

SHERIFF COURT OF GLASGOW AND STRATHKELVIN

[2015] FAI 31

B757/15

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

DETERMINATION

By

Sheriff John Beckett QC

in the Fatal Accident Inquiry into the deaths of

**John Kerr Sweeney
Lorraine Sweeney
Erin Paula McQuade
Stephenie Catherine Tait
Gillian Margaret Ewing
Jacqueline Morton**

GLASGOW, 7 DECEMBER 2015

The Sheriff, having heard and considered all of the evidence, and the submissions of parties, finds and determines that:

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

1.1 John Kerr Sweeney, born 15 April 1946 and who resided in Dumbarton, died at Queen Street, Glasgow at 2.29pm on 22 December 2014.

1.2 Lorraine Sweeney, born 2 March 1945 and who resided in Dumbarton, died at Queen Street, Glasgow at 2.29pm on 22 December 2014.

1.3 Erin Paula McQuade, born 27 September 1996 and who resided in Dumbarton, died at Queen Street, Glasgow at 2.29pm on 22 December 2014.

1.4 Stephenie Catherine Tait, born 10 February 1985, who resided in Glasgow, died at Queen Street, Glasgow at 2.29pm on 22 December 2014.

1.5 Gillian Margaret Ewing, born 2 February 1962, who resided in Cyprus and Edinburgh, died at Queen Street, Glasgow at 2.29pm on 22 December 2014.

1.6 Jacqueline Morton, born 30 May 1963, who resided in Glasgow, died at Queen Street, Glasgow at 2.29pm on 22 December 2014.

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

2.1 The cause of the death of John Kerr Sweeney was sustaining multiple injuries in a road traffic collision (pedestrian).

2.2 The cause of the death of Lorraine Sweeney was sustaining multiple injuries in a road traffic collision (pedestrian).

2.3 The cause of the death of Erin Paula McQuade was sustaining multiple injuries in a road traffic collision (pedestrian).

2.4 The cause of the death of Stephenie Catherine Tait was sustaining multiple injuries in a road traffic collision (pedestrian).

2.5 The cause of the death of Gillian Margaret Ewing was sustaining multiple injuries in a road traffic collision (pedestrian).

2.6 The cause of the death of Jacqueline Morton was sustaining multiple injuries in a road traffic collision (pedestrian).

2.7 The cause of the accident resulting in the deaths of John Kerr Sweeney, Lorraine Sweeney, Erin Paula McQuade, Stephenie Catherine Tait, Gillian Margaret Ewing and Jacqueline Morton was the loss of control of Glasgow City Council bin lorry registered number SB62 NKD by its driver, Henry Campbell Clarke, while he was driving northwards on Queen Street, as a result of which the lorry mounted the pavement on the west side of Queen Street and collided with a number of pedestrians.

2.8 Mr Clarke lost control of the lorry when he suffered an episode of neurocardiogenic syncope whereby he temporarily lost consciousness (he fainted) so that he was unable to control the movement and direction of the lorry.

3. In terms of section 6 (1) (c) of the Act the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

3.1 For Mr Clarke to have told the whole truth to Dr McKaig, Dr Lyons and Dr Langan about what had occurred on 7 April 2010.

3.2 For Dr Lyons to have advised Mr Clarke to notify DVLA given what he was told on 8 April following the incident on 7 April 2010.

3.3 For Dr Langan to have clarified with Dr Lyons the circumstances of Mr Clarke's faint on 7 April 2010 before concluding that he had suffered a simple faint.

3.4 For Mr Clarke to have provided true and accurate information in completing an occupational health questionnaire in connection with his application for employment with Glasgow City Council in December 2010.

3.5 For First Glasgow to have provided a full, accurate and fair employment reference to Glasgow City Council in respect of Mr Clarke's application for employment.

3.6 For Mr Clarke to have provided true and accurate information about his medical history on BUPA medical questionnaires in December 2011.

3.7 For Mr Clarke to have disclosed the incident of 7 April 2010 in DVLA form D47 and to Dr Willox in December 2011.

3.8 For Mr Clarke, after fainting at the wheel of his bus on 7 April 2010, to have refrained from continuing to drive buses and to have refrained from seeking further employment as a group 2 driver in the absence of his having told the truth to doctors and without having acted upon the advice which would have been forthcoming, and thereafter without making his relevant medical history known to Glasgow City Council to the extent required in its recruitment, appointment and promotion processes.

4. Section 6 (1) (d) of the Act

the defects, if any, in any system of working which contributed to the death or any accident resulting in the death;

I make no findings under this section.

5. In terms of section 6 (1) (e) of the Act

any other facts which are relevant to the circumstances of the death.

In my narrative of facts I set out facts relevant to the circumstances of the deaths. Not all of the facts narrated have direct relevance, but they are relevant to the recommendations which I am making.

Recommendations

I make the following recommendations:

5.1 Doctors generally, and general practitioners in particular, should take steps to ensure that medical notes are made and kept in such a way as to maximise their ability to identify repeated episodes of loss of consciousness, loss of or altered awareness, in the case of patients who are or may become drivers.

5.2 When a doctor is advising an organisation employing a driver as to that driver's fitness to drive following a medical incident whilst driving, that organisation should provide all available information about the incident to the doctor and the doctor should insist on having it prior to giving advice to the organisation and the driver.

5.3 Glasgow City Council, when employing a driver, should not allow employment to commence before references sought have been received.

5.4 Glasgow City Council should carry out an internal review of its employment processes with a view to ascertaining potential areas for improvement in relation to checking medical and sickness absence information provided by applicants, for example by having focussed health questions within reference requests for drivers and obtaining medical reports in relation to health related driving issues from applicants' GPs.

5.5 Glasgow City Council should provide its refuse collection operators with some basic training to familiarise them with the steering and braking mechanisms of the vehicles in which they work.

5.6 Local Authorities and any other organisations which collect refuse, when sourcing and purchasing refuse collection vehicles which are large goods vehicles, should seek to have AEBS fitted to those vehicles wherever it is reasonably practicable to do so.

5.7 Local Authorities and any other organisations which collect refuse, and which currently have large goods vehicles without AEBS but to which AEBS could be retrofitted, should explore the possibility of retrofitting with the respective manufacturer.

5.8 Glasgow City Council should seek to identify routes between refuse collection points which, so far as is reasonably practicable, minimise the number of people who would be at risk should control be lost of a refuse collection lorry.

5.9 The potential for the presence of exceptional numbers of pedestrians at particular times should be taken account of as part of route risk assessment in refuse collection.

5.10 The Driver and Vehicle Licensing Agency (DVLA) should satisfy itself as to precisely what the categorisation is intended to mean and to achieve in the loss of consciousness/loss of or altered awareness section of the guidance contained in its "At a Glance Guide to the Current Medical Standards of Fitness to Drive." ("at a glance")

5.11 Having done so, DVLA should then ensure that the meaning is made clear to those who apply the guidance in practice.

5.12 DVLA should consider if a flow chart could be provided to guide doctors through the categorisations contained in the loss of consciousness/loss of or altered awareness section of "at a glance."

5.13 DVLA should consider whether the section of "at a glance" on loss of consciousness/loss of or altered awareness gives sufficient weight to the absence of prodrome given its significance for road safety.

5.14 DVLA should consider whether the section of “at a glance” on loss of consciousness/loss of or altered awareness gives sufficient weight to a medical event occurring at the wheel of a vehicle and its consequences.

5.15 DVLA should change its policy on notification from third parties so that relevant fitness to drive information from ostensibly reliable sources, such as the police, can be investigated whether or not it comes in written form.

5.16 DVLA should redouble its efforts to raise awareness of the implications of medical conditions for fitness to drive amongst the medical profession.

5.17 The Secretary of State for Transport should instigate a consultation on how best to ensure the completeness and accuracy of the information available to DVLA in making fitness to drive licensing decisions with a view to making legislative change.

5.18 Part of this exercise should involve considering increasing the penalties and altering the mode of prosecution for contravention of section 94 of the Road Traffic Act 1988.

5.19 The Secretary of State for Transport should instigate a consultation on whether it is appropriate that doctors should be given greater freedom, by the General Medical Council, or an obligation, by Parliament, to report fitness to drive concerns directly to DVLA.

Matters for consideration:

I suggest that the following matters ought to be given consideration by those concerned.

6.1 Occupational health doctors performing D4 examinations and providing advice to employers on applicant drivers, and employers of drivers who facilitate their staff applying for renewal of group 2 licences without the involvement of GPs, should consider whether to require the applicant to sign a consent form permitting release by any GP of relevant medical records to the occupational health doctor.

6.2 DVLA, the Crown Prosecution Service and Crown Office and Procurator Fiscal Service should review whether there are policies in place which prevent or discourage prosecution for breaches of sections 94 and 174 of the Road Traffic Act 1988. If there are such policies, consideration should be given by DVLA and the prosecuting authorities to whether they are appropriate where the current fitness to drive regime is a self-reporting system which is vulnerable to the withholding and concealing of relevant information by applicants.

6.3 DVLA and the Department for Transport should consider how best to increase public awareness of the impact of medical conditions on fitness to drive and the notification obligations in that regard.

NOTE

Introduction

[1] In the first part of my note I set out a narrative of the important parts of what was established on the evidence together with some commentary as to my assessment of representations made by Henry Clarke. In the second part, I refer briefly to the law governing Fatal Accident Inquiries. I refer to parts of the evidence generally and consider evidence where there was controversy or a lack of clarity and explain my assessment of such evidence. I then examine particular issues which were raised in the course of the Inquiry.

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PART 1 – WHAT HAPPENED

The people who died

[3] Gillian Margaret Ewing was 52 years old when she died. She had moved to Cyprus some years ago but returned to Scotland for Christmas 2014. She had travelled with her daughter Lucy to Glasgow to replace a ring of sentimental value at a particular jeweller's. They were on Queen Street heading for the return train to Edinburgh when she was struck by the bin lorry, with her daughter standing next to her.

[4] Stephenie Catherine Tait was a dedicated 29-year old school teacher at St Philomena's Primary School, Glasgow. She had been Christmas shopping with her partner on 22 December 2014. She was queuing on the pavement at the Virgin Money cash dispenser when she was struck by the bin lorry.

[5] John Kerr Sweeney, aged 68, was retired after a full working life, including time spent in Canada, and lived with his wife.

[6] Lorraine Sweeney, aged 69, had worked in a coffee shop. Mr and Mrs Sweeney were very close with their children and grandchildren and spent much time together as a family.

[7] Erin Paula McQuade, aged 18, was the oldest of four siblings and was in her first year of studying English Literature at Glasgow University. She held a part time job and was a volunteer, actively involved in her local parish. She had been Christmas shopping with her mother Jacqueline McQuade and her grandparents Jack and Lorraine Sweeney and, having had lunch together, they found themselves on Queen Street when Mr and Mrs Sweeney and Erin McQuade were struck by the bin lorry.

[8] Jacqueline Morton, was 51 years old and worked for HMRC at Cochrane Street, Glasgow. She had finished work early as she was going to collect her two young granddaughters when she was struck by the bin lorry.

22 December 2014

[9] On 22 December 2014, Mr Henry Campbell Clarke, known to his colleagues as Harry, began his shift as a Glasgow City Council (GCC) refuse collection lorry driver at about 6am which was due to finish at about 3.30pm. Mr Clarke attended first at the Shieldhall Depot in Glasgow where he was seen by an acting supervisor, Alan Kernaghan. Mr Kernaghan saw nothing unusual about Mr Clarke to cause concern as to his health or sobriety and he issued him with keys for bin lorry, registration SB62 NKD. Mr Clarke carried out a number of safety checks on the vehicle as drivers were contracted to do each day.

[10] Mr Clarke then drove to the Anderson Depot arriving at about 7am to collect his crew, Matthew Telford and Henry Toal, who were employed as refuse collectors by GCC. All three men had been working together for some months on what was referred to in evidence as the “middle ground” or “route 2” collection route in Glasgow City Centre. Neither Mr Telford nor Mr Toal holds a full driving licence.

[11] Throughout the course of the morning Mr Clarke drove the lorry along the collection route, stopping to allow his crew to collect refuse at set collection points.

[12] At about 1045am Mr Clarke returned the crew to the Anderson depot for their lunch break. He then drove to the Shieldhall depot to empty the lorry. Whilst there, he had a lunch break of approximately half an hour. He ate a pot noodle, crisps and

chocolate biscuits. He kept water in the lorry. He spent some time with Ian Quigley, another driver, who found Mr Clarke to be his normal self.

[13] Thereafter, Mr Clarke returned with the lorry to the Anderson depot arriving at approximately midday and collected Mr Telford and Mr Toal. During the course of the afternoon Mr Clarke continued to drive the lorry along the collection route for that day, stopping at set collection points.

[14] After stopping to collect refuse from a bin on Mitchell Street, Mr Clarke drove the lorry along Argyle Street towards his next collection point at St Vincent Street. He stopped at traffic lights before turning left into Queen Street. Both crew members were seated in the rear passenger seats of the lorry wearing their seat belts. A handrail/safety barrier separated the crew from the front of the cab where the driver sat. Mr Telford and Mr Toal were talking about football.

[15] So far as can be accurately ascertained from tachograph data, the lorry was travelling along Queen Street at no more than 32 kilometres per hour (19.88 mph). It initially slowed as it approached the junction between Queen Street and Ingram Street but then began to gather speed.

[16] The crew felt the lorry veer to the left of the road as it approached the area near to the Gallery of Modern Art.

[17] Mr Telford said, "What are you doing, Harry?" and noticed that Mr Clarke's head was slumped to the left. Mr Clarke did not respond and appeared to be unconscious. Mr Clarke had lost consciousness suddenly, having felt no warning that anything was wrong. Mr Telford continued to shout at Mr Clarke whose whole body then slumped to the left. The seat belt appeared to be holding him up in his seat and his feet remained in place. Mr Clarke's hands were not on the wheel of the

lorry and appeared to be down at his side. Once again Mr Clarke did not respond. Mr Telford stretched his seatbelt and lifted himself up from his seat. He started to scream at Mr Clarke and punched him repeatedly on the back in an attempt to get a response. Mr Telford shouted, "You're killing people, Harry", but there was no response. Mr Telford then crouched down behind the driver's seat. Mr Toal, who was further away from the driver and the controls than Mr Telford, seems to have been in a state of shock throughout and took no action before he crouched down in order to protect himself prior to the final collision.

[18] The lorry had continued to veer to the left before mounting the west pavement near to the Gallery of Modern Art on Queen Street at approximately 2.29 pm and at this stage it was travelling at 26 to 30kph (16.16-18.64 mph). At further stages of its journey, which were not established with precision in the evidence, the lorry increased in speed to a maximum speed of between 39 and 42kph (24.23-26.09 mph).

[19] The lorry began to travel north on the pavement. It struck a number of pedestrians before the front of the lorry struck a black metal bin which was pushed north on the pavement, creating scratches there.

[20] As the lorry continued north it struck John Sweeney, Lorraine Sweeney, Erin McQuade and other pedestrians. The black bin separated from the lorry, the door of the bin opened and the metal insert was ejected from within. Both items came to rest on the west pavement. The front nearside wheel of the lorry struck the wall of the Virgin Money building, damaging the wheel studs and creating gouges in the stone wall of the building.

[21] The lorry continued to travel north and the front nearside of the cab struck the wall mounted Virgin Money and Pizza Express placard signs, removing the latter

from the wall. The lorry struck further pedestrians including Stephenie Tait and then Gillian Ewing.

[22] The lorry also struck and damaged various sign and traffic light poles. None of the poles were uprooted. Before the vehicle rejoined the carriageway it struck the traffic light pole at the corner of Queen Street and St Vincent Place causing the yellow pedestrian button control box fitted thereto to be detached and projected northwest into St Vincent Place.

[23] On entering the pedestrian crossing between Queen Street and St Vincent Place the lorry struck Jacqueline Morton and another pedestrian.

[24] The lorry then travelled north on George Square. At the junction of George Square and West George Street, the lorry struck and damaged a black Nissan Juke car, registration VK63 KSV, a silver Mitsubishi Lancer car, registration DV57 DZF, and a silver Skoda Octavia car, registration SJ60 VWN. All of these vehicles were stationary when struck and all were damaged.

[25] The Skoda Octavia was stationary at the traffic lights at the junction of Queen Street at West George Street when the lorry collided into the rear of the vehicle, pushing it through the junction to the canopy area of the Millennium Hotel.

[26] The lorry then crossed the north carriageway of George Square and mounted the north pavement whereby the front offside struck a wall of the Millennium Hotel, damaging metal window frames and smashing panes of glass and damaging the lorry, including the brake foot valve and brake distribution valve, before coming to a halt facing generally north on the north footway. At the point of impact, the approximate speed of the lorry was 18kph (11.18 mph).

[27] The period between the lorry first veering to the left and finally coming to a halt was approximately 19 seconds.

[28] The crew members got out of the lorry by the passenger door. At that time Mr Clarke appeared still to be unconscious at the wheel. He was groaning and was very grey in colour. An off duty nurse, Lauren Mykoliw, climbed into the cab in order to assist him. He was conscious by now and seated in an upright position in the driver's seat, wearing his seat belt.

[29] Mr Clarke was able to communicate with Ms Mykoliw and asked her if he had had a heart attack. Mr Clarke told her that he remembered sitting at the traffic lights and then woke up where he was in the lorry. He was pale, a bit sweaty and looked like he had had a shock. He told her that, at this point, he was feeling clammy and dizzy. Ms Mykoliw asked Mr Clarke if he had blacked out or felt dizzy before the crash and he replied that he had not.

[30] Ronald Hewitson, a paramedic, attended to Mr Clarke who seemed pale and slightly confused. Mr Hewitson carried out some initial tests including an ECG and took Mr Clarke's blood pressure. The results were normal.

[31] Mr Telford and Mr Toal sustained minor injuries. In addition, fifteen pedestrians were injured, either as a result of being struck by the lorry or as a result of getting out of its way. The noise of the metal bin being pushed along the pavement may have alerted some pedestrians to look around, see the approaching lorry and take avoiding action.

[32] Maureen Ann Quinn, Alexander Malcolm and their granddaughter aged 3, Ewan Robert Little, Mhairi McLaughlin, Joanne Wilson, Lynn Grieve, William Brannan, Alix Stewart, Danielle Dawson, Irene McAuley, Marie Weatherall, Elaine

Morrell, Sean Dunipace and George Reid sustained injury. The injuries sustained by Alix Stewart, Irene McAuley, Marie Weatherall and Elaine Morrell were serious and have had profound consequences for them.

[33] Mr Clarke was taken by ambulance to hospital for treatment and assessment.

The driver

[34] Henry Campbell Clarke, date of birth 10 January 1957, is 58 and currently lives alone. He is a professional driver of large vehicles. He left school at 15 and at some point worked for Glasgow Corporation. He was employed by John G Russell as a large goods vehicle driver in the early 1980s for around five years. He drove articulated trucks as he later did working for DHL. He enjoyed this role.

[35] Mr Clarke was employed as a bus driver for First Glasgow¹ from 2008 to 2010. He has been employed by GCC since 5 January 2011, first as a minibus driver for children and the elderly, thereafter driving a gritting truck before becoming a bin lorry driver.

Diagnosis and medical treatment after 22 December 2014

[36] This was proved in paras 6-18 of the third joint minute which I reproduce as appendix 4. There was no evidence from blood tests to suggest that Mr Clarke had taken alcohol or any other drug. Whilst three unopened bottles of beer were found in the cab of the bin lorry after the accident, consumption of alcohol had no part to play.

¹ The company's name is First Glasgow, but it was almost invariably referred to by parties and witnesses as "First Bus." For convenience I will refer to it as First.

[37] Mr Clarke remained in hospital as an inpatient at the Western Infirmary, Glasgow until his discharge on 5 January 2015, during which time he was examined and assessed by a number of doctors. Extensive testing revealed no abnormalities until a “tilt table” test offered some confirmation for an already presumed diagnosis of neurocardiogenic syncope. Monitoring of his heartbeat had revealed no abnormality by 20 April 2015. Ultimately, the conclusion was reached that on 22 December 2014, Mr Clarke had suffered an episode of neurocardiogenic syncope.

Neurocardiogenic syncope

[38] I derive the following from the evidence of two cardiologists, Professor Andrew Rankin and Dr Nicholas Boon. Their use of terminology was not identical, and I have sought to identify the essence of what they told the Inquiry, even if my use of certain terms would not commend itself to both of them.

[39] A simple faint is very common and by the age of 60, 30% of men and 40% of women are likely to have suffered a simple faint at least once. Fainting occurs more commonly from a standing position, but fainting whilst sitting is nevertheless quite common. Research from the United States of America has found that fainting is surprisingly common amongst drivers who have been sitting for long periods. People sometimes faint whilst seated in warm restaurants and in church. Fainting whilst lying down is very rare. From a purely medical perspective, a simple faint could occur when sitting down, but to be diagnosed as such there would generally need to be some identifiable provoking factor and some warning symptoms.

[40] Typically, before fainting people will feel a bit hot and sweaty, they may feel their heart racing and they feel a bit light-headed. Classically, nausea features, either

beforehand or on recovery. A person may suffer these symptoms but not go on to black out, perhaps because of remedial action such as lying down or putting the head between the legs. Such an incomplete event is called a pre-syncope.

[41] A simple faint may be an episode of neurocardiogenic syncope, which might also be referred to as a reflex vasovagal syncope.

[42] A syncope is a transient loss of consciousness caused by a reduction in blood flow to the brain. There will be a loss of postural tone so that muscles go slack causing a person who is standing to fall to the ground. Syncope is entirely distinct from an epileptic seizure, one difference being that in a seizure, muscle tone will be retained.

[43] Where the cause of syncope is heart failure it will be referred to as a cardiac syncope. The other forms of syncope are essentially caused by a failure of the systems which the body uses to control heart beat and blood pressure. These are known as reflex syncope.

[44] A typical example of a simple faint is the soldier fainting whilst standing on parade in the heat for a prolonged period. The mechanism is believed to be that circulating blood pools in the legs and does not return to the heart so that the heart beats faster and harder to compensate for the lack of returning blood. Blood pressure falls. The body misinterprets the signals and triggers a reflex which causes a further drop in blood pressure and a slowing of the heart which reduces blood supply to the brain so that the soldier passes out and crumples to the ground. The reflex is mediated particularly through the vagus nerve, giving rise to the term vasovagal. After falling, the process reverses. Heart function returns to normal, the reflex switches off and recovery usually occurs quite promptly. Recovery from vasovagal

syncope is generally slower than from a cardiac syncope. With vasovagal syncope, it is quite common to continue to feel unwell for some time afterwards.

[45] With vasovagal syncope, there are two components to the reduction in blood supply to the brain. One is the slowing of the heartbeat and the other is the opening up of the blood vessels (vasodilatation) which causes the drop in blood pressure. If the predominant problem is slowing of the heartbeat, it is known as cardio-inhibitory vasovagal syncope. If the predominant problem is a drop in blood pressure due to vasodilatation, it is vasodepressor syncope (which was indicated in Mr Clarke's case). Where both processes are significantly involved, it is mixed vasovagal syncope.

The location of the accident

The following facts were proved in the first joint minute.

[46] Queen Street is a one-way undivided carriageway extending generally north and south and carries a high volume of pedestrian and northbound vehicular traffic.

From the junction with Argyle Street to the south, the carriageway has two lanes for travel north expanding to three lanes after the junction with Ingram Street. To the east and west Queen Street is bordered by raised kerbs, footways and commercial premises beyond. Queen Street terminates at a traffic light (with pedestrian phase) controlled junction with George Square to both the east and north and St Vincent Place to the west.

[47] George Square is a one-way undivided carriageway extending on four sides around a central pedestrian area. The portion of George Square north of Queen Street has three lanes for northbound traffic and carries a high volume of pedestrian

and vehicular traffic. To the west this area is bordered by a raised kerb, footway and commercial premises whilst to the east it is bordered by a raised kerb, footway and pedestrian area containing various monuments and benches for seating (although on 22 December 2014 the square itself contained Christmas carnival attractions and an ice rink). On the south aspect of George Square where it joins with Queen Street vehicles travel west before either turning right to travel north on George Square or continue west into St Vincent Place.

[48] George Square continues north and forms a traffic light (with pedestrian phase) controlled T- junction with West George Street joining from the west and becoming George Square whilst continuing east. To the north of the T-junction there is a vehicular access road allowing traffic to drop off and pick up passengers for Queen Street railway station. To the north of the T-junction is a raised kerb and footway leading to Queen Street railway station extending west and the Millennium Hotel extending east.

[49] The speed limit in Queen Street and George Square is 30 miles per hour.

[50] On 22 December 2014 the road surface at Queen Street and George Square comprised a bitumen/tarmac mix and was in a good state of repair. The condition of the road surface had no effect with regard to the incident to which this Inquiry relates (hereinafter referred to as “the incident”). At the time of the incident the weather was good; the road surface was damp; there was no evidence of any surface contaminant; it was daylight; street lighting was present and was unlit and visibility for road users was excellent.

[51] Travelling north from Argyle Street into Queen Street and approaching the locus of the incident drivers travel along a straight and level section of road and have a

maximum potential view north in excess of 400 metres to Queen Street railway station and the Millenium Hotel. The driver of a large goods vehicle would have an enhanced view due to their elevated seating position in comparison to a car driver's seating position. This view would also be dependent on the presence, size and proximity of any preceding and parked vehicles as well as the level of consciousness of the driver.

[52] Correspondingly, pedestrians on the west footway would have a maximum potential view south of an approaching large goods vehicle, such as the lorry, in excess of 400 metres. However this view would depend on which direction the pedestrian was facing at the material time and the presence, size and proximity of any obstructions.

Vehicle information

The following facts were proved in the first joint minute.

[53] The vehicle driven by Mr Clarke was a Glasgow City Council, green coloured, Leyland DAF Model FAG CF, large goods vehicle with registration number SB62 NKD.

[54] In 2012, GCC entered into a 4 year contract with Imperial Commercial to supply them with DAF HGV lorries. Imperial Commercial are responsible for supplying the DAF chassis. On receipt of the technical specification from GCC, Imperial Commercial sub contract to Tekbo Ltd to refit the vehicles as bin lorries. The lorry was legitimately sourced, converted, tested and supplied under the contract.

[55] Before the lorry was released to GCC it was fully inspected to ensure it had been modified according to the specifications provided. GCC specified the following additional safety features:

- (i) Handbrake Interlock. This prevents the vehicle being driven or running away when the driver leaves the vehicle with the engine running.
- (ii) Rear safety features. These prevent incidents in relation to the emptying of bins.
- (iii) Monitor in cab. This allows the driver to see the back of the vehicle.

[56] The base DAF vehicle has a number of cab options. The lorry has a high roof line and space cab fitted. The space cab has been subsequently modified to enable a crew to be carried.

[57] The lorry was converted by Tekbo Ltd removing the front passenger seat along with the rear bed or beds and floor storage units. The cab was fitted with chequer plate anti-slip flooring, which covers not only the cab floor on the nearside but also the formed steps to the rear of the cab.

[58] The rear cab section, where the bed would have been originally fitted, had a bench seat fitted. The seat has the potential to carry four passengers. Each of the rear bench seat positions have a three point, inertia reel seat belt. The seatbelts were operative during the examination on 25 March 2015.

[59] The driver of the lorry sits in a standard seating area, the only noticeable difference being that there is a yellow barrier rail to the rear of the driving seat between it and the rear cab section, containing the crew seating. The driver seat has a three point seatbelt fitted.

[60] The bench seat had been tested and certified in line with European legislation applicable at the time.

[61] On 29 October 2014 European legislation came into force introducing mandatory testing of the bench seat mechanism for all new vehicles.

[62] On 8 May 2015 a vehicle of the same specification was sent to the Motor Institute Research Association (MIRA) for testing which took place on 17 June 2015. That vehicle passed the test and was deemed to be EC compliant.

[63] The barrier rail is 0.8 metres in height and extends 1.45 metres across the cab from the nearside. The nearside of the barrier has a 0.6 metre section that can be latched closed or folded over on itself to allow crew access. Where the barrier section is folded over on itself, the total height from the vehicle floor is 0.865 metres.

[64] The barrier rail was legitimately sourced and supplied. Its purpose was to provide the crew with a safe method of access when entering and egressing the vehicle. This is a repetitive task for the crew, in line with the primary purpose of the vehicle, and meets with Health and Safety Executive Guidance, HSG136. The barrier rail also provides the crew, when seated, with a grab handle to stabilise themselves should the vehicle move or jolt suddenly.

[65] On the nearside of the cab, in the vicinity of the nearside door, are grab rails designed to aid the crew members climbing into and out of the vehicle. These grab rails are complemented by the barrier rail extending onto the stepped area, thus providing the crew members with a safe exit/entry route out of and into the vehicle.

[66] Within the driver's area is a set of remotely positioned control/monitoring systems for the refuse body and included within these controls is an emergency stop

button. The fitment of an emergency stop button for the refuse body is a legislative requirement as the body is regarded as machinery, whereas the supporting vehicle has no requirement to comply with such legislation. The emergency stop button fitted had no link to the chassis or running gear of the underlying vehicle.

[67] As is standard to all road vehicles the lorry is fitted with a service brake (a foot brake) and a secondary braking system (a hand or parking brake) which in this case is actuated by a hand operated lever fitted to the dashboard at the driver's left side. Application of the service brake causes the brake lights at the rear of the vehicle to be illuminated. Application of the secondary brake (hand brake) causes no such illumination.

[68] On the secondary/parking brake control, the horizontal distance, when the parking brake was off, between the tip of the parking brake lever and the rear of the vertical barrier post is 0.55 metres. The straight line distance from the top of the barrier rail to the tip of the parking brake lever is 0.71 metres. When the parking brake is in the applied position the latter distance increases to 0.76 metres.

[69] The lorry has an Allison automatic gearbox fitted. The driver's controls consisted of three electronic selector switches: Drive (forward), Neutral and Reverse. Unlike a smaller passenger vehicle, there is no parking lock facility for the gearbox. In operation, even if a park function was available, it would not be expected that the gearbox would have been able to apply the park function.

[70] The lorry has an engine brake fitted. An engine brake is designed to be used in an "over-run" situation, i.e. no throttle applied, and is typically activated to provide slight retardation for the vehicle, most notably at higher engine/road speeds or in

downhill situations. The engine brake on the lorry could be manually switched on and off. Its effect at low engine and road speeds would be minimal.

[71] The lorry is fitted with a diesel engine. Empirical testing by police officers in a DAF vehicle similar to the lorry showed that only moderate pressure needed to be exerted on the pedal to achieve significant rises in engine speed.

[72] As a result of the incident the lorry was damaged as described in the first joint minute, the relevant section of which is reproduced as appendix 3.

[73] There were no pre-collision defects that could have led to a loss of control of the lorry or increased the severity of the incident. The mechanical condition of the lorry was not a contributory factor in the incident.

[74] Imperial Commercials offer maintenance contracts for all vehicles supplied by them. The lorry was subject to that contract and it was, in line with European legislation, checked every six weeks. Once the checks were complete GCC would carry out an independent audit, in respect of the standard of the work. There are no mandatory requirements for an independent audit to be carried out.

Mr Clarke's driving licences

[75] Mr Clarke has held a licence to drive both cars and large vehicles for most of his adult life. Prior to December 2014, he held full driving licences for vehicles in group 1 (which includes all cars and motor cycles) and group 2 (which includes large lorries (category C) and buses (category D)).

[76] As a group 2 driver, Mr Clarke required to renew his Large Goods Vehicle (LGV) licence every five years following his 45th birthday on 10 January 2002, in accordance with section 99 (1A) of the Road Traffic Act 1988 (RTA 1988). He did this

by completing DVLA form D47 and undergoing a D4 medical examination in 2001, 2006 and 2011 prior to his 45th, 50th and 55th birthdays. All of the renewal applications were granted. Neither Mr Clarke nor any medical practitioner provided any further medical information relating to him to DVLA between December 2011 and 22 December 2014.

[77] The process involves the applicant completing form D47 with personal details and responses to a series of questions about eyesight, hearing and health. The applicant must sign a declaration to the effect that he has checked the details given; the information given is true so far as known to the applicant; and that he understands that it is a criminal offence which may lead to prosecution if false information is given or if there is a failure to provide information. There must be a medical examination, and the only specification in The Motor Vehicles (Driving Licences) Regulations 1999/2864 (MVDLR 1999), 10 (5) is that it must be performed by a qualified medical practitioner. The doctor must complete form D4 and the applicant must countersign and make a declaration as to the accuracy of the details given, so far as known. The signature also confirms the giving of consent for the disclosure of medical reports to the Secretary of State's Medical Adviser.

Guidance to drivers

[78] DVLA exercises functions on behalf of the Secretary of State for Transport.

[79] DVLA issues general guidance for drivers. Until 2013 this was done through the publication of a hard copy guide, D100, which indicated that drivers should notify DVLA if they had ever had or currently had, amongst other conditions, fits or blackouts.

[80] Since 2013, guidance is to be found online on the DVLA website. The guidance outlines what is required of the driver and the likely consequences of failure to comply, and also sets out a list of examples of notifiable conditions. For some conditions, drivers are advised that they must notify DVLA; for others, drivers are advised that they need not notify.

[81] The section on “blackouts, fainting, syncope and driving” indicates that drivers should check with their doctor as to whether their blackouts, fainting or syncope affects their driving and report to DVLA if it does.

GP medical records

[82] By the 1980s, GPs would make and keep paper notes of consultations in a folder in the name of the individual patient. There would be a front page summary of significant medical events examples of which would be operations or heart attacks. Investigations which led to negative findings would be less likely to be entered in a summary although some doctors might include them. Mr Clarke’s current GP practice, Baillieston Health Centre, did not generally do so.

[83] A single simple faint is so normal an event that it would not necessarily be noted anywhere in GP notes. If there were recurrent episodes having an impact on lifestyle and employment, and which led to hospital investigations, these would be noted and might also be included in the summary.

[84] Baillieston Health Centre changed to a system of computerised notes in 2005. The task of transferring the clinical summary was undertaken by medical staff. Since 2005, all letters from hospitals were scanned and included in the patient’s computerised notes. In his individual surgery, a GP could access the patient’s

electronic record on a computer. The old paper records were kept in a records room at the practice although for many other practices the old records are archived and stored elsewhere.

Mr Clarke's medical history prior to 22 December 2014

[85] Medical records disclose that Mr Clarke attended with his GP from the early 1980s onwards on many occasions in connection with stress, anxiety and symptoms of depression and on some occasions was prescribed medicine, often for sedative effect. There are references to him getting headaches when driving. Some of his anxiety was associated with periods of work as a bus driver. On 9 December 1987 it is noted that he stopped work as a bus driver due to "nerves." There are references to stress and anxiety in 2008 and 2009 which are the last entries of that kind.

[86] Particular entries in his medical records were explored in more detail in the course of the evidence:

- 30/06/1976 GP Notes "Dizzy when bending – intermittent for 2 [months]...feeling tired."
- 15/06/1977 GP Notes "Vertigo-probably mild heatstroke."
- 10/08/1977 GP Notes "Vertigo - waxy ears."
- 17/08/1977 GP Notes "Persistent dizziness ... changes ... Wax in ears"
- 16/10/1987 GP Notes "Dizziness for a few moments when bending to tie laces or painting ceiling. Headaches afterwards. Probably just positional. [Reassured]. Ears ✓"
- 08/12/1988 GP Notes "Dizziness on standing up quickly." His sitting and standing blood pressure was noted. It was noted that his mother died recently and he drank 20 pints Thursday to Sunday. He was advised to reduce his consumption of alcohol and increase his fluid intake.
- 16/03/1989 GP Notes "Still has postural giddiness."
- 18/08/1989 "Vasovagal attack at work 2 days ago. O/E BP 140/80 ...Reassured"
- 25/02/1994 GP Notes "Had episode while driving bus of feeling 'dizzy' – had ? pain in chest & ? palpitations. O/E BP 130/80. [heart rate] irregular. For ECG & referral. Advice on caffeine consumptions. See on 3rd March –Chest Tightness"

[87] The last episode was entered in the clinical summary sheet in the paper medical notes but was not included in the equivalent document in the computerised notes.

[88] After the consultation on 25 February 1994, Mr Clarke was referred by his GP to the Department of Cardiology at Stobhill Hospital, Glasgow and was examined on 23 March 1994. In a letter dated 28 May 1994 the cardiology registrar who saw Mr Clarke (Dr M Malekianpour) stated:

"...I had the impression that he has two types of symptoms which are largely unrelated. The first one is that of chest tightness with no radiation for the past year which can come on exertion or if he is anxious at rest. He normally has relief from this after 10-15 minutes. He does not have any other cardiovascular symptoms. He also complained of intermittent dizziness for the past 4 years. This normally occurs on exertion, and is not related to pre-syncope. Again, this resolves after about 10-15 minutes, and he normally finds that he gets dizzy if he is in a warm environment. The dizziness and chest tightness do not occur at the same time and in fact he had relief from the dizziness for about a year in the past 4 years, however, this has recurred, at least for the past 18 months. He does not have any other symptoms attributable to middle ear disease, and there is no other past medical history of note. ...My impression was that his chest tightness may represent angina. I am not quite sure about the cause of his dizziness...I arranged for him to have an echocardiogram which was normal...an exercise tolerance test...no chest pain or ECG changes....we will assess his progress when he is next seen at the clinic. At that stage we may arrange other investigations to elucidate the cause of his dizziness."

[89] Mr Clarke was reviewed at the cardiology clinic on 27 May 1994 by Dr J

Faccenda, a Senior House Officer whose letter of that date to Mr Clarke's GP

includes:

"...All investigations were normal. We have not proven any cardiac cause for his chest tightness, which has not recurred since he was last seen in the clinic. His dizziness has also gone away. He managed to the end of Stage 4 on the full Bruce protocol, and there is nothing to prevent him getting his PSV licence back. I have told him that he should have informed the DVLC when he was under investigation for ?angina. I have discharged him from the clinic..."

[90] Further entries of interest in the GP notes include these:

- 10/07/2003 GP Notes "[complaining of] dizziness, dullness of hearing [observed on examination] wax both ears ...drops given...dizziness, stop tabs

2/7 ago?, episodes lessening. Drives OIL TANKER, do not drive meantime. Appt Mon for review."

- 14/07/2003 GP Notes ""Dizziness [reducing], still dull of hearing...Ears (L) canal...wax...do not syringe use almond oil...see practice nurse Friday (Flying to Spain Monday 21)"
- 06/08/2009 GP Notes "lethargy 2/52, occas vertigo with sudden head movements, no recent viral illness. bp cvs ok. bloods and review"
- 20/09/2013 GP Notes ""Tired all the time...no features to suggest depression or hypothyroidism, working full time, of many years. occasional episodes of feeling dizzy on standing for prolonged periods. no falls, no vertigo or ENT symptoms...Lifestyle counselling lose weight, blood work Sep 12 ok, will await letter from Pre Op clinic as well. symptoms diary and return if ongoing concerns."

Mr Clarke was occasionally suffering episodes of dizziness on prolonged standing shortly before 20 September 2013.

Mr Clarke's representations prior to April 2010

[91] On 29 November 2001 Mr Clarke completed and signed Form D47 for submission to DVLA as part of his renewal application for LGV and bus licences.

There is a declaration directly above the signature box that the applicant has checked the details he has given and that they are correct to the best of his knowledge. On Form D47 Mr Clarke made declarations that he had never had and did not suffer from fits or blackouts, severe and recurrent disabling giddiness, or serious psychiatric illness or mental ill health. A medical report in Form D4 signed by Dr. L. Copeland of Springburn Health Centre, his then GP, accompanied the application. The ECG tests in 1994 were referred to and Dr Copeland explained on form D4 that the ECG testing had found no evidence of any ischaemic changes.

[92] Given the qualification to giddiness as being severe and disabling, I am not convinced that Mr Clarke's answer in this respect was inaccurate or dishonest. Given the qualification "serious" which precedes psychiatric illness or mental ill health, I

am not convinced that Mr Clarke's answer in this respect was inaccurate or dishonest.

[93] The answer 'no' to "fits or blackouts" given by Mr Clarke to question 2 at section 5 A on form D47, "*Have you ever had or do you suffer from any of these conditions?*" and the entry in the GP notes for 18 August 1989 which referred to a vasovagal attack at work are contradictory and Mr Clarke's answer in that regard was not accurate. A vasovagal attack at work is something which a person would be expected to remember, and whilst in this instance it is difficult to be sure, I consider it more likely than not that Mr Clarke deliberately omitted reference to that episode.

[94] On 1 December 2006 Mr Clarke again completed and signed a Form D47 in which he declared that he had never had and did not suffer from the following conditions: fits or blackouts; repeated attacks of sudden disabling giddiness; or serious psychiatric illness or mental ill health. He signed the declarations as to accuracy and awareness of the consequences of providing false or incomplete details.

[95] Mr Clarke was medically examined by Dr McKaig, a GP at Baillieston Health Centre, who completed a medical report in Form D4. Dr McKaig performed the necessary medical examinations and went over the answers in form D47, even though some of them had already been filled in by the patient.

[96] Dr McKaig accessed the computerised clinical summary and he did not see anything that required a positive answer. When he was asked to consider the notes for July 2003, he did not think that these required a positive answer to the question about "*repeated attacks of disabling giddiness*" in D47, or "*sudden and disabling dizziness/vertigo within the last year with a liability to recur*" in D4.

[97] Dr McKaig could have accessed the paper medical notes for entries prior to 2005 which were held by his practice but it can be inferred that he did not do so. He did not pick up on the inconsistency between the answer 'no' to "fits or blackouts" given by Mr Clarke to question 2 at section 5A on form D47, *"Have you ever had or do you suffer from any of these conditions?"* and the entry in the GP notes for 18 August 1989 which referred to a vasovagal attack at work.

[98] Mr Clarke's answer in that regard was not accurate. For the same reasons which I explained in para 93, I consider it more likely than not that Mr Clarke deliberately omitted reference to that episode.

[99] On 18 September 2008 Mr Clarke completed and signed a health declaration as part of the recruitment process to obtain employment with First as a bus driver. He stated that he had never suffered from: fainting, blackouts, unconsciousness, dizziness or vertigo; depression or anxiety; he had never left previous employment for health reasons; he had never had any period of absence from work in the last eight years; and he had never had an ECG. More information would have been sought had Mr Clarke declared that he had previously suffered from dizziness, vertigo and that he had fainted at work. A false declaration would have been taken very seriously by First had it been discovered.

[100] Mr Clarke plainly had suffered from dizziness on several occasions, consistently so in 1994 and for some time previously. In 2003 on account of dizziness he got medical advice not to drive, even if only for a few days. He had many documented instances of depression and anxiety and he had left employment as a bus driver for health reasons, recorded in the GP notes for 1987 as "nerves." Whilst that was in 1987, since he was once again applying to be a bus driver, I do not believe

that he forgot about that. Mr Clarke's negative response to some of these questions is not explicable by anything but deliberate dishonesty. I conclude that he was deliberately concealing medical conditions which his prospective employer considered relevant. He was prepared to lie about his health to get a job as a bus driver.

Mr Clarke's employment as a bus driver, 2008-2010

[101] Mr Clarke commenced employment as a bus driver with First on 15 August 2008 and left on 28 December 2010 by which time he had already been interviewed and had been accepted by GCC for employment as a minibuss driver subject to references and a medical questionnaire.

[102] In the course of his employment with First, Mr Clarke had a number of absences and was subject to a final warning in November 2009. He was absent from work between 11 and 21 November 2009, apparently with stress. In 2010, he was absent between 25 February and 6 March on account of a "locked knee." He was absent again for almost 4 weeks following the incident on 7 April 2010 until he returned to work at the beginning of May.

[103] On 26 December 2010, which Mr Clarke had decided would be his final day at work, he was alleged to have been running his bus several minutes early at several stops rendering him liable to instant dismissal. He was suspended and due to attend a disciplinary hearing on 28 December 2010. It never took place as Mr Clarke left his employment and did not attend for the hearing. He was deemed to have resigned under suspension. His manager, Francis McCann, knew that Mr Clarke was leaving to work for GCC.

The events of 7 April 2010

[104] At about 9.35 am on 7 April 2010 Mr Clarke lost consciousness whilst sitting at the wheel of his bus at a bus stop on Paisley Road West for a period lasting between a few seconds and two minutes. Either before or afterwards he caused his passengers to leave the bus and he drove to a bus stop where he met a First bus inspector, Mr John Stewart, and told him that he had blacked out for a couple of minutes. He then became unwell again which led to Mr Stewart summoning an ambulance. Mr Clarke was checked over by paramedics who performed an ECG which gave normal results. Mr Clarke declined to go to hospital.

[105] Mr Clarke had suffered an episode of neurocardiogenic syncope.

[106] Mr Clarke was sent home from work and arranged a same day appointment with Dr McKaig. He told Dr McKaig that he had fainted in a warm canteen whilst queuing for food, implying that he had been standing.

Mr Clarke's representations in April 2010

[107] Mr Clarke deliberately misled Dr McKaig as to the location and nature of what had happened to him. He had lost consciousness whilst sitting on a bus and it was not true that this event had occurred in a canteen as he told Dr McKaig.

[108] On 8 April Mr Clarke deceived Dr Lyons, a GP who provided occupational health (OH) services to First, when he led him to understand that he had not lost consciousness. I infer that he did so in order to downplay the incident as far as he felt able to, anticipating that Dr Lyons may have access to information from Mr Stewart.

[109] On 22 April, Mr Clarke deceived Dr Langan, of Baillieston Health Centre, in giving him to understand that he had fainted in a canteen. He maintained the fiction he had first presented to Dr McKaig in order that a favourable report, or the least unfavourable report, would be given by Dr Langan to First.

[110] Mr Clarke deceived all three doctors in the hope that he would be able to return to work sooner rather than later so that he would not lose his job with First. Mr Clarke's attendances with Dr Lyons and Dr Langan gave rise to correspondence between them. Dr Langan did not seek clarification from Dr Lyons as to the location of the faint, despite receiving a letter referring to Mr Clarke fainting on a bus. Dr Langan was induced by Mr Clarke's false representations to advise Dr Lyons that Mr Clarke had suffered a simple faint. None of the doctors who saw Mr Clarke advised him to notify DVLA of this event and he did not do so.

Mr Clarke's employment with GCC and his representations after April 2010 but before December 2014

[111] On 14 July 2010 Mr Clarke completed and signed an application form for a job as a minibus driver with GCC declaring that he was "fit" and "very reliable". He was successful at an interview on 10 September 2010 at which he produced both of his driving licences, which fact was recorded. Before taking up employment he was required to identify two referees. He nominated First and DHL, both previous employers for whom he had worked as a driver. I infer that, at least by 25 March 2011, GCC did receive satisfactory references for Mr Clarke. On the basis of my findings in paras 102-104, a true, accurate and fair reference from First would not have been satisfactory to GCC.

[112] Mr Clarke also had to complete and submit an online BUPA Health Declaration which he did on 15 December 2010. I infer that in doing so, he declared that: he had not had any medical condition that he believed to have been caused, or made worse, by his work; he did not have any medical condition of which first aiders or occupational health in the workplace should be made aware; he had not had any medical condition that should be considered by an OH professional; he had only been absent from work for 7 days in the last two years due to sickness; he had never suffered from balance problems, dizziness or light-headedness; and he had never suffered from stress, depression, anxiety or difficulty sleeping.

[113] Most of these declarations were inaccurate and I conclude that Mr Clarke lied. His history of absences at First in 2009 and 2010 is not something which he could have forgotten and the fact that he fainted whilst at the wheel of a bus in April 2010 was plainly something that first aiders in the work place and OH should be made aware of.

[114] Mr Clarke applied for promotion to the position of HGV driver (gritting lorries) in 2011. In that connection, on 1 December 2011 he completed and submitted an online BUPA Health Declaration. I infer that he declared that: he had not had any medical condition that he believed to have been caused, or made worse, by his work; he did not have any medical condition of which first aiders or OH in the workplace should be made aware such as vertigo; he had not had any medical condition that should be considered by an OH professional such as stress related illness or depression; he had not been absent from work at all in the last two years due to sickness; and he had never suffered from a disorder affecting the hands or arms.

[115] Once again I conclude that most of these answers were lies, told because Mr Clarke wanted promotion to a better job.

[116] On 6 December 2011 Mr Clarke completed a BUPA OH Questionnaire as part of an employment screening process to ascertain whether he was fit to drive an HGV for GCC. He failed to disclose his relevant medical history. He further declared that he had never suffered from: balance problems, dizziness or light-headedness; trouble with nerves, stress, depression, anxiety or difficulty sleeping. He declared that he had never had hospital tests or treatment; he had never left a job for medical reasons; he had never had an illness caused by his work; he had never been away from work for two weeks or more due to illness in the last two years; and he did not suffer from any other health problem which was relevant to his job as an HGV driver.

[117] I conclude that most of these answers were lies, told because Mr Clarke wanted promotion to a better job.

[118] In December 2011 Mr. Clarke submitted another application for renewal of his Group 2 licence. Form D47P, was signed by him and dated 6 December 2011. He indicated that he had never had and did not suffer from: fits or blackouts; repeated attacks of sudden disabling giddiness; serious psychiatric illness or mental ill health.

[119] The medical report in Form D4 which accompanied the application was dated 6 December 2011 and was signed by Dr. Joanne Willox. Dr. Willox was employed by BUPA, and the medical examination of Mr. Clarke was carried out by her in terms of a contract between BUPA and GCC. It was advantageous for an employee to attend with GCC's OH provider as this could be done during working hours and he did not have to pay the fee which he would have to pay his GP.

[120] Mr Clarke also signed Form D4 on 6 December 2011, making declarations that: he had no history of blackouts or impaired consciousness in the last five years; and he had no medical condition that could affect safe driving.

[121] In declaring on forms D47 and D4 that he had never suffered from fits or blackouts, Mr Clarke deliberately concealed relevant information from DVLA, not least in relation to the incident of 7 April 2010.

DVLA – fitness to drive

[122] The Secretary of State for Transport acting through the medical advisers at the Drivers' Medical Group, DVLA, has the responsibility to ensure that all licence holders are fit to drive. The statutory underpinning in this regard is set out in this way in DVLA's publication, the "At a glance Guide to the Current Medical Standards of Fitness to Drive." ("at a glance").

"The legal basis of fitness to drive is the 2nd EC Directive on driving licences which came into effect in the UK in January 1997, the Road Traffic Act 1988 and the Motor Vehicles Driving Licences Regulations 1999 and particular reference is made to sections 92 and 93 of the Road Traffic Act 1988."

[123] It is the statutory duty of the holder of a driving licence to notify DVLA of any medical condition which may affect driving. The duty is primarily on the licence holder and it is only in exceptional circumstances where a doctor is entitled to make a notification. DVLA requires the notification to be in writing.

[124] This self-reporting system is heavily dependent on the candour of drivers and the alertness to fitness to drive issues of the doctors whom they consult.

[125] DVLA alone will determine if a licence is to be revoked or renewed. Once it receives a notification, it will send out a consent form to the driver and proceed to

ingather medical information. It will contact the driver's GP and may commission testing at the driver's local hospital. In most situations, the licence holder can continue to drive whilst investigation and consideration is ongoing but there are certain conditions, epilepsy being one example, where DVLA can immediately revoke a licence before further inquiry.

[126] On receiving notification, DVLA will send a questionnaire to the driver seeking detailed medical information including details of the driver's GP or treating doctor. Consent is sought from the driver to obtain information from the doctor, all of which is done in writing on standard forms.

[127] DVLA handles approximately 650,000 cases involving medical fitness to drive issues each year. Those cases are considered by a team of 22 qualified medical advisers (with a further adviser currently undergoing training) assisted by non-medically qualified staff who are guided by a detailed and highly prescriptive set of operating instructions.

[128] The medical advisers do not themselves examine or treat holders of, or applicants for, driving licences. DVLA determines issues of medical fitness to drive on the basis of information provided by licence holders or applicants; medical information and opinions provided by qualified medical practitioners who have examined and/or treated those licence holders or applicants; and in accordance with the guidance provided by the Secretary of State's honorary medical panels.

[129] There are six panels, each having responsibility for one of the following medical specialisms:

- (i) diabetes mellitus;
- (ii) neurology;

- (iii) vision;
- (iv) drugs and alcohol;
- (v) cardiovascular disease; and
- (vi) psychiatry.

[130] The medical members of the panels are appointed by the Secretary of State and are specialists in their particular field of national, and international, renown. Their guidance is encapsulated in “at a glance.” The panels are consulted by DVLA in relation to particular cases.

[131] “At a glance” covers fainting within the neurology section.

[132] The only medical issues affecting Mr. Clarke which were disclosed to DVLA before 22 December 2014 were: that he had undergone an ECG in 1994 with a satisfactory result; that he had a mild squint in his left eye which was only present when tired; that he suffered from heartburn; and that he suffered from gout. None of those issues or conditions raised any concern as to Mr. Clarke’s medical fitness to drive.

[133] Accordingly, there was no information which was disclosed to or known by DVLA before December 2014 which ought reasonably to have put DVLA on inquiry as to Mr. Clarke’s medical fitness to drive. There was no reasonable precaution which could have been taken by DVLA which might have prevented the events of 22 December 2014.

“At a glance Guide to the Current Medical Standards of Fitness to Drive”

[134] DVLA produces twice yearly an updated version which is accessible online to the general public. The clarity of the guidance is regularly reviewed. There is input

from a lay panel member giving a patient's perspective, user groups will be consulted and DVLA has a "Plain English" department.

[135] The introduction to "at a glance" supposes that doctors will advise their patients whether or not they should inform DVLA of their medical condition and what the outcome of medical inquiries is likely to be. All of the doctors who were asked accepted that they were subject to this twofold professional duty and it may be that it is derived from guidance issued by the General Medical Council which is set out at page 4 of "at a glance." In that part of the guidance, doctors are encouraged to ensure that patients understand the potential of a condition to impair their ability to drive. A doctor should report a relevant condition to DVLA if the driver cannot understand medical advice and the example of a patient with dementia is given. Doctors are also advised that if they learn that a patient is driving against their advice, and cannot be persuaded to self-report to DVLA, they should report the relevant medical condition directly to DVLA.

[136] In the introduction to "at a glance," it is stated:

"It is also emphasised that this booklet is for use as guidance only. Whilst it provides some idea of the anticipated outcome of a medical enquiry, the specific medical factors of each case will be considered before an individual licensing decision is reached."

[137] "At a glance" summarises licence groups in this way and sets out the reasons for their differential treatment:

*"Group 1 includes all cars and motor cycles.
Group 2 includes large lorries (category C) and buses (category D). The medical standard for Group 2 drivers are very much higher than those for Group 1 because of the size and weight of the vehicle. This also reflects the higher risk caused by the length of time the driver may spend at the wheel in the course of his/her occupation."*

[138] "At a glance" advises doctors "to document formally and clearly in the notes the advice that has been given." It makes plain that doctors can seek advice from DVLA in

writing or on a telephone helpline. The version which was current in April 2010 was reproduced as Crown production 72. The section on “loss of consciousness/loss of or altered awareness” (LOC, etc.) featured heavily in evidence and submissions and I set it out below:

[139] Each page of “at a glance” had a headnote in these terms:

“The applicant or licence holder must notify DVLA unless stated otherwise in the text.”

[140] Page 7 of the guidance stated:

“LOSS OF CONSCIOUSNESS/LOSS OF OR ALTERED AWARENESS

**** Excluding Cough Syncope**** (See Chapter 7)

A full history is imperative to include pre-morbid history, prodromal symptoms, period of time unconscious, degree of amnesia and confusion on recovery. A neurological cause, for example, epilepsy, SAH [sub-arachnoid haemorrhage], can often be identified by the history, examination and the appropriate referral made. The relevant DLVA guidelines will then apply. 50% of all cases have a cardiac cause and again, these can be determined by the history, examination and ECG. Investigate and treat accordingly and use the relevant DVLA guidelines.

The remaining cases can be classified under five categories in the FOLLOWING TABLE

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL-CAR M/CYCLE	GROUP 2 ENTITLEMENT VOC-LGV/PCV
1.Simple faint Definite provocation factors with associated symptoms and which are unlikely to occur whilst sitting or lying. Benign in nature. If recurrent, will need to check the “3Ps” apply on each occasion (provocation/prodrome/postural) (If not see number 3 below)	No driving restrictions. DVLA need not be notified.	NB Cough syncope, see Chapter 7 No driving restrictions. DVLA need not be notified.
2. Loss of consciousness/loss of or altered awareness likely to be unexplained syncope and low risk of recurrence. These have no clinical evidence	Can drive 4 weeks after event.	NB Cough syncope, see Chapter 7

of structural heart disease and a normal ECG.		Can drive 3 months after event.
3. Loss of consciousness/loss of or altered awareness likely to be unexplained syncope and high risk of recurrence. Factors indicating high risk: (a) abnormal ECG (b) clinical evidence of structural heart disease (c) syncope causing injury, occurring at the wheel or whilst sitting or lying (d) more than one episode in previous six months. Further investigations such as ambulatory ECG (48hrs) echocardiography and exercise testing may be indicated after specialist opinion has been sought. ** for Pacemakers see <u>Chapter 2</u>	Can drive 4 weeks after event if the cause has been identified and treated. If no cause identified, licence refused/revoked for 6 months.	NB Cough syncope, see <u>Chapter 7</u> Can drive 3 months after the event if the cause has been identified and treated. If no cause identified, then licence refused/revoked for one year.
4. Presumed loss of consciousness/loss of or altered awareness with seizure markers. This category is for those where there is a strong clinical suspicion of a seizure but no definite evidence. The seizure markers act as indicators and are not absolutes: -Unconsciousness for more than 5 minutes - amnesia longer than 5 minutes -injury -tongue biting -incontinence -remain conscious but with confused behaviour -headache post attack	6 months off driving from the date of an episode of loss of consciousness/loss of or altered awareness. However, if a person has a previous history of epilepsy, or a solitary seizure, 12 months' freedom from any further episode of loss of consciousness with seizure markers must be attained. If a person suffers recurrent episodes of loss of consciousness with seizure markers, 12 months' freedom from such episodes must be attained.	5 years off driving from the date of an episode if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan, where indicated.
5. Loss of consciousness/loss of or altered awareness with no clinical pointers. This category will have had appropriate neurological and cardiac opinion and investigations but with no abnormality detected.	Licence refused/revoked for 6 months	Licence refused/revoked for 1 year"

[141] The “3Ps” are provocation, prodrome and posture. Provocation refers to a factor which may trigger fainting such as standing for a long period or shock. Prodrome refers to symptoms experienced in advance of an episode which may serve as a warning that it is about to happen. Feeling warm, nauseous or light-headed would be examples. “Postural” is included because it is generally more common to faint whilst standing as opposed to sitting and fainting whilst lying down is very rare. It is well known that to get up quickly from a lying or sitting position may induce a faint or at least a feeling that one may faint.

[142] The reference to “benign” in box 1 encompasses a situation where there is no underlying pathology or illness which is causing loss of consciousness.

[143] A further box within the category of neurological disorders was in these terms:

LIABILITY TO SUDDEN ATTACKS OF UNPROVOKED OR UNPRECIPITATED DISABLING GIDDINESS Eg Meniere’s disease.	Cease driving on diagnosis. Driving will be permitted when satisfactory control of symptoms is achieved. If remains asymptomatic, till 70 licence restored.	Licence refused or revoked if condition sudden and disabling. Consider underlying diagnosis and if likely to cause recurrent attacks, must be symptom-free and completely controlled for 1 year from last attack before re-application.
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[144] At page 4 of “at a glance,” it was stated:

“Important Note.

Throughout the publication, reference is made to notification not being required where specified. For these conditions and others not mentioned in the text this is generally the case but very rarely, the conditions may be associated with continuing symptoms that may affect consciousness, attention or the physical ability to control the vehicle. In these rare instances, the driver should be advised to report the condition and symptoms of concern to DVLA.”

[145] Changes were made to the LOC etc. section of the guidance in 2011 and 2012.

Its current formulation, which remains as it was at 22 December 2014 and

throughout 2015, is in these terms.

“The remaining cases can be classified under six categories in the following table.

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT ODL-CAR M/CYCLE	GROUP 2 ENTITLEMENT VOC-LGV/PCV
1. Reflex Vasovagal Syncope Definite provocation factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or lying. Benign in nature. If recurrent, will need to check the “3 P’s” apply on each occasion (provocation/prodrome/postural). (If not, see number 6 below).	No driving restrictions. DVLA need not be notified.	No driving restrictions. DVLA need not be notified.
2. Solitary loss of consciousness/loss of or altered awareness likely to be unexplained syncope but with a high probability of reflex vasovagal syncope. These have no clinical evidence of structural heart disease and a normal ECG.	No driving restrictions DVLA need not be notified	Can drive 3 months after event.
3. Solitary loss of consciousness/loss of or altered awareness likely to be cardiovascular in origin (excluding 1 or 2) Factors indicating high risk: a. abnormal ECG b. clinical evidence of structural heart disease c. syncope causing injury, occurring at the wheel or whilst sitting or lying Further investigation such as ambulatory ECG (48hrs), echocardiography and exercise testing may be indicated after specialist opinion has been sought. ** for Pacemakers see Chapter 2	Licence refused/revoked for 6 months if no cause identified. Can drive 4 weeks after the event if the cause has been identified and treated.	Licence refused/revoked for 12 months if no cause identified. Can drive after 3 months after the event if the cause has been identified and treated.
4. Solitary loss of consciousness/loss of or altered awareness with seizure markers. This category is for those where	6 months off driving from the date of an episode of loss of	5 years off driving from the date of an episode if the licence holder has undergone

there is a strong clinical suspicion of a seizure but no definite evidence. Factors to be considered: - without reliable prodromal symptoms - unconsciousness for more than 5 minutes - amnesia longer than 5 minutes – injury - tongue biting - incontinence - remain conscious but with confused behaviour - headache post attack	consciousness/loss of or altered awareness. If a person has a history of epilepsy, an isolated seizure or a loss of consciousness/loss of or altered awareness with seizure markers within the preceding 5 years, then a period of 1 years' freedom from any such events must be demonstrated before being considered eligible to drive.	assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan, where indicated. If a person has a history of epilepsy, an isolated seizure or a loss of consciousness/loss of [or] altered awareness with seizure markers within the preceding 10 years then a period of 10 year's freedom from any such events must be demonstrated before being considered eligible to drive.
5. Solitary loss of consciousness/loss of or altered awareness with no clinical pointers. This category will have had appropriate neurological and cardiac opinion and investigations but with no abnormality detected.	Licence refused/revoked for 6 months.	Licence refused/revoked for 1 year.
6. Two or more episodes of loss of consciousness/loss of or altered awareness without reliable prodromal symptoms.	If the episodes have been within the last 5 years then licence revoked or refused for 12 months or until the risk has been reduced to [less than] 20% per annum.	If the episodes have been within the last 10 years then licence revoked or refused for 10 years or until the risk has been reduced to less than 2% per annum.

[146] It can be seen that a number of changes were made between 2010 and 2014. The panel instructed the changes because of a perceived lack of clarity within the guidelines and not on the basis of any change in medical knowledge.

[147] In box 1, "simple faint" was replaced with the term "reflex vasovagal syncope" and if the 3Ps are not present, the doctor is directed to box 6 as opposed to box 3. The change of terminology was recommended in March 2011 as a result of a group of cases which highlighted that the guidelines had been open to unduly wide interpretation.

[148] Box 2 now relates to a solitary event and "low risk of recurrence" was replaced with "unexplained syncope but with a high probability of reflex vasovagal syncope." For a group 1 licence holder, DVLA need not be notified.

[149] In box 3, the wording, "likely to be cardiovascular in nature excluding 1 or 2", has replaced 'likely to be unexplained syncope and high risk of recurrence.' The word "solitary" is introduced to qualify the event under consideration. Despite the removal of the term "high risk" from the opening sentence of box 3, it goes on to refer to, "Factors indicating high risk." Factor (d) is not reproduced in box 3 of the current guidance, but that is because it is subsumed in the new box 6.

[150] The word solitary was added to box 5.

[151] Box 6 was introduced in May 2012 following a particular case involving recurrent, unexplained, undiagnosed episodes of syncope without a reliable prodrome. The reliability of prodrome in advance of loss of consciousness is particularly significant for safe driving.

[152] Initially, box 6 was introduced with 1 and 5 year periods of revocation but this was subsequently changed to 1 and 10 years, subject to a qualification relating to probability of recurrence below a threshold of 20% for group 1 and 2% for group 2 licence holders. Those changes were made on account of a recognition that there could be a significant period of time during which a further episode of loss of consciousness may arise.

Mr Clarke's representations after the accident on 22 December 2014

[153] Given the medical evidence which I heard, and the traumatic circumstances in which he regained consciousness, I am not persuaded that anything said by Mr

Clarke as he was assisted and treated at the scene should be viewed as an attempt to conceal his past medical history.

[154] On 22 December 2014 at about 7.45pm, Mr Clarke was examined by Dr Elizabeth Clarke within the Accident and Emergency Department of the Western Infirmary Hospital, Glasgow. On being asked if he had ever suffered a similar experience previously he said that he had not.

[155] Given the events of 7 April 2010 and the lengths which Mr Clarke went to in order to conceal them and play them down both at the time and afterwards, I do not believe that Mr Clarke had forgotten or misunderstood their relevance. Mr Clarke lied to Dr Clarke.

[156] On 23 December 2014 at about 9.20am Dr Malcolm Shepherd examined Mr Clarke. On being asked if this had ever happened to him before, Mr Clarke said that in 2004 he had been driving a bus and had suffered a panic attack which caused him to pull the bus over and gave no further information.

[157] The evidence does not disclose whether there was such an event, but to the extent that the answer omits reference to 7 April 2010 and the real nature of that event, it was untrue.

[158] On 24 December 2014 at about 9.20am Dr John Paul Leach examined Mr Clarke. On being questioned on his medical history, Mr Clarke advised Dr Leach that he had no history of loss of consciousness. He said that there was an episode in 2008 where he felt shivery but that he did not lose awareness, and that an ambulance had been called but that he did not go to hospital. Dr Leach then recorded in the medical notes in relation to this disclosure that there was no loss of consciousness.

[159] It is possible that Mr Clarke forgot the year in which the event happened but insofar as he denied losing awareness, he lied to Dr Leach.

[160] On 13 February 2015 Mr Clarke told Professor Rankin there had been a previous incident when he was a bus driver in 2010 where he became unwell whilst driving a bus. This is the first record of a precise reference to this event being made by Mr Clarke after the fatal incident on 22 December. Again, he denied having lost consciousness which was a lie.

Mr Clarke's interaction with DVLA in 2015

[161] The history of Mr Clarke's entitlement to hold group 1 and group 2 driving licences after 22 December 2014 was conclusively proved in a section of the third joint minute which is reproduced as appendix 5. Set out below is a brief chronology, taken from those proved facts and other facts derived from the evidence of witnesses and documents.

[162] On 7 January 2015 Mr Clarke surrendered his licences to the police who notified DVLA in writing that there was a diagnosis of epilepsy so that the licences were revoked on 8 January.

[163] On 13 February 2015 Mr Clarke phoned DVLA to advise that he had a diagnosis of another condition. He did not have a fit on 22 December 2014; it was some kind of syncope. Mr Clarke said he would send in evidence to DVLA.

[164] Also on 13 February 2015, Mr Clarke had been seen by Professor Rankin who reported in his letter of 6 May 2015 that, "When I spoke to him, he had accepted that he would not return to work as a lorry driver." Professor Rankin had told Mr Clarke

in that meeting that, in his opinion, Mr Clarke should not drive a heavy goods vehicle.

[165] On 19 February Dr Gillian Simpson of Baillieston Health Centre wrote to DVLA to advise that Mr Clarke had not suffered a seizure but that he had a diagnosis of neurocardiogenic syncope.

[166] On 27 February Mr Clarke phoned DVLA inquiring about progress.

[167] On 10 March 2015 DVLA wrote to Dr Simpson inviting her to complete a medical questionnaire form Fep 2 and to submit any further relevant information.

This did not prompt disclosure to DVLA of the events of 7 April 2010.

[168] On 13 March Mr Clarke phoned DVLA inquiring about progress.

[169] On 26 March, in response to a further phone call to DVLA, Mr Clarke was sent an application form for his group 1 licence which was completed on 2 April.

[170] On 2 April Mr Clarke phoned DVLA to inquire if he could now apply for a vocational licence and in response DVLA sent him an application form for his group 2 licence. Mr Clarke completed it on the same date.

[171] On 10 April Mr Clarke phoned DVLA to reiterate that he had not suffered a seizure in connection with applying for a vocational licence.

[172] On 10 April Mr Clarke completed and signed DVLA Form Fep 1V, medical questionnaire, in which he ticked the box on page 4 to confirm that his medical condition related to blackout(s)/altered level of consciousness and on page 6 completed the date for "First event" as 22/12/2014 and for "Last event" he entered the word "none." He signed the form at page 7 under a declaration that to the best of his knowledge and belief the details were correct and that he understood that it is a

criminal offence to make a false declaration to obtain a driving licence which can lead to prosecution. Mr Clarke did not disclose the incident of 7 April 2010.

[173] On 28 April, DVLA wrote to Mr Clarke to say that on the information received, which included a letter² from Dr Freel to Mr Clarke, Mr Clarke met the medical standards and issued group 1 and group 2 licences.

[174] On 25 June Mr Clarke was advised by DVLA that his licences would be revoked. DVLA records suggest that on 25 June Mr Clarke's case was reviewed, "In light of detailed medical notes received from FAI process." On 26 June DVLA confirmed in writing to Mr Clarke that his group 1 licence was revoked for one year and his group 2 licence for ten years. The explanation given was that Mr Clarke had lost consciousness in 2010 and 2014 without reliable prodrome.

[175] The period of revocation of a licence on the ground of a faint or any other medical condition or event causing an accident would normally commence from the date of the accident and this is likely to be corrected administratively in due course.

NOTE – PART 2

Representation

[176] On behalf of the Procurator Fiscal – The Solicitor General and G Ross, Advocate
For the family of Jacqueline Morton – DR Bain QC, D Forbes, Advocate
For the family of Gillian Margaret Ewing – AJM Forsyth, Advocate
For the families of John Kerr Sweeney, Lorraine Sweeney and Erin Paula McQuade – ML Stewart QC, EC Toner, Advocate
For the family of Stephenie Catherine Tait – R Conway, Solicitor-Advocate
For DVLA – RR McIlvride QC
For Glasgow City Council – PL Gray QC
For Henry Toal and Mathew Telford – L Ewing, Solicitor-Advocate
For Dr McKaig, Dr Langan and Dr Willox – MB McGregor, Advocate
For Dr Lyons – HM Watts, Advocate

² see appendix 4 and JM 3 para 25.

For Henry Clarke – P Reid, Advocate

I express my appreciation for the constructive manner in which the evidence was presented. Substantial agreement of evidence was achieved, which spared many witnesses from attending court and helped to focus issues. The researches, questioning of witnesses and submissions of parties were of great assistance to the Inquiry.

Introduction

Evidence

[177] Evidence was led over 24 consecutive days. Numerous facts were proved by agreement in 8 joint minutes. In this Inquiry, the findings required under section 6 (1) (a) and (b) were essentially established by joint minute. That was appropriate because there was no room for doubt as to those facts and there would have been no advantage in leading evidence to establish undisputed facts.

[178] In addition, 31 witnesses were called to give evidence and they are listed in appendix 1. I have carefully considered all of the evidence led in the Inquiry.

Submissions

[179] The hearing on submissions extended over 25, 26, 27 and 28 August 2015. Some of the submissions were lengthy and detailed and I will not rehearse or summarise all of them. I have given all of the parties' submissions full and careful consideration, even where there is no specific reference or comment in the relevant part of my Determination.

Assessment of evidence

[180] Facts which are agreed by joint minute are treated as being conclusively proved so I am bound to accept such facts as being established.

[181] I considered that nearly all of the evidence which I heard from witnesses was credible, i.e. the witnesses were trying to tell the truth. Much of the evidence was also reliable, i.e. accurate and correct, but where witnesses were giving evidence about events which occurred some years ago, I had to consider carefully to what extent I could rely on it. In many instances, the reliability of such evidence was reinforced by contemporaneous notes, letters, application forms and other documents. Where witnesses gave evidence of their usual practice, it could provide a basis for accepting evidence even where specific recollection was imperfect or lost.

[182] Where skilled witnesses gave opinion evidence, assessment of competing opinions did not really involve issues of credibility or reliability. It was a matter of evaluating the qualifications and experience of the witnesses and examining the comparative reasoning in the light of the information available to the witnesses.

[183] A fact finder is entitled to accept part of a witness's evidence whilst rejecting another part, and in some respects I did so.

The legal framework

[184] Section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the 1976 Act) 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.”

[185] This Inquiry was held under section 1(1)(b) on the ground stated in the application by 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 deaths.”

[186] The application gave notice of certain objectives, namely:

“To publicly establish the circumstances of the deaths to include in particular-

- i) examination of the medical assessments and DVLA review process of Henry Clarke’s fitness to hold an LGV and PCV driving licence;
- ii) examination of whether any design feature of the motor vehicle or other measures or intervention could have been in place to bring said motor vehicle to a controlled stop after control had been lost;
- iii) examination of the safety of the refuse collection route undertaken by said motor vehicle.”

[187] The procedure to be followed in the conduct of Fatal Accident Inquiries is governed by the provisions of the 1976 Act and rules³ made under section 7(1) of the 1976 Act. Subject to the provisions of the 1976 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 alone⁴.” The standard of proof is the balance of probabilities and corroboration is not required. Hearsay evidence is admissible, as is affidavit evidence, and undisputed evidence may be proved by joint minute of agreement.

[188] Section 6(1) of the 1976 Act provides that the purpose of a Fatal Accident Inquiry 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;

³ The Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977.

⁴ Section 4(7) of the 1976 Act.

- (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.

[189] The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and any other party to the Inquiry. Any determination must be based on the evidence presented at the Inquiry and is limited to the matters defined in section 6(1) of the 1976 Act.

[190] Section 6(1)(c) refers to reasonable precautions whereby the death and accident may have been avoided and this has been interpreted as meaning that a finding under that provision need not arise from a probability. A “(real and) lively possibility” is sufficient⁵. 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.

[191] As well as being satisfied that the precaution might have prevented the accident or death, the court must be satisfied that the precaution was a reasonable one. In that regard, I agree with Sheriff Principal Lockhart’s observation in his Determination in the FAI into the Rosepark Care Home deaths, 20th April 2011, at para 8.

“The question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or an unreasonable way, but whether or not there is a precaution which is a reasonable one and which might have made a difference.”

⁵ Carmichael, Sudden Deaths and Fatal Accident Inquiries, 3rd Edn at para. 5-75, adding the words in parentheses to Sheriff Kearney’s expression in his Determination in the FAI concerning the death of James McAlpine, issued on 17 January 1986.

In this context, “reasonable” implies consideration of the availability, suitability and practicability of the precaution contemplated.

[192] “Precaution” has been interpreted widely by sheriffs in determining what is to be identified as a reasonable precaution in the particular circumstances of the case. I proceed on the basis that “precaution” means an action or measure taken beforehand to ward off a possible danger or risk.

[193] Assessment under section 6 (1) (c) involves retrospective consideration of the circumstances with the benefit of hindsight and on the basis of the information and evidence available at the time of the Inquiry. Since a reasonable precaution may be identified with the benefit of hindsight it need not have been foreseeable as necessary at the time.

[194] Before a finding can be reached under section 6 (1) (d), the sort of possibility relevant to section 6 (1) (c) will not suffice. It must be shown that any defect in any system of working actually contributed to the death or any accident resulting in the death.

[195] A Fatal Accident Inquiry is primarily concerned with fact finding and it is not a forum designed to establish legal fault. As Lord President Hope explained⁶:

“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.”

[196] I agree with and adopt the approach taken by Sheriff Normand⁷:

“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

⁶ in *Black v Scott Lithgow Limited* 1990 SC 322, at page 327.

⁷ at para 1.8 of his Determination of 14 November 2014 concerning the deaths of Mhairi Samantha Convy and Laura Catherine Linda Stewart.

do so. This is important when having regard to future safety and the prevention of a recurrence of the accident or the death”.

Lord Cullen of Whitekirk stated in the course of his review⁸:

“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.”

It has been said of FAIs that:

“...findings may be very persuasive in ensuring that precautions are taken or defects are remedied with the result that the public could be protected from some recurring hazard or danger to life⁹.”

[197] I proceed on the basis that the underlying purpose of a Fatal Accidental Inquiry is to establish what happened, and how it came to happen, with a view to trying to ensure that the same circumstances do not avoidably recur. In the particular circumstances of this Inquiry, all parties recognised that I would have to evaluate whether certain representations made by Mr Clarke were accurate, inaccurate or false before being able to determine the issues to be addressed under sections 6 (1) (c), 6 (1) (d) and 6 (1) (e).

[198] The 1976 Act does not refer to recommendations at all, but it was accepted by all parties that it is an established practice for sheriffs to make recommendations where justified on the evidence¹⁰.

⁸ Report of the Review of Fatal Accident Inquiry Legislation (2009) at para.3.23.

⁹ in para 520 of the Stair Memorial Encyclopaedia.

¹⁰ Inquiry into the death of Mildred Allan 14 Nov 1985, Sheriff Kearney:

“The provisions of section 6 (1) (e) are still wider and, in my view, entitle and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the course of the inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation.” Recently adopted by Sheriff Bicket in his Determination of 7 August 2015 concerning the death of Dawn McKenzie.

1976 Act Section 5

[199] In this Inquiry, the driver of the vehicle which was involved in the accident was to be called as a witness. On 25 February 2015, the Crown had publicly stated that it would not take criminal proceedings against Mr Clarke. In the course of the Inquiry, the Solicitor General restated the Crown's position in this way:

"On 25th February, the information put into the public domain was:
"Crown Counsel have concluded that the driver of the lorry should not be prosecuted in respect of this tragic incident. Despite its catastrophic consequences there is no evidence to suggest that the driver's conduct at the time amounted to a breach of the criminal law."

In reaching its decision that Mr Clarke should not be prosecuted, Crown Counsel considered both the manner of his driving on the day and the information which he had previously provided to doctors and the DVLA about his loss of consciousness in April 2010. The same considerations which were taken into account in relation to the information provided to the DVLA also applied to the information which he provided to Glasgow City Council in relation to his employment with them. My position therefore, my Lord, is that I consider that the scope of the decision in February 2015 described as in respect of this tragic incident extends to all aspects of the manner of Mr Clarke's driving on 22nd December, as well as the information previously provided to doctors and the DVLA and Glasgow City Council in respect of the incident in April 2010 when he was employed by First Bus."

[200] Accordingly, the Crown had renounced the right to prosecute in respect of all of the matters alluded to by the Solicitor General. The question then arose as to how the terms of section 5 of the 1976 Act would bear on the situation.

[201] Section 5 is in these terms:

"5.— Criminal proceedings and compellability of witnesses.
(1) The examination of a witness or haver at the inquiry shall not be a bar to criminal proceedings being taken against him.
(2) No witness at the inquiry shall be compellable to answer any question tending to show that he is guilty of any crime or offence."

Where a witness is entitled to decline to answer any question, it is inherent in the judicial function that he should be warned of that right by the presiding judge.

[202] Read literally, and in isolation from subsection 5 (1), subsection 5(2) might appear to mean that regardless of the potential for prosecution, any witness need not answer any question tending to show that he is guilty of any crime or offence. I am doubtful that that is what Parliament intended when this provision was first introduced in the Fatal Accidents Inquiry (Scotland) Act 1895, section 5 (4). My impression is that in the 1976 Act, subsection 5 (2) should be read along with subsection 5 (1) as meaning that the witness is not compellable when he could still be prosecuted. That would be consistent with the position at common law and I apprehend that the legislative intent was to afford the witness the same protection that he would enjoy at common law. That view may gain some support from recent judicial observations¹¹.

[203] Ordinarily, I might well have determined that Mr Clarke, having immunity from the Crown, would have to answer all questions. In the event, parties came to present me with a consensus that Mr Clarke should be given a section 5 warning, so that I did not hear a full debate on the construction of these provisions.

[204] During the course of the Inquiry, it became apparent that solicitors for the Morton family had made a statement to the media suggesting that there would be an attempt made to mount a private prosecution. Whilst it is a very rare occurrence, the High Court of Justiciary does have power to authorise a private prosecution, and has done so twice in the last hundred years or so¹².

[205] On day 19 of the Inquiry, Ms Bain QC announced that she was instructed to take the initial steps of preparing a bill of criminal letters and she moved to adjourn

¹¹ *Singh v HM Advocate* 2004 SCCR 604.

¹² *Sweeney v X* 1982 JC 70, *J & P Coats Ltd v Brown* (1909) 6 Adam 19.

the Inquiry for 3 months to allow that to progress so that the question of whether there would be a private prosecution could be resolved before Mr Clarke gave evidence. All parties were in agreement that the Inquiry should hear the rest of the evidence, other than that of Mr Clarke, before I adjudicated on that motion.

[206] In due course, the motion was withdrawn by Ms Bain. It became the position of the Morton family that the Inquiry should proceed to a conclusion so that they joined with the Tait family in opposing a motion made on behalf of Mr Clarke on day 22 to adjourn until it became clear if a private prosecution would be permitted. Having considered the competing interests, and in particular the public interest, I refused to adjourn the Inquiry.

[207] Once it had been made clear that the Morton family would be seeking to raise a private prosecution, it was the Solicitor General's position that Mr Clarke fell to be protected by the provisions of section 5(2) and that I should accordingly warn him that he need not answer any question tending to show that he is guilty of any crime or offence. None of the parties suggested that I should not.

[208] In order to allow me to understand which questions might have the potential to incriminate in the proposed prosecution of Mr Clarke, I invited Ms Bain to set out the scope of the case which she envisaged bringing. Ms Bain contemplated prosecution for causing death by dangerous driving (RTA 1988 section 1) or for causing death by careless or inconsiderate driving (RTA 1988 section 2B). Consideration was also being given as to whether her clients had title to prosecute for statutory offences arising out of allegedly false declarations to DVLA and fraud in relation to a variety of representations, including those connected to Mr Clarke's application for employment with GCC.

[209] Ms Bain explained that in due course it would be argued that driving in circumstances where it was foreseeable that he would faint was dangerous or at least careless/inconsiderate driving whereby Mr Clarke had made sufficient contribution to the causing of death so as have committed an offence under section 1 or 2B. This analysis, she contended, would overcome the difficulty involved in him not “driving,” i.e. controlling the movement and direction of the lorry by reason of his being unconscious, when the collisions occurred. Any evidence which showed or tended to show that Mr Clarke was aware that he had fainted before, or suffered conditions or symptoms which bore on his ability to drive safely, might be germane. Any attempts made by him to conceal from employers, potential employers and DVLA his relevant medical history, might be germane in yielding inferences suggesting knowledge on his part relevant to the issue of foreseeability.

[210] Ms Bain explained that she envisaged a very widely drawn circumstantial case against Mr Clarke such that almost any answer he gave in relation to his health and his employment history might incriminate him. It was her view that he should be warned that he need not answer any questions beyond his name and age. The Solicitor General came to acquiesce in that approach and no one demurred.

[211] Counsel for Mr Clarke also supported the view that Mr Clarke should be given a warning along the lines proposed by Ms Bain. He also sought to reserve the right to intervene to request that the court should remind Mr Clarke of his right not to answer particular questions.

[212] I considered that in order for the right afforded to Mr Clarke by section 5(2), and the common law, to be practical and effective, he would require to understand which questions might tend to show that he was guilty of an offence. I considered

that it would be very difficult for him to grasp the scope of the circumstantial case contemplated by Ms Bain and its implications. I concluded that the most practical and effective means of warning Mr Clarke was to tell him that he need not answer any question other than his name and age.

[213] When he was called as a witness, I confirmed with Mr Clarke that he had had legal advice that morning and then said to him:

“You can choose to answer questions if you wish to do so...But I must tell you this: the law says that you do not have to answer any question if the answer would tend to show that you are guilty of any crime or offence. In practice, that means that you do not have to tell any of the people who ask you questions any more than your name and age.”

[214] From time to time, I reminded Mr Clarke of this when I deemed it appropriate.

For the most part he chose not to answer questions, but he did choose to give a full account of the events of 22 December. Since I gave Mr Clarke a warning that he was entitled in law to refrain from answering questions, his declining to answer certain questions and the absence of evidence from him has played no part in my drawing inferences adverse to him.

Evidence led for the families

[215] In addition to the evidence in joint minutes and elicited in cross-examination of witnesses called by the Solicitor General, for convenience, there was interposed amongst the evidence of the Crown’s witnesses, evidence from four witnesses. Ms Bain led the evidence of Dr Nicholas Boon and Dr Daniel Rutherford. Mr Stewart QC for the Sweeney and McQuade families led the evidence of Kenneth Wilson and Nicholas Ward. When these witnesses gave evidence, the respective family lawyer

elicited evidence in chief and re-examined where applicable with the parties cross-examining in normal sequence, and the Crown cross-examining last.

[216] I will come to examine the evidence of Dr Boon and Dr Rutherford in considering some of the medical issues which were explored. It is convenient to say something about the evidence of Mr Wilson and Mr Ward at this point.

[217] Kenneth Wilson, head of Environment and Estates at North Lanarkshire Council (NLC) gave evidence as to his council's approach to route risk assessment¹³ and its response to the events of 22 December 2014.

[218] NLC has almost completed a programme of replacing bin lorries where the crew sit behind the driver with lorries where they sit alongside him in the cab. This is not with a view to allowing passengers better access to the controls, it is simply because that happens to be the seating arrangement in vehicles which NLC considers to be superior. NLC has commenced a process of trying to develop for itself some guidance to passengers of bin lorries who might find themselves in the position of the crew in this case, but that has not been finalised.

[219] NLC performed an experiment which had demonstrated that a 26 tonne bin lorry travelling at 29mph was brought to a halt within 5 metres by application of the secondary handbrake without skidding or deviating. That evidence went unchallenged and perhaps it is correct, but it does not sit comfortably with stopping distances to be found in the Highway Code. NLC still awaits advice from its insurers and will consult employees, unions, the Freight Trade Association and its own health and safety department, and consider the outcome of this Inquiry, before taking matters further in this regard.

¹³ which is set out in production 164.

[220] Discussions are ongoing in NLC as to whether there should be an annual health check for its large vehicle drivers, and whether that should be carried out by the employees' individual GPs. Such a regime is considered to be manageable for NLC but it will await the outcome of the Inquiry before it finalises how it will proceed. At present, there is a five yearly medical performed by NLC's OH advisers.

[221] Mr Ward, a freelance health and safety consultant, had prepared a report for the Sweeney and McQuade families, which was their production 5. He gave evidence broadly in line with his report. In his report he disclosed his acquaintance with Mr Matthew McQuade with whom he had worked in 2010 but whom he had not met since 22 December 2014. As best he could from the information available to him, he had compared GCC's approach to risk assessment in refuse collection with that of 15 other Scottish councils. He considered NLC's approach to represent best practice.

[222] This was the first "expert" report Mr Ward had ever prepared and he did not consider himself to be an expert witness. He did however have some practical experience of aspects of health and safety in a variety of environments and he had some relevant academic qualifications. He did not have any experience of refuse collection.

[223] No objection was taken to Mr Ward giving opinion evidence, but on the basis of information elicited by him in cross-examination, Mr Gray QC for GCC suggested that I should put little or no weight on it.

[224] Mr Gray founded on what he suggested was a lack of the necessary independence of a skilled witness giving opinion evidence. He founded on a lack of understanding of the role of a skilled witness; a lack of practical experience or expertise regarding waste collection and the associated guidance and the relationship

between health and safety and road traffic regulation. Mr Gray gave Mr Ward credit for accepting that, by virtue of his qualifications, experience and knowledge of the facts, Mr Baker¹⁴ was better placed to assist the Inquiry in all material respects. In short, Mr Gray invited me to prefer the opinion evidence of Mr Baker where there was conflict with that of Mr Ward.

[225] It was not demonstrated that Mr Ward had no practical experience and practical experience provides a basis on which a witness can give opinion evidence. By the time he had concluded his evidence, Mr Ward did understand the role of a skilled witness and it was not apparent that his evidence had been influenced by his connection with Mr McQuade. Accordingly, for what it was worth, I was prepared to give such weight to Mr Ward's evidence as seemed appropriate having evaluated it issue by issue in terms of his reasoning, his experience and how his evidence fitted with other evidence in the case, notably that of Mr Baker.

[226] I generally found the opinions offered by Mr Baker to be well reasoned and based on a firm understanding of a wide range of health and safety issues. It was plain that Mr Baker had substantial experience and knowledge of waste collection from a health and safety perspective. Generally, if there was dispute between them, Mr Baker seemed better placed to offer an opinion and back it with reasoning. There were a number of areas where there was no real dispute between them. I took account of Mr Ward's evidence as part of my overall assessment of the issues in the Inquiry to which it was relevant.

¹⁴ Barry Baker, Principal Inspector with the Health and Safety Executive (HSE).

Assessment of the events of 7 April 2010

[227] On 7 April 2010, John Stewart was working as an inspector for First. His daily report includes the following entries:

*“0938 leave to assist driver on 54. Passenger reported he collapsed at wheel in stop.
0944 bus 61392 service 54 arrived at location driver H Clark p/c 966437
Advised he taken unwell at stop and blacked out for couple of minutes
0950 depot advised of incident
1000 driver H Clark starting to feel unwell ambulance called depot informed
1015 paramedic has arrived at locus to attend driver.
1038 driver checked out given all clear with paramedic driver refused to travel to
hospital with ambulance
1044 bus and driver on way to P/head depot spare driver taking bus back.”*

Scottish Ambulance Service records confirmed that an ambulance had attended a number 54 bus at 1220 Paisley Road West and broadly confirmed the accuracy of parts of what Mr Stewart recorded.

[228] Mr Stewart has little recollection of the incident, but was able to give some evidence on the basis of his notes which he had made contemporaneously on a hand held computer. Mr Stewart understood the importance of making his notes carefully and did so on this occasion which was the first time he had had to deal with a report of a driver being unconscious at the wheel of a bus.

[229] Mr Stewart had been at a bus stop on Paisley Road West near to Bellahouston Park carrying out routine checks when a passenger, who had alighted from a number 9 bus, had told him about a bus driver having collapsed at the wheel of a number 54 bus at an earlier stop. He contacted his depot to find out if the incident was known about which it was not. A number 54 bus then arrived. The driver was Mr Clarke. There were no passengers on the bus which was unusual and I infer that Mr Clarke had caused passengers to get off his bus on account of what happened to him which is what Mr Clarke told Professor Rankin in 2015 about that incident. It is

not possible to know on the evidence led whether that happened before or after Mr Clarke “blacked out.”

[230] Mr Stewart spoke to Mr Clarke who told him that he had “taken unwell at stop and blacked out for couple of minutes.” Mr Stewart told Mr Clarke that he could not drive the bus. As he was speaking to him, Mr Clarke became unwell again and Mr Stewart was sufficiently concerned to call an ambulance. Ambulance paramedics attended and, having examined Mr Clarke, gave him the all clear but offered to take him to hospital which offer Mr Clarke declined. Another driver attended and drove the bus and Mr Clarke back to the depot. Mr Clarke would have to be medically examined by Dr Lyons before he could return to driving a bus.

[231] Mr Stewart impressed me as a careful witness who was telling the truth and his notes of 7 April 2010 provide an account which I accept as reliable. I find his evidence, which was based on those notes, to be reliable.

[232] Mr Clarke chose the words “blacked out for a couple of minutes” to tell his Inspector what had happened to him within a few minutes of the event. That same day he told his GP that he had lost consciousness. I do not take literally the words “two minutes” but do consider that Mr Clarke was communicating that the event was of at least some significant duration. The medical evidence would suggest that a period of two minutes would be unusual for this kind of event and that perhaps twenty seconds would be more typical.

[233] For these reasons, I make the findings in fact set out at para 104.

Mr Clarke’s interactions with doctors in April 2010

[234] Mr Clarke made an appointment to see his GP at Baillieston Health Centre,

Glasgow on 7 April 2010 and Dr Gerard McKaig made this computerised note of Mr Clarke's attendance:

"Had 5s loc [loss of consciousness] at work, in canteen hot environment no warning signs, felt slightly disorientated on revival then felt fine. Paramedics attended no cvs [cardiovascular system] anomalies advised vasovagal. On balance I agree, works dr apt tomorrow. HGV driver, BP 130/83."

[235] Mr Clarke completed a form in connection with statutory sick pay on 9 April 2010 in which he entered the term "vasovagal" as his illness.

[236] Dr Kenneth Lyons, a GP of long experience, examined Mr Clarke on 8 April 2010 in his capacity as an OH adviser to First. He was familiar with "at a glance" and he had been conducting D4 medicals for over thirty years. The only written information he had available to him was the detail of Mr Clarke's medical on joining First in 2008. No problems had been highlighted at that time. Dr Lyons performed relevant tests which gave no indication of any abnormality to heart, lungs or blood pressure and there were no seizure features. He understood that Mr Clarke had been sitting on a stationary bus when the incident occurred.

[237] His findings are summarised in the letter he wrote to his employers on 8 April which includes the following:

"...Medical History

*Mr Clarke has been off driving duties since yesterday. **He tells me that he had an episode of impaired, or loss of, consciousness whilst at work yesterday. The episode lasted about 5-10 seconds, according to an eye witness account. He had no particular warning of the event although he was aware of feeling warm.** An ambulance was called and he was examined on the bus by the Paramedics, who did not identify any particular abnormality. The Paramedics made a diagnosis of a vasovagal attack, or fainting episode. He attended his GP later that day and his GP agreed that this was the diagnosis and that he did not need to inform the DVLA.*

Current symptoms

*Mr Clarke has felt no symptoms since the episode. **He is keen to return to work.** There do not appear to be any features suggestive of a seizure.*

Examination

The blood pressure, heart rate and rhythm, and heart and lung sounds are all normal.

Fitness for work

Mr Clarke is fit to return to non-driving duties, but I would advise that he should remain off driving duties meantime. **I have written to his GP for a medical report to ascertain his GP's advice on any restriction to his fitness to drive,** and I will provide Management with an up-dated report on receipt of his GP's reply.

Prognosis

The prognosis will depend on the GP's interpretation of the DVLA's guidelines on episodes of impaired consciousness. It is likely that his GP will place Mr Clarke in one or other of two possible diagnostic categories, which carry a different restriction to bus driving; "a simple faint where there are definite provocation factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or lying" or "loss of consciousness/loss of or altered awareness likely to be unexplained syncope and low risk of recurrence". The first category has no restriction to bus driving but the second carries a 3 month suspension from driving.

Further appointment

I have not arranged a review appointment at this stage but I would be happy to see him at the request of Management.

Consent

I have received his written consent to complete medical reports at the request of his Manager and he has indicated that he may wish to have access to medical reports."

[The emphasis is mine.]

[238] Dr Lyons also wrote to Baillieston Health Centre on 8 April and his letter

included the following passages:

"Re: Henry Clarke. The above named is a bus driver with First Glasgow Bus Company.

He has been off driving duties since yesterday, following an episode of loss of, or impaired, consciousness while on a stationary bus. I understand he was examined by paramedics and the diagnosis was a vasovagal attack. I have been asked by Management to advise them about the likelihood of him returning to bus driving duties. I would therefore be grateful if you could provide me with a medical report including the diagnosis, any planned investigations, and your views on his prognosis regarding a return to bus driving.

I understand that he has been advised that he does not need to inform the DVLA of the incident.

Looking at the wording of the DVLA 'At a Glance Guidelines' on fitness to drive I expect that he fits in to one or other of two possible diagnostic categories, which carry a different restriction to bus driving: 'a simple faint where there are no definite provocation factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or lying', or 'loss of consciousness/loss of or altered awareness likely to be unexplained syncope and low risk of recurrence'. The first category has no restriction to bus driving and there would be no need to inform the DVLA, but the second category carries a 3-month suspension from bus driving, and the DVLA should be informed."

[The emphasis is mine.]

Dr Lyons did not include in his letter to Dr Langan that there was little by way of warning (prodrome) about which he had informed First.

[239] The last paragraph in the letter was referring to boxes 1 and 2 of the guidance relating to LOC etc. in “at a glance.” Dr Lyons made no reference to box 3. In evidence, he explained that he felt that syncope involved a complete loss of consciousness which was not what he was being presented with by Mr Clarke. With hindsight he feels that he should also have mentioned box 3 in his letter to the GP practice.

[240] Whilst he had not in terms asked for it, Dr Lyons envisaged that the GP would review Mr Clarke’s medical records because past medical history would be of significance in determining diagnosis and prognosis. He would himself have provided that in response to his letter. He assumed from the absence of any such information in the reply that there was nothing of significance in Mr Clarke’s past medical history. He had never been sent a patient’s whole medical notes by another GP in response to an inquiry but he would sometimes get quite a full summary. Had he known the full extent of Mr Clarke’s relevant medical history, he would have told Mr Clarke on 8 April 2010 not to drive, informed management that he was not fit to drive and most likely he would have told Mr Clarke to notify DVLA.

[241] In a letter dated 26 April 2010, Dr Langan wrote to Dr Lyons:

“This gentleman was waiting to have his lunch in a hot environment. He felt light-headed and then lost consciousness for a short length of time. It was felt by the Paramedics attending him that this was a simple faint and they did not take him to hospital.

No investigations are planned and I think he is unlikely to have another one. I think he is fit to return to work as a Bus Driver.”

[242] When Dr Lyons received Dr Langan's letter, he did not think that he was being presented with information different to what he had been told by Mr Clarke. Had it been sufficiently obviously different for him to have noticed, he would have inquired further of the GP. With hindsight, he has lowered the threshold at which he would challenge another doctor's judgement of a fitness to drive issue.

[243] Having taken account of Dr Langan's views, Dr Lyons reported to management on 29 April that Mr Clarke was fit to return to work as a bus driver. At the time, with all the information which he had, he did not feel that the GP diagnosis of a simple faint was wrong. With hindsight, he is now of the view that both he and Dr Langan were wrong to accept that this was a simple faint in terms of box 1 of the guidance but he feels that the guidance could have been clearer. He would now err on the side of reporting to DVLA if there was more than one interpretation open on the guidance.

[244] Notwithstanding that he knew that Mr Clarke had an event of impaired consciousness, Dr Lyons accepted that he had in effect told Mr Clarke both on 8 and 29 April that he could continue to drive, albeit not for First until 29 April.

[245] Mr Clarke attended at Baillieston Health Centre on 13 and 22 April 2010 and was seen by Dr John Langan. 13 April simply related to the formality of the signing of a form in connection with fitness to work and Dr Langan recorded in a computerised note:

"Vaso vagal attack bus driver awaiting letter from employer."

[246] On 22 April, Dr Langan recorded

"probable vaso vagal brought on by hot environment waiting for lunch felt light headed fit to return to driving bus."

[247] Dr Langan would have read Dr McKaig's notes of 7 April 2010. At the consultation on 22 April, Dr Langan would have been looking at Mr Clarke's computerised medical notes over the last 5 years for any information relevant to blackouts or faints or cardiology investigations but saw nothing of that kind. He knew that Mr Clarke had been an HGV driver over that period and he saw nothing to suggest that he should not be driving. He explained that dizziness can be caused by wax in the ears and that would be very commonplace such that it would not go into the medical notes front page summary which was intended for major diagnoses. He would not have considered relevant a vasovagal episode from twenty years previously. Dr Langan felt sure that he noted the discrepancy in accounts, raised it with his patient and was reassured by the answer that he got. He was absolutely certain that Mr Clarke had not described himself as being at the wheel of a bus. He felt that he had been given a description of a prodrome (light headedness) by the patient which confirmed that this was a simple faint. Dr Langan thought that he would have dictated his letter to Dr Lyons in the presence of Mr Clarke on 22 April.

[248] Dr Langan would likely have viewed the incident as falling within box 2 if he had seen the history which Dr Langan had given to management. If he had received that letter, with its reference to there being no prodrome, he would have asked Mr Clarke to come back in so that he could have questioned him further.

[249] Dr Langan did not view the fact that a driver was sitting when he fainted as necessarily excluding for DVLA that he had suffered a box 1 simple faint. It was not clear to him that that was what DVLA intended and he felt that the guidance could be clearer and simpler. He pointed out that box 1 did not say that a simple faint never occurred when sitting, it seemed to be saying that it was unlikely. Whilst he

had in the past used the DVLA phonenumber for guidance, he had not felt that he needed to on this occasion.

[250] Dr Langan said that even if he had known that Mr Clarke had been seated at the wheel of a bus, he would have put the event in box 1 on the assumption that he was satisfied that there was prodrome and provocation. He proceeded on the basis of his medical knowledge which was that whilst fainting occurs more commonly when someone is standing, it also commonly occurs in the sitting position. He did not feel that the guidance precluded a doctor from proceeding on the basis of his own medical assessment.

[251] For Mr Clarke, Mr Reid contended that I should conclude that Dr McKaig's notes were erroneous in referring to the canteen as they were out of keeping with other descriptions of events, including some given by Mr Clarke. Counsel submitted that it has been recognised by courts that medical notes, particularly hospital records, may not always provide a complete record of what was said and/or observed¹⁵. I have also taken account of the evidence of Dr Boon to the effect that if he had seen Mr Clarke in hospital and Mr Clarke had given an account which conflicted with what Dr McKaig had recorded, he would have favoured the patient's account because medical records can be inaccurate.

[252] I have considered these points and all of Mr Reid's submissions. I have borne in mind evidence that patients who have lost consciousness will not always realise what has happened afterwards.

[253] I am not in the same position as that which Dr Boon was invited to imagine. I am not treating Mr Clarke and having to rely on his account for that purpose. I have

¹⁵ *McConnell v Ayrshire and Arran Health Board* [2001] Rep LR 85 at para 28.

heard evidence on oath from Dr McKaig who confirmed that the wording of his note, whilst it would not be a complete record of everything said, was based on what Mr Clarke told him on 7 April 2010. I asked Dr McKaig to consider the possibility that he had been told by this patient that the incident had occurred on a bus. Dr McKaig confirmed that he was clear and confident that in noting that the event occurred in a canteen, he was recording the history as given by the patient.

[254] I found Dr McKaig to be a straightforward witness who was doing his best to tell the truth. He had no memory of the consultation but he was confident that his notes were accurate as far as they went. I accept his evidence as being reliable and I conclude that Mr Clarke told him that the incident took place in a canteen. Such is the difference in that representation from what really happened, and having regard to what Mr Clarke told Dr Lyons to the effect that the incident was on a bus, I conclude that what Mr Clarke said to Dr McKaig was a deliberate deception. He lied to his doctor. I am fortified in that view by the whole pattern of representations which Mr Clarke made about the incident on 7 April 2010.

[255] Mr Clarke is recorded in his medical notes to have had a vasovagal attack at work at a time when he was an HGV driver in 1989. On 25 February 1994 whilst driving a bus he felt dizzy and may have had pain in his chest such that he was referred for cardiac investigation. In that connection, he was later told that he should have advised DVLC that he was being investigated for angina. On 10 July 2003 he was told, for a few days, to stop driving on account of suffering from dizziness. Even without those experiences, it is reasonable to infer that a bus driver would recognise that fainting at the wheel of his bus could jeopardise his employment.

[256] I infer from the whole evidence that Mr Clarke's motivation in lying to Dr McKaig on 7 April 2010, was to downplay the incident with a view to retaining his job as a driver with First.

[257] I conclude that whilst he would not have expected to get away with telling the same lie to Dr Lyons about the incident occurring in a canteen, he again sought to downplay the extent of what had happened to him. He told Dr Lyons that he had not lost consciousness and that the episode lasted for about 5-10 seconds. Whatever the true duration, the previous day Mr Clarke had told Mr Stewart that he had, "blacked out for a couple of minutes."

[258] Mr Clarke deceived Dr Langan by leaving him with the impression that he had fainted in a canteen.

[259] Whilst I have taken account of Mr Reid's submissions that many of Mr Clarke's representations might be explicable on the basis that he had relied on doctors to advise him whether he could or could not drive, any significance which that consideration may have in relation to 7 April 2010 and thereafter is substantially undermined by Mr Clarke's patent deception of doctors McKaig, Lyon, Langan and, in due course, Dr Willox.

[260] The pattern of deception about that event extends even beyond 22 December 2014¹⁶.

Group 2 licence renewal December 2011

[261] In assisting Mr Clarke to complete form D4, Dr Willox had asked him in elaboration of the question relating to blackouts or impaired consciousness, "Have

¹⁶ See paras 154-160 above.

you had any blackouts, or fits, or faints, or any funny episodes, or anything, over the last five years?" His answer was in the negative.

[262] Mr Clarke completed form D47 beforehand and Dr Willox did not look at it.

She completed form D4 on the basis of her medical examination and the answers he gave her, but Mr Clarke signed the declaration at the end of the form in her presence.

She performed a full body examination which included assessment of height, weight, body mass index, a urine test for diabetes, blood pressure, hearing and eyesight.

[263] In performing D4 medicals, Dr Willox does not have access to GP records. To require that would introduce delay and cost as it would be necessary to have the patient sign a consent form and await the arrival of medical information from the GP thereafter. However, it would be useful and preferable to have such information.

[264] Dr Willox considered that driving a heavy goods vehicle was safety critical work. If Mr Clarke had told her that he had fainted at the wheel of a bus in April 2010, she would have declared him temporarily unfit for work. She would have told GCC that he was not fit to drive. She would have obtained his medical records with a mandate and she would have flagged up all of this on section 7 of form D4. She would have told Mr Clarke to speak to his GP about car driving.

[265] Had Dr Willox been told of dizziness, she would have entered that on the form, but whether she would have told him not to drive at all would have depended on how long ago it happened and the nature of it.

Mr Clarke's written and oral representations

[266] Ms Bain in particular elicited material in cross-examination which underpinned her persuasive submission, delivered by Ms Forbes, to the effect that Mr Clarke had

repeatedly lied. Mr Reid submitted that I should conclude that Mr Clarke was simply a poor historian due to frailties of memory. I acknowledge the thoroughness and ingenuity of all of his submissions in this regard. I have considered all of the relevant evidence and submissions on how I should assess Mr Clarke's various representations and I have done so with an open mind. For the reasons which I have given both in this chapter and in commentary to the narrative of facts, I conclude that in making many of the representations which he did, Mr Clarke gave inaccurate information. It is my further conclusion that he repeatedly lied in order to gain and retain jobs and licences in the instances which I have specified.

MEDICAL EVIDENCE - OPINION

Professor Andrew Rankin

[267] Professor Andrew Rankin is Professor of Medical Cardiology at Glasgow University and an Honorary Consultant of Cardiology at Glasgow Royal Infirmary. Mr Clarke was referred to him in 2015 and they met on 13 February and again on 19 May to review his progress.

[268] Much of the evidence that Professor Rankin could give is summarised in the third joint minute¹⁷. I have incorporated parts of his evidence in paras 38-45.

[269] Professor Rankin was satisfied that Mr Clarke had suffered an episode of neurocardiogenic syncope on 22 December 2014. At the time of treating Mr Clarke he had access to some medical records, but not the whole GP notes. He had not known of the events of 1989, 1994 and 2003 at that time. He had been made aware of the whole medical history in preparation for the Inquiry. He was very cautious about

¹⁷ See appendix 4.

reaching any conclusion on the sparse information contained in the GP notes. He felt it possible that 1989 was a vasovagal episode which involved a loss of consciousness. He could not exclude 1994, but he did not think that 2003 was of any relevance.

[270] Professor Rankin did not deem it appropriate to assume that previous instances of dizziness were related to episodes of syncope or pre-syncope. He explained that there were other causes for dizziness noted such as waxy ears. Dizziness can be associated with anxiety and depression, episodes of which were recorded. He did not regard dizziness on bending as being of vasovagal origin. Dizziness on bending or getting up is so common and non-specific that he did not think that it could be considered to give warning that a patient may go on to suffer a vasovagal syncope.

[271] When he saw a reference to it in Dr Langan's letter of 26 April 2010, which he was able to access from computerised records, Professor Rankin asked Mr Clarke about the incident on 7 April 2010. Mr Clarke had told him that he had not lost consciousness but Professor Rankin considered that there were symptoms of a neurocardiogenic event. On the assumption that Mr Clarke had in fact lost consciousness, Professor Rankin would view it as an episode of neurocardiogenic syncope. If it was accepted that Mr Clarke lost consciousness whilst at the wheel of a bus, that would fall within box 3 of the LOC etc. section of the 2010 version of "at a glance." GPs would not generally be deciding if an event fell within box 3 because that conclusion would only be reached after specialist cardiac testing. However, the event would not fall within box 1 and it was therefore notifiable to DVLA. It was counterintuitive medically to exclude a faint which occurred sitting down from the category of "a simple faint," but he understood that that was what was indicated by the 2010 version of "at a glance" with a view to ensuring notification of such events.

[272] He explained that most people who have one episode of neurocardiogenic syncope will not have another. Some people may have a susceptibility to suffer repeated episodes. There is no specific effective treatment but patients are advised to avoid provoking factors and to maintain hydration.

[273] It was his position that,

“Very, very little that we saw in the records or in his history said that this was likely to have happened in December 2014.”

[274] Professor Rankin referred to self-reporting as a recognised weakness in the fitness to drive regime and he understood there to be statistically significant evidence of failures to report following medical advice so to do.

Dr Nicholas Boon

[275] Dr Boon was a Consultant Cardiologist at Edinburgh Royal Infirmary from 1986 to 2010 and President of the British Cardiovascular Society from 2006 to 2008. He continued to provide out-patient service to ERI until November 2014. He remains active in medical research and teaching.

[276] Dr Boon said that it is quite common when patients experience vasovagal attacks for them to have a secondary event after the main event and this would fit in well with Mr Stewart’s description of Mr Clarke becoming unwell for a second time on 7 April 2010.

[277] The victim of a vasovagal attack may not have a clear recollection of events afterwards and may not be sure if consciousness was or was not lost.

[278] Statistical evidence showed that it is quite common following a vasovagal attack for there to be a second attack within 3 months and Dr Boon understood that

this knowledge underpinned the revocation regime set out by DVLA in “at a glance.” A person who had an unexplained syncope had a 20% likelihood of a second attack in the two years after the attack and the risk of recurrence is approximately 40% in those who have already had 3 episodes of unexplained syncope. These figures would apply to neurocardiogenic syncope.

[279] When he was asked what a cardiologist would have made of the events of April 2010 had there been a referral, Dr Boon envisaged that the doctor would have seen the medical notes for both 1989 and 1994. Professor Rankin was not provided with that information, diminishing the weight to be put on Dr Boon’s expectation.

[280] Dr Boon concluded that the April 2010 event would have been diagnosed as a vasovagal syncope. He would expect a cardiologist to treat the situation as falling within box 3 of “at a glance” and to advise Mr Clarke not to drive and to inform DVLA and his employer’s OH adviser. If it was the case that Mr Clarke had felt warning symptoms which led him to stop and cause passengers to alight, that would be prodrome, but he did not agree that it would be reliable prodrome. Reliable prodrome would encompass pre-event symptoms which occurred every time. If Dr Boon had been treating Mr Clarke in 2010, he would expect to be asked to report by DVLA, but he would not offer an opinion on whether it was safe for Mr Clarke to hold a group 2 licence; that was DVLA’s decision to make. There would be some treatment in the form of a management strategy.

[281] The most common prodromal symptom of vasovagal syncope is light-headedness. Feeling warm, yawning and queasiness or nausea are also common. It is unusual not to have any prodrome; there is normally quite a significant prodrome.

[282] Dr Boon offered the following view about the relevance of prodrome to road safety:

“...I think the DVLA have probably taken the view - and I think many people might think on the face of it that their regulations are quite generous in respect of vasovagal syncope, but I think that reflects the fact, the knowledge that most people who have vasovagal syncope have a prodrome and are therefore in a position to either abort the attack or take action to avoid an accident. So we don't see many accidents as a result of these conditions...”

[283] Dr Boon favoured the view that a unifying diagnosis could be reached that Mr Clarke has “vasovagal syndrome.” Whilst syncope should be understood as an event, syndrome would refer to an illness which gave rise to a series of events. He felt that at least some of the documented episodes of dizziness could be instances of “pre-syncope.” He considered that dizziness or light-headedness on getting up was quite typical of vasovagal syndrome and he felt that there was no alternative explanation in the medical record.

[284] For Dr Boon, there is significant overlap between postural hypotension and vasovagal syncope and in clinical terms it can be quite difficult to separate them. Both conditions will have a history of light-headedness and they are both conditions that present with symptoms that are related to orthostatic stress; standing up for a long time, or standing up suddenly. They are however different entities with different mechanisms.

[285] He explained that when one changes posture, the blood pressure tends to fall a little causing the body to adapt by resetting the tone of the blood vessels and the heart rate. The complex nervous systems involved in this process can malfunction which may cause reduction in heart rate and opening up of the blood vessels

(vasodilatation) which results in a drop of blood pressure and blood flow to the heart.

[286] The observations of dizziness occurring in a hot environment, described by the investigating doctors in 1994, were in keeping with vasovagal syncope. In his view, references in the medical notes to headaches occurring after episodes of dizziness were also in keeping with vasovagal causation.

[287] Dr Boon considers that a clinician needs substantial experience to be able to diagnose vasovagal syndrome and he was not critical of any of the doctors who had dealt with Mr Clarke over the years. He would not have expected a GP to be able to see the significance of the pattern in Mr Clarke's medical history which Dr Boon felt could be seen. On being asked whether in the case of Mr Clarke in his 40s and 50s it would be recognised as part of a pattern that a past history of dizziness or light-headedness might go on to involve more serious episodes of black-outs, Dr Boon replied:

"I think it's easy to say that with the benefit of hindsight, but I think you have to recognise that these symptoms as reported to his doctors were pretty non-specific. It's not very clear how severe they were, although I imagine they must have been quite severe, because they occasioned so many consultations, but I don't think it would be fair to say they should have alerted them to the possibility he was going to go on to experience more severe episodes later in life, although the fact that he did, I think, makes those earlier symptoms relevant and is entirely consistent with the view that this was all part of the vasovagal syndrome."

Assessment

[288] I observe that in making any assessment of the actions of the various doctors who dealt with Mr Clarke in 2010, it is pertinent to keep in view quite how differently two eminent cardiologists would view his medical history.

[289] Parties showed little enthusiasm for persuading me whether I should prefer the opinion of Dr Boon or Professor Rankin where they differed and suggested that there may not be much material difference between them. Counsel for the Morton family suggested that I should favour Dr Boon's position on account of his confidence and because he was able to offer a unifying diagnosis. Otherwise, to the extent that some other parties suggested that I might prefer the evidence of Professor Rankin, the reason for that seemed to be his status as the treating doctor. I will set out my conclusions.

[290] Whilst a unifying diagnosis might be attractive, it must be borne in mind that it is common to suffer from more than one condition as Professor Rankin was at pains to point out.

[291] In the letter dated 28/3/94¹⁸, the cardiology registrar who saw Mr Clarke, Dr M Malekianpour, wrote

*"...He also complained of intermittent dizziness for the past 4 years. **This normally occurs on exertion, and is not related to pre-syncope.** Again, this resolves after about 10-15 minutes, and he normally finds that he gets dizzy if he is in a warm environment."* [the emphasis is mine.]

Dr Boon did not refer to this feature, that the cardiologist who saw Mr Clarke in 1994 did not consider that his dizziness, at that time, was related to pre-syncope.

[292] Having accepted the evidence of Professor Rankin that Mr Clarke did at times suffer from other conditions which could give rise to dizziness, I do not accept that there was no credible alternative explanation, at least for some of the instances of dizziness. Dizziness and light-headedness may not refer to the same phenomenon and much may depend on what is meant by the patient. Mr Clarke did not give

¹⁸ Quoted more fully at para 88 above.

evidence as to what he meant by the use of the word dizziness and whether what he felt was the same each time he used it. For these reasons, I would prefer the more cautious approach of Professor Rankin and view the situation as being one where it may be said that Mr Clarke has a susceptibility to suffer episodes of neuro-cardiogenic syncope as opposed to having a vasovagal syndrome.

[293] Although Professor Rankin was the treating consultant, he did not have the full medical records when he was dealing directly with Mr Clarke. Dr Boon had access to that information before he prepared his report and therefore may have had a wider view from the outset of his consideration.

[294] I note that for both Professor Rankin and Dr Boon, and indeed in the evidence of other doctors, a classical example of an episode of neurocardiogenic syncope/reflex vasovagal syncope occurs when someone stands for a long period. In a medical note of 20 September 2013 which did not receive very close attention in the Inquiry, Mr Clarke was recorded to be complaining that occasionally he was suffering dizziness on prolonged standing. That entry appears to me to be of some potential significance. Professor Rankin accepted that particular instances of dizziness could be consistent with a vasovagal event. On 22 December 2014, when it is accepted that he did suffer an episode of neurocardiogenic syncope, Mr Clarke told Ms Mykoliw that he was feeling clammy and dizzy.

[295] I also have regard to Dr Boon's explanation of the reflex involved in both postural syncope and vasovagal syncope and why he sees them as being related. Whilst both doctors considered them to be different conditions, Dr Boon regarded the overlap as significant.

[296] Whilst I prefer Dr Rankin's more cautious conclusion of susceptibility rather than syndrome, I consider that Dr Boon is probably correct to conclude that at least on some of the occasions when Mr Clarke described himself as being dizzy, but did not lose consciousness, he was suffering an episode of pre-syncope.

20 September 2013

[297] The GP notes for 20 September 2013 were put to Mr Clarke in the course of his evidence and he chose not to comment. Dr McKaig was referred to this entry in his evidence. This entry was also proved by the second joint minute to be an entry in medical records, which have the status of business documents. In these civil proceedings, hearsay can prove what was recorded and I conclude that Mr Clarke was occasionally suffering episodes of dizziness on prolonged standing shortly before 20 September 2013.

[298] It is true, as the Solicitor General submitted, that there was evidence from Mr Clarke's work colleagues to the effect that none of them were aware of any episodes of fainting or dizziness or any related difficulty whilst he was working in refuse collection. However, the Crown's submission to the effect that:

"There's no medical evidence, reports or doctor attendances before the Inquiry to suggest that Mr Clarke had ever complained of dizziness or reported an episode of fainting from 7th April 2010 to 22nd December 2014,"

is not one which I can wholly accept. I consider how this evidence relates to the issues in the Inquiry at para 377.

Dr Ronald Neville

[299] Dr Neville, who has lengthy experience as a GP and an interest in professional standards appraisal, was invited by the Crown to provide opinion evidence on the

actions of some of the GPs who had dealings with Mr Clarke. He had prepared a final report, production 167, which followed several drafts, two of which were also productions.

[300] Dr Neville assisted the Inquiry by offering a brief account of the history and current practice concerning GP notes. Dr Neville did not expect a GP at the Baillieston Health Centre in 2010 to go back before 2005, when the notes of GP consultations became computerised, when dealing with a fitness to drive issue for a group 2 driver of Mr Clarke's age. There is a medical debate as to what now constitutes a patient's medical record. He did not expect a GP to record a single simple vasovagal episode in the patient's medical notes and it would not be included in the summary.

[301] Dr Neville recognises that there are arguments in favour of D4 medicals being performed by an experienced OH practitioner who may have greater expertise in fitness to drive issues and may be less tempted towards advocacy on the patient's behalf. There are advantages in the medical being performed by a GP who may have advantages of trust and rapport such that a patient may be more forthcoming.

[302] Dr Neville's own approach is that he will not perform a D4 assessment for anyone but patients in his own practice. The decisive consideration is access to the patient's medical history which the GP will have. He considers that if the examining doctor is not the applicant's GP, then the GP should be asked to verify from his records that the applicant has no condition likely adversely to affect his fitness to hold a relevant licence.

[303] That was the recommendation of Sheriff Caldwell in a recent FAI in which Dr Neville gave evidence¹⁹. Unless this is done, there is a very real risk of important medical conditions not being disclosed and, for this reason, he agreed with Mr Conway's suggestion that the current system may not achieve its purpose. Dr Neville understood that approximately 60,000 D4 examinations are performed each year by OH practitioners.

[304] From the medical notes and correspondence, Dr Neville perceived that Dr Langan had failed to pick up on a discrepancy between what Dr Lyons had written and what was known to Dr Langan from his practice notes and the patient. He was critical of Dr Langan's actions in this and a number of respects. Dr Langan should have referred to the DVLA guidelines in his letter to First. He felt that Dr Langan should have provided more detail about the medical history in his reply to Dr Lyons.

[305] Dr Neville saw some advantage in a reply to a medical inquiry from another doctor being prepared to a standard template.

[306] Dr Neville also criticised Dr Lyons, suggesting that he ought to have identified a discrepancy which ought to have been apparent on receipt of the letter from Dr Langan.

[307] In his evidence, Dr Neville's position was that both Dr Lyons and Dr Langan had erred in treating the episode of 7 April 2010 as a simple faint within box 1 of the guidelines.

[308] During cross-examination by Ms Watts for Dr Lyons, it was demonstrated that until he produced the final draft of his report, Dr Neville viewed the incident on 7 April 2010 as potentially falling within box 1 with no reporting obligation. I have

¹⁹ Determination, 19 November 2014: Fatal Accident Inquiry into the death of John Paul Pratt.

carefully considered Ms Watt's submissions about this but it is unnecessary to explain my conclusions at this point. They are set out in appendix 6.

[309] Dr Neville's criticisms of other doctors, some of whom may have more experience of fitness to drive issues than he does, fall to be seen in the light of his own difficulties in applying the guidance retrospectively. To be fair to Dr Neville, who was doing his best to assist the Inquiry, the guidance as it stood in 2010 was viewed by the experienced cardiologists Rankin and Boon to be difficult to interpret and apply and Dr Parry experienced difficulty when he was asked during his evidence to apply it retrospectively. It was changed between 2010 and 2014 with a view to improving its clarity.

[310] Under cross-examination by Mr McIlvride QC for DVLA, Dr Neville accepted that there are a number of adults who are not registered with a GP and that there is currently no legal obligation for a D4 form to be certified by a GP and that if that duty were to be imposed, a fee would have to be payable. He did not dispute Mr McIlvride's contention that Parliament has determined that the performance of a D4 examination does not have to be undertaken by the applicant's GP.

Observation

[311] The approach taken by DVLA in the situation governed by box 6 of the current LOC etc. section of "at a glance" raises an important issue for medical record keeping. Once there is a second faint without reliable prodrome, regardless of where it occurs, within five years in the case of a group 1 driver and within ten years for group 2, then DVLA must be notified and the appropriate licence will be refused or revoked for a significant period.

[312] In order for that situation to be recognised and appropriate advice given to a driver to notify, a doctor must be aware of the accumulation of events. One solution may be for GPs when dealing with any patient who is a driver or prospective driver, to ensure that any episode of loss of consciousness or loss of or altered awareness without reliable prodromal symptoms is immediately included on the patient's clinical summary page. However, I am not in a position to judge what would be most effective and I limit my recommendation to this:

- Doctors generally, and GPs in particular, should take steps to ensure that medical notes are kept in such a way as to maximise their ability to identify repeated episodes of loss of consciousness in the case of patients who are or may become drivers. (5.1)

Dr Daniel Rutherford

[313] Dr Rutherford prepared a report²⁰ offering his opinion on the actions of some of the doctors who dealt with Mr Clarke. He had reviewed the whole of Mr Clarke's medical records and his report set out a helpful summary. He has more than thirty years of practice as a doctor, but has not been a full-time GP since 2000. He has advised a bus company and has performed in the region of 600 D4 medicals. Whilst it is fair to say that he does not, as Mr McGregor and Ms Watts submitted, have the same experience of GP practice as Dr Langan and Dr Lyons, I was satisfied that he does have relevant practical experience to permit him to offer some opinion evidence. Where he did not, he said so.

[314] In Dr Rutherford's opinion, wax in the ears does not cause dizziness. On that point his opinion is in conflict with both Professor Rankin and Dr Langan whose position I accept over Dr Rutherford's.

²⁰ Production 3 for the Morton family.

[315] Dr Rutherford professed no expertise in neurocardiogenic syncope and he had never had a patient who had fainted sitting down.

[316] Nevertheless, Dr Rutherford said that if he had been given a diagnosis of neurocardiogenic syncope in 2010, he would have felt that at last he had an explanation for a thirty year history of “funny turns” and he would have advised Mr Clarke that he would be unlikely ever to be allowed by DVLA to drive again.

[317] Whilst it may be that that is what Dr Rutherford would have done, having regard to the views of Dr Parry, Dr Boon and Professor Rankin, I am not convinced that Dr Rutherford’s assessment that Mr Clarke would have been unlikely ever to be allowed to drive again is well-founded.

[318] According to Dr Rutherford, even before 2010, the pattern was such that Mr Clarke was not fit to be a bus driver. Given his history, any GP should have advised Mr Clarke in April 2010 to notify DVLA. That was required regardless of prior medical history as it was a box 3 event because, on any view, it had occurred when Mr Clarke was sitting down.

[319] Dr Rutherford could not understand why Dr Lyons had not referred to box 3 in his letter to Mr Clarke’s GP. Dr Lyons should have identified a discrepancy when he received the letter from Dr Langan and he should have spoken to Dr Langan to clarify the position.

[320] In Dr Rutherford’s view, Dr Langan should have given Dr Lyons a resumé of Mr Clarke’s medical history and he should at the very least have noticed the event involving vertigo in 2009 on the computerised notes and brought it to the attention of Dr Lyons. In cross-examination by Mr McGregor (for doctors McKaig, Langan and Willox), he accepted that all that was reasonably to be expected was to review the

electronic record for the last five years. In cross-examination by the Solicitor General he reverted to saying that Dr Langan should have examined all of the GP records.

[321] Dr Rutherford said that many GPs will lack experience of the “at a glance” guidance, which he described as long and dense. If a GP does not perform the D4 medical, there is a weakness which might be overcome by the patient taking a print-out of his computerised medical record to any OH doctor.

[322] According to Dr Rutherford, Dr Langan should have “interrogated” Mr Clarke about the discrepancy and he should have alerted Dr Lyons to it. Dr Lyons should have asked Mr Clarke if he was having episodes beyond those already noted.

[323] It was Dr Rutherford’s opinion that if Mr Clarke had disclosed his medical history in 2011 he would not have been driving a group 2 vehicle in December 2014. On that point, his opinion is in conflict to a greater or lesser degree with what I take from the evidence of Professor Rankin, Dr Boon and Dr Parry all of whom I consider better qualified to make that judgment. Their more cautious views fit better with the guidance. On the whole evidence, I consider that the likelihood is that Mr Clarke would have had a group 2 licence in 2014, even if DVLA had been notified about the events of 7 April 2010 whether that be in April 2010 or December 2011. However, for reasons which I will come to explain, I consider that there is, at the very least, a lively possibility that he would not have been employed by GCC when he was if he had disclosed the full truth about 7 April 2010 to his doctors.

Difficulties in interpreting DVLA Guidance on loss of consciousness etc

[324] Professor Rankin and Dr Boon, both consultant cardiologists, acknowledged that the application of the DVLA guidance on loss of consciousness and loss of or

altered awareness can be difficult. It was most likely to be appropriately applied by those with substantial clinical experience and normally it would not, in their view, be a GP who would be determining if an event fell within box 3. That assessment would normally only be made after specialist cardiac investigation. I have referred above to the difficulties which Dr Neville encountered in trying retrospectively to apply the 2010 guidelines.

[325] Dr Gareth Wynn Parry is the Senior Medical Adviser to the DVLA, a position he has held since March 2014. He has practised medicine since 1984, mostly specialising in chest and heart surgery. As Senior Medical Adviser, he oversees the work of the DVLA's medical advisers and he has his own caseload, comprising difficult, complex and high profile cases. He came to deal with Mr Clarke's licences following 22 December 2014.

[326] In the course of his evidence, Dr Parry was asked to consider how the incident on 7 April 2010 would have been viewed under the 2010 guidelines. At first, Dr Parry considered that whilst DVLA would have expected notification, it would have been deemed by DVLA to be a box 1 event, even accepting that the faint happened when the driver was sitting at the wheel of his bus. The information from the bus inspector, having particular regard to the element of a second episode following shortly after the first, might have pointed to box 3.

[327] When he was reminded of the wording of box 3, it was only after substantial prompting that Dr Parry came to view it as a box 3 event. His final position was that being seated at the wheel of the bus was, of itself, a basis for the incident to be categorised in box 3.

[328] I do not intend to embarrass Dr Parry by pointing this out. I recognise that he was not applying the 2010 version of the guidance as Senior Medical Adviser. He only took office in 2014. His responses on this issue provide strong evidence of an ambiguity in the manner in which the categorisation was expressed which has caused real difficulty in interpretation. That difficulty must be borne in mind in evaluating any criticism made of any of the doctors who gave evidence to the Inquiry of how they did or would categorise under the LOC etc. section of “at a glance.”

[329] DVLA is entrusted to regulate medical fitness to drive. There is inevitably a difficult judgment to be made as to where to strike the correct balance between the general public interest in road safety and the interests of the individual who wishes to continue to drive. For professional drivers, revocation of entitlement to drive could lead to loss of employment. Dr Parry explained that DVLA expects doctors to err on the side of caution. Medical opinion in the Inquiry generally seemed to accept that in any situation of doubt, a doctor should err on the side of road safety and refer the matter to DVLA in order that it could make the decision on fitness to drive.

Assessment of the actions of the doctors who dealt with Mr Clarke in April 2010

Dr McKaig

[330] Only Mr Conway criticised Dr McKaig in relation to 7 April 2010. He suggested that since the GP notes included the phrase “no warning signs,” Dr McKaig should have concluded that this was not a DVLA box 1 simple faint. Accordingly, he should have advised Mr Clarke not to drive meantime and to notify DVLA.

[331] Dr McKaig appeared to be familiar with the relevant section of “at a glance” and to have a good understanding of it. His judgment, based on the information

which he was given by his patient, was that this was a simple faint which would not be notifiable to DVLA. Whilst he had not noted that he had done so, he may well have communicated his view to Mr Clarke.

[332] Dr McKaig explained that the notes represented only a summary of what was said in the consultation. The information that there was no warning was a partial record of what Mr Clarke said to him, but he knew that such information from a patient about the prelude to and aftermath of a faint was not always reliable. Given what he understood Mr Clarke to have said to other doctors thereafter, he suspected that he may in fact have been told of prodromal symptoms by Mr Clarke.

[333] I think it likely that Dr McKaig did explore the situation more fully and was given some reassurance by Mr Clarke which allowed him to be satisfied that this was a simple faint.

[334] Dr Boon thought that Dr McKaig was correct on the information he was given to view the incident as belonging in box 1 with no requirement to notify DVLA.

[335] On 7 April 2010 Dr McKaig was very substantially misled by Mr Clarke as to the nature and location of the incident earlier that day. In my view, it cannot be said that he should have done anything materially differently and there is no valid criticism of what he did.

Dr Lyons

[336] The actions of Dr Lyons attracted considerable criticism in submissions which I have fully considered along with all of the evidence concerning Dr Lyons and the submissions made by Ms Watts on his behalf. I acknowledge that application of the guidance was shown to be difficult for many of the doctors who gave evidence in the

Inquiry. It must also be recognised that whilst Dr Lyons was not deceived by Mr Clarke to the same extent as Dr McKaig and Dr Langan, he was nevertheless deceived in that he was given an account of events by Mr Clarke which was less than the whole truth and which sought to play down their gravity.

[337] Dr Lyons candidly explained that he has been very troubled by his involvement with Mr Clarke in light of subsequent events. He has reflected fully on his actions and has changed his practices in a number of respects.

[338] Dr Lyons would now call for any independent source of information such as the report made by Mr Stewart and I consider that he should have done so in April 2010. A bus driver fainting at the wheel of his bus at a bus stop, such that passengers were caused to disembark, was surely a matter of the greatest significance to First and had such obvious implications for public safety that it should have been evaluated with the utmost care by the doctor who was advising the company.

- I recommend that if a doctor is advising an organisation employing a driver as to that driver's fitness to drive following an incident whilst driving, that organisation should provide all available information about the incident to the doctor and the doctor should insist on having it prior to giving advice to the organisation and the driver. (5.2)

[339] It should also have been apparent to Dr Lyons that the driver's GP, whilst he might be expected to have more information about the driver's medical history, may have less information about the event itself than was available to Dr Lyons in his position. As he conceded, Dr Lyons should not have deferred to the judgment of Dr Langan on the issue of fitness to drive to the extent which he did. It is difficult to understand why Dr Lyons, who prepared his letters and reports on a computer, would have given less information about the events of 7 April to Dr Langan than he reported to the company on the same date. If he was seeking the assistance of the GP

practice, I consider that he should have provided all of the relevant available information, and certainly all of the information known to him. If Dr Lyons intended that Mr Clarke's GP should have provided information as to his previous medical history then he should have said so in terms.

[340] Having regard to all of the evidence, even on what was known to him, Dr Lyons should have advised Mr Clarke to notify DVLA. He should have advised him of the consequences of DVLA categorising the event in box 3. Dr Lyons should not have declared Mr Clarke fit to drive on 29 April until DVLA had been notified by Mr Clarke and it had reached a decision on the episode of 7 April 2010.

[341] Ms Watts submitted that, applying the approach of Sheriff Braid in his Determination concerning the death of Marion Bellfield²¹, no finding in terms of section 6 (1) (c) should be made in relation to Dr Lyons. The short answer to that submission is that Dr Lyons was not in a situation which *solely* involved the exercise of clinical judgment.

Dr Langan

[342] Dr Langan was placed at a disadvantage in two significant respects. Mr Clarke was lying to him and Dr Lyons wrote to his practice giving a less than complete

²¹ 18 April 2011, at para 41 "...when one has a situation which solely involves the exercise of clinical judgment, where a range of reasonable actions might be taken, and the choice as to which to take rests on the skill and experience of a doctor based upon such information as is available to him at the time, and the doctor happens to choose a course which results in death, it would be wrong to hold that the selection of another option within the range, which might have prevented the death, was a reasonable precaution which ought to have been taken. Not only does that involve straining the meaning of precaution, but such a finding would be of no real practical benefit to others in the future. A Fatal Accident Inquiry cannot prescribe how doctors or nurses should exercise their judgment. Put another way, the true precaution which ought to be taken in any given case may simply be a requirement that a patient is seen by a suitably skilled doctor, rather than how the doctor exercises his skill and judgment thereafter."

account of what Dr Lyons knew of the incident on 7 April 2010. I have taken account of that and all of the submissions made by Mr McGregor on Dr Langan's behalf.

[343] I accept Dr Langan's evidence that he did notice a discrepancy in what he and his colleague had been told by Mr Clarke on the one hand and what Dr Lyons wrote to him on the other, and that he raised the issue with Mr Clarke on 22 April and was given some reassurance. He accepted and proceeded on Mr Clarke's account that the incident had taken place in the canteen. Dr Boon would accept what a patient says over another indirect source of information and most of the doctors who gave evidence would take the same course. Given the doctor/patient relationship, a doctor will reasonably proceed on the basis of what his patient tells him in most circumstances. I sympathise with Dr Langan's observation that he is not trained and cannot be expected to carry out the kind of forensic examination of multiple sources of information which was undertaken in the Inquiry.

[344] However, on this occasion, there was one source of information contradicting what Mr Clarke was telling the GP practice. Dr Lyons had written that the episode occurred on a stationary bus. Such a source of information would seem likely to be reliable. Given the obvious importance of a careful assessment of the fitness to drive of a bus driver, Dr Langan ought not to have been sufficiently reassured by Mr Clarke's word alone and he ought to have contacted Dr Lyons.

[345] Whilst I would accept that the interpretation of the guidance which Dr Langan took was one which was open to him given its terms, in the situation where he was dealing with a bus driver, and having regard to the weight of the evidence as to how the guidance ought to be interpreted, I would not agree with Dr Langan's opinion that even if Mr Clarke was sitting down when he fainted, that would still be a box 1

simple faint. That however, was simply his response to a scenario he was asked to consider in the Inquiry. In April 2010, he was misled into believing that Mr Clarke had fainted whilst standing in a hot canteen waiting for his lunch and having felt light headed.

[346] Whilst there was much criticism of Dr Langan for not providing a summary of Mr Clarke's medical history, there is not much support for that in the evidence. It is important to note that Dr Lyons did not ask for medical history or records. Dr Rutherford was inconsistent about what was to be expected. Dr Neville accepted that access to the computerised notes would suffice. The notes from 2009 did not suggest that a notifiable event had taken place as the guidelines refer to "liability to sudden attacks of unprovoked or unprecipitated disabling giddiness" which was not what was described and there was nothing else of any significance in the computerised record. In any event, Professor Rankin and Dr Boon did not place much weight on the entry from 2009 as bearing on their proposed diagnoses.

[347] A number of parties sought to persuade me that the actions of Dr Lyons and Dr Langan should give rise to findings under section 6 (1) (c) of the 1976 Act. Given the interval of more than 4 years between the events of April 2010 and December 2014, such suggestions raise issues as to causation which merit careful consideration.

What would have happened if Mr Clarke had notified DVLA of the events of 7 April 2010?

[348] Ms Bain asked Dr Parry to consider what would have happened had Mr Clarke notified DVLA. He agreed that DVLA would have sought further information from

the cardiologist who would have treated Mr Clarke had there been notification in 2010.

[349] Dr Parry assented to Ms Bain's suggestion that had Mr Clarke been referred to a cardiologist in 2010, and had it been known that he may have had vasovagal events in 1989 and 1994 and that he had been dizzy at the wheel in 2003, and had a cardiologist indicated that the risk of a further event of neurocardiogenic syncope was more than 20% in the next two years, then neither his group 1 nor his group 2 licence would have been returned to him at the end of the period of revocation. In cross-examination by Mr Reid, Dr Parry said that he saw no significance in the events of 1989, 1994 and 2003 to Mr Clarke's entitlement to drive in 2010 or 2015.

[350] It was not made clear how all of this fits in with "at a glance." In 2010, the 20% and 2% percentages of future risk featured in the section on epileptic seizure, but they did not feature in the section on LOC etc. They do feature in box 6 of the LOC etc. section now, but box 6 was not part of the guidance in 2010. Dr Parry did however assent to a suggestion by Ms Bain that DVLA had been taking account of research which gave rise to those percentages of risk since the 1980s.

[351] On the basis of those parts of the evidence of Dr Parry, counsel sought to persuade me that Mr Clarke would not have got his group 2 licence back after the event in April 2010 and that he would not have been in a position to have been employed as a driver by GCC in 2011. On this basis, it was argued that omissions or failures relating to the incident of 7 April 2010 would give rise to findings under section 6 (1) (c). Mr Stewart made similar submissions.

[352] Evidence from an authoritative source such as Dr Parry might be thought to give rise to at least the sort of lively possibility which could give rise to a finding

under section 6 (1) (c). However, that evidence should be viewed along with the rest of Dr Parry's evidence, and with the whole evidence.

[353] In considering the issue of what would have followed had there been notification to DVLA in 2010, Ms Watts, Mr McGregor and Mr Reid invited me to compare the situation with what happened in April 2015 and conclude that much the same would have happened. On 22 December 2014, six people died and 17 were injured and yet, having seen the letter from Dr Leach, DVLA made no further inquiry and re-issued Mr Clarke with a group 2 licence, primarily on the basis that 3 months had elapsed since the incident. DVLA knew from what Mr Clarke had said on his application form that he had been treated by Professor Rankin, but no information was sought from him at all. He was not asked to estimate the likelihood of a repeated episode on a percentage basis, or at all. Had information been sought from him, he would not have known of what was recorded in medical notes for 1989, 1994 and 2003. Had he known of those entries he would not have considered them significant in 2010 or 2014/5. Notwithstanding the notoriety of the accident and its consequences, Mr Clarke was able to be reissued with a group 2 licence in April 2015 when there was no prodrome on 22 December 2014. It is of course true that in due course his licence was revoked, but that was on the basis that further information showed that 2015 was the second occasion on which Mr Clarke had fainted whilst driving with little prodrome.

[354] Against that background, it was questioned whether it was sufficiently realistic to consider that a different view would have been taken in 2010, such that I could conclude that there is a lively possibility that Mr Clarke would not have been holding a group 2 licence in July and/or September 2010. My conclusion is that the

changes to “at a glance” serve to explain why what was done in April 2015 does not infer that DVLA would necessarily or even probably have done the same in 2010.

[355] Had Mr Clarke told the whole truth, I think it likely that he would have been told by his GPs to notify DVLA. Dr Lyons should have given him that advice in any event. On notification, it is of course possible that DVLA would have viewed the incident as falling in box 1 as Dr Parry initially did on being asked about it in the Inquiry, but I think that is unlikely. The event ought to have been viewed as falling within box 3.

[356] In 2010, box 3 provided that for a group 2 licence, there would be revocation for one year if no cause was identified. If the cause had been identified and treated then driving would be permitted 3 months after the event.

[357] Events unfolded as they did in April 2015 because Dr Parry viewed the December 2014 event as falling within box 2 of the *current* guidance²². Box 2 of the current guidance permits driving after 3 months without further qualification and so there is no requirement for a cause to be identified or treated before a licence holder can drive and it explains why no inquiry was made of Professor Rankin before the licence was reissued. That is an important distinction to recognise in understanding why the situations might be different in 2010 and 2015.

[358] Dr Rutherford stood alone in suggesting that notification in April 2010 would have meant that Mr Clarke would not have been able to hold a group 2 licence in December 2014.

²² Dr Parry faced some criticism from parties and at para 435, I explain why I consider that that criticism was misdirected at him.

[359] Dr Boon was not prepared to agree to that proposition when it was put to him in re-examination, pointing out that there would have been no further episodes of fainting in the twelve months following April 2010. Dr Parry explained that in determining whether Mr Clarke was to be deemed fit to drive at the end of a period of revocation following April 2010, the primary issue would be whether there had been any further fainting episodes. On the evidence led in the Inquiry, it was not established that Mr Clarke fainted again within 3 or 12 months of April 2010.

[360] In order to understand the significance of the consequences had there been notification in April 2010, it is necessary to examine how it may have affected Mr Clarke's prospects of being employed by GCC.

Would Mr Clarke have been employed by GCC had notification been made to DVLA in 2010?

[361] Douglas Gellan and Geraldine Ham were invited to comment on whether Mr Clarke would have gained and retained employment as a driver for GCC in a number of scenarios. After they gave evidence, further inquiries were made of GCC which led to the sixth joint minute. I will not quote its whole terms, as they are somewhat repetitive and because it is left to me to make a judgment on all of the evidence, including the joint minute.

[362] It is clear that if the incident on 7 April 2010 had been notified to DVLA contemporaneously, then any revocation of entitlement to hold a group 2 licence would have run from that date.

[363] Had Mr Clarke's group 2 licence been revoked for one year and his group 1 licence for six months, which would be one option under box 3, then he would not have been in a position to apply for employment with GCC when he did.

[364] Under box 3, there would be group 2 entitlement to drive 3 months after the event if the cause of the loss of consciousness had been identified and treated.

Nevertheless, there is a process to be undergone which takes at least some time, so that even if the revocation was for 3 months, Mr Clarke would have been unlikely to have been the holder of a group 2 licence when he made his application, which might have inhibited him from doing so.

[365] Dr Boon in particular sought to determine what would have happened had the events of 7 April 2010 been notified. Both he and Dr Rankin envisaged that similar testing to that performed after 22 December 2014 would have been undertaken, probably giving rise to similar findings. Accordingly, a cause of neurocardiogenic syncope would have been identified. Whether it had been treated would be a more difficult question because both cardiologists agreed that there is little effective treatment for a patient who has had an episode of neurocardiogenic syncope.

However, there is some advice that a patient would be given in relation to mobility and hydration, and Dr Boon described this as a management strategy, which could be viewed as treatment.

[366] Even if Mr Clarke had got his licence back in time, which I think unlikely, and he had applied to GCC, I would infer that it would have become apparent at interview that his licence had recently been revoked. GCC required a driver applicant to present at interview all the licences which he held. That would either

have caused him to fail at interview or at least it would have prompted further inquiry by GCC which might have led to his application being rejected.

[367] In its response which gave rise to the sixth joint minute, GCC chose to assume that any decision would have been made in the light of full knowledge of Mr Clarke's true history of absences from work in the preceding two years. The firm impression given is that even if Mr Clarke was considered fit to drive, had his absence record over the last two years been known it is unlikely that he would have been employed. On some scenarios Mr Clarke would not have been interviewed as he did not hold the requisite licence at the requisite time. If the question arose, it seems that GCC would have sought and acted upon advice from its OH adviser on the question of whether Mr Clarke was fit to drive. Ms Ham considered that if information about the events of 7 April 2010 had come to light after the job offer had been made but before he commenced employment, it was a real possibility that the job offer would have been withdrawn.

[368] If it had become known to GCC in December 2011 that Mr Clarke had failed to disclose the April 2010 incident it would, subject to any explanation or mitigation, have been deemed gross misconduct for which there is a range of sanctions including dismissal. According to Ms Ham, had this occurred, there is a real possibility that his employment would have been terminated which seems consistent with the terms of the sixth joint minute.

[369] Having carefully considered all of the evidence, I conclude that there is a lively possibility that notification to DVLA would have resulted in a position whereby Mr Clarke would not have been able to gain employment with GCC when he did. Had he not been employed by GCC, he would not have been driving the bin lorry on 22

December 2014. Accordingly, I am satisfied that there is a chain of causation so that I can conclude in terms of section 6 (1) (c) of the 1976 Act that different actions being taken by Mr Clarke, Dr Lyons and Dr Langan in April 2010 can be viewed as reasonable precautions, whereby the deaths and the accident resulting in the deaths may have been avoided.

A further reasonable precaution?

[370] Counsel for the Morton family submitted that I should make a finding under section 6 (1) (c), to this effect in relation to Mr Clarke:

“in the knowledge of his previous medical history, not seeking employment as a professional driver, particularly of an LGV vehicle or a PCV.”

[371] Whilst account has to be taken of Mr Clarke concealing the events of 7 April 2010, there is no evidence that any doctor told him prior to 22 December 2014 that he had a susceptibility to episodes of neurocardiogenic syncope, let alone a vasovagal syndrome.

[372] Dr Rutherford’s opinion might lend some support to this submission, but I did not find his views persuasive where they were in conflict with the cardiologists. The opinions of Professor Rankin and Dr Boon do not offer much support for any suggestion that Mr Clarke ought to have known by this stage that he was not fit to drive for a living. A succession of doctors, including GPs, had not given him any indication on his D4 examinations that he ought not to drive group 2 vehicles.

[373] On the other hand, the lengths he went to in order to conceal his medical history and, in particular, the events of 7 April 2010, give rise to an inference that he

suspected that his having fainted at the wheel of a bus rendered him unattractive to employers as a driver. I have drawn that inference.

[374] The Morton family's submissions included this passage, based on the evidence of Dr Boon, as to what a cardiologist would have done had Mr Clarke been referred in 2010 following the faint on the bus:

"He or she would then be expected to tell Mr Clarke that there was no need for specific treatment beyond taking care to avoid potential triggers such as prolonged standing, dehydration, overheating etc. In this context, Dr Boon explained that he would have made every effort to try and identify possible common factors or triggers for the attacks in 1989, 1994 and 2010. Mr Clarke would also have been told how to recognise prodromal symptoms such as yawning, nausea and light-headedness and advised to try and abort any future attacks by lying down and or exercising his legs.

The risk of recurrence would undoubtedly have been discussed and he would have told Mr Clarke that this was significant (around 20% in the next two to three years) but that recurrence was not inevitable, particularly if he adopted the recommended lifestyle measures. Moreover, any future attacks might be quite mild and would not necessarily result in complete loss of consciousness. Mr Clarke would also have been advised to seek further advice if he went on to experience troublesome symptoms."

[375] The evidence on which that submission was based suggests that had he been entirely open and forthcoming, Mr Clarke may have gained advice which, had he acted on it, may have rendered it safe for him to drive. It was Dr Boon's position that whilst he would have advised Mr Clarke not to drive until the situation had been evaluated by his employer's OH doctor and DVLA, he was not willing to say that it would necessarily be dangerous for Mr Clarke to drive. The question of prodrome would be very important in that regard. On being contacted by DVLA, which he anticipated would have followed notification, he would not offer an opinion as to whether or not it was safe for Mr Clarke to be issued a vocational driving licence. He considers that to be a matter for the DVLA to determine.

[376] The weight of the evidence suggests that had there been a revocation of 3 or 12 months following April 2010, Mr Clarke's licence would have been returned to him thereafter by DVLA.

[377] With hindsight it may be seen as possible that the spells of dizziness which gave rise to the medical note for 20 September 2013 could have signalled to Mr Clarke that he retained a susceptibility to faint, but there is no direct evidence that he did interpret his symptoms in that way at this time. Professor Rankin would not have viewed the matter in that way, but Dr Boon may well have done. Dizziness had featured in the past, significantly so leading up to 1994, but that was 19 years previously. Mr Clarke was told to stop driving for a few days in 2003 but the impression there is that drops being given to reduce wax in his ears reduced the extent to which he was suffering from dizziness. Dizziness was not mentioned following 7 April 2010. There is no indication that he was advised in September 2013 that he should not be driving. It is possible that perhaps he would have been given such advice had the full extent of what happened on 7 April 2010 been disclosed by him to his GP, but there is no real foundation for that in the evidence. The significance of 20 September 2013 was not explored in evidence in this way and my findings must be based on the evidence, and reasonable inferences from it, not speculation.

[378] Mr Clarke should have been candid about what happened in April 2010 and obtained relevant medical advice in the light of what really happened as opposed to his pretences. He should not have sought to retain or gain employment as a professional driver on false pretences. Those conclusions are reflected in my findings 3.1, 3.4, 3.6 and 3.7, all made under section 6 (1) (c). For the reasons I have given, I am

not persuaded that the evidence supports the further finding in its proposed terms.

However, a reasonable precaution which, if taken, might have avoided the accident and deaths on 22 December 2014 is this:

For Mr Clarke, after fainting at the wheel of his bus on 7 April 2010, to have refrained from continuing to drive buses and to have refrained from seeking further employment as a group 2 driver in the absence of his having told the truth to doctors and without having acted upon the advice which would have been forthcoming, and thereafter without making his relevant medical history known to Glasgow City Council to the extent required in its recruitment, appointment and promotion processes.

Did Glasgow City Council receive employment references for Mr Clarke?

[379] GCC's practice was to send a part printed reference form to applicants' referees. The form requested, amongst other formal matters, information as to dates of sickness absence in the last two years, the applicant's reasons for leaving and *"other relevant information that you feel a prospective employer should be aware of eg live disciplinary actions etc."* First does not retain a copy of any reference provided by it to GCC. GCC does not hold employment references or copies in connection with Mr Clarke's application for employment.

[380] Mr Conway submitted that the latter absence could potentially suggest that no references were received or that unfavourable references had been made to disappear. Whilst viewed in isolation the absence appears suspicious, the evidence established that no references could be found for any but two of a group of 24 applicants/employees including Mr Clarke. In the case of those two employees, there was a medical disclosure made by them which was considered by the OH provider.

[381] I have taken account of the possibilities contended for by Mr Conway in the light of all of his submissions but, on the basis of all of the evidence on this issue, I do not reach any conclusion adverse to GCC from its inability to find the references.

[382] Mr Clarke nominated "First Bus" and DHL as former employers who could provide references. There is documentary evidence that those references were being chased up by GCC, probably on or around 21 December 2010. That material named a contact at DHL and made reference to a suggestion that Darryl Turner at "First Bus" should be contacted rather than Frank McCann. Mr Turner worked in the First human resources department at that time.

[383] According to Francis McCann of First, who accepted that he must be the Frank McCann referred to, whilst ordinarily he would be the person who would provide a reference for someone in Mr Clarke's position, it might be done in his absence by his assistant Robert Donnelly or it might be done by staff in the human resources section. It was proved by agreement that Mr Turner told the police that he did not provide a reference for Mr Clarke and that his manager, James Leslie, cannot recall if First received a reference request for Mr Clarke. I accept Mr Donnelly's evidence that he did not provide a reference for Mr Clarke.

[384] There is no direct evidence as to who, if anyone, provided a First reference. There is some evidence to suggest that GCC probably did receive a reference from First. Mr McCann could not recall providing the reference but at one stage in cross-examination by Mr Forsyth, he seemed to accept that he would have done so. His evidence was that any reference provided by First would have disclosed Mr Clarke's absences in the course of 2009 and 2010. If he had done it, Mr McCann would have completed a reference form stating, "resigned under suspension."

[385] Ian Buick, a former manager at GCC's Land and Environmental Services Department, whilst he has no recollection of it, was able to say on the basis of documentary evidence that he did receive and consider satisfactory references for a group of applicants/employees including Mr Clarke. Surviving email correspondence showed that he had been asked by GCC recruitment services on 25 March 2011 to consider a batch of references including those for Mr Clarke. On 28 March he sent an email message stating, "I can confirm that I am satisfied with the content of all the references."

[386] It was Mr Buick's evidence that had Mr Clarke's reference from First disclosed the true extent of Mr Clarke's sickness absences in 2009 and 2010, and that he had resigned under suspension, he could not have failed to notice such information. There was a large group of acceptable candidates in excess of the vacancies and he would not have found a reference containing such information to be satisfactory.

[387] I am bound to accept the following facts which were proved in the seventh joint minute, introduced after Mr McCann gave evidence.

"4. In 2010 and 2011 any request to First Bus for an employee who had left the company required to be sent to their Human Resources department. That department would then send the reference request via internal envelope to the manager of the depot at which the employee had been working prior to their departure (or to a Human Resources manager if the employee had been working in the Head Office of First Bus). When a reference was sent to a depot the process to be followed was that the manager would then provide the reference directly to the new employer. The only input provided by the Human Resources department would be on occasions confirming dates of employment to the new employer.

5. The personnel files of the First Bus employee were held locally at the depot where they worked and remained there after the employee left First Bus. The medical file for an employee was held centrally. Depot managers would not have had access to the medical file but on each occasion an employee was seen by the company doctor or a GP for a work-related illness, the depot manager would receive a report or a summary of the report to store in the depot file."

[388] Neither Mr McCann nor Mr Buick can be criticised for having little or no recollection of what must have been routine events which may have occurred almost five years previously.

[389] I found the evidence of Mr Buick to be straightforward, credible and as far as it went, reliable. His position was based on and supported by some documentary evidence, albeit a far from complete record. He understood the potential importance of the issue in the Inquiry. Whilst it was put to him that he may have been sufficiently casual to have reported what he did in the absence of his having read references for Mr Clarke, he emphatically refuted that suggestion, explaining that he is careful in all aspects of his work and personal life.

[390] Mr McCann had completed and signed a pro forma "employee exit form" on 28 December 2010 in respect of Mr Clarke. The form included the printed statement *"Please note that this must be an accurate account of the employee's history."* It was recorded by Mr McCann that Mr Clarke was suitable for re-engagement and that there was nothing to report in relation to attendance, conduct issues or "early running." This was despite Mr Clarke's numerous documented absences in 2009 and 2010 and his having left First whilst under suspension for early running. As his manager, Mr McCann had interviewed Mr Clarke, had access to the inspector's report and knew that Mr Clarke had fainted on his bus on 7 April 2010 and that this was the reason for his absence from work for more than three weeks thereafter. Mr McCann insisted that the exit form was completed for internal First's purposes only and would not be used as the basis for a reference. Mr Donnelly gave evidence to similar effect. Mr McCann said that any reference would be prepared after perusal

of an employee's whole employment file. In Mr Clarke's case, this would have disclosed his absences, the incident in April 2010 and the fact that he was under suspension for early running when he left. That information would be disclosed in any reference.

[391] Mr McCann said that the exit form would be relevant if a departed employee was to re-apply for employment with First but even then, the whole employee record would be considered and the exit form would not be relied on. Accordingly, Mr McCann was unable to explain what real purpose the exit form would serve. He said that the exit form was sent to the human resources department and retained there. He was unable to explain how it would benefit that department to be sent erroneous information. He was unable to explain why he would have completed the exit form so flagrantly inaccurately.

[392] I accept that Mr McCann was having difficulty in reconstructing his memory of events from 2010, but I did not find his evidence altogether satisfactory on the subject of the reference. I gained the impression that he was seeking to distance himself from it. That impression was somewhat strengthened by the agreed facts which I have quoted in para 387.

[393] If, contrary to his evidence as to normal practice, the exit form was used by Mr McCann as the sole basis for a reference, or if it was completed by him with the intention that its terms would be consistent with any reference, then that reference would have nothing adverse to report and Mr Clarke would be recorded to be suitable for re-engagement. In that situation, any reference could be expected to be favourable or at least satisfactory.

[394] Whilst it is neither complete nor entirely satisfactory, on the basis of the evidence which I heard, I conclude that it is more likely than not that First provided GCC with a reference for Mr Clarke in favourable/satisfactory terms. Such a reference was not true, accurate and fair and it gave a misleading impression.

[395] Evidence from council employees was not capable of confirming whether references had been received by the time Mr Clarke commenced his employment with GCC on 5 January 2011. It was an agreed fact that an otherwise successful applicant could be permitted by the Human Resources Department to commence employment in advance of receipt of references.

[396] At the close of his submissions, Mr Gray for GCC conceded that the reason why para 9 of the seventh joint minute recorded searches of council systems being undertaken from 1 March 2011 was that it had been established that references for Mr Clarke had not been received by 26 February. Accordingly Mr Clarke had commenced work as a minibuss driver before his references were received. I proceed on the basis that that is the true factual position²³.

What was the impact of Mr Clarke's references?

[397] In his submissions for the Ewing family, Mr Forsyth drew my attention to case law and commentary vouching his proposition that whilst an employer is not obliged to provide a reference, if it does so, then the reference must be true, accurate

²³ Macphail, Sheriff Court Practice, 3rd ed at para 16.102.

and fair.²⁴ I accept that contention and would add that whilst a reference need not be full and comprehensive, it must not give a misleading impression.

[398] A true, accurate and fair reference from First would have disclosed many days of sickness absence in 2009 and 2010. On the basis of the evidence in the sixth joint minute, viewed against the whole evidence, I conclude that if an accurate reference had been received by GCC from First before Mr Clarke was employed on 5 January 2011, he would not have been employed by GCC.

[399] I have concluded that a reference was received from First, but that it came at some point after 26 February and before 25 March 2011. I have concluded that it did not disclose Mr Clarke's full absence record or anything about the events of 7 April 2010. Had it done so, there must be a lively possibility that Mr Clarke would have been dismissed having regard to the terms of the sixth joint minute and the evidence of Mr Gellan and Ms Ham.

[400] Accordingly, I conclude that for First to have provided GCC with an accurate employment reference was a reasonable precaution whereby the deaths and the accident resulting in the deaths may have been avoided.

[401] I have concluded that First provided a favourable, or at least a satisfactory, reference for Mr Clarke. Whilst there is little material to go on, having accepted Mr Buick's evidence, I think it more likely than not that GCC received a satisfactory reference from DHL. Accordingly, I cannot say that it would have been a reasonable precaution whereby the accident and deaths might have been avoided, for GCC to

²⁴ Harvey on Industrial and Employment Law at 11-580; *Bartholomew v London Borough of Hackney* [1999] IRLR 246, CA.

refrain from commencing Mr Clarke's employment before both references were received.

[402] I am unable to accept Mr Conway's contention that I should determine in terms of section 6 (1) (d) that the absence of a requirement by GCC for Mr Clarke to permit access to his GP records and for these to be checked by GCC prior to his employment with them was a defect in a system of working which contributed to the deaths or any accident resulting in the deaths. There was a system in place to check the accuracy of information supplied by the applicant and it included an independent element, namely the requirement for two references. Had First provided an accurate reference, Mr Clarke would not have been employed by GCC in 2014.

[403] However, I do consider that a lesson should be learned from this case. Mr Clarke was not being employed to drive bin lorries in January 2011 but he was driving children and the elderly in minibuses. A capacity to drive safely must be a pre-requisite of such employment.

[404] I take from the evidence of Mr Gellan and Ms Ham that an employment reference is an important part of the mechanism by which an employer such as GCC ensures that its drivers are fit and suitable to be employed as a driver.

[405] Accordingly, I consider that it was not appropriate for Mr Clarke's employment to commence in advance of both references being received and:

- I recommend that GCC, when employing a driver, should not allow employment to commence before references sought have been received. (5.3)

[406] That approach may commend itself to other local authorities and indeed any organisation employing a driver. It is of particular importance in the case of

organisations which employ drivers of large goods vehicles and multi passenger vehicles.

Recruitment considerations

[407] Counsel for the Morton family submitted that I should make a finding under section 6 (1) (c) to the effect that certain reasonable precautions by GCC might have avoided the accident and deaths.

“(i) Implementing an adequate system of recruitment in relation to those employees who perform “safety critical roles” (such as an LGV driver who is responsible for driving for long periods of time in a busy city centre) robust enough to reveal information material to the issue of whether they are fit for the job they are employed to undertake. The following issues are relevant to consideration of this reasonable precaution:

- (a) the medical enquiry process carried out by the Occupational Health organisation for GCC relies entirely on the honesty of the individual completing the health questionnaire;
- (b) in order to have an independent verification of the information provided, a report could be requested from the individual’s GP with regard to the job matrix for the prospective role. The matrix could describe the role and the health and safety issues that may arise in that role. The report could also require the doctor to respond to a series of pertinent and searching questions about the applicant’s fitness for the role;
- (c) a face to face meeting with a health professional tasked with properly assessing the individual’s fitness for work could be put in place in order to test, where possible, the veracity of the individual’s report;
- (d) a signed mandate disclosing full medical records to an Occupational Health doctor employed by GCC could be required. This is on the basis that Occupational Health doctors do not currently disclose any health difficulties to the employer without the permission of the individual and the question for them is whether they are fit for the prospective position. The family can foresee no issue regarding equal opportunities given that this information is confidential and the question is whether prospective employees are fit for such a safety critical role.”

[408] Mr Conway went further and contended that a finding under section 6 (1) (d) fell to be made, but I have rejected that submission for the reasons given at para 402.

[409] The Solicitor General proposed her recommendation 5 which, for the reasons I go on to explain, I adopt.

Assessment

[410] Mr Clarke was required to complete an application form for his first job at GCC and it informed him that:

“...it is also essential that the Council identify health problems at an early stage to allow it to respond effectively to actual and potential problems with service delivery. Therefore, all employees are expected to maintain an acceptable level of attendance and each department has a target attendance level.”

The evidence was that the target was a maximum of 6.9 days of absence *per annum*.

[411] Mr Clarke signed this declaration:

“I certify that all the information contained in this form and any attachments is true and correct to the best of my knowledge. I realise that false information or omissions may lead to dismissal without notice...”

[412] Mr Clarke had an interview at which he was required to produce his licences.

Since he was over 45, his group two licence could only be held after five yearly D4 medicals. There were obligations on him under section 94 of the RTA 1988 to notify if any new health conditions affecting his ability to drive safely had come to light.

Accordingly, his holding those licences ostensibly demonstrated his fitness to drive.

[413] On being selected as suitable for appointment, Mr Clarke was required to complete an online health questionnaire which was reviewed by an OH provider. It was directed to determining his fitness for the post he sought.

[414] I conclude that the importance of being fit to drive was made abundantly plain to Mr Clarke. It is true that the medical enquiry process carried out by GCC's OH provider relied entirely on the honesty of the applicant. However, two of the

measures in place involved independent checks; the holding of driving licences and the requirement for a reference.

[415] The reference form sent out by GCC to First ought to have prompted disclosure of Mr Clarke's sickness absences and the reasons for it which ought to have prompted disclosure of the incident of 7 April 2010.

[416] Dr McKaig's D4 medical in 2006 and Dr Langan's letter to Dr Lyons in April 2010 were focussed on his fitness to drive and nothing was brought to light about Mr Clarke's medical history rendering him unfit to drive. I consider it unlikely that any request for information from the GP practice directed toward fitness to drive would have prevented Mr Clarke's appointment by GCC.

[417] Given how successfully Mr Clarke duped a number of doctors, it is not immediately obvious to me to what would have been achieved by a face to face interview with the OH provider.

[418] The issues raised by the fourth element of the Morton family proposal were canvassed to some extent with witnesses. Ms Ham and Mr Gellan were plainly shocked when they came to learn in evidence of Mr Clarke's medical history compared to the information which he had disclosed in the recruitment process.

[419] Ms Ham recognised the value of having an independent and reliable source confirm the accuracy of information provided by an applicant in the health questionnaire. On Mr Conway's hypothesis that it might cost in the region of £50 to get some such confirmation from an applicant's GP, she did not regard that as prohibitive. She accepted a suggestion that it would be permissible for GCC to obtain a written consent from an applicant for his GP to disclose medical records to the OH provider to consider alongside the questionnaire so long as it was confined to

relevant information. Another potential solution would be to invite the applicant's GP to provide a reference specifically addressing fitness to hold the post. Such solutions would require further consideration by GCC.

[420] Ms Ham's evidence does not support disclosure of "full medical records."

Such disclosure to the OH provider would have had the potential to demonstrate the falsity of declarations in Mr Clarke's OH questionnaire. Whilst passing reference was made to the Equality at Work Act 2010, I heard no detailed submissions about it. It has not been demonstrated that it would be permissible even for an OH provider acting at arm's length from an employer to seek "full medical records" as opposed to inquiring as to the candidate's fitness to carry out functions intrinsic to the work concerned.

[421] Whilst in a very general way, Ms Ham's evidence may be supportive of the reasonable practicability of some further medical inquiry as part of the appointment process, it was her position that GCC would require to consider matters further.

[422] Given the extent of Mr Clarke's medical history and that it is recorded only in paper form for decades prior to 2005, there is a very real issue of reasonableness and practicability in making available "full medical records."

[423] For these reasons, I am not persuaded that I should make the finding proposed under section 6 (1) (c) in this regard. However a vulnerability to dishonest applicants has been identified in a recruitment process which the evidence suggested is a fairly standard one for large organisations.

[424] GCC has undertaken through the evidence of its employees in the Inquiry to give further consideration to all of these issues and in particular to the possibility of some further independent check from a medical source of fitness to drive. Some

further check could in some instances catch unsuitable applicants who would otherwise slip through the net. I consider that there is nothing to be lost and there may be something to be gained by specifying that a referee should disclose any information of which he or she is aware which would affect the applicant's fitness to drive the type of vehicle concerned.

[425] Having considered the relevant evidence and the submissions, I recommend that:

- Glasgow City Council should carry out an internal review of its employment processes with a view to ascertaining potential areas for improvement in relation to checking medical and sickness absence information provided by applicants, for example by having focussed health questions within reference requests for drivers and obtaining medical reports in relation to health related driving issues from applicants' GPs. (5.4)

DVLA and the "at a glance" guide – the evidence of Dr Parry

[426] Dr Parry knew of research²⁵ which found that there is a recognisable lack of awareness of the guidelines, even amongst the medical profession. He explained that negotiations are under way with the GMC about how awareness can be increased. Dr Parry considers that there would be some benefit in raising public awareness generally about the need to notify medical conditions to DVLA.

[427] Whilst he agreed with a suggestion that prosecution for providing false information on a D47/D4 form would raise public awareness, he was not aware of any such prosecution ever having occurred.

[428] If a doctor learns that a patient is driving against advice, then the GMC permits the doctor to notify DVLA. In busy urban practices, there can only be a very slight

²⁵ Department for Transport: Road Safety Research Report 91: The Attitudes of Health Professionals to Giving Advice on Fitness to Drive – Dr Carol Hawley on behalf of the project team from University of Warwick, January 2010.

prospect of a doctor making such a discovery. Dr Parry acknowledged that it is a weakness in the current regime that if a patient is advised to notify DVLA, but chooses not to, the doctor will generally be unaware. Having been referred to legislation in Ontario, Dr Parry acknowledged that what might be a difficult situation for GPs would be made simpler, at one level, if they were given a statutory duty to notify DVLA directly of any patient suffering a relevant event or condition. In their submissions Mr Conway and the Solicitor General favoured the introduction of a statutory “dual reporting” obligation on both the patient and the doctor.

[429] It was demonstrated that whilst some states in Canada and Australia have adopted such legislation, other states have not and it was not within the scope of the Inquiry to establish fully the reasons for each position.

[430] The introduction of such legislation would certainly raise awareness amongst doctors. Dr Parry considered that it might be resisted by the profession on the ground that it would fundamentally alter the doctor/patient relationship to which confidentiality is integral.

[431] Dr Parry understood that approximately 60% of D4 medicals are performed by a doctor who is not the applicant’s GP. He recognised the potential for an applicant to conceal relevant medical information and suggested that the best means of ensuring that DVLA receives accurate information would be for D4 medicals to be performed by GPs. He acknowledged practical difficulties. Not all GPs would be prepared to perform D4 medicals and they are not contractually obliged to; not all drivers will be registered with a GP; and Dr Parry considers that to require that D4 medicals are performed by an applicant’s GP would require legislative change. For the reasons I set out below at para 453, I consider that Dr Parry is correct.

[432] The terms of box 2 of “at a glance” as it now stands caused Dr Parry initially to place the incident of 22 December 2014 in box 2 so that Mr Clarke would be entitled to drive a group 2 vehicle 3 months after the event. Dr Parry was faced with some incredulity by some of those who questioned him.

[433] The decision ultimately to revoke Mr Clarke’s group 2 licence for ten years came when DVLA received formal notification of the events of 7 April 2010. That incident had been mentioned verbally to Dr Parry on 26 January 2015 when he was interviewed by the police in preparation for the Inquiry. DVLA has no mechanism for acting on information received in that way and no action was taken in relation to it in the absence of the police submitting written notification. Dr Parry agreed that that was not an acceptable position and indicated that it was under consideration by DVLA’s policy department.

[434] Dr Parry volunteered that the situation which led to Mr Clarke’s licence being returned in April 2015, essentially after three months, was not ideal from the point of road safety and he indicated that the apparent lack of relevance of prodrome in the current box 2, and the short period of revocation, are likely to be reconsidered soon. He accepted a suggestion that it was clearly wrong that the fact that an episode of neurocardiogenic syncope had occurred at the wheel would not be taken account of by DVLA.

Comment

[435] On a plain reading of the current categorisation, Dr Parry’s decision in April 2015 is perfectly understandable. Box 1 refers to “definite provocational factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or

lying.” There is no such qualification in box 2 which relates simply to a solitary event likely to be unexplained syncope with a high probability of reflex vasovagal syncope where there is no clinical evidence of structural heart disease and where the ECG result is normal. Box 3 relates to a solitary event which is likely to be cardiovascular in origin and excludes boxes 1 or 2. Box 3 then goes on to refer to factors indicating high risk. High risk is no longer mentioned elsewhere in boxes 1, 2 or 3 and box 2 no longer refers to low risk of recurrence. The effect of all this is that despite injury being caused to 23 people, six of whom died, those consequences would be ignored if the event fell within box 2.

[436] Given the care and expertise which is brought to bear by the appropriate specialist medical panels, I would hesitate to suggest that there has been any inadvertent weakening of the categorisations. Nevertheless, I find it surprising that the 3 Ps matter in box 1 and yet they do not matter in box 2 where there is less certainty as to the nature of the medical event. I also find it difficult to follow what the high risk referred to in box 3 now refers back to.

[437] It would be perfectly legitimate on policy grounds to stipulate that any syncope which causes injury or occurs at the wheel, or when sitting or lying, ought to fall within the reporting requirements and restrictions of box 3.

[438] I consider that that is probably what the position was in April 2010 under box 3 as it then stood. That however, is not a construction so easily reached in the contemporary version of box 3, with its exclusion of boxes 1 and 2.

[439] If it is the intention that any loss of consciousness or altered awareness which occurs when a driver is sitting, or sitting at the wheel of a vehicle, should be notified to DVLA, and there are obvious public safety considerations which justify that

approach, then the LOC etc. section of the guidance could be restructured into a form of flow chart which would make that inescapably clear. Dr Parry saw the attraction of that kind of presentation. It would surely be of assistance to primary medical practitioners to be able to follow unambiguous guidance.

Submissions

[440] Mr Stewart contended that the absence of an independent check of medical records from the process by which DVLA determines fitness to drive on a group 2 five yearly renewal was a defect such that I should make a finding under section 6 (1) (d). In support of this contention, he drew attention to the situation whereby Dr Willox had no access to GP records when she performed her D4 examination of Mr Clarke in December 2011 and DVLA's decision in April 2015 to reissue licences to Mr Clarke. The latter event, since it post-dates the deaths, cannot give rise to a finding under section 6 (1) (d).

[441] Had Dr Willox learned of the episode of 7 April 2010 and some detail of Mr Clarke's medical history then, whilst it may be theoretically possible that Mr Clarke would not have been entitled to drive a group 2 vehicle in December 2014, the evidence for that is not at all strong and mostly points in the other direction. Mr Clarke might have lost his job with GCC at that stage, but I cannot say that he would have done. In any event, the reason why he might have lost his job with GCC would relate to the revealing of his dishonesty on applying for it. Whilst the absence of access to an independent check of an applicant's health declarations in forms D47 and D4 is a weakness, I am not persuaded that it has been shown in this case that it

can be said to be a defect in a system of working which contributed to the deaths or any accident resulting in the deaths.

[442] In his measured submissions on what the evidence had established and what conclusions ought to be reached from it, DVLA's counsel, Mr McIlvride, made a number of pertinent observations.

[443] Counsel pointed out that the Ontario system had not been universally adopted in Canada and the reasons for that were not known. He submitted that it could be inferred that neither Dr Langan in 2010 nor Dr Willox in 2011 would have notified DVLA had there been a statutory reporting requirement on the driver's doctor. Such a measure would not have made any difference in this case.

[444] He reminded the Inquiry that before Mr Clarke was reissued with driving licences in 2015, Mr Clarke's GP practice was invited to submit "any further information which you may feel is relevant." That did not prompt disclosure of the medical notes of 7 April or 22 April 2010 or Dr Lyons's letter. No reference was made to that episode in the letter of 19 February 2015 referred to in para 23 of the third joint minute.²⁶

[445] Mr McIlvride questioned whether in respect of some of the proposals of parties the Inquiry had heard sufficient evidence to formulate recommendations and whether a Fatal Accident Inquiry ever could be an appropriate forum in which usefully to weigh competing considerations in the absence of broad consultation with relevant bodies such as the GMC and the British Medical Association.

[446] Referring to the evidence of Dr Parry, Mr McIlvride reminded the Inquiry, at para 39 of his submissions, that:

²⁶ See Appendix 5.

“[39] It has been made clear to the Inquiry that:

(a) even if the court finds that nothing done or omitted to be done by DVLA caused or contributed to the events of 22 December 2014;

(b) regardless of the fact that all of the medical practitioners who have given evidence have made it clear that they are familiar with the existence and content of the “At a Glance Guidance”; and

(c) regardless of the fact that the existing Guidance in relation to recurrent vasovagal episodes appears to be much stricter and more safety conscious than the equivalent guidance in, say, Canada (see Production 20 for the Tait Family, pp 254 and 258),

DVLA has set in motion a review of:

(i) Its procedures for responding to oral notifications of fitness to drive issues;

(ii) The clarity of the language employed in the Guidance;

(iii) The periods of restriction from driving imposed in accordance with the Guidelines; and

(iv) The further steps to be taken, in partnership with the GMC and otherwise, to improve awareness of medical fitness to drive issues within the medical profession and the general public.”

[447] I accept the validity of all of these observations which are supported by the evidence.

[448] Mr McIlvride suggested that proposals to allow OH doctors and/or DVLA extensive access to patient medical notes, and legislation which would require a doctor to provide confidential medical information to DVLA, would have implications in relation to article 8 of the European Convention on Human Rights²⁷.

[449] That may be so, but such requirements may well be permissible under the qualification in article 8 para 2. They are proposed legislative changes and they are plainly relevant to public safety.

²⁷ “1 Everyone has the right to respect for his private and family life, his home and his correspondence.

2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

Assessment

[450] Whilst there may be features in the guidance used in other countries which appear to have some advantages, it was not demonstrated that any of the regimes would necessarily offer more or better protection to the public than the system operated by DVLA. In order to reach any conclusion on other systems, there would need to be a comprehensive study and evaluation of a kind which is beyond the scope of this Inquiry.

[451] I have concerns that an unintended consequence of a statutory duty on doctors to report medical conditions or events bearing on fitness to drive directly to DVLA could be to inhibit some patients from seeking medical advice. That in turn may have adverse implications not just for road safety but also for patient wellbeing. It is apparent from its consultation launched on 25 November 2015 that the GMC has long recognised such potential. Its revised draft advice, and the consultation process, should serve to remind doctors to consider the implications for driving of a patient's condition. However, the draft makes no material change to its advice in relation to when a doctor can and should notify DVLA.

[452] Parliament has enacted a framework which seeks to balance the general public interest in road safety and the freedom of individuals to drive and, for some, to make a living from doing so. Respect for the private life of drivers has to be taken into account in determining how, and to what extent, medical information which would otherwise be confidential is to be accessed by DVLA. Where the balance is to be struck is a political decision to be made by those who have been democratically elected, assisted by those to whom they have delegated authority.

[453] Mr McIlvride pointed out that the provision in para 10(5) of the MVDLR 1999²⁸ does not require that a medical report in support of a group 2 application should be prepared by a general practitioner, simply a qualified medical practitioner. I accept his submission that it follows that to require that practitioner to be the driver's GP would necessitate legislative change.

[454] On a related issue, Mr Conway submitted:

“Section 10 of the D4 form incorporates a Consent and Declaration by the applicant to provide medical information as requested. Question 7 of the D4 appears to be predicated on the basis that the applicant will allow access to his own hospital notes. There is no statutory bar which would prevent the Secretary of State requiring that medical records (whether from the primary or secondary health care sector), be made available to the qualified medical practitioner at the time of the D4 examination.”

[455] I prefer Mr McIlvride's analysis. Section 94 (5) of the RTA 1988 empowers the Secretary of State to obtain information in the two circumstances set out in subsection (4). The first is where “the prescribed circumstances” obtain which refers to certain “drink drivers.” The second is where,

“the Secretary of State has reasonable grounds for believing that a person who is an applicant for, or the holder of, a licence may be suffering from a relevant or prospective disability.”

[456] Accordingly, DVLA is empowered to obtain information following a notification whether in form D4, D47 or otherwise such that it has reason to believe that the applicant or licence holder may be suffering from a condition, but not beforehand. It appears to me that the consents sought in the forms are requested there with a view to exercising those powers if there is a notification in the forms. In any event, what is contained in forms does not override the statutory provisions.

²⁸ See appendix 2 for the various provisions referred to here.

[457] I do not know the detail of what was argued before Sheriff Caldwell²⁹ but, accepting Mr McIlvride's analysis, I do not agree that without legislative change DVLA could require that "where the examining doctor is not the applicant's GP, that GP is asked to verify from his records that the applicant has no condition likely to adversely affect his fitness to hold a relevant licence."

[458] Mr Conway put to witnesses the results of research which might suggest that doctors may not be as alert to fitness to drive issues as would be hoped and find difficulty interpreting "at a glance", but there was no examination of the sections which would relate to the experiments conducted. I do not have an evidential basis for concluding that "at a glance" as a whole lacks clarity. The introductory section was examined and it is perfectly clear.

[459] I have considered all of the proposals for recommendations in relation to DVLA which came particularly from the Solicitor General, Mr Conway and Ms Bain. I recognise that many of the proposed recommendations cannot be shown to have the potential to have prevented this accident in the circumstances in which it happened. However, I am not prepared to conclude that nothing can be done which might reduce the chance of such an accident recurring.

[460] These events do not stand in isolation. Dr Boon said that,

"... the vast majority of people who have vasovagal syncope do have a prodrome, and that's why we have a condition that's very prevalent, very common, yet not many accidents are recorded as a result of it."

People in Glasgow may have a different perception. In the years 2010-2014, there have been 3 fatal road traffic accidents in which what could be described as an episode of vasovagal syncope seems to have played a part.

²⁹ Determination, 19 November 2014: Fatal Accident Inquiry into the death of John Paul Pratt.

[461] On 17 December 2010 Mhairi Samantha Convy and Laura Catherine Linda Stewart were struck and fatally injured by a car in North Hanover Street, Glasgow. Following a Fatal Accident Inquiry, Sheriff Normand determined that the accident was caused when the driver, William Payne, suffered a vasovagal episode³⁰.

[462] On 31 March 2012, Ian Lochrie died when he was struck by a bus driven by David Logue who suffered an episode of vasovagal syncope³¹ on Cathcart Road, Glasgow. Dr Parry made some reference to that event in his evidence.

[463] 9 people have died in these 3 accidents which occurred within a 4 year period. One avoidable death is too many.

Conclusions and recommendations relating to DVLA and DfT

[464] It was only one short section of “at a glance” which was closely analysed in the Inquiry, that on loss of consciousness, and loss of or altered awareness. So far as that section is concerned, I conclude from the difficulties encountered by several of the doctors who gave evidence about it that it did indeed lack clarity in 2010. From the analysis of the current guidance during the evidence of Dr Parry, it was shown that the LOC etc. section continues to present difficulty in interpretation and application. The wording of box 1 is little changed and, in my view, continues to lack clarity. More importantly, Dr Parry agreed that it is “a little unclear in its wording” and it could be “profitably changed.” He agreed that the wording of box 3 can cause confusion.

³⁰ See footnote 7.

³¹ Determination of Sheriff JK Mitchell, published 20 November 2015.

[465] In the course of his submissions on behalf of DVLA, Mr McIlvride explained that:

“There is already a long established practice of subjecting the Guidance to review by the specialist panels twice each year, although the reviews which will now be undertaken will obviously be informed by the evidence and any recommendations which emerge from this Inquiry.”

[466] As a first step, I would invite their attention to the observations which I have made and to Dr Parry’s concessions, referred to at paras 426-434 and 464.

[467] Whilst a number of suggestions have been made as to how DVLA’s regulation of fitness to drive can be rendered more effective, none provides a complete answer. GP notes which were made before computerisation are not always readily available. GPs may rely on clinical summaries which may not include relevant information. GPs may not be able to recognise patterns of symptoms which would be significant to some cardiologists. Cardiologists themselves may not agree on which symptoms are significant. A patient may lie to a GP in order to create a misleadingly benign record. Nevertheless, whatever imperfections any solution may have, the system would be more effective if DVLA had a means of cross-checking information from an applicant with reliable sources of information.

[468] Many of the proposals have the potential to increase pressure on the health service, particularly GPs. Requiring GPs to carry out more D4 medicals and to certify job applications or provide medical reports would take time away from other patients. The Inquiry heard that there are already situations where a GP may have to certify a patient’s medical fitness, for example to join the armed forces or to hold a firearms licence.

[469] A GP, even if he or she may not always identify every relevant consideration, may still recognise details on an application form as being incorrect. The GP would at the stage of performing a D4 medical at least have access to the patient's notes whereas DVLA does not and OH doctors generally will not. Whether the most effective and workable solution would be for all D4 medicals to be conducted by the applicant's GP, or whether it would lie in GPs providing OH doctors and/or DVLA with their clinical summary or such medical records as are computerised, or whether it would involve a GP countersigning forms D4 and D47 as being accurate, might best be determined after consultation with relevant bodies such as the GMC and the BMA.

[470] In his Determination published on 20 November 2015, Sheriff Mitchell recommended that the Secretary of State for Transport should consider introducing a number of legislative changes of which his recommendation 1(a) might be another potential means of addressing vulnerability to incomplete disclosure by applicants. That proposal was not advanced in the Inquiry before me and I heard no submissions on it. Accordingly I will not comment on it further, beyond noting that it is another option for DfT to consider.

[471] At present the regulations do not require GP input or the provision of medical records and legislative change would be required in order to introduce any such system. Such legislative change would have to be preceded by consultation of relevant bodies including GMC, BMA and organisations speaking on behalf of patients. On the basis of the evidence led and submissions made in the Inquiry, I can make only tentative observations in the recognition that there will likely be implications which were not apparent to the Inquiry. I have referred to three

possible options which were identified. Whilst none of these proposals would necessarily prove watertight, and there would remain the problem of the driver who is not registered with a GP, each of them could provide an independent check of some efficacy in most cases. The Inquiry did not hear enough evidence to evaluate which is the most effective. Issues of allocation of resources and respect for privacy would also have to be balanced against the general public interest in road safety and that exercise is one for the legislature.

[472] Option 1 - a requirement that D4 medicals can only be performed by an applicant's GP.

Option 2 - a requirement that form D47 and form D4 should be countersigned by the applicant's GP to confirm their accuracy.

Option 3 - a requirement that if a D4 medical is not performed by an applicant's GP, medical records should be sought from the GP in order to confirm the completeness and accuracy of what has been declared.

[473] OH specialists may bring experience and knowledge of fitness to drive issues beyond that of most GPs and are perhaps less likely to be tempted to engage in advocacy on the applicant's behalf. That experience would be lost under the first option. Option 1 would significantly increase GP workload and at present GPs are not obliged to carry out such work.

[474] Option 2 might prove time consuming and a GP may have less knowledge of what to look for than an OH doctor and it denies the OH doctor direct access to the notes.

[475] Option 3 may meet resistance on grounds of privacy and confidentiality. Whilst at present option 3 may appear to be quite burdensome if it has to go back in time

before computerisation of GP notes, older records would not be necessary in most cases. If the whole of the computerised parts of GP notes were made available, with consent of the patient, then the OH doctor would have the raw material to enable an assessment of the accuracy of the information provided by the applicant. There would be scope to identify medical information the significance of which was not apparent to the applicant and/or the GP.

[476] In what follows, I am not referring to any prosecution decisions relating to Mr Clarke. It is no part of my function in this Inquiry to comment on prosecutorial decision making in individual cases. I am referring to the evidence of Dr Parry who said that despite DVLA being dependent on self-reporting by drivers, there have not been any prosecutions for failing to provide fitness to drive information or giving false information. The latter offence carries a potential penalty of imprisonment for two years on indictment³². Dr Parry's evidence was not challenged by counsel for DVLA or by the Solicitor General and I accept it. This is a surprising state of affairs, to say the least. Given Dr Parry's acknowledgement of the vulnerability of DVLA's licensing system to a dishonest applicant, DVLA and those with responsibility for criminal prosecution may consider it timely to review whatever prosecution policies are in place.

[477] On 20 November 2015, Sheriff Mitchell recommended that the Secretary of State for Transport should give consideration to legislating in order to, amongst others,

“(8) increase the penalties and alter the mode of prosecution for a contravention of either section 94(1) and (3) or section 94(3A) of the Road Traffic Act 1988, as amended;

³² Road Traffic Act 1988 Section 174 (1) (a), and Road Traffic Offenders Act 1988 schedule 2.

(9) create a discrete indictable offence of driving whilst unfit to do so by reason of the driver not having followed medical advice to maintain fitness to drive.”

Recommendation 8 reflects an issue about which I asked Dr Parry and it is equally relevant in the light of what has been established in the Inquiry before me and I adopt it. However, as parties observed in submissions, increased penalties will have little effect if there are no prosecutions.

[478] Recommendation 9 is not directly relevant to the circumstances established in the Inquiry before me. In his submissions on day 26 of the Inquiry, Mr Stewart raised an issue which did not feature in his written submissions. He came to suggest that a new offence ought to be created to provide for a situation where it is not considered that there is sufficient evidence to prosecute for dangerous or careless driving but the driver suffered a medical event related to a condition which he had failed to disclose to DVLA. Mr Stewart was seeking to assist the Inquiry by raising a matter which he and others explained is of serious concern to some of the families of the deceased. However, the creation of some new offence along the lines suggested, and only then in a barely embryonic form, is not a matter on which I can make a recommendation or even a suggestion for further consideration in the absence of detailed submissions which I did not hear. There would require to be a close examination of just what gap there is between the potential for prosecution under RTA sections 94 and 174 on the one hand and sections 1, 2, 2B and 3 as interpreted by courts in both England³³ and Scotland³⁴ on the other and, in Scotland at least, existing common law offences; if it should be filled and how it should be filled.

³³ *R v Marison* 1997 RTR 457.

³⁴ *McLeod v Mathieson* 1993 SCCR 488.

[479] For the reasons which I have set out in the preceding analysis, I make

recommendations 5.10, 5.11, 5.12, 5.13, 5.14, 5.15, 5.16, 5.17, 5.18 and 5.19.

- DVLA should satisfy itself as to precisely what the categorisation is intended to mean and to achieve in the loss of consciousness/loss of or altered awareness section of the guidance contained in its “At a Glance Guide to the Current Medical Standards of Fitness to Drive.” (5.10)
- Having done so, DVLA should then ensure that the meaning is made clear to those who apply the guidance in practice. (5.11)
- DVLA should consider if a flow chart could be included to guide doctors through the categorisations contained in the loss of consciousness/loss of or altered awareness section of “at a glance.” (5.12)
- DVLA should consider whether the section of “at a glance” on loss of consciousness/loss of or altered awareness gives sufficient weight to the absence of prodrome given its significance for road safety. (5.13)
- DVLA should consider whether the section of “at a glance” on loss of consciousness/loss of or altered awareness gives sufficient weight to a medical event occurring at the wheel of a vehicle and its consequences. (5.14)
- DVLA should change its policy on notification from third parties so that relevant fitness to drive information from ostensibly reliable sources, such as the police, can be investigated whether or not it comes in written form. (5.15)
- DVLA should redouble its efforts to raise awareness of the implications of medical conditions for fitness to drive amongst the medical profession. (5.16)
- I respectfully recommend that the Secretary of State for Transport should instigate a consultation on how best to ensure the completeness and accuracy of the information available to DVLA in making fitness to drive licensing decisions with a view to making legislative change. (5.17)
- Part of this exercise should involve considering increasing the penalties and altering the mode of prosecution for contravention of section 94 of the Road Traffic Act 1988. (5.18)
- I respectfully recommend that the Secretary of State for Transport should instigate a consultation on whether it is appropriate that doctors should be given greater freedom, perhaps by the GMC, or an obligation by Parliament, to report fitness to drive concerns directly to DVLA. (5.19)

The issue alluded to in recommendation 5.19 may be a particularly difficult one and wide consultation may be necessary, but it was recognised as a weakness by DVLA’s Senior Medical Adviser in his evidence.

[480] I conclude that relevant parties should give consideration to the matters

identified at 6.1, 6.2 and 6.3:

- 6.1 Occupational health doctors performing D4 examinations and providing advice to employers on applicant drivers, and employers of drivers who facilitate their staff applying for renewal of group 2 licences without the involvement of GPs, should consider whether to require the applicant to sign a consent form permitting release by any GP of relevant medical records to the occupational health doctor.
- 6.2 DVLA, the Crown Prosecution Service and Crown Office and Procurator Fiscal Service should review whether there are policies in place which prevent or discourage prosecution for breaches of sections 94 and 174 of the Road Traffic Act 1988. If there are such policies, consideration should be given by DVLA and the prosecuting authorities to whether they are appropriate where the current fitness to drive regime is a self-reporting system which is vulnerable to the withholding and concealing of relevant information by applicants.
- 6.3 DVLA and the Department for Transport should consider how best to increase public awareness of the impact of medical conditions on fitness to drive and the notification obligations in that regard.

The actions of the crew

[481] The Inquiry heard from Mark Hill, a principal consultant with the Transport Research Laboratory (TRL) who specialises in collision investigation. He also has twenty years of relevant police service. Mr Hill specialises in the study of “human factors” which bear on responses to road traffic accidents. He had prepared a report on the instructions of the Procurator Fiscal to consider the actions of the passenger crew. The Inquiry also heard from Philip Balderstone of TRL, an expert in vehicle technology, and there was also some evidence from other drivers as to how a bin lorry might behave in certain circumstances. There was no dispute as to how the two passengers responded as events unfolded.

[482] Mr Hill had established that whilst the whole event lasted for 19 seconds, the interval between the first deviation of the lorry to its first collision with the building

line was 5 seconds. Mr Hill explained that it would take some reaction time for the crew to process that something so unexpected was really happening and how they should react to it. He considered that they had little more than 2 seconds within which to take any action. It was a perfectly rational first response to try to rouse Mr Clarke as Mr Telford did. During road traffic accidents, actions may be affected by the powerful human instinct for self-preservation. Some people are disabled by feelings of helplessness.

[483] Mr Hill did not consider that the crew had sufficient time to avert a collision with the building line. It was likely that they would have expected the vehicle to stop on first striking a building, which it did not. Once it moved on, there was little they could have done as the vehicle pursued its unstable course.

[484] Mr Hill ascertained that the Driver Vehicle and Standards Agency does not provide approved driving instructors with any training on how to react to driver collapse. He had not been able to find any such training for passengers anywhere. He concluded that, at present, the best that can be done is to rely on the innate knowledge of passengers who find themselves in such a situation.

[485] I have had regard to the evidence of Kenneth Wilson of NLC, summarised at paras 218 and 219.

[486] The safety rail performed what Mr Hill and Mr Balderstone considered to be one of its functions by limiting access to the driver position and, in doing so, provided a physical obstacle to any intervention by the crew. There was no detailed consideration in the Inquiry of the relative advantages and disadvantages of having such a barrier/rail and it was not demonstrated that it was inappropriate.

[487] Mr Telford holds a provisional driving licence and Mr Toal held a provisional driving licence in 1985, however he failed a test and has never returned to driving. Neither Mr Toal nor Mr Telford has ever touched any of the driver controls within the bin lorry, and they did not know how the secondary brake is operated.

[488] Mr Toal was further away both from the driver and the controls and it would have been very difficult for him to have taken any effective action. Mr Telford was closer and he did attempt to rouse Mr Clarke, to no avail. His actions in that regard were appropriate. Whilst it may be physically possible to reach and operate the secondary brake from his position with the vehicle at rest and with the seatbelt on, that was estimated by Mr Balderstone to be a remote possibility. In practice, to reach the secondary brake, Mr Telford would have had to remove his seat belt and perform an awkward manoeuvre as the lorry pursued its uncontrolled course at speed. His innate instinct for survival would likely have directed him away from doing so.

[489] If the secondary brake had been activated, the consequences would be unpredictable. It would have some slowing effect, but it may have caused the vehicle to skid and Mr Quigley (GCC driver) feared that a bin lorry would become uncontrollable. Mr Balderstone explained that the secondary brake is not connected to the systems which cause application of the service brake (the driver's footbrake) to activate braking lights. The secondary brake does not have the ABS anti-lock braking system which features on the service brake.

[490] Mr Hill explained that it was possible that the lorry would have skidded further along the pavement. If that happened, there could have been even more casualties. The change of course which removed the lorry from the pavement probably prevented there being an even greater number of casualties.

Conclusions

[491] Mr Balderstone considered, generally, that there may be safety concerns in training crew members to apply the secondary brake in an emergency situation. The crew may misjudge when to apply it. It may cause a skid. Those concerns have to be borne in mind. It was not a realistic option for the crew in this case in any event. Ultimately, there was no criticism of the actions of the crew advanced by any of the parties to the Inquiry and I conclude that there was no reasonable precaution which they could have taken which might have avoided the accident with its fatal consequences.

[492] Although I do not consider that it would have made any practical difference to the events of 22 December 2014, it would nevertheless seem sensible that where there are crew members within a large vehicle such as a bin lorry, they should have at least some training as to the operation and potential of the vehicle's controls.

[493] It is conceivable that a vehicle with an incapacitated driver might be steered to safety. Mr Hill was able to give an example of two bus passengers doing that in Poland in 2013. The driver had been thrown clear of the controls which offered an opportunity denied to Mr Telford. There was an incident in Croftside Avenue, Glasgow on 14 April 2015 in which crew members had sufficient know how to engage the secondary brake of a GCC bin lorry once it had come to a halt following driver incapacitation at low speed. The details of that event were proved in the fifth joint minute which I reproduce in appendix 7.

[494] For these reasons,

- I recommend that Glasgow City Council should provide its refuse collection operators with some basic training to familiarise them with the steering and braking mechanisms of the vehicles in which they work. (5.5)

Vehicle technology

[495] In preparation for the Inquiry, the Procurator Fiscal had instructed Philip Balderstone of TRL to consider safety devices used on large vehicles of various kinds. He has expertise in vehicle technology and has previously been employed to perform vehicle examination for Thames Police.

[496] He examined bin lorry SB62 NKD. He explained that the barrier/rail which separates the driver's compartment from the passenger seating operates to aid entry to the vehicle, to allow crew to steady themselves when the vehicle is moving and to separate the crew so as to reduce the risk that they will accidentally interfere with the driver. In the driver cabin were controls for operating the refuse body and an emergency stop button for it. This is a legislative requirement for what is regarded as machinery.

[497] Mr Balderstone had considered mechanisms used on other vehicles. He had examined and excluded the types of devices available on trains and trams having regard to the absence of trackside infrastructure and the comparative complexity of driving a road vehicle. European legislation would prohibit the use of a "dead man's handle" on a road vehicle.

[498] A manual emergency brake switch could be engineered into a position to minimise the risk of accidental application. It could be designed so as to apply the brakes progressively, to disable the drive and engine and illuminate warning lights. Mr Balderstone has not seen such a device fitted, but it is a technical possibility. The

DfT provided its views³⁵. It is thought that there are insurance and liability implications. One implication, mentioned in passing in the evidence, is that in certain circumstances, a person who activated such a device might be deemed to be driving.

[499] Mr Hill had considered what use might have been made of a crew-activated emergency stop button and he concluded that it may have mitigated the consequences. He expressed concern that such a device would carry a potential for inappropriate activation where crew members made well-intentioned misjudgements which could cause accidents with serious consequences. As for use of the existing secondary brake by passengers, Mr Hill considered it to be extremely difficult to provide realistic and relevant training for a very challenging situation which requires a decision to be made with potentially high stakes and where judgment can vary greatly between individuals. I infer that similar difficulties would be present in training crew in the use of an emergency stop button.

[500] Mr Balderstone explained that some industries such as mining and construction have used the somewhat misleadingly entitled “facial recognition” technology. It might be better understood as a body position monitor which can trigger audio/visual alerts or inform a remote monitoring centre. It would be technically possible to combine this with other systems such as Autonomous Emergency Braking Systems (AEBS) so as to bring a vehicle with an unconscious driver to a halt. This however is for the future.

[501] AEBS is of immediate relevance. AEBS combines camera and radar sensors to identify vehicles or large objects in a vehicle’s path with a view to preventing

³⁵ in a letter of 13 August 2015, the accuracy of which is proved in para 12 of the seventh joint minute. The relevant section of the letter is reproduced in appendix 8.

collision. On initial sensing, the driver is alerted to possible collision by a warning light. As the distance decreases there will be an audible warning. If the driver does not react to either alert, the autonomous emergency braking will apply the service braking at optimum efficiency. AEBS is already used in some cars and in Volvo trucks and became mandatory for all newly registered heavy goods vehicles from November 2015, subject to exemptions, and all new types of HGVs have been required to be fitted with AEBS since November 2014. In production 184, the Department for Transport offers the view that:

“Due to the complexity of these systems they are not suitable for retrofitting to vehicles and are only installed at the time of manufacture.”

[502] At present such systems, insofar as they relate to large vehicles, require capability to react to a saloon car and will detect large objects but are unlikely to detect pedestrians. They would be expected to react to an obstacle such as the statue on the west side of Queen Street, depending on the angle of approach. It is possible that they would react to the pavement bin which was first struck by the lorry. Some broadly comparable technologies on certain cars can detect pedestrians, for example the Pedestrian Protection System. Lane Deviation Warning Systems (LDWS), primarily intended for long distance lorry driving, will sound an alert if a driver deviates without indicating and is intended to address the problem of driver inattention. Blind Spot sensors are also in development. Mr Balderstone suggested that in future such systems could be integrated with AEBS.

[503] Certain agreed facts and the law relating to AEBS and LDWS were set out in the seventh joint minute and I reproduce the relevant section as appendix 9.

[504] At present, the evidence suggested that AEBS would be very unlikely totally to have averted the collisions which took place but with technological developments there may be systems with such potential in the future.

[505] Mr Balderstone indicated that it is far cheaper and better to manufacture in AEBS and that to retrofit would be expensive.

[506] Subject to a slight rewording, I adopt the Solicitor General's proposals for recommendations 6 and 7, for the following reasons.

[507] It is very difficult to eliminate the risk to the public caused by a heavy vehicle losing control and there is no single solution. There may be some reduction in risk if measures of partial effectiveness are deployed.

[508] It is possible that had AEBS been fitted to the bin lorry, some of the consequences could have been avoided.

[509] Para 31 of the seventh joint minute states:

“AEBS was introduced on the type of vehicle to which the truck belongs, namely a DAF C75 Euro 5 model in 2014. AEBS was accordingly not available as an option on the truck when it was procured by Glasgow City Council. AEBS cannot be retro-fitted to DAF Euro 5 type vehicles and can only be retro-fitted to DAF Euro 6 type vehicles at present.”

[510] It was not suggested by anyone in the Inquiry that to have fitted AEBS was a reasonable precaution in terms of section 6 (1) (c) and the terms of paras 31 and 32 of the seventh joint minute would preclude any such determination. That does not prevent me from making a recommendation and I broadly agree with the Solicitor General's sixth proposal.

[511] Whilst the observation made on behalf of the DfT and quoted above at para 501 does not offer much cause for optimism as to the efficacy of the Solicitor General's

seventh proposal, it does not impose much of a burden and it is possible that some manufacturers may be able to offer a viable retrofit.

[512] For these reasons, I recommend that:

- Local Authorities and any other organisations which collect refuse, when sourcing and purchasing refuse collection vehicles which are large goods vehicles, should seek to have AEBS fitted to those vehicles wherever it is reasonably practicable to do so. (5.6)
- Local Authorities and any other organisations which collect refuse, and which currently have large goods vehicles without AEBS but to which AEBS could be retrofitted, should explore the possibility of retrofitting with the respective manufacturer. (5.7)

Collection routes and risk assessment

[513] In his submissions, Mr Gray for GCC accepted the following propositions in law to apply:

- All employers have a general duty under Section 2 of the Health and Safety at Work Act 1974 to ensure, so far as reasonably practicable, the health, safety and welfare at work of their employees.
- All employers have a general duty under Section 3 of the Health and Safety at Work Act to conduct their undertaking in such a way so as to ensure, insofar as is reasonably practicable, that members of the public who may be affected are not exposed to a risk to their health or safety.
- In order for employers to fulfil their statutory obligations, employers are required by Regulation 3 of The Management of Health and Safety at Work Regulations of 1999 to undertake a suitable and sufficient risk assessment of the hazards which may arise in the course of their undertaking with a view to identifying and implementing adequate control measures to reduce or eliminate the risks which have been identified.

[514] In preparation for the Inquiry, the Procurator Fiscal had instructed Mr Barry Baker, a Principal Inspector with the Health and Safety Executive (HSE) to give his opinion on certain issues relating to GCC's refuse collection risk assessment. He had prepared a report and gave opinion evidence in the Inquiry.

[515] Mr Baker explained generally that the regulatory regime distinguishes between the refuse collection activity itself, which is subject to health and safety legislation,

and driving from depot to collection point, between collection points and returning to depot which is not. The regulatory framework there comprises the Road Traffic Acts, construction and use legislation relating to the condition of vehicles and the driver licensing regime operated by DVLA which seeks to ensure the health and competence of drivers. Commercial drivers of buses and large goods vehicles must also possess a Certificate of Professional Competence (CPC). A driver must undergo 35 hours of training to achieve the CPC and must then perform a further 35 hours over the next 5 years to retain it. GCC also provided in-house training for drivers at its training centre.

[516] HSE publishes advice on the process of refuse collection, which it recognises as a hazardous activity, particularly for operatives. Mr Baker explained that a bin lorry reversing towards collection points is recognised to present a significant hazard to members of the public and detailed and prescriptive guidance and training is intended to address that issue. Another significant hazard for both crew and members of the public is presented by the operation of the machinery at the rear of the bin lorry and there is an emergency shut off button both at the external rear of the vehicle and in the driver's cab.

[517] Extensive reference was made in the Inquiry to HSE Waste 23 "Safe waste and recycling collection services" and some reference was made to HSE Waste 04 "Waste and recycling vehicles in street collection."

HSE Waste 23 suggests that risk assessment:

"... should be about identifying and taking sensible and proportionate measures to control the risks in your workplace, not creating huge amounts of paperwork."

HSE Waste 04 suggests that operators should:

“Make collections, so far as is reasonably practicable, at suitable times to reduce risks to crews and the public. Examples include:

- collect at less busy times or before traffic builds up on major roads
- avoid shopping areas during opening hours
- avoid school start and finish times
- ...”

[518] The guidance explains that defining prescriptive rules is unlikely to be effective, but suggests that hazards can be identified and risks assessed so as to reduce the risk of injury. Examples of route hazards are identified and include, “high-risk pedestrianised areas (e.g. schools)” and school holidays are identified as an occasional hazard. It is suggested that good route planning between collection points is important.

[519] Mr Baker explained that “the focus of both sets of guidance in terms of route assessment is to assist a duty holder to carry out a suitable assessment of the collection vehicle and collection activity and not general road safety.” Mr Ward agreed.

[520] Drivers and crew should be able to identify hazards and take appropriate action as they encounter new circumstances and unplanned/unknown hazards. Mr Baker referred to this as “dynamic risk assessment.”

[521] The Inquiry heard from a number of employees about the approach which GCC took to risk assessment in relation to refuse collection services. In the course of his evidence, Mr Quigley said that:

“You take in the pedestrian risk at all points of your route... it's a busy city centre and you have a lot of people rushing about trying to get to wherever they're going...a lot of people are walking about ... looking [at] their phones, and you have [to] try and anticipate where they're going to walk out in front of you at a green light when it's okay for you to go, or even just run across the road to get to where they're going. That happens [on] numerous occasions every day...

You're trained as a driver through your HGV training and you take that into your job. Plus, if you've done the risk assessment, you've wrote the risk assessment, you know. You don't really need to look at a risk assessment to realise what it's like, maybe, in Sauchiehall Street and places like that where it's full of people. You have to just take it as part of your day that you have to be very, very observant."

[522] Whilst GCC did not carry out seasonal route risk assessments or for particular events so far as the driving in between collection points was concerned, Mr Quigley explained that information about special events is generally shared on an *ad hoc* basis. Robert Soutar said that supervisors would tell the drivers if there was an event on. If the crew learned of spontaneous developments such as pop-up events they would report back and a supervisor would go out and make an assessment of the area.

[523] I accept the evidence of Mr Gellan to the effect that from 2011, GCC embarked upon a programme over a period of 18 months in which it undertook a generic risk assessment concerning its cleansing operations. It sought to identify hazards and to identify appropriate control measures with a view to reducing the risks identified insofar as that was reasonably practicable.

[524] Mr Gellan chaired a group which met weekly over that period and which comprised appropriate personnel including an employee with expertise in health and safety matters, a risk assessor, a training officer, a driver and a crew member. Regard was had to HSE Waste 23 and HSE Waste 04. This process culminated in the preparation of a substantial document headed:

"Land and Environmental Services, Glasgow City Council, Risk Assessment Documentation, subject area of assessment: Cleansing operations (Driver, Operator, Temporary Worker) for Domestic, bulk, managed weekly collections, commercial, glass refuse collection."

[525] It featured as production 52. It is set out in a systematic manner so as to record the identification of hazards, the potential scope of injury, those at risk, current preventative and protective measures, a risk rating and any further action which was required. Section 2 (f), against which no further action was noted as being required, was in the following terms:

Hazard description	Potential injury/damage	Persons at risk	Current preventative and protective measures	Risk rating
Travelling to and from site on public highway-Road traffic incident, Collision with other vehicles overhead obstructions and pedestrians.	Sprains, strains Cuts bruises, Fractures, Fatalities, head injuries	Employees Temporary Workers, MOP	HSPA 29 Transport Safety Driver training(DT1, DT2) Seatbelts provided, Seatbelt Extension provided where Required. Monitoring by supervisor/crew. Driver licence inspections (DM2) Purchasing programme, vehicle machinery assessment groups. Regular maintenance. Daily vehicle inspections, log sheet and defect reporting. Council Accident Reduction Scheme (CARS) Refuse Collection Vehicle Training (RCV1) One day H&S Refuse Collection Training Course (SG18). Route Specific Risk Assessments for all routes.	Tolerable

[526] Mr Gellan said that in or after 2011, HSE had examined and considered satisfactory the way in which GCC was developing route risk assessment.

[527] The route risk assessment relating to the route driven by Mr Clarke on 22 December 2014 was production 78, "Route Risk Assessment Documentation: refuse collection operations: Mon Route 2." Mr Baker said that it is typical of what the HSE

sees and it adequately addresses issues that should be covered in a route risk assessment.

[528] Mr Gellan explained that in order to prepare a route risk assessment, the route would be driven by a driver and a supervisor with risk assessment training to visit the collection points and identify hazards. The route risk assessment was available in the depot for staff to look at, but in practice the information was cascaded down through the supervisors, who would have been involved in initially assessing the route. On a daily basis, supervisors would be out walking and driving the routes to monitor crews and ensure that they were performing their function adequately and that they were complying with health and safety requirements.

[529] Production 78 records that the collection points include West Regent Street, Hope Street, Bath Street, Wellington Street, St Vincent [Street], Waterloo Street, Argyle Street, Renfield Street and Killermont Street.

[530] Most of the collection points are situated in busy streets where there will ordinarily be many pedestrians using the pavements at most times of the day and most potential routes between them will involve passage along streets which are busy with traffic and pedestrians.

[531] On the afternoon of 22 December, the bin lorry had had to do a collection at Mitchell Street which had not been accessible in the morning. Thereafter, the next collection was from St Vincent Street. Travelling along Argyle Street and up Queen Street and turning left into St Vincent Place, leading onto St Vincent Street, was the most direct route between these points. Mr Quigley thought that it was the only possible route given the presence of one way systems in the city centre but he was not necessarily correct about that. Mr Gellan accepted that there are other routes by

which St Vincent Street could be reached from Argyle Street, but they would still have involved streets which tend to be reasonably well populated with pedestrians.

[532] Alternative routes along those reasonably busy streets would be significantly longer, prolonging the potential risk to members of the public, even if at some points there might be fewer of them.

[533] It is relevant to note that despite much questioning of witnesses about George Square and the Christmas carnival, but for the loss of control the lorry would not have been on George Square, it would have turned away from its south west corner at the Queen Street/St Vincent Place junction.

[534] Comparisons were made with NLC's approach to route risk assessment with reference to production 164 which is a substantial set of documents compiled in relation to policy and risk assessment for waste collection. Kenneth Wilson gave some evidence about it and it was also commented on by Mr Baker and Mr Ward. Mr Wilson explained that every street in North Lanarkshire is subject to individual street risk assessment using a standard form (page 187 of production 164) which would enumerate the range of risks at different road speeds, traffic flow rates, spacing and parked vehicles. A grid identified nine hazards which should be considered: schools, play areas, blind bends, poor visibility, markets, steep inclines, adverse camber, concealed entrances and aged person facilities. At page 189 of production 164 there was a table of hazards associated with effects of pedestrians and man-made obstructions which specify amongst others: schools/play areas/community centres; shopping centres/markets traders. The form invites consideration of whether activity around schools/play areas and community centres

are changeable in school holidays or permanent. NLC uses a standard risk matrix with a view to evaluating risk consistently.

[535] Mr Baker had not examined all of the underlying documentation referred to in production 52, GCC's "generic risk assessment" for refuse collection, but he gave his overview of what could be gleaned from it in the light of his relevant experience and consideration of relevant witness statements.

[536] In summary, Mr Baker's view was that GCC had, "taken a sensible and informed approach to the process of risk assessment" and had "identified the risks that are considered appropriate to the business of waste collection." The use of a risk matrix was one method of carrying out risk assessment, but it is not the only method, nor necessarily the best method, of assessing risk.

[537] Mr Baker was complimentary about production 164, but he did not consider that it was necessarily superior to the way in which GCC had assessed risk. He was satisfied that GCC had complied with the law, but he recognised that a council may choose to identify and implement standards above the minimum required by law.

[538] He summed up his view as to the most effective protective measure in this way:

"The primary thing, I would have thought, would be to prevent it happening, not to mitigate the consequences when it did happen, and I would imagine that [local authorities] will look at the guidance that's available in terms of their duties under medical fitness to drive and general road safety."

Mr Baker was referred to "Medical Fitness to Operate Construction Plant Good

Practice Guide,³⁶ published in February 2013 and available online. Its recommended

³⁶ Para 8.4: "It is therefore recommended that full re-assessment of fitness for people operating plant is set at a fixed periodic review, after first assessment, of three years, unless otherwise advised by the OHSP. Reassessment of fitness for people operating plant with any substantial change in medical circumstances is also recommended. Such an assessment need only address the specific change in those medical circumstances, with full re-assessment when next scheduled. It is also helpful for employees to

regime of regular health checks was considered by Mr Baker to exceed what is required by law but, once again, he acknowledged that organisations may reasonably choose to exceed the legal minimum.

Submissions

[539] The Solicitor General proposed that I should recommend that:

“(9) Local Authorities should, if they have not already done so, consider the introduction of risk assessments of roads between waste collection points, and to and from the start of waste collection routes, to supplement their existing risk assessments of the collection points themselves.

(10) Local Authorities should carry out a risk assessment when there are higher than anticipated numbers of pedestrians anticipated to be in a location (whether that be due to the day or the time of day or special event or seasonal variations) to establish whether refuse trucks should continue to operate at the usual frequency; usual time of day or on the usual route at and near to the location.”

[540] Mr Stewart submitted that GCC’s risk assessment had been inadequate. In particular, he criticised the absence from the generic risk assessment of a discrete identification of the risk to members of the public of a driver becoming ill whilst driving in the city centre and a failure to identify suitable control measures in that regard. The Monday route 2 route risk assessment was little more than a list of hazards at collection points and not all of the streets on the route were subject to risk assessment. That could feasibly be undertaken.

[541] Sweeney/McQuade production 7 was an example of First carrying out what Mr Stewart contended were road specific risk assessments which he commended. It and NLC’s approach to route risk assessment should be seen as best practice.

fill in a self-declaration questionnaire every year. These should be reviewed by a competent person and any concerns raised with the OHSP.”

[542] Whilst Mr Gellan had thought that production 78 was assessing risks on the routes between collection points as well as actual collection, Mr Baker and Mr Ward were united in considering that its scope was limited to activity at collection points. Counsel for GCC accepted that they were correct about that. To be fair to Mr Gellan, he had explained that the route risk assessment was primarily concerned with collection points.

[543] Without being unduly specific, Mr Stewart went on to submit that I should make a determination both in terms of section 6 (1) (c) and section 6 (1) (d) on the basis of the “totality of inadequacies” which he alleged in relation to GCC’s assessment and management of risks posed by refuse collection in the city centre but for which the deaths *might* have been avoided. The latter suggestion falls to be rejected because Mr Stewart was addressing me on an analysis which could go no further than a finding under section 6 (1) (c).

[544] Mr Gray conceded that the possibility of a driver falling ill at the wheel was not specifically considered in the generic risk assessment, but he pointed out that employees were aware that if a driver did fall ill they would either call emergency services or their depot. That, submitted Mr Gray, was all that could reasonably be done and therefore all that could have been identified in any specific risk assessment. Mr Gray referred to the evidence of Mr Hill, Mr Balderstone and Mr Baker and submitted that it was neither reasonable nor practicable to provide training for this eventuality.

Assessment

[545] On that issue I agree with Mr Gray. I accept the evidence of Mr Hill and Mr

Baker that they were not able to discover any training as to what a passenger should do in the event of driver collapse. Given the complex combination of thought processes which any crew member would have to perform within a second or two before making any decision which, if it was to apply the secondary brake, could make matters worse, against the background of the human factors spoken of by Mr Hill, I am not persuaded that it would be reasonably practicable to provide training to crew beyond familiarisation with the vehicle controls. I am not persuaded that such familiarisation would have ameliorated the situation on 22 December, but the Croftside Avenue incident in April 2015 demonstrates its benefit in other circumstances which can arise.

[546] GCC's control measure in relation to the risks presented by their bin lorries moving between collection points was primarily the employment of qualified and competent drivers. Mr Baker explained that there is an acceptance that the roads on which collection vehicles will move constitute an unpredictable and variable environment. It is almost inevitable that route changes will be required on occasion, and HSE guidance outlines the need for drivers and collection staff to have the ability and authority to react to changing conditions, taking action to ensure the health and safety of themselves and others.

[547] I accept his evidence about that and conclude that it would not be reasonably practicable or even useful to send out a route assessor each day to assess the route not least because by the time the bin lorry goes out, conditions may well have changed. The risk presented by other vehicles and pedestrians is addressed by driving qualifications which are reinforced for drivers who require the CPC.

[548] As it happens, the Monday route 2 risk assessment exhorts drivers to watch out for pedestrians and cars at each of the 23 listed collection points as any driver must at all times anyway.

[549] The First risk assessment, insofar as it relates to actual hazards on the roads, appears to be concerned with permanent features such as low bridges, roundabouts and awkward junctions. It does not directly address any issue of increased pedestrian traffic at particular times of the day or the year.

[550] Mr Baker's view was that if drivers are properly trained in the hazard presented by pedestrians, that is sufficient so that it is not necessary to carry out specific seasonal assessments for a higher volume of people. A number of GCC staff suggested that the city centre is always busy with pedestrians and that it is not necessarily materially busier during the Christmas season.

[551] 22 December 2014 fell in school holiday time. There was a Christmas carnival featuring an ice rink and funfair on George Square and Christmas shopping could be expected to bring increased footfall to the city centre. This does seem to be a time of increased potential hazard.

[552] However, this accident and what followed was not caused by excited children running in front of a bin lorry on the roadway, it was caused by a driver fainting and his vehicle moving onto the pavement and striking pedestrians there. It is not possible to say, on the evidence, that fewer people would have been killed or injured had this event taken place in some other month.

[553] Whilst it was suggested to witnesses that Edinburgh City Council had a policy of avoiding collecting in the city centre during the daytime, and there was some evidence from Mr Ward that that may be the case in the parts of the old town most

frequented by tourists, it was ultimately proved in para 33 of the seventh joint minute that it:

“... recently introduced "Time Windows" specifically to Edinburgh city centre locations. The specific times for collection in [the] city centre are 0930 to 1200 hours, 1400 hours to 1600 hours. These times operate seven days per week and are applicable to all waste contractors.”

Those times would plainly include 2.29pm when the accident happened in Glasgow.

[554] Both Mr Baker and Mr Ward identified that there could be different risks to be negotiated if city centre collection was to take place at night. The different pedestrian mix which would include people who have been drinking, the effect of darkness on the visibility of pedestrians and the effects on crew of night time working would all require careful consideration and management. It has not been demonstrated in the Inquiry that it would necessarily be safer to carry out collections at night.

[555] It is difficult to identify times when the centre of Glasgow is not busy with people although there may be relatively quieter times during the day and GCC takes account of that in determining when vehicles can be driven along pedestrian precincts.

[556] Whilst suggestions were made that other streets in the centre of Glasgow may carry fewer pedestrians than Queen Street, I am not persuaded that there are any streets down which motor vehicles can travel in the city centre where there would not be significant numbers of pedestrians on the pavements. Had a different route been chosen, then Mr Clarke would still have fainted and the likelihood is that people would still have been killed and injured, different people in a different place.

[557] For these reasons, I am not persuaded that it has been shown that it would have been a reasonable precaution which might have avoided the causing of an accident

and deaths to have required the bin lorry to use a different route at a different time.

Nor am I able to identify cumulative failures which would give rise to a

determination under section 6 (1) (c) as Mr Stewart invited me to do. Nevertheless,

the events of 22 December demonstrate that if a bin lorry loses control, then the

potential for injury and death is substantial.

[558] Perhaps routes can be identified which may minimise the numbers of people at

risk without unduly prolonging the potential risk. Perhaps collection times could be

adjusted when required to take account of exceptional numbers of pedestrians being

present at particular locations, e.g. at the time of a funfair, concert or demonstration

in, for example, George Square and its surrounding area. Such measures may have

some potential to reduce the extent of the harm which an accident may cause. Whilst

there was some mention of North Lanarkshire in particular, Edinburgh and

Shetland, there was no full examination of the locations where refuse collection is

carried out in those areas.

[559] Mr Gellan envisaged that GCC would review and reconsider its choice of city

centre refuse collection routes and times to establish if beneficial changes could be

made. Nevertheless, I will make recommendations, if not quite in the terms proposed

by parties. In recommendation 5.8 I refer only to GCC because the nature of the area

in which collection takes place will vary widely between different local authorities,

but it is open to other organisations to give consideration to it.

- I recommend that GCC should seek to identify routes between collection points which, so far as reasonably practicable, minimise the number of people who would be at risk should control be lost of a refuse collection lorry. (5.8)
- I recommend that the potential for the presence of exceptional numbers of pedestrians at particular times should be taken account of as part of route risk assessment in refuse collection. (5.9)

Concluding remarks

[560] On 22 December 2014 six people died and seventeen were injured when the driver of a bin lorry fainted and lost control in Queen Street in the centre of Glasgow.

[561] The most effective measure to prevent such an occurrence would be to seek to avoid drivers becoming incapacitated at the wheel. Responsibility in that regard lies with drivers themselves and DVLA.

[562] It may well be that the single most useful outcome of this Inquiry would be to raise awareness of the dangers involved in driving if subject to a medical condition which could cause the driver to lose control of a vehicle. Media outlets reporting on the issuing of this Determination would be performing a valuable service to the public if they include the following information in their reporting:

Guidance, including a list of relevant conditions, can be found on the DVLA website: www.gov.uk/driving-medical-conditions. Drivers can contact DVLA if they are not sure what to do. They can consult their doctor if they are in doubt or if they are in need of advice.

I reproduce in appendix 10 the list of medical conditions for which there is advice on the DVLA website as to their implications for driving and notification.

[563] DVLA's task is complex and difficult and it must act within the statutory framework created by Parliament. I have accepted that there was no reasonable precaution which might have been taken by DVLA which might have prevented the events of December 2014.

[564] Nevertheless, Dr Parry, DVLA's Senior Medical Adviser, acknowledged that there are weaknesses in the current system of self-reporting. What happened in this case demonstrates how the group 2 licensing scheme can be circumvented by

determined deception. Lack of awareness and the difficulty in interpreting guidance could also permit the presence of unfit drivers on the road.

[565] Even if Parliament decides to make changes to the means by which DVLA establishes fitness to drive, consultation and changes to legislation could take years. In the meantime, GCC and other employers of those who drive large vehicles may wish to consider if they can implement effective measures to ensure that, so far as is reasonably practicable, their drivers are fit to drive on appointment and remain so. They may choose to seek independent confirmation from GPs of the accuracy of what successful applicants for employment as group 2 drivers tell them. This in turn would increase the burden on GPs and might involve duplication, particularly if DVLA also comes to require such confirmation by one means or another. If a system can be devised through which DVLA is able to ensure with greater certainty that licensed drivers are fit to drive, some duplication may be avoided.

[566] From the age of 45, a group 2 licence only has to be renewed every five years and much could change in a driver's state of health in that time. Employers ought to be alert to that. Annual medicals of the kind contemplated by NLC would not have identified that Mr Clarke was going to faint on 22 December 2014, but might identify relevant conditions in some cases.

[567] Technological advances may come to offer the most effective remedial measures to reduce harm when a driver suffers incapacitation from any cause. In the future, if the type of pedestrian protection system which can detect pedestrians, and which is available on some cars, could be deployed on large vehicles, that would provide a more reliable protection for pedestrians than AEBS. Again, looking to the future, it is possible that some form of "facial recognition" technology could be

integrated with AEBS. In the meantime, AEBS offers at least some prospect of reducing the harm which may be caused when control of a large vehicle is lost.

[568] It may be that the extent of the harm which may be caused by a large goods vehicle, such as a bin lorry, losing control can be reduced further by careful route risk assessment, although there is a limit to what that can achieve and much will continue to rest with the health and competence of drivers.

[569] If all or even some of my Recommendations are followed then, whilst the risks presented by large vehicles can never be eliminated, they may be reduced. That must surely be a worthwhile objective. The events of 22 December 2014 demonstrate quite how real those risks are. The Inquiry was shown a short compilation film of the passage of the bin lorry from when it went out of control until it came to a halt by crashing into a building. No one who saw that film will ever forget the horror of the dreadful events recorded.

[570] Following the collisions with pedestrians, the instant reaction of members of the Glasgow public was to offer comfort and assistance to the injured and to preserve the dignity of those who had died. These extraordinary events presented the emergency services with an extremely difficult challenge which they did their utmost to meet. Of the many members of the public and professionals who responded, the Inquiry heard evidence only from an off-duty nurse, Lauren Mykoliw, and an ambulance paramedic, Ronald Hewitson, but I pay tribute to the compassion and skill of all of those concerned in the aftermath.

[571] The Inquiry heard of the serious injuries sustained by Alix Stewart, Irene McAuley, Marie Weatherall and Elaine Morrell with life changing consequences for them. I hope that they are able to continue their recovery and I express my

admiration for the courage they have shown in facing up to what has befallen them. I express sympathy to all those who were injured and traumatised by these terrible events.

[572] The whole country was deeply shocked by what happened on 22 December 2014, but for the families of six people who died, the consequences extend beyond shock to the pain of permanent loss. As it neared its conclusion, the Inquiry heard some detail of just how important and valuable those six people were to their families, their friends and the wider community.

[573] It cannot have been easy to listen to the evidence, but many relatives of those who died steadfastly attended the Inquiry demonstrating their love, loyalty and commitment for those they have lost. I am aware that others chose to keep in touch with the progress of the Inquiry in other ways and I can understand why they would do that.

[574] Relatives in court managed to maintain composure, dignity and respect in circumstances which must at times have been very difficult indeed. I pay tribute to the way that they conducted themselves throughout the Inquiry.

[575] Finally, I record my personal expression of sympathy to the families and friends of,

John Kerr Sweeney,

Lorraine Sweeney,

Erin Paula McQuade,

Stephenie Catherine Tait,

Gillian Margaret Ewing,

and Jacqueline Morton

and offer condolences on behalf of Glasgow Sheriff Court and everyone involved in the Inquiry.

APPENDIX 1 – LIST OF WITNESSES WHO GAVE EVIDENCE

1. Mathew Telford, passenger.
2. Henry Toal, passenger.
3. Alan Kernaghan, acting supervisor who issued lorry keys to Mr Clarke.
4. Ian Quigley, a council bin-lorry driver who saw Mr Clarke at lunch on 22 December 2015 between 1115 and 1145 am.
5. John Stewart, Inspector with First Glasgow.
6. Philip Balderston, an expert witness who spoke to his report, production 3.
7. Andrew Wilson, who described a bin lorry driver being involved in a “road rage” incident on Cowcaddens Road on 22 December. It was not established that this involved Mr Clarke’s lorry and even if it did, it would not have had any bearing on an episode of neurocardiogenic syncope occurring 30-60 minutes later.
8. Lauren Mykoliw, an off duty nurse who assisted a taxi driver and then Henry Clarke and spoke to him at the scene.
9. Ronald Hewitson, an ambulance paramedic who assisted a taxi driver and then Henry Clarke and spoke to him.
10. Robert Soutar, manager of Anderson Depot.
11. Rae Robertson, a bin lorry crewman who knew Henry Clarke.
12. Mark Hill, an expert witness who spoke to his report, production 153.
13. Douglas Gellan, area manager for GCC Land and Environmental Services.
14. Geraldine Ham, strategic HR manager for GCC Land and Environmental Services.
15. Dr Gerard McKaig, of Mr Clarke’s GP practice.
16. Dr Kenneth Lyons, OH doctor for First Glasgow.
17. Dr John Langan, of Mr Clarke’s GP practice.
18. Dr Joanne Willox, an OH doctor providing services to GCC.
19. Professor Andrew Rankin, cardiologist.
20. Dr Ronald Neville, a GP who had reviewed for the Procurator Fiscal the records of Mr Clarke’s interactions with Dr McKaig, Dr Lyons, Dr Langan and Dr Willox.
21. Dr Daniel Rutherford, a former GP who had reviewed for the Morton family Mr Clarke’s medical history and the records of Mr Clarke’s interactions with Dr McKaig, Dr Lyons, Dr Langan and Dr Willox.
22. Dr John Paul Leach, a neurologist who treated Mr Clarke and obtained information from him.
23. Dr Gareth Wyn Parry, Medical Adviser to the DVLA since 2014.
24. Francis McCann, a manager at First Glasgow who had dealings with Mr Clarke.
25. Dr Nicholas Boon, a cardiologist who reviewed Mr Clarke’s medical history for the Morton Family.
26. Ian Buick, a former manager at GCC who interviewed Mr Clarke in 2010 and was involved in recruiting him as a driver for GCC.
27. Barry Baker, a Chief Inspector with the HSE who had prepared production 161 and gave opinion evidence.

28. Kenneth Wilson, head of Environment and Land Services at NLC.
29. Nicholas Ward, who had prepared production 5 for the Sweeney and McQuade families and offered opinion evidence on matters of health and safety.
30. Henry Campbell Clarke.
31. Robert Donnelly, formerly of First Glasgow

APPENDIX 2 – CERTAIN LEGISLATION RELEVANT TO DVLA

[6] The Motor Vehicles (Driving Licences) Regulations 1999 provide *inter alia*:

10. Applications for the grant of licenses: general

(1) The Secretary of State may consider an application for the grant of a licence before the date on which the grant of the licence is to take effect if the application is received by him—

(a) in the case of an application for a Group 2 licence, during the period of three months ending on that date,

(b) in any other case, during the period of two months ending on that date, and may during such period grant the licence so that it takes effect on that date...

(5) An applicant for a Group 2 licence shall, if required to do so by the Secretary of State, submit in support of his application a report (in such form as the Secretary of State may require) signed by a qualified medical practitioner, prepared and dated not more than four months prior to the date on which the licence is to take effect, for the purpose of satisfying the Secretary of State that he is not suffering from a relevant or prospective disability."

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

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

(b) severe mental disorder;

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

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

74. Disabilities requiring medical investigation: High Risk Offenders

(1) Subject to paragraph (2), the circumstances prescribed for the purposes of subsection (5) of section 94 of the [Road] Traffic Act, under subsection (4) of that section, are that the person who is an applicant for, or holder of, a licence—

(a) has been disqualified by an order of a court by reason that the proportion of alcohol in his body equalled or exceeded—

(i) 87.5 microgrammes per 100 millilitres of breath, or

(ii) 200 milligrammes per 100 millilitres of blood, or

- (iii) 267.5 milligrammes per 100 millilitres of urine;
- (b) has been disqualified by order of a court by reason that he has failed, without reasonable excuse, to provide a specimen when required to do so pursuant to section 7 of the Traffic Act;
- (bb) has been disqualified by order of a court by reason of failure, without reasonable excuse, to give permission for a laboratory test of a specimen of blood taken pursuant to section 7A of the Traffic Act; or
- (c) has been disqualified by order of a court on two or more occasions within any period of 10 years by reason that—
 - (i) the proportion of alcohol in his breath, blood or urine exceeded the limit prescribed by virtue of section 5 of the Traffic Act, or
 - (ii) he was unfit to drive through drink contrary to section 4 of that Act...

The Road Traffic Act 1988 includes the following provisions:

92. Requirements as to physical fitness of drivers.

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

(2) In this Part of this Act

“disability” includes disease and the persistent misuse of drugs or alcohol, whether or not such misuse amounts to dependency],

“relevant disability” in relation to any person means —

(a) any prescribed disability, and

(b) any other disability likely to cause the driving of a vehicle by him in pursuance of a licence to be a source of danger to the public, and

“prospective disability” in relation to any person means any other disability which—

(a) at the time of the application for the grant of a licence or, as the case may be, the material time for the purposes of the provision in which the expression is used, is not of such a kind that it is a relevant disability, but

(b) by virtue of the intermittent or progressive nature of the disability or otherwise, may become a relevant disability in course of time.

(3) If it appears from the applicant's declaration, or if on inquiry the Secretary of State is satisfied from other information, that the applicant is suffering from a relevant disability, the Secretary of State must, subject to the following provisions of this section, refuse to grant the licence...”

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

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

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

(b) that a relevant or prospective disability from which he has at any time suffered (and which has been previously so disclosed) has become more acute since the licence was granted,

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

(2) The licence holder is not required to notify the Secretary of State under subsection (1) above if

(a) the disability is one from which he has not previously suffered, and

(b) he has reasonable grounds for believing that the duration of the disability will not extend beyond the period of three months beginning with the date on which he first becomes aware that he suffers from it.

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

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

(4) If the prescribed circumstances obtain in relation to a person who is an applicant for, or the holder of, a licence or if the Secretary of State has reasonable grounds for believing that a person who is an applicant for, or the holder of, a licence may be suffering from a relevant or prospective disability, subsection (5) below applies for the purpose of enabling the Secretary of State to satisfy himself whether or not that person may be suffering from that or any other relevant or prospective disability.

(5) The Secretary of State may by notice in writing served on the applicant or holder—

(a) require him to provide the Secretary of State, within such reasonable time as may be specified in the notice, with such an authorisation as is mentioned in subsection (6) below, or

(b) require him, as soon as practicable, to arrange to submit himself for examination—

(i) by such registered medical practitioner or practitioners as may be nominated by the Secretary of State, or

(ii) with respect to a disability of a prescribed description, by such officer of the Secretary of State as may be so nominated,

for the purpose of determining whether or not he suffers or has at any time suffered from a relevant or prospective disability, or

(c) except where the application is for, or the licence held is, a provisional licence, require him to submit himself for such a test of competence to drive as the Secretary of State directs in the notice.

(6) The authorisation referred to in subsection (5)(a) above—

(a) shall be in such form and contain such particulars as may be specified in the notice by which it is required to be provided, and

(b) shall authorise any registered medical practitioner who may at any time have given medical advice or attention to the applicant or licence holder concerned to release to the Secretary of State any information which he may have, or which may be available to him, with respect to the question whether, and if so to what extent, the applicant or licence holder concerned may be suffering, or may at any time have suffered, from a relevant or prospective disability.”

108. Interpretation.

(1) In this Part of this Act...

...“prescribed” means prescribed by regulations...

99. Duration of licences.

(1) In so far as a licence authorises its holder to drive motor vehicles of classes other than any prescribed class of goods vehicle or any prescribed class of passenger-carrying vehicle, it shall, unless previously revoked or surrendered, remain in force, subject to subsection (2) below —

(a) except in a case falling within paragraph (b) or (c) of this subsection, for the period ending on the seventieth anniversary of the applicant's date of birth or for a period of three years, whichever is the longer...

(b) except in a case falling within paragraph (c) of this subsection, if the Secretary of State so determines in the case of a licence to be granted to a person appearing to him to be suffering from a relevant or prospective disability, for such period as the Secretary of State may determine...

(1A) In so far as a licence authorises its holder to drive any prescribed class of goods vehicle or passenger-carrying vehicle, it shall, unless previously revoked, suspended or surrendered, remain in force —

(a) except in a case falling within paragraph (c) or (d) of this subsection —

(i) for the period ending on the forty-fifth anniversary of the applicant's date of birth or for a period of five years, whichever is the longer, or

(ii) where the applicant's age at the date on which the licence is to come into force will exceed forty-five but not sixty-five years, for the period ending on the sixty-sixth anniversary of the applicant's date of birth or for a period of five years, whichever is the shorter,

(b) except in a case falling within paragraph (d) of this subsection, where the applicant's age at that date will exceed sixty-five years, for a period of one year,

(c) except in a case falling within paragraph (b) or (d) of this subsection, if the Secretary of State so determines in the case of a licence to be granted to a person appearing to him to be suffering from a relevant or prospective disability, for such period of not more than three years and not less than one year as the Secretary of State may determine...

...and any such period shall begin with the date on which the licence in question is expressed to come into force.”

174.— False statements and withholding material information.

(1) A person who knowingly makes a false statement for the purpose —

(a) of obtaining the grant of a licence under any Part of this Act to himself or any other person, or

(b) of preventing the grant of any such licence, or

(c) of procuring the imposition of a condition or limitation in relation to any such licence, or

(ca) of obtaining a document evidencing the successful completion of a driver training course provided in accordance with regulations under section 99ZA of this Act, or

(d) of securing the entry or retention of the name of any person in the register of approved instructors maintained under Part V of this Act, or

(dd) of obtaining the grant to any person of a certificate under section 133A of this Act, or

(e) of obtaining the grant of an international road haulage permit to himself or any other person,

is guilty of an offence.

(2) A person who, in supplying information or producing documents for the purposes either of sections 53 to 60 and 63 of this Act or of regulations made under sections 49 to 51, 61, 62 and 66(3) of this Act—

(a) makes a statement which he knows to be false in a material particular or recklessly makes a statement which is false in a material particular, or

(b) produces, provides, sends or otherwise makes use of a document which he knows to be false in a material particular or recklessly produces, provides, sends or otherwise makes use of a document which is false in a material particular,

is guilty of an offence.

(3) A person who—

(a) knowingly produces false evidence for the purposes of regulations under section 66(1) of this Act, or

(b) knowingly makes a false statement in a declaration required to be made by the regulations,

is guilty of an offence.

(4) A person who—

(a) wilfully makes a false entry in any record required to be made or kept by regulations under section 74 of this Act, or

(b) with intent to deceive, makes use of any such entry which he knows to be false,

is guilty of an offence.

(5) A person who makes a false statement or withholds any material information for the purpose of obtaining the issue—

(a) of a certificate of insurance or certificate of security under Part VI of this Act, or

(b) of any document issued under regulations made by the Secretary of State in pursuance of his power under section 165(2)(a) of this Act to prescribe evidence which may be produced in lieu of a certificate of insurance or a certificate of security,

is guilty of an offence.

APPENDIX 3 – DAMAGE TO THE BIN LORRY

The following facts were proved in the first joint minute.

The damage to the bin lorry as a result of the incident was as follows:

- (i) There was major impact damage at the front offside corner pushing the bumper bar rearwards and surrounding components were damaged including the steering box, brake foot valve, brake distribution valve and the cab suspension mounts.
- (ii) The entire cab unit was pushed rearwards on its mountings crushing the vertical exhaust stack between the cab and the refuse collector body.
- (iii) The offside upper cab step was pushed rearwards and the offside lower step was detached and missing.
- (iv) There was a vertical crease from the impact to the offside extending the full height of the cab from bumper bar through the windscreen (smashed) to top of cab.
- (v) There were two cloth prints on the green horizontal grille at the front of the vehicle.
- (vi) Both headlight units were destroyed.
- (vii) There was further major impact damage at the front nearside corner of the cab damaging various components. The upper nearside step was pushed rearwards and the lower step was detached and missing.
- (viii) There were yellow and silver scuff marks on the front of the cab, 1.2 metres above ground level. Semi-circular dents on the bumper bar below the yellow scuffing.
- (ix) The front grille was extensively damaged and the windscreen wipers were dislodged.
- (x) The front nearside wheel mounting studs were scuffed and ground down. Stone dust was trapped between the nuts and studs.

APPENDIX 4 – TREATMENT OF MR CLARKE AFTER 22 DECEMBER 2014

The following facts were proved in a section of the third joint minute which is reproduced below:

6. At 2004 hours on the 22nd of December 2014, a sample of Henry Clarke's blood was obtained by police officers and forwarded for toxicological analysis on the 29th of December 2014. That analysis was completed by the 14th of January 2015 and identified that his blood was negative for alcohol, over the counter and prescription medication, drugs of abuse and a range of new psychoactive substances.

7. Between the 22nd of December 2014 and the 5th of January 2015, Henry Clarke was admitted as an in-patient at the Western Infirmary Hospital, Glasgow. During that period he was examined and/or assessed by a number of doctors, including Dr Elizabeth Clarke, a General Medical Registrar; Dr Malcolm Shepherd, a Consultant Physician; Dr Marie Freel, a Consultant Physician; Dr John Paul Leach, a Consultant Neurologist and Dr Roy Gardner, a Consultant Cardiologist.

8. During the course of his admission at the Western Infirmary Hospital, Glasgow Henry Clarke underwent the following procedures:

(i) A Computerised Tomography (CT) scan of his brain, chest, abdomen and pelvis on the 22nd of December 2014.

(ii) A Magnetic Resonance Imaging (MRI) scan of his brain on the 23rd of December 2014.

(iii) The insertion of a 24 hour ambulatory ECG to monitor heart rhythm on the 23rd of December 2014.

(iv) Carotid and vertebral arterial ultrasound to check for narrowing in the arteries that supply blood to the brain on the 24th of December 2014.

(v) An echocardiogram, which is an ultrasound of the heart, on the 29th of December 2014.

(vi) Carotid sinus massage, which is a firm massaging of the carotid artery for several seconds whilst monitoring heart rhythm and blood pressure, on the 31st of December 2014.

These procedures revealed no abnormalities relevant to the Inquiry.

9. On the 29th of December 2014 a "tilt table" test was carried out on Henry Clarke. His blood pressure before the test started was 130 over 94 with a heart rate of 89 bpm. On standing there was a small reduction in blood pressure but not an abnormal reduction and, as Mr Clarke relaxed, his blood pressure came down to similar levels to those found when he had been on the hospital ward. His blood pressure was not abnormal until 18 minutes when his systolic blood pressure reading (i.e. his blood pressure when his heart was contracting) went below 100 for the first time. At 20 minutes Mr Clarke's heart rate was 86 bpm and his blood pressure 94 over 75. At this point GTN spray, which lowers blood pressure by relaxing blood vessels, was administered under Mr Clarke's tongue to see if a faint could be provoked. Mr Clarke fainted at 27 minutes into the test. He lost consciousness, had an unrecordable blood pressure and his heart slowed to 50 bpm. The table was placed immediately back in the flat position and, as soon the table was flat, he regained consciousness and his blood pressure returned to normal. The test was recorded as positive.

10. On the 1st of January 2015 Mr Clarke was seen by the said Dr Roy Gardner. A decision was taken to insert an Implantable Loop Recorder, known as an ILR. An ILR is similar to a USB stick and continues to record the patient's heartbeat, documenting

any slow or fast rhythms of the heart. If something occurs, either a slowing or a quickening of the heart, the device will record the event. There is also a manual feature which allows the patient to record immediately before or after they feel an episode. The data is recorded to the device and is able to be downloaded at hospital.

11. On the 8th of January 2015 at the Golden Jubilee Hospital an ILR was inserted into Henry Clarke's chest and this will monitor his heartbeat for 3 years.

12. On the 14th of January 2015 data from the said ILR was downloaded at the Western Infirmary, Glasgow with nothing of note recorded although Henry Clarke did report one occasion of light headedness on that day.

13. On the 13th of February 2015 Henry Clarke was seen by Crown witness Professor Andrew Rankin, Professor of Medical Cardiology at Glasgow Royal Infirmary for a review and no further symptoms were reported by Henry Clarke.

14. On the 25th of February 2015 Henry Clarke was seen by the said Dr Freel for review and no issues were identified.

15. On the 20th of April 2015 data from the said ILR was downloaded at the Western Infirmary, Glasgow with nothing of note recorded.

16. In a letter dated the 6th of May 2015 but dictated on the 28th of April 2015 from the said Professor Andrew Rankin to Dr Stewart Russell, an Occupational Health Physician with PAM [People Asset Management], Dr Rankin wrote:

"Thank you for your letter requesting a report relative to employment for this 58 year old man. He had an episode of loss of consciousness resulting in a fatal road traffic accident in December 2014.

Mr Clarke underwent extensive investigation as an inpatient at the Western Infirmary in Glasgow, including imaging of brain and heart. He was assessed by Dr John Paul Leach, Consultant Neurologist, who felt that the diagnosis was more likely to be syncope rather than seizure.

This was supported by a positive tilt test, during which he had an unrecordable blood pressure associated with loss of consciousness. This supports the diagnosis of neurocardiogenic syncope (vasovagal syncope). It has a high specificity but false positive results can occur and so he was given an implanted loop recorder to provide information about heart rhythm should he have any further episodes.

An implanted loop recorder is a small device that is inserted subcutaneously and it records heart rhythm in a continuous loop but only saves the recordings of rhythm should they be abnormal or if the device is activated by the patient at the time of an event. During follow-up, no abnormal heart rhythms have been recorded from the device. He has a history of a previous symptomatic episode in 2010 when he became unwell while driving a bus. On that occasion he had associated symptoms more typical of a neurocardiogenic episode.

I saw him as an outpatient in February 2015, when I reviewed his history and the results of investigations. The most probable diagnosis is neurocardiogenic syncope based on a positive tilt test, the absence of a likely alternative diagnosis, and some aspects of his history, including the description of witnesses. The atypical features of the history are that he did not have any of the typical prodromal or associated symptoms, such as sweating or nausea, and a clear provocation has not been identified.

There is no specific treatment for infrequent episodes of neurocardiogenic syncope and management is usually reassurance and the avoidance of situations where episodes have occurred.

He will continue to be reviewed and his implanted loop recorder interrogated but no further interventions are planned. He has had no further episodes and his general health has been good, although he is finding it difficult psychologically. There is no specific health issue to prevent him returning to work.

However, with respect to the likelihood of his Large Goods Vehicle (LGV) license being restored, I would have concerns related to the absence of provocation and the limited prodrome which would allow him little time to respond should symptoms recur. The DVLA guidance (At a Glance) reflects this with the requirement to check the "three Ps" (provocation/prodrome/postural). The guidance is that two or more episodes without reliable prodromal symptoms would lead to a LGV license being revoked for ten years. When I spoke to him, he had accepted that he would not return to work as a lorry driver. He should be fit to return to other duties. I trust this information will help you with regards to his future employment. Please feel free to contact me again if you require further clarification on any aspect."

17. On the 19th of May 2015 Henry Clarke was seen again by the said Professor Andrew Rankin for a review and no issues of concern were identified. In a letter dated the 19th of May 2015 and dictated that same day from the said Professor Andrew Rankin to Crown witness Dr Gerard McKaig, Baillieston Health Centre, Dr Rankin wrote (when corrected for Typographical errors):

"This 58 year old former bin lorry driver was seen at the Arrhythmia Clinic. He has a history of an episode of loss of consciousness resulting in a fatal road traffic accident in December 2014. Following extensive investigation as an inpatient, the most likely diagnosis was considered to be neurocardiogenic syncope, supported by a positive tilt test with a predominantly vasodepressor response. He has an implanted loop recorder in case he had recurrent arrhythmia as an alternative diagnosis. He has a structurally normal heart, other than mild left ventricular hypertrophy.

He has remained well with no recurrent symptoms and has recently started back at work on light duties only. He tells me that he has been given his driving licence back but it is agreed that he will not return to driving bin lorries. No driving restriction is consistent with the DVLA Guidance following a solitary loss of consciousness likely to be unexplained syncope, but with a high probability of reflex vasovagal syncope, with no evidence of structural heart disease and a normal ECG.

In this context, then there would be no driving restrictions for a general licence and Group 2 entitlement can be restored after three months. He does have a history of a previous episode in 2010, during which he says he did not lose consciousness and had a clear prodrome with warning symptoms. As such, he has not had multiple episodes of syncope without warning.

His Reveal device was interrogated today and there were no arrhythmias documented. There were events logged as "asystole" but these were all due to undersensing of normal sinus rhythm. He will be seen for review."

18. As a result of the medical enquiries that have been described, the diagnosis of Mr Clarke's medical event on the 22nd of December 2014, which gave rise to the accident with which the Inquiry is concerned, is neurocardiogenic syncope.

APPENDIX 5 – LICENCE HISTORY AFTER 22 DECEMBER 2014

The following facts were proved in a section of the third joint minute which is reproduced below:

19. On the 7th of January 2015 Henry Clarke surrendered his driving licences for Group 1 vehicles, namely cars and motor cycles, and Group 2 vehicles, namely lorries and buses, to the DVLA and provided the licences to the police for submission to the DVLA. The form sent to DVLA that accompanied the surrender of these licences was completed and submitted by the police and specified a blackout caused by epilepsy as the medical condition which appeared responsible for the incident on 22 December 2014.

20. On the 8th of January 2015, and as a result of receiving the aforementioned form, the DVLA revoked Henry Clarke's Group 1 and Group 2 licences on the basis of epilepsy and made no further medical enquiries at that time. By letter of the 8th of January 2015 Mr S Thomas of the DVLA wrote to Henry Clarke to advise him that they had received information about his ability to drive. He advised that the Drivers Medical Unit of the DVLA had recommended that he should not drive and that this meant he had to return his driving licence to DVLA as his entitlement to drive would cease from the 9th of January 2015. Mr Thomas also wrote two additional letters to Henry Clarke of the 8th of January 2015 explaining the medical reason for the decision with one letter referring to his Group 1 licence and the other referring to his Group 2 licence. The letter referring to his Group 1 licence stated that, from the information received, it was clear that he had suffered a seizure and that he was currently unable to meet the recommended standards of fitness to drive; that a period of 12 months of not driving was considered necessary but certain conditions may allow a 6 month period off driving instead and advised him to discuss the timing of his re-application with his doctor. The letter referring to his Group 2 licence stated that the medical information provided had established that he could not meet the requirements prescribed for the holding of a Group 2 licence and that the law required a person to be free from epileptic attacks for at least 10 years and the person not to have taken any anti-epileptic medication for 10 years. The letter stated that re-application would only be accepted when these requirements could be met.

21. By letter of the 12th of January 2015 Henry Clarke wrote to the DVLA to advise that he had surrendered his licence to the police on the 7th of January 2015.

22. On the 13th of February 2015 Henry Clarke phoned DVLA to advise that he had a diagnosis of another condition and that he did not have a fit on the 22nd of December 2014 but rather it was some kind of syncope. Mr Clarke said he would send in evidence to the DVLA.

23. By letter of the 19th of February 2015 Dr Gillian Simpson of Baillieston Health Centre wrote to DVLA to advise that the information in DVLA's letter to Henry Clarke of the 8th of January 2015 was inaccurate and that Henry Clarke had not had a seizure. Dr Simpson advised that Mr Clarke had been thoroughly investigated and the diagnosis was of neurocardiogenic syncope.

24. By letter of the 10th of March 2015 Crown witness Dr Wyn Parry of the DVLA wrote to Dr Simpson asking her to complete a Fep2 medical questionnaire to DVLA and to submit any further information it was felt was relevant.

25. A letter of the 17th of March 2015 was sent to Henry Clarke from Dr Marie Freel that stated (when corrected for typographical errors):

"Just to confirm that the reason you lost consciousness in December is because you have a condition called neurocardiogenic syncope.

This is a condition where the nerves supplying the blood vessels and the heart are slightly abnormal for a short period of time, meaning you do not receive sufficient blood supply to the brain and so you may briefly lose consciousness.

The difficulty is you had no warning when you had this event which makes it very difficult to allow you to take steps to prevent it from happening again. Nevertheless you have a completely normal heart, you have no abnormalities of heart rhythm so far, all of which are very reassuring features.

It is obviously very difficult to predict whether this will ever recur. Only time will tell if that is the case. As emphasised however you are physically very healthy with a completely normal heart.

I hope this information is helpful and in particular is informative for the DVLA. As discussed I am very happy to be contacted by the DVLA if they require a formal report."

26. By letter of the 26th of March 2015 the DVLA wrote to Henry Clarke to provide him with the relevant application forms for re-applying for his Group 1 driving licence. The letter indicated that, before returning the application, he should check with his doctors that he was able to satisfy the medical standards for driving. On the 2nd of April 2015 Henry Clarke completed the relevant application forms in which he provided consent for disclosure of his medical information from his doctors to the DVLA. The DVLA received this application on the 7th of April 2015.

27. On the 2nd of April 2015 the DVLA wrote to Henry Clarke to provide him with the relevant application forms for re-applying for his Group 2 driving licence. The letter indicated that, before returning the application, he should check with his doctors that he was able to satisfy the medical standards for driving. On the 10th of April 2015 Henry Clarke completed the relevant application forms in which he provided consent for disclosure of his medical information from his doctors to the DVLA. The DVLA received this application on the 13th of April 2015.

28. At some point between the 17th of March 2015 and the 24th of April 2015 the aforementioned letter from Dr Freel to Henry Clarke was provided to the DVLA.

29. On the 28th of April 2015 the DVLA wrote to Henry Clarke to say that, from the information they had received, Mr Clarke satisfied the medical standards for safe driving and issued a car and motorcycle licence and a lorry and bus licence to him.

30. On the 25th of June 2015 the said Dr Parry reviewed Henry Clarke's case. Dr Parry noted on the DVLA computer system as follows (when corrected for typographical errors):

"Case reviewed in light of detailed medical notes received from FAI process. These reveal the 2010 LOC (which DVLA were unaware of until the FAI process revealed this) was similar to that in 2014, specifically in that there was no reliable prodrome.

In view of this, the licence decision has to be revised with revocation of both Gp 1 and Gp 2 licences. Decision discussed with legal and policy."

31. By letter of the 25th of June 2015 Mr S Thomas of the DVLA wrote to Henry Clarke to advise him that they had received information about his ability to drive. He advised that the Drivers Medical Unit of the DVLA had recommended that he should not drive and that this meant he had to return his driving licence to DVLA as his entitlement to drive would cease from the 27th of June 2015. Mr Thomas also wrote two additional letters to Henry Clarke on the 25th of June 2015 explaining the medical reason for the decision with one letter referring to his Group 1 licence and the other referring to his Group 2 licence. The letter referring to the Group 1 licence stated:

"The Secretary of State's Honorary Medical Advisory Panel on Diseases of the Nervous System and Driving recommends a 12 month period off driving following recurrent episodes of loss of consciousness or altered awareness without prodromal symptoms. The revocation period may be reduced if medical opinion can show that the risk of recurrence is less than 20% per annum."

The letter referring to the Group 2 licence stated:

"It is clear from information received that, within the last twelve months, you have suffered a loss of consciousness or episode of altered awareness, the cause of which has not been determined. Therefore you are currently unable to meet the recommended medical standards of fitness to drive Group 2 vehicles. The Secretary of State's Honorary Medical Advisory Panel on Diseases of the Nervous System and Driving recommends a period of 12 months off Group 2 driving from the date of such an event. If there is no recurrence you may re-apply for your licence. If however, any further medical investigation by your doctors subsequently identifies the cause of the blackout(s) and if the condition can itself be satisfactorily controlled with medication or otherwise to reduce the risk of recurrence, earlier re-application may be considered."

The reference in this letter to 12 months off driving was erroneous and the figure stated should have been 10 years.

32. By letter of the 26th of June 2015 the said Dr Parry wrote to Henry Clarke to advise him that DVLA was withdrawing his Group 1 and Group 2 driving licences but the letter did not indicate for how long.

33. By further letter of the 26th of June 2015 the said Dr Parry wrote to Henry Clarke in similar terms to the other letter of the same date but in that letter Dr Parry stated:

"Reviewing the detailed medical information submitted, it is clear that unfortunately you sustained an episode of loss of consciousness in 2010 in addition to that in 2014. Both of these episodes of loss of consciousness occurred without reliable prodrome, that is to say without any warning that they were about to happen. In view of this, DVLA's guidelines are that an ordinary driving licence and, if applicable as in your case, a driving licence for lorries and/or buses both need to be withdrawn. Your ordinary driving licence will be revoked for 12 months and your driving licence for Lorries or buses will be revoked for 10 years."

34. Both Henry Clarke's Group 1 and Group 2 licences have been revoked by DVLA for periods of 12 months and 10 years respectively and both with effect from the 27th of June 2015.

APPENDIX 6 – ASSESSMENT OF MS WATTS’S CONTENTION ON DR NEVILLE’S REPORTS

Ms Watts submission

“As my learned friend Mr McGregor has already observed, Dr Neville, who was the Crown’s GP expert witness, indicated to the court unequivocally on numerous occasions during the course of his evidence that the April 2010 event could only be a category 3 event, and he did this despite having produced a number of reports, three of which were lodged in court, in which he had stated expressly that the episode could be a category 1 event. It was put to him in cross-examination that he had effectively changed his mind on this matter and I would respectfully submit that his position in relation to that point was unconvincing.

He attempted to justify his change in position by reference to additional information which he said had become available to him as later redrafts of his report were prepared. However, in my submission, it is clear from the list of documents pertaining to even his very first report that by that stage, he had already seen both the contemporaneous notes of the bus inspector Mr Stewart, and the witness statement provided by Mr Stewart. Dr Neville could not therefore have been in any doubt at all at the time of preparing all three of his reports which have been disclosed that there was at the very least a material possibility that the April 2010 episode had taken place while Mr Clarke was seated and at the wheel of his bus. And despite this, Dr Neville had confidently stated in his reports that this could be, and in fact probably was, a category 1 episode, which in my submission was effectively the opposite of the evidence that he then gave to the Inquiry.”

Assessment

Dr Neville was in his first draft of report, production 94 (dated 30 May 2015 reviewed 2 June 2015), at section 6.4 proceeding on the basis of what he understood Mr Clarke was telling the Procurator Fiscal as to what had happened on 7 April 2010 and that information, from Mr Clarke’s precognition, was not admissible evidence and did not feature in the Inquiry. It does appear however, from what Dr Neville reported, that the scenario on which Dr Neville proceeded involved Mr Clarke driving his bus, feeling unwell but not suffering loss of consciousness. It is that understanding which is relevant to evaluating if his position changed as Ms Watts suggested. At section 6.7 he stated:

“If this event was indeed a simple vasovagal attack then Mr Clarke was under no obligation to disclose it to DVLA.”

At section 6.7 of production 141, (revised 17 June and finalised 24 June 2015), Dr Neville stated:

“If this event was indeed an uncomplicated vasovagal attack or episode of neurocardiogenic syncope then Mr Clarke was under no obligation to disclose it to DVLA.”

At section 6.12 of his final report, production 167 (supplementary changes made on 16 July 2015), he stated:

“If this event was indeed an uncomplicated “vaso-vagal” attack then Mr Clarke was not under obligation to disclose it to DVLA. However, if Mr Clarke had in fact experienced a loss of consciousness whilst at the wheel he was under an obligation to disclose this to DVLA”

The new information he had received between the final draft and the finalised report comprised an updated precognition from Dr McKaig, information that DVLA had revoked Mr Clarke’s licence for ten years and Dr Rutherford’s report. It is apparent that Dr Neville had always been aware that bus inspector John Stewart had recorded that Mr Clarke had said that he had blacked out for a couple of minutes. Dr Neville always proceeded on the basis that Mr Clarke was driving a bus.

Dr Neville faced the difficulty of having a number of different versions of events to consider and I take that into account. Nevertheless, there is a change in the opinion expressed at para 6.12 of the final report, production 167, compared to his earlier drafts. Despite his attempts to explain his change of expression, I remain unsure whether it came about simply on the basis of his own further consideration or whether it was reached in light of considering further information but he was always proceeding on the basis of a vasovagal attack whilst Mr Clarke was sitting at the wheel of his bus.

APPENDIX 7 – CROFTSIDE AVENUE BIN LORRY ACCIDENT

The following facts were proved in the fifth joint minute.

3. After commencing duty at 0630 hours on Tuesday the 14th of April 2015, the 48 year old driver of Glasgow City Council Leyland DAF refuse truck, registration SB62 UNJ was driving the vehicle east on Croftside Avenue, Glasgow as part of his normal collection route at about 1110 hours that day. One of the two refuse collectors who was working with the driver was standing with two bins approximately 25 metres in front of the vehicle on the north footpath and the other refuse collector was standing to the rear of the vehicle emptying two bins. The driver was sitting idle with his foot on the foot brake. The collector with the bins signalled for the driver to move forward however, as he did, the driver felt warm, clammy, sweaty and light headed; was seen to look disorientated and then slumped over the wheel unconscious. The vehicle continued travelling east at a slow pace, at a maximum of 5 miles per hour, mounted the kerb on the north side of the street and entered the front garden area of a house in Croftside Avenue, flattening a hedge. The vehicle came to a standstill with no damage to any building or injury to any person. The two collectors immediately entered the driver's cab and removed the keys from the vehicle and secured the handbrake. The driver came round after approximately 2 minutes. Ambulance personnel attended and he was conveyed to the Glasgow Victoria Hospital.

APPENDIX 8 – EXTRACT FROM LETTER FROM DfT

“A possible alternative may be an emergency stop control that is engaged by a positive action to apply the brakes on. However, the possibility that such a device might be activated (either accidentally or deliberately) by a person other than the usual driver of the vehicle has significant legal implications (in particular, in terms of liability and insurance) which would have to be analysed in detail. In addition, it should be recognised that the design and installation of such a system is not trivial. Modern braking systems are complex and any additions or modifications require careful design. Ideally this should be achieved with the support of the vehicle manufacturer.

Any device fitted would need to be designed so that it cannot present a danger, even under failure condition, and that it will not adversely affect any other system, e.g. service braking, steering, etc. on the vehicle. The original systems engineered by the vehicle manufacturer are subject to type approval tests to ensure a minimum performance and that they do not affect any other systems on the vehicle.

Any request to mandate such an emergency control would require a change to legislation. To change the overarching legislation would need the agreement of all of the governments (Contracting Parties) that are signatories to the UN ECE Regulation 13 on vehicle braking. A full impact assessment would be necessary before the Department for Transport could consider proposing a change of this nature.

If a manufacturer chose to fit the system as an option then a change in legislation would not be required. The manufacturer would have to ensure the braking system installed with this device complied with type approval requirements and obtain an extension to the vehicle type approval. An extension is obtained once the modification has been reviewed and checked by the Type Approval Authority that had issued the original type approval; this may not necessarily be in the UK.

If the original type approval has been issued in the UK then the Vehicle Certification Agency (VCA), an agency of the Department for Transport, would be responsible for endorsing the modification.”

APPENDIX 9

The seventh joint minute included the following.

Legislative position on AEBS and LDWS

13. Commission Regulation (EU) Number 347 of 2012, which is dated 16th April 2012 (and hereinafter referred to as 'Regulation 347') implemented Regulation (EC) Number 661 of 2009 of the European Parliament and of European Council with respect to type-approval requirements for certain categories of motor vehicles with regards to advanced emergency braking systems (also known as autonomous emergency braking systems and hereinafter referred to as 'AEBS'). Regulation 347 inter alia makes provision for the compulsory fitting of AEBS to all new types of heavy goods vehicles from November 2013 and for the compulsory fitting of AEBS to all newly registered heavy goods vehicles from November 2015.

14. Paragraph 6 of the preamble of Regulation 347 states that:

“Technical and physical constraints make it impossible to install the collision detection equipment in a way that would ensure their reliable functioning on certain special purpose vehicles, off road vehicles and vehicles with more than three axles. Vehicles of those categories should therefore be exempt from the obligation to install AEBS.”

15. Article 1 of Regulation 347 specifies the four categories of motor vehicles the Regulation applies to which includes heavy goods vehicles. However, Article 1(5) states that 'special purpose vehicles' of these categories, as referred to in point 5 of part A of Annex II to Directive 2007/46/EC are excepted from the Regulation. Article 1 also exempts both heavy goods vehicles with a maximum mass between 3.5 and 8 tonnes capable of towing semi-trailers and trailers with more than three axles from the Regulation.

16. Commission Regulation (EU) Number 351 of 2012, which is dated 23rd April 2012 (and hereinafter referred to as 'Regulation 351') implemented Regulation (EC) Number 661/2009 of the European Parliament and of the Council as regards type-approval requirements for the installation of lane departure warning systems in motor vehicles (hereinafter referred to as 'LDWS'). Regulation 351 inter alia makes provision for the process of obtaining type-approval of LDWS where there is an obligation to install those systems.

17. Paragraph 3 of the preamble of Regulation 351 states:

"It is considered that due to their typical use in specific traffic conditions the installation of lane departure warning systems would generate only limited safety benefits for ..."

And the Regulations then specify certain categories of vehicles:

"... as well as for certain special purpose vehicles, off-road vehicles and vehicles with more than three axles. Those vehicles should therefore be exempted from the obligation to install those systems."

18. Article 1 of Regulation 351 specifies the four categories of motor vehicles the Regulation applies to, which includes heavy goods vehicles. However, Article 1(5) states that 'special purpose vehicles' of these categories as referred to in point 5 of part A of Annex II to Directive 2007/46/EC are excepted from the Regulation. Article 1 also exempts heavy goods vehicles with a maximum mass between 3.5 and 8

tonnes capable of towing semi-trailers and trailers with more than three axles from the Regulation.

19. Point (or section) 5 of part A of Annex II to Directive 2007/46/EC (and hereinafter referred to as 'the Directive'), to which both Regulation 347 and Regulation 351 refer, contains a table that lists specific types of vehicles that are considered to be special purpose vehicles refuse vehicles are not specifically listed but could fall into the category of 'special group' under Section 5.8 of the table. That category is defined as:

"A special purpose vehicle which does not enter in any of the definitions mentioned in the section."

The definition of 'special purpose vehicle' within the Directive is:

"A vehicle of category M, N or O [category N being the heavy goods vehicles] having specified technical features in order to perform a function which requires special arrangements and/or equipment."

And goes on to state that:

"The various types of special purpose vehicles are defined and listed in Section 5 of the directive which is the aforementioned table."

20. Prior to the introduction of Regulation 347 and Regulation 351 a cost benefit analysis was undertaken for the European Commission by the Transport Research Laboratory (hereinafter referred to as 'TRL') regarding AEBS and LDWS. TRL then undertook a further study on AEBS and LDWS exemptions for the European Commission, which was completed in July 2010. Within that report, TRL recorded the motivation advanced by stakeholders for AEBS and LDWS exemptions on vehicle types. In relation to AEBS on heavy goods vehicles the motivation for exempting special purpose vehicles was:

"Some special chassis/body adaptations for special purpose vehicles might cause a problem to install sensors. These vehicles are not normally driven as long distance trucks. Drivers are most probably very active."

In relation to LDWS on heavy goods vehicles the motivation for exempting special purpose vehicles was:

"LDWS are most efficient for "long distance" trucks travelling on highways. Drivers of special purpose vehicles are probably "very active."

21. For a type of vehicle to obtain approval as a special purpose vehicle, the vehicle manufacturer would propose to the Type Approval Authority (hereinafter referred to as the 'TAA' and which, for UK vehicles, would be the Vehicle Certification Agency) that the manufacturer uses for their approval work that the vehicle type should be considered as a special purpose vehicle. If the TAA so classifies the type of vehicle, all European Member States must then accept all vehicles conforming to that type.

22. To establish whether the vehicle should be considered to be a special purpose vehicle, the TAA will check the vehicle specification to ensure it falls within the specific types of vehicles listed in the aforementioned table at Section 5 of part A of Annex II of the Directive. If it does, then the derogations outlined in the appendices of Annex XI of the Directive relevant to that specific type will be applied and exemption as a special purpose vehicle is only permitted when the manufacturer satisfactorily demonstrates to the TAA that the vehicle, due to its special purpose, cannot meet one or more of the general type-approval requirements.

23. If a refuse truck was a heavy goods vehicle with a maximum mass between 3.5 and 8 tonnes and capable of towing semi-trailers, or if it was a vehicle of any mass which had more than three axles, then it would be exempt from the AEBS and LDWS requirements.
24. Alternatively a refuse vehicle would be exempt from the AEBS and LDWS requirements of the TAA and discussion with the manufacturer considered that the vehicle had specific technical features in order to perform function which requires special arrangements and/or equipment and as a result could not comply with one or more of the general requirements as described in paragraph 26.
25. As a refuse vehicle is not specifically listed, it is likely to be considered as a 'special group' and therefore the relevant text for determining acceptable non-compliance is Appendix 4 of Annex XI, which outlines the requirements for 'other special purpose vehicles (including special group, multi-equipment carrier and trailer caravans)'. The introduction to this appendix makes a very clear point that the exemptions are not applied 'carte blanche' and the general type approval requirements should be fulfilled to the greatest extent. The manufacturer has to determine which particular general type approval requirements cannot be met. If the TAA agrees that the general requirements cannot be met and the vehicle is deemed to be a special purpose vehicle, then by virtue of the footnote to Item 65(AEBS) in the table of Appendix 4, the vehicle is automatically exempted from AEBS fitment.
26. There is an approval process defined as 'multi-stage' build and a refuse vehicle could be manufactured via this process. A chassis and cab will be constructed as an ordinary heavy goods vehicle and would therefore have AEBS and LDWS fitted to it. This vehicle will be approved as an 'incomplete' vehicle by a 'first stage' manufacturer.
27. The 'second stage' manufacturer would be responsible for the conversions or additions required to complete the vehicle and would apply for an approval for the vehicle as a 'completed' vehicle. It would only be identified as a special purpose vehicle during the final manufacturing stage of fitting the body, (for example, a refuse collection body) when it became a 'completed' vehicle. In this instance it would appear in the marketplace as a 'special purpose vehicle' and is likely to still have AEBS and LDWS fitted.
28. A purchaser of a refuse vehicle which is exempt, for example a company or a local authority, could specify as part of the purchase contract that AEBS or LDWS must be fitted to the vehicle notwithstanding it is not legally required.
29. AEBS on DAF trucks is a safety function which is developed to intervene if a collision cannot be avoided by a normal evasive steering manoeuvre or a braking intervention of the driver. AEBS always respects a warning phase before emergency braking actually becomes active. The length of time between phases depends on the traffic situation, but complies with AEBS legislative requirements. The warning phase is meant to alert the driver and motivate him to take over control by steering or braking. During the first part of the warning phase, a forward collision warning, which is an internal acoustic and visual warning, activates and the brake light engages and brakes 'pre-fill'. In the second part of the warning phase a haptic collision warning, which is further acoustic and visual warning, activates and partial braking engages. Finally the emergency braking activates, providing further acoustic and visual warning, full braking and flashing hazard lights. Constant levels of

braking force are applied, the level of which depends on the traffic situation, and the vehicle is very unlikely to skid. The braking performance of the truck is a factor in determining the stopping distance once AEBS has been activated. The AEBS will stop intervening if the risk for a collision has ceased.

30. The legislative requirement is for AEBS to be able to detect a saloon car. AEBS on DAF trucks will detect passenger cars, commercial vehicles, motorcycles, or any kind of object which reflects the AEBS radar beam. An absolute minimum size for detection cannot be defined. Factors such as material, size, shape and orientation/position of the object will influence whether detection will occur. It is difficult for pedestrians to be detected by the AEBS radar beam. Depending on the reflective quality of their clothing it may be possible for them to be detected by AEBS on DAF trucks.

31. AEBS was introduced on the type of vehicle to which the truck belongs, namely a DAF C75 Euro 5 model in 2014. AEBS was accordingly not available as an option on the truck when it was procured by Glasgow City Council. AEBS cannot be retro-fitted to DAF Euro 5 type vehicles and can only be retro-fitted to DAF Euro 6 type vehicles at present.

32. The procurement process that ultimately resulted in the truck being supplied to Glasgow City Council commenced around 15th June 2010. The tender was dispatched to be advertised in the Council's E-Tender website, Public Contracts Scotland, and the Official Journal of the European Union on 17th June 2011. After a competitive procurement exercise, Imperial Commercial Limited won the contract for procurement and maintenance of refuse collection vehicles from Glasgow City Council. That contract was awarded in or around the summer of 2012. The period of the contract was to be for three years from the 25th July 2012 until 24th July 2015 with the option to extend for a further year, which has since been exercised.

APPENDIX 10 – CONDITIONS LISTED ON DVLA WEBSITE FOR WHICH DVLA OFFERS ADVICE ABOUT THE IMPLICATIONS FOR DRIVING AND NOTIFICATION www.gov.uk/driving-medical-conditions

Use the link, “Health conditions and driving”

A

Absence seizures
Acoustic neuroma
Addison’s disease
Agoraphobia
AIDS
Alcohol problems
Alzheimer’s disease
Amyotrophic Lateral Sclerosis
Amputations
Angina
Angioma
Angioplasty
Ankylosing spondylitis
Anorexia nervosa
Anxiety
Aortic aneurysm
Arachnoid cyst
Arnold-Chiari malformation
Arrhythmia
Arterial defibrillator
Arteriovenous malformation
Arthritis
Asperger syndrome
Ataxia
Attention deficit/hyperactivity disorder (ADHD)
Autistic spectrum disorders (ASD)

B

Balloon angioplasty (leg)
Bipolar disorder
Blackouts
Blepharospasm
Blood clots
Blood pressure
Brachial plexus injury
Brain abscess, cyst or encephalitis
Brain aneurysm
Brain angioma
Brain haemorrhage
Brain injury (traumatic)

Brain tumours
Branch retinal vein occlusion
Broken limbs and driving
Burr hole surgery

C

Caesarean section
Cancer
Cataracts
Catheter ablation
Cardiac problems
Carotid artery stenosis
Cataplexy
Cerebral palsy
Chronic aortic dissection
Cognitive problems
Congenital heart disease
Convulsions
Coronary artery bypass or disease
Coronary angioplasty
Cystic fibrosis

D

Deafness
Defibrillator
Déjà vu
Dementia
Depression
Diabetes
Diabetic retinopathy
Dilated cardiomyopathy
Diplopia (double vision)
Dizziness
Drug misuse

E

Eating disorders
Empyema (brain)
Epilepsy
Essential tremor

F

Fainting
Fits
Fractured skull
Friedrich's ataxia

G

Giddiness (recurring)
Glaucoma
Global amnesia
Grand mal seizures
Guillain-Barré syndrome

H

Head injury
Heart attack
Heart arrhythmia
Heart failure
Heart murmurs
Heart palpitations
Heart valve disease or replacement valve
Hemianopia
High blood pressure
HIV
Hodgkin's lymphoma
Huntington's disease
Hydrocephalus
Hypertension
Hypertrophic cardiomyopathy
Hypoglycaemia
Hypoxic brain damage
Hysterectomy

I

Implantable cardioverter defibrillator (ICD)
Intracerebral haemorrhage
Ischaemic heart disease

K

Kidney dialysis
Kidney problems
Korsakoff's syndrome

L

Labyrinthitis
Learning difficulties
Left bundle branch block
Leukaemia
Lewy body dementia
Limb disability
Low blood sugar
Lumboperitoneal shunt
Lung cancer

Lymphoma

M

Macular degeneration

Malignant brain tumours

Malignant melanoma

Manic depressive psychosis

Marfan syndrome

Medulloblastoma

Memory problems (severe)

Meningioma

Mini-stroke

Monocular vision

Motor neurone disease

Multiple sclerosis

Myasthenia gravis

Myocardial infarction

Myoclonus

N

Narcolepsy

Night blindness

Nystagmus

O

Obsessive compulsive disorder

Obstructive sleep apnoea

Optic atrophy

Optic neuritis

P

Pacemakers

Palpitations

Paranoia

Paranoid schizophrenia

Paraplegia

Parkinson's disease

Peripheral arterial disease

Peripheral neuropathy

Personality disorder

Petit mal seizures

Pituitary tumour

Post traumatic stress disorder (PTSD)

Psychosis

Psychotic depression

R

Renal dialysis
Retinal treatment
Retinopathy

S

Schizo-affective disorder
Schizophrenia
Scotoma
Seizures
Sight in one eye only
Sleep apnoea
Sleepiness (excessive daytime)
Spinal problems and injuries and driving
Stroke
Subarachnoid haemorrhage
Syncope

T

Tachycardia
Temporal lobe epilepsy
Tonic clonic fits
Tourette's syndrome
Transient global amnesia
Transient ischaemic attack (TIA)
Tunnel vision

U

Usher syndrome

V

Valve disease or replacement valve
Ventricular defibrillator
Vertigo
Vision in one eye only
Visual acuity (reduced)
Visual field defects
VP shunts

W

Wolff-Parkinson-White syndrome

Last updated: 12 October 2015