

SHERIFFDOM OF LoTHIAN AND BORDERS AT SELKIRK

[2015] FAI 33

DETERMINATION

BY SHERIFF MICHAEL M. WOOD

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)

ACT 1976

into the death of

JEREMY JENKINS

Selkirk, 9 September 2015.

The Sheriff, having heard evidence and having resumed consideration of the cause, finds and determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that:-

1. In terms of section 6(1)(a) of the Act that Jeremy Jenkins, born 14 March 1960, died on 1 May 2014 at 15.38 in a road traffic accident on the A7 Edinburgh to Carlisle Road at a point near Torwoodlee, north of Galashiels.
2. In terms of section 6(1)(b) of the Act the cause of death was:-
 - a) Head injury due to,
 - b) Road traffic collision (tractor driver)
3. In terms of section 6(1)(c) of the Act there were no reasonable precautions whereby the accident resulting in the death might have been avoided.
4. In terms of section 6(1)(d) of the Act there were no defects in any system of working which contributed to the accident resulting in the death.

5. In terms of section 6(1)(e) of the Act there were no other facts which are relevant to the circumstances of the death.

Sheriff Michael Wood

Note

1. This is an Inquiry held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the death of Jeremy (known as Hew) Jenkins who died on 1 May 2014 while in the course of his employment with BAM Nuttall Limited. Consequently, in terms of Section 1 (1)(a)(i) of the Act it is mandatory that an inquiry be held.
2. The Crown was represented by Fiona Caldwell, Procurator Fiscal Depute. BAM Nuttall Ltd was represented by Katherine Brydon solicitor. They had entered into an extensive Joint Minute which admitted a significant number of facts, productions and the written statement of one witness, Alan Watt, a paramedic, as the equivalent of his oral evidence. Rather than narrate the terms of the Joint Minute at the outset I propose to make reference to matters agreed where appropriate in course of this Determination.
3. On 5 and 6 May, I heard evidence, in the order they were called, from the undernoted witnesses:
 - i. William Brearley, aged 67, a garage proprietor in Galashiels;
 - ii. Darren Howlett, aged 41, Police Service of Scotland based at Galashiels;
 - iii. Mark Laidlaw, aged 41, Police Service of Scotland based at Galashiels;
 - iv. Paul Gibson, aged 36, Police Service of Scotland based at Duns;
 - v. Darren Grieve, aged 59, Yard Manager Hawick Plant Auctions;
 - vi. Stephen Wilson, aged 49, Police Service of Scotland based at Fettes, Edinburgh;

vii. Margaret Fitzpatrick, aged 66, c/o Police Service of Scotland;

viii. Dr Joel Barker, aged 37, Teviot Medical Practice, Hawick.

I will consider the evidence of these witnesses in the chronological order of events leading up to and subsequent investigation of the accident. However I can say at the outset that I found all these witnesses both reliable and credible. In addition there was before me the effectively agreed evidence of the three further witnesses:

ix. Dr Robert Ainsworth, Consultant Forensic Pathologist, University Hospitals

Division, NHS Lothian whose Autopsy Report, (Crown Production) was agreed by Paragraph 1 of the Joint Minute;

x. Alan Watt, aged 47, Paramedic based at Galashiels whose written statement was agreed by (properly numbered) Paragraph 13 of the Joint Minute;

xi. Jane Douglas, aged 50, Ambulance Care Assistant based at Galashiels whose sworn affidavit was read to the Inquiry. It may be appropriate to record here that Mrs Douglas was an eye witness to the accident which is doubtless why it was felt appropriate to lead her evidence by affidavit rather than agree a police statement. While I was, obviously, unable to observe Mrs Douglas give evidence and so form a view as to her credibility, I found her evidence to be entirely in accord with all other relevant evidence, and in particular that of Constable Wilson, the Collision Investigator, and so accept her evidence as reliable.

4. From the foregoing it will not be immediately apparent that the driver of the other vehicle involved in the road traffic accident in which Mr Jenkins was killed did not give evidence. That driver was John Boyes, born 9 July 1938, who died on 17 August 2014. Crown Production 10 is the post mortem report relating to Mr Boyes and it certifies the cause of his death as cardiomegaly and coronary atherosclerosis. That report was

agreed by Paragraph 10 of the Joint Minute which also agreed that Mr Boyes' death was not related to the road traffic collision which occurred on 1 May 2014. However, while the circumstances of that collision are entirely clear on the evidence led before me, the same is not true as to whether any prior medical condition of Mr Boyes contributed to it. To a major extent that was the principal issue for consideration by me.

5. I turn accordingly to the circumstances leading up to the collision. Witness David Grieve, Yard Manager for Hawick Plant Auctions, explained that his business dealt in generators and generator plant. He knew Mr Boyes as Ian Boyes who had been employed by Hawick Plant as an HGV driver until he reached 65 (in 2003) since when he continued to drive for the business on a self-employed basis, paid for those occasions when he drove and responsible for his own tax and national insurance. He confirmed Mr Boyes was free to accept or reject requests "but that wasn't his approach to life" and sometimes he would drive each day of a week, then not for a fortnight if not required. The business owned one vehicle, a MAN 3 axle unit registration number EU05 TBO. Mr Boyes was the only driver of the vehicle and held the Operator's Licence for it. It was agreed in Paragraph 9 of the Joint Minute that he had last driven the vehicle on 17 April 2014.
6. On 30 April Mr Boyes had been asked to deliver a radiator to Glasgow the following day. He had been to the premises previously so did not require directions and was free to choose his own route. He had, Mr Grieve understood, come in on 1 May between 5.00 and 6.00am to collect the vehicle which had been attached to a three axle flatbed trailer, loaded the day before. He had left before Mr Grieve started work and so he had not spoken with him on the day of the accident. When they had last spoken there had been nothing about Mr Boyes' health to cause any concern.

7. On 1 May it appears that Mr Boyes reached Glasgow, made his delivery and set out back to the Borders. At about 1.30pm witness Margaret Fitzpatrick was driving to Glasgow on the M8, leaving at junction 15 onto a double width slip road. She was in the inside lane intending to turn left at traffic lights. She became aware of a vehicle behind her and to her offside – a transporter with white tractor unit and unladen trailer – and felt her car being bumped. It was not possible to stop in the queuing traffic but when the traffic lights turned red she did, got out and saw damage to her rear offside passenger door and adjacent bumper. The driver of the transporter saw her and indicated he would turn right but as she was committed to turning left she did so and then turned in a side street to return stopping behind the transporter which had stopped as well. Mrs Fitzpatrick said the driver of the transporter (who was Mr Boyes) immediately accused her of having undertaken him and caused the accident. She denied being at fault to which he responded it would be a 50/50 then. It was not a good place to remain stopped so although some details were exchanged Mr Boyes said she should call Hawick Plant for insurance details.
8. She was shown Crown Production 15 which was a piece of paper on which Mr Boyes wrote his name, address, (home) phone number, Hawick Plant and its number to which she added the registration number of his vehicle. The next day she had called Hawick Plant, became aware of the subsequent accident and contacted the police. Mrs Fitzpatrick said that in the course of her conversation with Mr Boyes she had no concern with his demeanour. He had seemed a bit blasé, showing no emotion, almost too calm though she thought he became agitated towards the end and jumped into his vehicle and sped away. At no point did she feel he was unwell. Even in the light of subsequent events I do not feel I can attribute any significance to this incident other than that Mr

Boyes' demeanour and conduct gave no indication of his being unwell or unfit to drive his vehicle, whether he was or was not responsible for what was on any view a minor accident.

9. The affidavit of witness Jane Douglas discloses that on 1 May she was working for the Patient Transport Service from Galashiels. She had driven a patient and his wife to an appointment in Glasgow that morning and was returning with them, leaving Glasgow at about 1.30pm. They travelled along the M8 to Edinburgh, then round the A720 Edinburgh City Bypass to the Sheriffhall roundabout before proceeding down the A7 to Selkirk. On the outskirts of Newtongrange (some 3.5 miles from Sheriffhall) she came up behind the MAN EU05TBO being driven by Mr Boyes. She could clearly see the words "Hawick Plant Auction" on the rear of the lorry cab as shown in photo 23 of Crown Production 6. She continued to follow immediately behind that vehicle through Heriot and Stow towards Galashiels over a distance of approximately 20 miles. Nothing in the way the lorry was being driven caused her any concern although when the lorry braked the tyres smoked. I pause here to observe that the evidence thus far discloses that Mr Boyes drove to Glasgow where he made the delivery and drove back virtually the whole return journey, at least as far as Torwoodlee, just north of Galashiels, on a mixture of single and dual carriageways, motorway and city streets without incident (other than the minor matter involving Mrs Fitzpatrick) and without any suggestion that he was unwell or in any sense impaired in his ability to drive his vehicle. On the contrary, his driving was described as normal.
10. However, approximately one mile north of the scene of the accident, Mr Boyes' vehicle followed by Ms Douglas came up behind a tractor and trailer. This was the vehicle being driven by the deceased Jeremy Jenkins. He was employed by BAM Nuttall Ltd in

the construction of the Borders rail link from Edinburgh to Tweedbank and at that time was driving the flat unladen trailer pulled by a John Deere tractor registration number OU62 HHC as shown in photo 14 of Crown Production 6. It is understood that Mr Jenkins was travelling on the A7 from one of the railside work depots to another. His vehicle was displaying flashing lights and was travelling at about 25mph. Mr Boyes was a safe distance behind him and travelling at a similar speed. There is a layby which has separate entry and exit points for southbound traffic shortly before the locus. At the southern (exit) of that layby Mr Boyes is described by Ms Douglas as having stopped his lorry for 5- 6 seconds and then pulled away again. She could see no reason for that action being taken and none emerged in other evidence led. Mr Boyes then recommenced his journey, as did Ms Douglas who was, by reason of the road curvature, able to see Mr Jenkins' tractor - trailer again some 60 to 70 metres ahead. Mr Boyes accelerated into that gap, as did Ms Douglas as the road then straightened out. There was no oncoming traffic but Mr Boyes gave no indication of any intention of overtaking either by signalling or the positioning of his vehicle.

11. Ms Douglas then describes Mr Boyes' lorry continuing to accelerate, not braking, and "ramming" the rear of Mr Jenkins' trailer. She describes the tractor cab tipping backwards and its front lift up which evidence is wholly consistent with the evidence of the collision investigator, PC Stephen Wilson. The lorry appeared to bounce back but then to accelerate once more while moving off the road onto the left grass verge and thus roughly parallel with the tractor - trailer which remained on the road and was thereafter undertaken by Mr Boyes' lorry. Ms Douglas did not see the lorry further contact the tractor - trailer or drag it. It continued on the road while the lorry returned to the road from the nearside verge and continued round a right hand bend travelling

the fastest seen by Ms Douglas since she came behind it at Newtongrange. Meantime the tractor-trailer continued in a straight line to the bend when it hit a telegraph pole and stopped. Ms Douglas stopped and dialled 999.

12. Though not the first police officer to attend the locus it is convenient now to turn to the evidence of the Collision Investigator, PC Stephen Wilson. Aged 49 he had been engaged in road policing since 1999 and collision investigation from 2007. He was made aware of the incident and attended on the day of its occurrence, observing the locus and examining the vehicles. He subsequently prepared a Collision Investigation Report which is both Crown Production 2 and 3, identical but for the final sentence in the Conclusions Section at 8.17 which relates to whether Mr Boyes suffered “a medical episode” immediately prior to the initial impact. I will address that issue subsequently following narration of the evidence relevant to that issue.
13. Meantime I am content to accept Constable Wilson’s thorough report as accurate. It is based wholly on the physical evidence and takes no account of eye witness evidence, though in this matter there does not appear to me to be any material difference (with the possible exception of whether the lorry crossed to the northbound carriageway after impact with the tractor-trailer) between those different sources which rather serve to mutually confirm what happened. I do not intend to rehearse its terms here, but simply draw from it facts which further explain the mechanics of the accident, and matters relevant to the statutory questions I am required to consider. Constable Wilson also prepared Crown Productions 4 and 5 being, respectively, a Collision Investigation Map and a Collision Investigation Reconstruction Plan. The former shows the physical evidence found at the locus and the latter illustrates the inferences as to what happened

which can be drawn from that evidence, showing the travelling positions of the respective vehicles as the accident unfolded.

14. As is set out in Sections 2.4 to 2.6 of the Report the physical evidence establishes the tractor trailer combination was struck in the rear by the MAN articulated lorry combination causing both to leave the (southbound) carriageway. As a result of the initial impact the driver of the tractor was ejected through the rear window of the vehicle and he has fallen between the tractor and trailer unit. The offside wheels of his trailer unit and the offside wheels of the MAN tractor and trailer travelled over him causing severe head injuries and almost immediate death.
15. Per Section 4.16 the first physical evidence was a 1 metre long gouge mark in the road surface some 30 metres south of the datum reference point (a double bend warning sign). The gouge was caused by the tow bar eye and bar between Mr Jenkins' tractor and trailer being forced into the ground by the impact from behind. To achieve that the front of the tractor would require to be raised a considerable distance off the ground. This is, as stated above, wholly consistent with Ms Douglas' evidence. Although she did not see this, the rear of the tractor was thus forced down with such force that Mr Jenkins, who was not wearing a seat belt, was propelled out the rear of the tractor. As shown on the Reconstruction Plan (Crown Production 5) examination of a mixture of locked and rolling tyre marks established that the nearside tyres of both vehicles entered onto the nearside verge, and subsequently both vehicles left the road entirely during which early stage the tyre marks left on the road confirm the tyres from both vehicles struck the deceased whose body came to rest on the roadside immediately beside the east verge. Further tyre marks established that the now driverless tractor - trailer returned to the roadway while the MAN lorry continued along the nearside

verge passing the tractor as it did so. The MAN lorry then returned to the roadway in front of the tractor, confirmed by the overprinting of tractor - trailer tyre marks on those from the MAN lorry which crossed for a period from the southbound carriageway to the northbound before regaining the southbound once more. Meantime the tractor - trailer continued in more or less a straight line to the start of the right hand bend before leaving the road to the nearside coming to rest against a telegraph pole some 237 metres south of the datum point. Parallel tyre marks consistent with locked wheels from the MAN lorry however continued southbound for 1650 metres (approximately 1 mile) to the point at which it came to a halt in the outskirts of Galashiels. Section 6.5 of the Report explained that "sturdy vegetation" on the nearside verge caused damage to the main air storage tank under the trailer causing rapid escape of air from the trailer braking system and locking the brakes. Flat spots on the trailer tyres confirmed they had been dragged, locked, along the road surface for a significant distance (Section 6.6). The mile long section of road over which the MAN lorry passed includes several bends and, within the outskirts of Galashiels, parked vehicles none of which were struck by it as can be seen clearly in photos 20 and 21 of Crown Production 6.

16. I turn now to the evidence of those who approached the locus travelling north from Galashiels and witnessed the accident or its immediate aftermath. Witness William Brearley was driving his Skoda, having left his garage in Galashiels at about 3.30pm. As did others he confirmed it was dry and road conditions were good. As he approached Torwoodlee Golf Course he saw the tractor - trailer and the lorry behind it on the straight some 200 yards away. The tractor - trailer was travelling at about 25mph. He then saw the lorry go into the back of the trailer of the tractor in a "straight on collision". The rear of trailer went up in the air, its nose went down forcing the front of

the tractor to “rear up” with both front wheels off the ground. The lorry did not deviate, just drove straight into the trailer and carried straight on. Mr Brearley expected both vehicles to stop but neither did which he thought bizarre. Mr Brearley was the sole eye witness travelling north. From his description of events it seems clear that while the initial impact occurred in front of Mr Brearley the consequences played out behind him. Had the MAN lorry crossed to the northbound carriageway when Mr Brearley was approaching he too would have been involved in the accident rather than watching it unfold in his rear view mirror.

17. Witness Special Police Constable Mark Laidlaw (whose principal job is Watch Commander with Scottish Fire and Rescue Service) was on shift that day and was called to attend at the locus at about 3.40pm. Making his way there with Constable Kerr while on the outskirts of Galashiels they saw an articulated lorry with severe frontal impact damage. Constable Wilson was tasked with securing the further scene where that vehicle was situated adjacent to the Salon 55 Hairdresser (all as shown particularly in photos 24, 27 and 28 of Crown Production 6). He was concerned to ascertain where the driver was and whether injured. He found Mr Boyes in the passenger seat of his cab. He knew Mr Boyes through part time employment as a vehicle examiner. He described Mr Boyes as “in an agitated state, fumbling around as if looking for something, asking a whole load of questions”. He said he was not injured but seemed in an “irrational and irritable state” and could not understand what had happened other than saying “someone hit my vehicle” and that he couldn’t drive his vehicle any further. Constable Laidlaw was concerned about Mr Boyes’ state of mind. He described Mr Boyes as “oblivious to what had happened” and explained that he kept repeating himself saying “What happened? I couldn’t drive my lorry. Something happened. Something has hit

my lorry". Mr Boyes was definitely behaving differently - suffering from severe mental shock or trauma, clearly distraught and in definite need of medical attention.

Meanwhile he had seen Police Constable Howlett pass, northwards, on his way to the locus and was still with Mr Boyes when Constable Howlett returned at about 4.15pm. For the sake of completeness I should add that Constable Laidlaw confirmed he had seen the tyre marks left by the locked wheels as shown in photos 21 and 22 of Crown Production 6 and that these had been left when the air brakes were damaged and the rear axle brakes locked.

18. Witness Constable Darren Howlett of the Road Policing Unit based at Galashiels attended the scene of the accident travelling from the south. As he did so he first saw the MAN lorry outside the Salon 55 Hairdresser and then the seemingly solid tyre marks from its rear extending the whole mile back to the locus where he met colleagues Wilson and Valentine who told him what they understood had happened resulting in the driver of the tractor being ejected through its rear window. He then returned to Galashiels to speak with Mr Boyes who was still in the cab of his vehicle speaking on his mobile phone. Mr Boyes asked him what had happened. Constable Howlett replied that he had been hoping that was what he (Mr Boyes) could tell him. He did not, repeatedly asking "what happened?". To the officer Mr Boyes seemed "vacant" and "a bit confused". Constable Howlett appeared satisfied that Mr Boyes "didn't have a clue what had happened". He was required to and did provide a breath test which proved negative. On Saturday 3rd May he seized Mr Boyes' mobile phone but did not know what examination of it had showed. Paragraph (8) of the Joint Minute agreed that subsequent examination showed that the phone was not in use immediately prior to or during the time of the collision. On 5th May he took possession of the MAN lorry's

tachograph charts (5) and Defect Book. Examining the latter showed that it had been regularly used (by Mr Boyes) but that nothing of concern arose. Apparently Mr Boyes had completed the Book daily whether or not a defect existed.

19. Witness Constable Paul Gibson was the reporting officer. Based at Duns he arrived at 4.10pm and as did his colleagues spoke to the locus, to the markings on the road and to the damage to both vehicles as shown in the photos within Crown Production 6 and on the subsequently prepared plans (Crown Productions 4 and 5). He too examined the Defect Book and found nothing of concern. He arranged for the tachographs to be examined which likewise revealed nothing of concern. Paragraph (9) of the Joint Minute agreed that the chart for the day in question showed that Mr Boyes drove for approximately 5 hours in total prior to the collision and that sufficient breaks were taken to accommodate the necessary legal requirements. Examination of previous tachograph charts show that Mr Boyes had not driven the vehicle previously since 17 April 2014. Constable Gibson's enquiries also secured recovery of a CCTV disc depicting the journey north of X95 First Bus through Galashiels and onto the A7 which showed the aftermath of but not the collision itself.
20. It seems likely that when Constable Howlett saw Mr Boyes using his mobile phone the latter was speaking with the Yard Manager of Hawick Plant Auctions, David Grieve. He spoke to having received a call in the afternoon from Mr Boyes who told him the lorry was a write-off. When asked what happened Mr Boyes said he did not know. He seemed "agitated - difficult to get sense out of". Asked what he had hit, or had hit him, he replied "nothing". Challenged that he must have hit something, that there must have been something in front of him he said "No, nothing in front of him". He kept on saying he did not know what had happened. He asked that his wife be contacted and that he

had to go because the police were arriving. About an hour later Mr Grieve called Mr Boyes who said the police were still with him, and that he had been told he had collided with a tractor, that he had asked how the driver was and the police wouldn't tell him which he said made him very worried. Then he handed the phone to the police. Mr Grieve was then asked about Mr Boyes' driving history. He said there had been an incident in 2006 when he collapsed at the wheel and was taken to hospital but was given the all clear and came back to work. He was a very experienced driver and had undergone annual health checks as required of HGV drivers aged 65 or above.

21. While it will already be clear that the evidence thus far narrated clearly establishes that the impact between the front of the MAN lorry driven by Mr Boyes and the rear of the trailer being towed by the tractor driven by Mr Jenkins caused Mr Jenkins to be ejected through the rear of the tractor cab, subsequently being struck by the trailer and lorry wheels, it is necessary to make mention of the evidence of two witnesses whose evidence was agreed by the Joint Minute by Paragraphs (1) and (properly numbered) (13) respectively. The latter agrees the written statement of the Witness Alan Watt as the equivalent of his oral evidence. That statement confirms that at 3.34pm on 1 May 2014 he was on duty at Galashiels Ambulance Station when he was called to the incident on the A7. He too drove past Mr Boyes' MAN lorry and arrived at the locus at 3.38pm. He was told by a person present that Mr Jenkins had taken his last breath some 4 minutes earlier. Examination of the body disclosed a severe head injury. There was no pulse, no breathing and no purpose in attempting resuscitation. Life was pronounced extinct at 3.38pm though it seems reasonable to conclude that in fact Mr Jenkins had died some few minutes earlier at or about the same time as the ambulance was being called. Mr Watt also stated that, as requested by the police, on their return to Galashiels, he

examined Mr Boyes and after full examination decided to take him to Borders General Hospital for further tests. During his examination by Mr Watt Mr Boyes stated, once more, that he did not know what had happened and could not understand why his lorry was damaged. Paragraph 1 of the Joint Minute agrees as an admitted fact that "Jeremy Jenkins was born on 14 March 1960 and died on 1 May 2014 at 15.38 hours and the cause of death was certified as 1 (a) Head Injury; due to 1 (b) road traffic collision (tractor driver) for the medical reasons set out in Crown Production Number 1 which report is agreed as accurate for its terms." The report referred to is the autopsy Report of 5 May 2014 by Dr Robert Ainsworth following post mortem examination of the deceased which confirmed that death was due to significant head trauma such that death would have occurred almost immediately. It also confirmed that there was no evidence of any significant natural disease, and that a full standard toxicology screen was entirely negative. Having regard to this evidence, and as agreed, I make the findings as set out above in respect of Sections 6 (1) (a) and (b) of the 1976 Act.

22. I turn now to whether or not there is sufficient evidence to allow me to make any further factual findings, and whether those facts justify any conclusion that there were any reasonable precautions whereby the death might have been avoided, any defect in the system of work which contributed to the accident resulting in the death, or any other facts relevant to the circumstances of the death. Both the Procurator Fiscal and Mrs Bryden for BAM Nuttall submitted that no findings should be made in respect of any of the matters mentioned immediately above. While considering these issues it appeared to me that there were 3 topics to address:

- i. the fact that Mr Jenkins was not wearing the seatbelt provided;

- ii. whether Mr Boyes was in control of his vehicle prior to and at the point of collision;
- iii. whether his medical history suggests he ought not to have been driving an HGV that day.

23. Looking at the first of those issues the Reporting Officer, Constable Gibson, gave evidence about the seatbelt fitted to the John Deere tractor. Photos 42 and 43 of Crown Production 6 show the seatbelt as found immediately after the accident. As can be seen there it is a lap belt only, and is fixed in position with the clip engaged in the socket, tight across the seat. The tractor was fitted with two flashing warning lights as shown in photos 45. Constable Gibson stated eye witnesses to the accident had reported that both green and yellow (orange) lights were flashing. The light on the driver's nearside was orange or red and was intended to show the tractor was in use. The other situated to the offside flashed green and was intended to show that the seatbelt was in use. Constable Gibson had spoken with representatives of BAM Nuttall who confirmed it was their policy to require employees driving tractors to wear the seatbelt provided. The sole purpose of the green flashing light was to allow an observer to tell whether the seatbelt was in use and so motivate its use. Constable Wilson stated that in addition the tractor was fitted with a warning buzzer which would sound if the belt was not secured. That buzzer was found post accident to be operating properly as were both flashing lights. It is clear therefore that Mr Jenkins was driving that day with the seatbelt underneath him, clipped into fixed position with the result that the warning buzzer was switched off, and the green flashing light activated. Both safety precautions had consequently been overcome.

24. There was some dubiety as to whether Mr Jenkins was legally required to wear the seatbelt at the time. Constable Gibson thought not because it was an agricultural vehicle while Constable Wilson thought that exemption did not apply when the vehicle was on a public road. However I do not consider I require to resolve that issue because it is clear that Mr Jenkins' employers required the use of the belt and the tractor was fitted with two devices to encourage proper use. Mr Jenkins had deliberately chosen to override those safety features but that does not necessarily mean that had he not done so his death might have been avoided. Constable Wilson thought that had the belt been in use Mr Jenkins would have been retained within the cab but acknowledged he was not medically qualified and accepted that if so restrained Mr Jenkins would have struck the rear window with extreme force. Constable Gibson was not asked for his opinion on this issue. In considering it I accept the test to be applied is not that the accident resulting in death would have been avoided, but rather whether it might have been avoided. On the limited evidence available I cannot say that I am satisfied even that lesser test is met. I so say because it is clear the impact on the rear of the trailer was very significant. I do not know whether that alone might have overcome the resistance of the seatbelt. Equally the force might have been such as to cause head injury to Mr Jenkins as he was thrown backwards - on which as Constable Wilson rightly said medical opinion would be required. Finally I consider it must be remembered this belt was a lap belt only and the extent to which such a belt would restrain a body against rearward forces is wholly unknown. Generally seatbelts are intended to provide protection against the body moving forward. Lap belts would seem to provide less protection in that direction and, inferentially, even less when the body is moving both backwards and upwards as the front of the tractor reared up. In my judgement, given the limited

information actually available which is restricted to no more than that Mr Jenkins was not wearing the lap belt available to him, it would be entering the realms of speculation to find that had he been wearing that belt his death might have been avoided. Such a conclusion might be reached if there were evidence as to the forces involved in the impact, the tolerances of the seatbelt fixings and perhaps particularly the significance of the direction of those forces, but no such evidence was available.

25. The final paragraph of the Collision Investigator's Report (Crown Production 3) states at 8.17: "It is the investigating officers (sic) opinion whilst considering all the available physical evidence that the impact between the two vehicles was due solely to the actions of the driver of the MAN articulated combination registered number EU05TBO. The actions would infer that the vehicle has been driven dangerously". The final paragraph of the previous draft of that report (Crown Production 2) contains those two sentences but adds a third as follows: "However it is highly likely that the circumstances are the result of the driver of the MAN articulated combination suffering a medical episode immediately prior to the initial impact". That sentence was deleted from the final report because it was felt this was a conclusion that unlike the remainder of the report was not drawn from the physical evidence and required consideration of both the evidence of Mr Boyes' condition immediately after the accident and of his whole medical history. It is to the unfortunately limited evidence on those matters that I turn, but in so doing must say that I consider that I could only conclude that "the vehicle had been *driven* (my emphasis) dangerously" if I was satisfied that at that time the driver was consciously in control of his vehicle. If he was not then he was not actually "driving" the vehicle whether dangerously or carelessly at the critical moments

notwithstanding all the evidence of his control of the vehicle on its trip to and from Glasgow earlier in the day.

26. The starting point of the actual incident appears to be the evidence from Ms Douglas that, having followed the tractor - trailer for some distance in an unremarkable manner, Mr Boyes stopped his vehicle for some seconds. There was no apparent reason for his so doing and none has since emerged. He then accelerated into the rear of the tractor trailer and appears on all the evidence to have done so without braking or taking any other avoiding action. From impact on it would seem that Mr Boyes lost control of his vehicle as first his nearside and then the whole of his vehicle mounted the nearside verge and continued along it for some distance during which the trailer airbrakes were damaged. His vehicle returned to the road, crossed briefly to the northbound carriageway and continued southwards. Mr Boyes' ability to control his vehicle thereafter was materially affected by the brakes locking. I consider however that during the post accident period he must have had some conscious control. I so conclude for two reasons. Firstly it appears evident that the lorry was steered through a series of bends approaching Galashiels and avoided parked cars within the town. It travelled approximately one mile. The tyre marks shown in Photos 20, 21 and 22 of Crown Production 6 appear to me to indicate the vehicle was steered and that had it not been it would have at some point left the road and or collided with a building or vehicle. Secondly Mr Boyes' reaction on stopping seems to have been not that he stopped because he had hit something but because he could not proceed further as the lorry would not go further - due to the locking brakes. He was not saying he did not know where he was, but rather did not know what had happened. He was, moreover, able to converse with police officers albeit appearing agitated, irrational and in need of medical

attention. It is possible that the symptoms displayed were shock and it is not inconceivable that the shock flowed from a realisation of what he had done. I have deliberately set out in preceding paragraphs the impression of all those who spoke with him in the aftermath from which I draw the conclusion that no one who spoke with him appears to have harboured any suspicion that Mr Boyes was anything other than genuine. Those persons include experienced police officers who knew they were dealing with a fatality and that potentially Mr Boyes faced a charge of causing death by dangerous driving if not even more serious charges at common law. The paramedic Alan Watt found Mr Boyes unable to explain what had happened, or why his vehicle was damaged. Mr Grieve added that Mr Boyes was anxious to learn of what had happened to the tractor driver once he had been told he had been in collision with a tractor - providing further evidence that Mr Boyes remained consistent in his bewilderment post accident. Albeit at greater remove when I explored matters generally with his General Practitioner, Dr Joel Barker (whose evidence I will consider further below), he said that although he did not know Mr Boyes well he believed him to be of good character and had no reason to suspect he was being deceitful and his feelings of concern subsequently appeared heartfelt and genuine. Accordingly, I cannot on the evidence thus far find anything to support a conclusion that Mr Boyes drove consciously and deliberately or recklessly into Mr Jenkins' trailer, and on the contrary such evidence as there is of Mr Boyes' state of mind post incident suggest he may well have suffered a medical mishap.

27. What that medical mishap might have been was explored to an extent with the only medical witness to the Inquiry, Doctor Joel Barker, formerly of the Teviot Medical Practice in Hawick and since April 2014 at a practice in Jedburgh. Properly speaking Dr

Barker could only give evidence of his meetings with Mr Boyes and his knowledge of him through the practice records which were not lodged. Although Mr Boyes was not registered as a patient with him personally he felt he had a rapport with him and he did subsequently consult Dr Barker. He confirmed that he had carried out the DVLA required annual medical check on Mr Boyes on 8 January 2014. This involved a standardised approach starting with reading the patient's notes, previous medical examinations and identifying any areas of concern in advance of meeting the patient. In so doing he followed the DVLA guidance which he had on his computer. Areas of concern were such matters as obstructive sleep apnoea, any seizure activity, indications of epilepsy, heart complaint or other heart condition. The form that has to be completed requires specific answers from the driver about any medical condition which might affect his ability to drive, but the doctor undertakes a systematic inquiry as well, and each question is separately considered with the patient. Following the questioning the doctor would take a urine specimen for analysis and carry out a physical examination. Dr Barker did not have available his notes of that examination but had no reason to doubt that was what happened, and it was his recollection that Mr Boyes produced a report from his optician which was transcribed into Dr Baker's report and then signed and stamped by him. Dr Barker advised that from a DVLA perspective there was nothing of concern although regarding Mr Boyes' general health his blood pressure was a little high and there was some evidence of blood in his urine. Both these matters were subsequently investigated and all was found to be in order. Consequently on the basis firstly of his reading of the notes, and secondly his meeting and examining Mr Boyes that day he had no concerns about Mr Boyes continuing to drive Heavy Goods Vehicles. He was aware that subsequent to the accident on 1 May 2014 Mr Boyes had surrendered

his HGV licence. He had also seen the correspondence sent to the Teviot Medical Practice about the investigations carried out since that date, and helpfully explained that the cardiomegaly listed as a cause of Mr Boyes' death meant simply that his heart was enlarged.

28. The Crown chose to use Dr Barker as the means by which to read into evidence the records of Borders General Hospital. I am bound to say I did not find this entirely satisfactory. While I appreciate that it is not practical to lead the author of each entry in medical records the decision here meant that although Consultant Neurologists and Consultant Cardiologists were involved in Mr Boyes' care both before and after 1 May 2014 the Court did not have the opportunity of exploring matters with them at all, far less seeking their opinion on the likelihood or not of medical mishap being the explanation of this accident. It would not have been proper to ask Dr Barker to comment on matters beyond his expertise and in consequence I can do little more than note what emerged on reading of Mr Boyes' medical records in Crown Production 8.
29. The records show that on 16 October 2006 (when aged 68) Mr Boyes suffered a "neurological episode" when he appeared to be choking, bleeding from the mouth and unaware of what had happened. He was admitted to hospital for observation, appeared to have fully recovered that day and was discharged but advised not to drive until authorised so to do by the DVLA. It was confirmed there was no past history of seizures but epilepsy was suspected and he was referred for neurological opinion. That opinion was provided on 14 November 2006. It was felt the history of a seizure was not convincing in the absence of symptoms of jerking of limbs or incontinence of urine and it was confirmed there should be no restriction on driving. Subsequent follow up by the

referring Consultant Physician confirmed that a 24 hour ECG carried out that month showed a normal sinus rhythm throughout.

30. On 3 September 2007 Mr Boyes, while driving, vomited frank blood and when examined by paramedics was sweaty, clammy and slightly confused. Admitted once more to hospital he was discharged the following day after normal ECG and Chest X-Ray reports. He underwent oesophago-gastro-duodenoscopy which confirmed that he had oesophagitis and that the incident was caused by his aspirating blood from his oesophagus. Apart from one minor and irrelevant other matter Mr Boyes does not appear to have attended hospital again until 1 May 2014.
31. In the circumstances based on the evidence of Dr Barker's examination of Mr Boyes on 8 January 2014, and on the absence of any presenting medical complaint in the nearly seven years prior to that there appears nothing from Mr Boyes' medical history to suggest there was any reason why he ought not to have been driving on 1 May 2014 far less any reasonable precaution which could have been taken by him, or indeed by anyone else, which might have prevented the accident. Neither of the incidents mentioned above appear in any sense to have been precursors of what seems to have happened on 1 May 2014 and each was investigated properly at the time, with consequent diagnosis in no sense indicating any risk in Mr Boyes continuing to drive. I do also observe that Mr Boyes, with his wife, acted promptly on each occasion in seeking medical advice which perhaps further confirms his character as sensible and responsible.
32. Although I conclude that on the basis of the knowledge of Mr Boyes' health as at 1 May 2014 the accident cannot be said to have been reasonably foreseeable, and hence any precaution whereby the death might have been avoided could not be reasonable, I do

consider it important to examine the post 1 May investigations to see whether or not they shed any further light on what might have happened and assist or not in determining whether and what sort of “medical mishap” might have occurred. The initial assessment as recorded at p31 of the notes records the patient as very distressed and suggests a “likely transient LOC (loss of consciousness) whilst driving”. The history taken is entirely in accord with earlier accounts viz: “First thing recollects is noticing smoke coming from back wheels of truck (so) pulled over. When got out of truck he realised he must have been in collision as extensive damage to front of truck”. The Consultant Physician, Dr Bennison, wrote to the Teviot Practice on 8 May 2014 reporting the impression of the Consultant Cardiologist, Dr Neary as “there was evidence of cardiac rhythm disturbance though (it was ?) unusual for atrial fibrillation or flutter to cause loss of consciousness and also unusual (for?) cardiac compromise to allow him to continue driving for approximately a mile”. A cardiac explanation therefore seemed unlikely. Dr Bennison also reported that following review by the Neurology Team “their impression was of unexplained loss of awareness” but that it was difficult to reach a clear diagnosis and not easy to understand how (he) would have been able to continue to control his vehicle if this was indeed a seizure”. Dr Barker was able to offer some further explanation that, as was the case in 2007, seizure was unlikely in the absence of symptoms of twitching or shaking, incontinence, or tongue biting.

33. Mr Boyes experienced a further episode of collapse on 19 July 2014, reported as “collapsed episode, loc for several minutes”. He was on this occasion a passenger in a car being driven by his wife who described him as being “on and off for 30 minutes, being vacant during each episode.” It involved uncontrolled shaking. He happened to be wearing a 24 hour ECG monitor at the time which tape “showed a lot of muscle

twitching at the time of the LOC but no arrhythmia". This was felt to exclude a cardiological explanation and neurological follow up was sought. That was provided by Dr Myles Connor, Consultant Neurologist, in an undated letter, being page 2 of the notes. With reference to the incident of 1 May 2014 he confirmed that in the absence of a witness account (of shaking etc) it was not possible to make a diagnosis of seizure before saying: "The fact that he was able to control the HGV for a mile beyond the accident made a seizure very unlikely but not impossible" before concluding that "We would not have been able to predict the further event in July based on history of events available in May or clarify the cause of the episode further in May". In short, it would appear neither Neurologists nor Cardiologists can offer any explanation but each excludes their area of expertise as a likely cause. Into that state of affairs Dr Barker was able to add that temporary LoC is not uncommon in the population at large. Its causes range from the simple positional to the serious neurological or cardiological. He could not say it occurred in 50% of the population though that figure did not surprise him and the incidence certainly increased in the elderly by which he meant aged 75+.

34. Faced with such medical uncertainty it is difficult to reach any conclusion other than that such evidence as was adduced of Mr Boyes' appearance and condition immediately after the accident is consistent with his having suffered likely transient LOC while driving. The extent of the loss could not be established and it is possible that, as was reported by his wife on 19 July, he was "on and off" which might explain the lorry being driven for the post accident mile.
35. I am however clear that the medical uncertainty makes it legally clear that there is no basis on which to find that there was any reasonable precaution whereby the accident

resulting in the death might have been avoided. Accordingly I make no finding under Section 6 (1) (c).

36. Likewise there was no evidence on which to make any finding that any defect in any system of work contributed to the death. For the sake of completeness I should record that Paragraph 11 of the Joint Minute, under reference to a vehicle examination report contained in Crown Production 11, agreed that the MAN lorry EU05 TBO was in good condition prior to the collision. Similarly Paragraph 12, under reference to a similar report contained in Crown Production 12 found that both the tractor OU62 HHC and trailer QPB10-695 were in good order and that with reference to all three there were no pre impact defects which could have caused or contributed to the collision and accordingly I make no finding under Section 6 (1) (d).
37. I was not invited to make any finding under Section 6 (1) (e) and see no basis for so doing. It remains only for me to offer my condolences to the family of the late Mr Jenkins for their loss following this tragic accident. Though not represented at the Inquiry family members were present throughout and did, at the conclusion of evidence, raise their concern that a man of Mr Boyes' age was driving an HGV. Had the DVLA been represented at the Inquiry, or had the Court had the benefit of independent expert opinion evidence, all as occurred in the Inquiry into the death of Elaine Dunne as recorded in the Determination of Sheriff Andrew Berry at Wick on 30 January this year, I might have been able to consider that issue. I should however add that I can well understand the conclusion he reached that age alone is no real basis for subjecting the elderly to closer scrutiny by medical advisers and the DVLA, certainly not beyond the current regime which in the present case required annual renewal.