dr Cleland had no particular recollection of William Payne*". At the start of his evidence Dr Cleland stated that in answering questions about his examination of William Payne on 13 January 2009 he could only go by the letter that he sent to the GP, to which reference has been made (Production 7 page 5). The medical records produced at the Inquiry included no handwritten record for Dr Cleland, the explanation being that the notes were lost.

10.216 As Ms Ceresa also stated in her submission, Dr Cleland "*had a limited remit for reviewing William Payne*". I have noted Dr Cleland's evidence about that above. Dr Cleland

did not give evidence that his limited remit involved consideration of Mr Payne's fitness to drive. His evidence included a statement that at the time he did not go into details of earlier incidents and symptoms because there were no further episodes since October 2008 and his remit was to ask about any incidents in the three month period since Mr Payne's October admission. However, he said he knew about the provoking circumstances in relation to the December 2007 and October 2008 episodes, and that the "earlier admissions had clear provocation and prodrome".

10.217 I do not have a note of Dr Cleland stating in terms during the course of his evidence that he did in fact go through a process of applying the DVLA guidance to Mr Payne's circumstances at the relevant time. However, some of his statements mentioned in my outline of his evidence above seemed to suggest that he did so. An example is the statement that at the time he saw Mr Payne his clinical judgment was that Mr Payne was not high risk and so no lifestyle restriction was appropriate. (In the context I understood this to relate to driving.)

10.218 As regards the application of the DVLA guidance, Dr Cleland's approach appeared to contrast with the view of the medical witnesses associated with the DVLA. To repeat what I have noted above - Professor Marson considered that the guidelines are very clear, that they are written in "a very prescriptive manner" and they are "intended to be applied in a very rigid way". Dr Griffith described the guidance as "unequivocal" and stated that it is very clear that the DVLA "have taken a strict approach to the guidance". Dr Hanley, Professor Marson and Dr Griffith all emphasised that if faints are recurrent the doctor must consider the "3Ps" on each and every occasion and the "3Ps" must be present on each and every occasion for box 1 to apply. If not the DVLA require to be notified and there are driving restrictions.

10.219 Dr Cleland's emphasis in his evidence was on whether the episodes were "unexplained" and he attached great importance to clinical judgment. In relation to the need to identify the presence of all three of the "3Ps", when it was suggested that he did not know if there was a trigger for what was described as the second incident on 6 October 2008 (i.e. the collapse in the hospital) Dr Cleland replied "I don't know, but that doesn't stop me from applying clinical judgment." When asked about the need to check that the "3Ps" apply

on each occasion of recurrent blackouts, he said: “Yes, but you need to use clinical judgment.” He further commented that in relation to the application of the DVLA guidance: “It is not as simple as applying three things. It is a helpful guide, but clinical judgment is necessary.”

10.220 As I have noted, Professor Marson and Dr Griffith did not give oral testimony and so were not available for examination on Dr Cleland’s approach, including the question of the role of “clinical judgment” in the operation of the guidance. Dr Hanley was not questioned about this. The expert witness Dr Northcote was asked about this in one particular context, to which I refer below.

10.221 Key propositions advanced by Ms Ceresa in her submission were that there should be no section 6(1)(c) determination concerning Dr Cleland because Dr Cleland was not aware of the April 2008 episode of loss of consciousness by William Payne and that Dr Northcote’s criticism of Dr Cleland was in effect nullified by Dr Northcote’s “crucial concession” (as Ms Ceresa put it) that Dr Cleland was entitled to come to a different clinical judgment because only limited information about Mr Payne’s history was available to Dr Cleland .

10.222 I accept Dr Cleland’s evidence that he did not know about the April 2008 episode. However, it does not necessarily follow from that acceptance that I require to accept the submission that no section 6(1)(c) determination can be made in relation to Dr Cleland, as Ms Ceresa submitted. What is described by Ms Ceresa as Dr Northcote’s “crucial concession” relates to the question put to Dr Northcote by Ms Ceresa whether (to quote Ms Ceresa’s actual question) “if there was evidence that Dr Cleland did not have all of the paperwork” available to him at the time he saw Mr Payne and the letter calling a halt to investigations resulted from that, Dr Cleland was entitled to a different clinical opinion. I accept Dr Cleland’s evidence that he did not have all the records before him. However, he did have what he described as the “admission bundle” and that “bundle”, as Mr Fitzpatrick demonstrated in his cross examination of Dr Cleland and as Dr Cleland accepted, included Dr Ireland’s note which stated that there had been “*2 similar collapses this year resulting in brief hospitalisations*”. As I understood it, that reference covered the 30 April 2008 collapse.

10.223 A further submission by Ms Ceresa, which prayed in aid Professor McColl's evidence about his experience in relation to out-patient consultations as regards the limited time available for consideration of medical records, is also relevant.

10.224 Dr Cleland's evidence about whether he read Dr Ireland's entry in the medical notes was somewhat confusing. As I noted it he said: "I didn't read this. I saw '2 collapses' and may have thought that was December 2007." He went on to say that he was not asking questions about previous collapses. I did not understand it to be argued that Dr Cleland entirely missed Dr Ireland's note because of limited time for review of the records. Dr Cleland's evidence suggested that he may have read Dr Ireland's note, but he misinterpreted it. If Dr Cleland did read the note by Dr Ireland and he was forming a clinical judgment about whether Mr Payne was high risk and whether lifestyle advice should be given to him, it would have been relevant, reasonable and easy for him to have asked Mr Payne for clarification of the entry.

10.225 Dr Cleland's evidence was that had he been aware of the April 2008 episode that would have affected his approach and "might have changed things".

10.226 My view of the position, on the basis of the evidence, is that when Dr Cleland examined William Payne on 13 January 2009, he was not aware of Mr Payne's blackout in April 2008, but the bundle of medical notes that was available to him when he saw Mr Payne included an entry which, had he read and understood it or sought clarification of it, would have led him, on his evidence, to take a different approach that might have changed things.

10.227 Looking at the matter with the benefit of hindsight and taking account of the evidence of the expert witnesses, my conclusion is that there was an opportunity for Dr Cleland when he saw William Payne on 13 January 2009 to take action that might have had the result that Mr Payne's medical condition that made him unfit to drive may have been discovered earlier, with consequent revocation of his entitlement to drive. It would have been reasonable for him to do so. It would have been a reasonable precaution that might have prevented the accident and deaths for Dr Cleland to have arranged for further appropriate tests to be carried out in relation to Mr Payne's episodes of loss of consciousness and to have advised Mr Payne not to drive and to report his blackouts to DVLA.

10.228 I do not consider it appropriate in the circumstances to make a determination about the *"treating clinicians at Stobhill Hospital"* in the terms sought by the families, although I understand the reason for that submission. Nor do I believe it would be appropriate to make a determination under this subsection of the Act in the terms suggested by the Crown in their section 6(1)(e) submission that William Payne would not have been the holder of a valid licence at the time of the fatal accident if DVLA guidelines for medical practitioners had been properly followed and William Payne's condition had been properly diagnosed.

10.229 I believe a determination on this matter should be more specific about the particular occasion or occasions when the evidence suggests there was a clear opportunity to take specific action that might have had the result of preventing the accident and deaths. That is why I have concluded that my determination about a reasonable precaution should relate to the specific occasion when Dr Cleland saw Mr Payne.

10.230 There are some important comments to be made about a determination that relates to Dr Cleland's involvement with William Payne. The first is to emphasise that my approach has involved applying hindsight. Secondly the determination, of course, simply addresses the statutory question of whether there was any reasonable action that Dr Cleland could have taken that might have had the result of avoiding the accident and deaths. Further, the evidence suggested that Dr Cleland would have taken a different approach, which may have involved further tests and advice not to drive, had it not been for two unfortunate circumstances. The first was that at the consultation on 13 January 2009 Dr Cleland did not know about the April 2008 episode. The second was that he did not have the opportunity to examine William Payne in September 2009 after Mr Payne's collapse on 5 June 2009, because Mr Payne did not attend the appointment.

10.231 Turning to the General Practitioners, Dr Keatley's only relevant consultation with Mr Payne was on 4 September 2008 and that was in connection with a sore throat not a faint, although Mr Payne was concerned that he had fainted previously when he had a sore throat. In fact, he had another blackout a month later. Mr Stewart's submission was that Dr Keatley's actions were reasonable and there was nothing further she should have done in the circumstances outlined in his submission.

10.232 It was evident that Dr Keatley had been shocked and upset about the circumstances which had resulted in her having to come to court as a witness. I believe that had affected her initial reaction when she gave a statement to the police, in which she said that Mr Payne should have been told not to drive, and possibly also her position in court, when she was clearly trying to help the court although her evidence was not entirely consistent. It was to her credit that she frankly admitted her lack of familiarity with the DVLA guidance at the time. In the circumstances, though, I reached the view that that lack of familiarity had not been sufficiently relevant to Dr Keatley's own dealings with William Payne to justify a section 6(1)(c) determination relating specifically to Dr Keatley and I accepted Mr Stewart's submission in that regard.

10.233 Although Dr Keatley would fall within the category of *"the General Practitioners treating Mr William Payne from April 2008 onwards"* in the families' submission, a determination in the general terms sought by the families does not commend itself to me, for reasons that I have mentioned above in relation to the clinicians at Stobhill Hospital and that I shall explain further below.

10.234 As regards Dr Cox, it is right to record at the outset that Dr Cox's decisions to arrange to see William Payne after the phone call about the jury excusal letter and then to refer William Payne back to Dr Cleland were clearly sound and sensible decisions. As noted, events may have turned out very differently if Mr Payne had attended and been examined again by Dr Cleland.

10.235 In assessing Dr Cox's evidence I have noted Mr Stewart's submissions about the content and interpretation of Dr Cox's evidence, and the view that I should take of it and of Dr Cox's credibility and reliability as a witness. My assessment is based on my analysis of Dr Cox's evidence, as outlined above. What Dr Cox's evidence seemed to come to was that, although she said she would take care to phrase a jury excusal letter appropriately, she invited the court to accept that she inadvertently misrepresented the nature of Mr Payne's condition in the letter she provided to assist him to avoid jury service, while maintaining in her evidence that there was a risk that having to undertake jury duty may have caused a problem to Mr Payne (by having a blackout) and disruption to the court process, because jury service is very stressful to patients in her experience. In her perception such service

was, in terms of stress, quite different from driving. In context I took that to mean that it is more stressful than driving. While her purpose in writing the jury excusal letter was “safeguarding his (Mr Payne’s) health and avoiding disrupting the court process” in relation to jury service, I interpreted her evidence to mean that she did not discern a similar need to safeguard the patient or others in the context of driving. Whether that was the result of active consideration of that issue at the time or not was not clear to me, but in any case I did not find the distinction that Dr Cox sought to make between jury service and driving persuasive.

10.236 I was uncertain when hearing and reviewing Dr Cox’s evidence whether at the time she dealt with William Payne she gave any consideration to Mr Payne driving or not. She answered some questions in a way that gave the impression that she had at the time given thought to the matter of Mr Payne driving, without clearly stating that she had in fact done so. On various occasions Dr Cox said she “would” have thought or done or not done certain things. At other times, her evidence seemed to suggest retrospective consideration.

10.237 As regards expert comment on Dr Cox’s evidence, Mr Stewart’s representation of Dr Northcote’s position (at page 76) was that Dr Northcote declined to criticise Dr Cox in relation to the letter that Dr Cox had written regarding jury service. However, I have noted that although Dr Northcote said that it was difficult to criticise Dr Cox on the letter rather than a clinical history, he expressed the view that based on what the GP had written she should have advised the patient to stop driving. It was also Dr Hanley’s view that Dr Cox should have told Mr Payne not to drive. Dr Grubb agreed with the proposition that by the stage of the letter from Dr Cox about excusal from jury duty Mr Payne should have been told not to drive and DVLA should have been informed.

10.238 Dr Cox’s revisal of her original written statement in her letter that Mr Payne’s episodes of collapse were “unexplained” might have gone some way to meet the opinions of the expert witnesses, but that was not a part of Dr Cox’s evidence that I found convincing.

10.239 Dr Cox said in her evidence that she had never assessed Mr Payne after a faint and Mr Stewart suggested that this was of some significance. However, the reason for Dr Cox arranging to see William Payne on 10 July was the phone call from Mr Payne which resulted in the jury excusal letter that Dr Cox wrote. The specific subject matter of that phone call

and that letter was Mr Payne's collapses and that appears to have been the reason for Dr Cox seeing Mr Payne on 10 July 2009. Dr Cox's record of that consultation started with the statement: "*worried by further vasovagal episode that occurred last month*" (Production 6 page 8).

10.240 The Procurator Fiscal submitted in relation to Mr Payne's consultation with Dr Cox that "*(t)here having been a recurrent vasovagal episode the 3P's should have been examined and the matter reported to DVLA*" and: "*Dr Cox should in July 2009 have advised William Payne not to drive and to report his condition to DVLA.*" Ms Bain for the families submitted that Dr Cox should have appreciated that the June 2009 collapse was a new unexplained event "*and the appropriate steps taken – examination and direction to inform the DVLA.*"

10.241 In the circumstances I believe it would have been reasonable for Dr Cox when she saw William Payne on 10 July 2009 to have given consideration or closer consideration to the question of Mr Payne's fitness for driving - taking account of the recent episode of collapse on 5 June 2009, Mr Payne's anxiety about that, Dr Cox's view that Mr Payne was unfit for jury duty and her decision to refer him back to Dr Cleland - and to have advised him not to drive and to inform DVLA of his blackouts. It would have been a reasonable precaution whereby the accident resulting in the deaths might have been avoided for Dr Cox to have advised William Payne not to drive and to inform DVLA of his blackouts, pending his further consultation with Dr Cleland.

10.242 I have previously mentioned the families' submission relating to "*the General Practitioners treating Mr William Payne from April 2008 onwards*" and the precaution it was suggested they could have taken. Not all of the treating General Practitioners were witnesses at the Inquiry, including at least one whose view of the episode with which he dealt was queried. There was therefore no opportunity for comment or explanation from them, including about the application of the DVLA guidance.

10.243 As with the clinicians I believe a determination in relation to GP examination and treatment of William Payne should be more specific about the particular occasion or occasions when the evidence suggests there was a clear opportunity to take specific action that might have had the result of avoiding the accident and deaths. In all the circumstances I think it appropriate to restrict any section 6(1)(c) determination about the General Practitioners to the occasion when Dr Cox dealt with William Payne.

Reasonable Precautions – DVLA

10.244 For completeness I should record here that the DVLA submission under section 6(1)(c) was: *“there are no reasonable precautions that the DVLA could have taken by which the accident resulting in the deaths of Mhairi Convy and Laura Stewart might have been avoided.”* No issue was taken with that submission and there was no evidence that would lead me to make any other finding. I accept the DVLA submission.

Part 11. Section 6(1)(d)

The defects in any system of working which contributed to the death or any accident resulting in the death -

11.1 There was no evidence and there were no submissions that there was any defect in the DVLA system relating to fitness for driving and there is no basis for any determination in this regard. A suggestion was made in the Crown submission about a possible recommendation about a particular aspect of the system of medical examination for renewal of Group 2 licences. That is dealt with below under section 6(1)(e). The DVLA submission under section 6(1)(c) was: *“there are no defects in the DVLA’s system of dealing with fitness to drive which contributed to the accident resulting in the deaths of Mhairi Convy and Laura Stewart”*. I accept that submission, which was not challenged.

11.2 It is appropriate to record here that there was evidence that the DVLA reviews its medical guidelines on fitness to drive on a regular basis, taking advice from expert medical advisory panels.

11.3 The only reference to any other system of working in any other submission was a reference by Ms Ceresa to the missing medical records at Stobhill Hospital when Dr Cleland saw William Payne in January 2009. There was no issue taken with this and I accept the submission that the sub-section is not relevant to Dr Cleland and there should be no finding in relation to him.

Part 12. Section 6(1)(e)

Other facts which are relevant to the circumstances of the death -

Submissions

12.1 **Crown** - I have noted above that the Procurator Fiscal made submissions for the Crown in support of a suggested section 6(1)(e) determination that given William Payne's medical condition he should not have been driving a motor vehicle on the road and he would not have been the holder of a driving licence at the time of the fatal accident if "(a) *he had acted upon DVLA recommendations to drivers and acted honestly and responsibly*"; (b) *DVLA guidelines for medical practitioners had been properly followed*", and (c) *"William Payne's condition had been properly diagnosed"*. I have previously set out the Crown's further submissions in that regard.

12.2 In a supplementary Crown submission relating to the families' submission, the Procurator Fiscal submitted: *"The purpose of a Fatal Accident Inquiry being to inquire into the circumstances of a particular death or deaths no finding should be made in terms of section 6(1)(e) of the 1976 Act in relation to any matter concerning decisions in relation to criminal proceedings."*

12.3 The Procurator Fiscal separately also invited me to make certain recommendations, as follows:

"1. DVLA should give consideration to making it a requirement that the Doctors conducting medical examinations for Class 2 driving licence renewals should be required to have sight of an applicant's medical records or at least a medical history form completed and stamped by a GP.

2. That training in DVLA Guidelines should be included in Continuing Professional Development (CPD) programmes for doctors. There could be a particular emphasis on the need to tell patients of their duty to inform DVLA of blackouts and the relevant criteria."

I propose to deal with these recommendations in this section of the Determination.

12.4 The first proposed recommendation was based on comments by Dr Duff in which he expressed some concern that the system of allowing Group 2 medical examinations to be carried out by a doctor who was not the driver's GP could result in the driver concealing relevant information about his medical history in order to keep his licence.

12.5 In relation to the second point the PF noted in the Crown submission that it was suggested in evidence that knowledge and understanding of DVLA guidelines could be

included in Continuing Professional Development training administered by the Royal Colleges such as the Royal College of Physicians.

12.6 Families – The families’ submissions under section 6(1)(e) were:

“(FIRST) Prior to the FAI, in correspondence to Mr Jamie Hepburn MSP, the Solicitor General for Scotland has explained why there has been no prosecution of Mr Payne for contravention of the RTA 1988. In light of the evidence, the Solicitor General’s reasoning for this, as detailed in her letter, has been shown to be seriously flawed. The Solicitor General should reconsider matters in light of the evidence – evidence that was available before the FAI and not referred to in her letter.

(SECOND) Prior to the FAI, in correspondence and in meetings with the families of Laura and Mhairi, representatives of the Crown Office and Procurator Fiscal Service (“COPFS”) have explained why there has been no prosecution of Mr Payne for contravention of the RTA 1988. In light of the evidence, the reasoning provided by COPFS for this has been shown to be seriously flawed. COPFS should reconsider matters in light of the evidence – evidence that was available before the FAI and not referred to by COPFS in their correspondence and meetings with the families.

(THIRD) Knowledge and understanding of DVLA guidelines should be included in Continuing Professional Development training administered by the Royal Colleges for all practicing medical professionals.”

12.7 In relation to the first and second submissions Ms Bain for the families referred to correspondence written by the Solicitor General for Scotland and the COPFS. The families’ submission contained a fairly detailed account, analysis and critique of that correspondence and of statements and explanations in it about why there had been no prosecution of William Payne. The submission sought determinations inviting reconsideration of matters by the Solicitor General for Scotland and the Crown Office and Procurator Fiscal Service. Ms Bain’s “proposition” in that connection was: *“The Solicitor General for Scotland and COPFS should reconsider their previous assessments of the evidence and revisit their decision on the prosecution of Mr Payne for contraventions of the RTA 1988. The previous assessments of the evidence made by both the Solicitor General and the COPFS are seriously flawed and fail to take into account important features in the evidence.”* It was further suggested that the previous

assessments were contradicted by the written submissions provided to the FAI by the Procurator Fiscal.

12.8 The third submission for the families appears to follow from averments in the families' submission, such as that *"the GP practice had a lack of awareness of the DVLA guidance"*.

12.9 **DVLA** – The DVLA submission was: *"there are no other facts relating to the DVLA and the DVLA's system of dealing with fitness to drive which are relevant to the circumstances of the deaths of Mhairi Convy and Laura Stewart."*

12.10 Mr Olson in the DVLA submission offered comment on the families' Third submission, the related recommendation suggested by the Crown and the further recommendation proposed by the Crown about the licence renewal medical examination system.

12.11 As regards the point about DVLA guidance training for doctors Mr Olson argued that notwithstanding the agreement of certain doctors with the PF's suggestion that it might be helpful if their knowledge of the DVLA guidelines was improved, there was no evidence that lack of familiarity with the *"At a Glance Guide"* and the requirement to notify the DVLA was a widespread or significant problem among doctors. There was no evidence that there was a particular unmet need in relation to education about fitness to drive. Mr Olson suggested in the DVLA submission that all of the doctors were aware of the DVLA *"At a Glance Guide"*. He proposed what he described as two reasonable assumptions, the first being that if the doctors involved in Mr Payne's case needed any further advice, they would have asked the DVLA for advice, and the second being that as they had not done so it could be assumed that that was because they did not consider that they needed further advice.

12.12 Reflecting what had been said in evidence by witnesses such as Dr Hanley, Mr Olson stated in the DVLA submission that the DVLA relies on doctors being aware of the issue of fitness to drive and the obligation to notify the DVLA of conditions that may affect safe driving. He expressed the view in his submission that *"it appears from the evidence to this Inquiry that all the doctors were aware of the issue of fitness to drive."*

12.13 So far as the question of appropriate training of medical professionals and continuing professional education was concerned, Mr Olson noted that this is primarily the responsibility of those organisations that provide training and education. In his submission

there was no evidence that those organisations were not providing appropriate training and education about fitness to drive either in general or in particular cases and that there were therefore steps that the DVLA should take to train and educate doctors to fill a gap in their professional education.

12.14 Mr Olson also commented in some detail on the possible changes in the system of medical examination for Group 2 licences suggested in the Crown submission. Several arguments were advanced by Mr Olson in resisting the Procurator Fiscal's suggestion, some of which had been discussed in Mr Olson's cross-examination of Dr Duff. I do not intend to repeat them all here. They included the point that in Dr Duff's experience most examinations do not reveal problems and it would therefore be an unreasonable imposition on hard-pressed GPs to have to check what in most cases would be a correct "no" answer. Some of the other points raised were – not all drivers have a GP and doctors who regularly carry out such examinations build up familiarity and expertise that might make them better placed to carry out these examinations than GPs.

12.15 **William Payne** - The only submission in relation to this section was that the first and second determinations sought by the families "*are not competent*".

12.16 **Dr Ireland and Dr Cleland** – Ms Ceresa submitted that there were no relevant facts so far as Dr Ireland and Dr Cleland were concerned.

12.17 **Dr Sambale, Dr Keatley, Dr Cox and Dr Padgham** – Mr Stewart submitted that there were no other relevant facts so far as the GPs were concerned.

12.18 It is appropriate to mention, however, that the evidence of Dr Sambale was relevant to the suggestion made by the Procurator Fiscal about the medical examination system for Group 2 driving licence renewal. Dr Padgham gave evidence about the procedure she followed in that regard when she dealt with William Payne's licence renewal application and examination in June 2005. There was no issue with the procedure carried out by Dr Sambale.

Discussion

12.19 I have dealt with the Crown submissions in support of a suggested section 6(1)(e)

determination in my discussion above concerning section 6(1)(c) of the Act. I do not consider it necessary to discuss them further. I have focussed there on the question of whether, given that William Payne's medical condition made him unfit to drive a motor vehicle on the road at the time of the fatal accident, there were any reasonable precautions that might have had the result that he would not have been driving at that time and the accident and deaths might therefore have been avoided. I was not specifically addressed by the Procurator Fiscal on why it was thought more appropriate to include the matters raised in the Crown submission as other relevant facts under section 6(1)(e), rather than matters to be considered under section 6(1)(c).

12.20 I have noted and considered the terms of the first and second families' submissions and the supporting proposition and argument. The submission proposes determinations inviting reconsideration by the Solicitor General for Scotland and the Crown Office and Procurator Fiscal Service of the question of prosecution of William Payne. I do not regard determinations of that nature and in terms such as are proposed to be appropriate or competent determinations under the 1976 Act. I refer to the discussion in the section headed "Particular Legal Issues".

12.21 I have, however, recorded in an earlier part of this Determination that it was expressly stated by the Procurator Fiscal that the Crown reserved the right to prosecute and it was my clear understanding that the Crown would review the matter after completion of the Fatal Accident Inquiry. No doubt in the course of any such exercise account will be taken of the families' submission, a copy of which was passed to the Crown.

12.22 The third submission for the families and second of the Crown proposals about a recommendation concerned training of medical practitioners in relation to the DVLA guidance. I noted that in the course of his evidence Dr Northcote stated that one thing he had learned from his involvement in this case was that the DVLA "At a glance" Guidelines are not as widely known or known in as much detail as they should be by medical practitioners. He suggested this should be addressed in the training of doctors, for example by the Royal Colleges. One of the GP witnesses, Dr Keatley, admitted that her knowledge of the guidance had been limited, although she said her GP practice is now much more aware of the DVLA guidance and driving issues.

12.23 There were three medical witnesses connected with the DVLA, Dr Hanley, Dr Griffith and Professor Marson. Their evidence was that the guidelines are clear. I have already noted that Dr Hanley stated in evidence that the system and the DVLA rely heavily on the DVLA guidance being familiar to members of the medical profession who are looking after individual drivers.

12.24 On my assessment of the evidence the familiarity with the DVLA guidance of doctors involved in Mr Payne's case was less clear than Mr Olson suggests. It appeared to vary among the doctors who were witnesses. In the case of several doctors not called as witnesses it was not known. My view of the evidence was that not all of the medical practitioners who dealt with William Payne were familiar with the DVLA guidance or the detail thereof. I did not find convincing support in the evidence for Mr Olson's proposed "reasonable assumptions" about the doctors involved in Mr Payne's case.

12.25. Dr Northcote's suggestion about training resulted from what he said he had learned about knowledge of the DVLA guidelines based on his involvement in this case. It was not clear that he was suggesting that there was a widespread unmet need in relation to education about fitness to drive and there was no evidence to that effect. There was no evidence about the extent to which training about the DVLA guidance forms part of the training of doctors, including continuing professional development training. In the circumstances I do not believe a formal determination about this matter in the terms sought by the families or a recommendation such as is proposed by the Crown would be justified. However, as the evidence in this Inquiry may raise a question about the level of awareness of the DVLA guidance among medical practitioners I believe the best course in the circumstances is to direct the Sheriff Clerk to bring this Determination to the attention of the appropriate medical bodies – the relevant Royal Colleges – for information, consideration and any action they think appropriate in connection with the training of their members in respect of the DVLA guidance and the relevant duties of doctors.

12.26 I turn now to the other recommendation proposed by the Crown, namely that the DVLA should give consideration to making it a requirement that doctors conducting medical examinations for Group 2 driving licence renewals should be required to have sight of an applicant's medical records or at least a medical history form completed and stamped

by a GP. I have mentioned above submissions that William Payne deliberately chose to go to Dr Duff rather than his GP so that he could conceal relevant information about his medical history in order to keep his licence. Whether that was the case or not, Mr Payne's decision to go to Dr Duff meant that – unlike on the previous occasion when he went to his GP - the examining doctor was not in a position to consult relevant medical records. The Crown's suggested recommendation is understandable in that context.

12.27 However, Mr Olson pointed out a significant number of objections to changing the existing system, in the way suggested by the Crown. Some of these may have been met by the particular formulation of the suggested change that is recommended, but the change would at the least appear potentially to mean a general increased level of involvement in the process for GPs. There was no information available about the scale and seriousness of the problem that the change is intended to address and it is not therefore possible to assess whether the proposed requirement would be a proportionate response. The suggested change relates to an aspect of the DVLA system and it was not supported by the DVLA, one of the parties to the Inquiry. In all the circumstances I am not persuaded that I should make a recommendation that the DVLA should consider the proposed requirement.

12.28 Finally I accepted Ms Ceresa's and Mr Stewart's submissions that there were no other relevant facts so far as the consultants and GPs were concerned.

Annex 1 - List of Witnesses

Crown Witnesses:

Karen Maginnis
Mark Hopwood
Gary McGinley
John Connelly
Darren Bell
Mark Harrison
Philip Docherty
David Toner
John Hutchison
Brian McCabe
P.C. Dawn Lindsay
D.I John Anderson
P.C. Gary O'Donnell
P.C. Gordon McIntyre
P.C. Alan Stewart
Dr Gordon Duff
Dr Alistair Ireland
Dr Claire Keatley
Dr Stephen Cleland
Dr Roy Gardner
P.I. Bryan McGeoch
Dr William Tullett
Dr J P Leach
Dr Neil Grubb
Paul Little
Professor Kenneth McColl
Dr J G G Hanley
William Payne
Dr Katy Padgham
Dr Natasha Cox

Families' Witnesses:

Dr Robin Northcote
Dr Petra Sambale
Claire Wotherspoon
Dr Frances McManus
Dr Sandeep Bawa
Helen Little

In addition, as noted in the Determination, the evidence of a number of witnesses was agreed by Joint Minute or was given by affidavit.

The witnesses in question were:

Crown Witnesses:

Dr John Clark
Dr Julia Bell
Gail Audrey Ann Cooper
Karen Skinner
Alisdair Cameron
Jane Alexandra Officer
Sunella Lakshmi Brahman
John Santarossa
Dr Anthony Hamilton Moors

Families' Witnesses:

Dr Michael Griffith
Professor Anthony Guy Marson

Glasgow City Council Witnesses:

Peter Smith
James Rodden

Annex 2

JOINT LIST OF AUTHORITIES

1. Fatal Accidents and Sudden Deaths (Scotland) Act 1976.
2. Carmichael on Sudden Deaths and Fatal Accident Inquiries (3rd Edition).
3. Determination of Sheriff Principal Lockhart in “the Rosepark Inquiry” (Hamilton Sheriff Court 20th April 2011).
4. Determination of Sheriff Anderson in the Fatal Accident Inquiry into the deaths of Niamh Bysouth & Terrie Oliver (Paisley Sheriff Court 1st May 2012).
5. Black v Scott Lithgow Ltd 1990 SC 322.
6. Road Traffic Act 1988.
7. R v Hughes [2013 UKSC 56].
8. Motor Vehicles (Driving Licences) Regulations 1999/2864.
9. Smith v Lord Advocate (1995) SLT 379.
10. FAI Steven Dekker 2000 SCLR 1087.
11. Determination of Sheriff Fiona Reith QC in the Inquiry into the death of Sharman Weir issued 23rd January 2003.
12. Determination of Sheriff Kearney in the Fatal Accident Inquiry at Glasgow Sheriff Court dated 20th July 1993.
13. Determination of Sheriff Liddle in the Fatal Accident Inquiry into the death of Kieran Nichol dated 3rd June 2010.
14. Determination of Sheriff Principal Dunlop into the Fatal Accident Inquiry into the death of Colin Marr dated 21st April 2011.
15. Determination of Sheriff Mitchell in the Fatal Accident Inquiry into the death of Alexander Cusker dated 16 December 2008.
16. Determination of Sheriff Miller in the Fatal Accident Inquiry into the death of Mildred Rosenshire (July 2010).
17. Determination in relation to the death of James McAlpine, 17 January 1986, Sheriff Kearney.
18. Determination of Sheriff Stephen in the Fatal Accident Inquiry into the death of Lynsy Myles, February 2004.
19. Determination of Sheriff Braid in the Fatal Accident Inquiry into the death of Marion Bellfield March 2011.