SHERIFFDOM OF SHERIFF COURT

[2021] FAI 35

LAN-B26-20

DETERMINATION

BY

SHERIFF NIKOLA C STEWART, ADVOCATE

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

into the death of

HETAL LALLUBHAI PATEL

Larnark, 7 August 2020

The Sheriff having considered the productions, the terms of the Notice to Admit Information and the submission presented to the Inquiry finds and determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 that:

[1] In terms of section 26(2)(a) of the 2016 Act Hetal Lallubhai Patel, born 24 May 1972, died at approximately 1022 hours on 30 May 2018 on the A702, near to [redacted].

[2] In terms of section 26(2)(b) of the 2016 Act the accident resulting in his death took place at approximately 0834 hours on 30 May 2018 on the northbound lane, A702, near to [redacted].

[3] In terms of section 26(2)(c) of the 2016 Act the cause of death was head injury due to road traffic collision (driver).

[4] In terms of section 26(2)(d) of the 2016 Act the accident was caused by Mr Patel, who was driving his work vehicle Mercedes van registration number BT67 ZDK, failing to negotiate a left hand bend whilst travelling at approximately 41 mph. As a result the vehicle crossed from the southbound carriageway across solid double white centre lines into the opposing carriageway, mounting the west kerb and continuing south across the pavement before striking an electricity pole and colliding with a mature tree. Mr Patel was not wearing a seat belt at the time and was projected forward on impact, colliding with the windscreen. At the time of the accident Mr Patel had failed to take adequate rest breaks to ensure that he was fit to drive. This failure had been repeated over a prolonged period. He had gone without adequate sleep in the days prior to the accident.

[5] Makes no findings in terms of sections 26(2)(e), (f) and (g) of the 2016 Act.

RECOMMENDATIONS

In terms of section 26(1)(b) of the 2016 there are no recommendations as to any of the matters mentioned in sub-section (4) which might realistically prevent other deaths in similar circumstances.

NOTE

The legal framework

[1] A fatal accident inquiry was held under the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act") into the death of Hetal Lallubhai Patel

who died on 30 May 2018. At the time of his death he was acting in the course of his employment as a self- employed delivery driver and his death was the result of an accident which occurred in the course of that employment. In terms of section 2(3) of the 2016 Act an inquiry was required to be held into the circumstances of his death.

[2] The Procurator Fiscal issued notice of the inquiry on 3 March 2020. The first order was granted on 9 May 2020 and a preliminary hearing was to be held within Lanark Sheriff Court on 5 May 2020. Difficulties associated with intimation and the interruption to court business resulting from Covid 19 resulted in the discharge of the inquiry assigned for 9 June 2020 and the assigning of a fresh date of 22 June 2020 for a preliminary hearing. Mr Richard Hill, Procurator Fiscal Depute, appeared throughout for the Crown. No interested parties were represented at the hearing. The inquiry was held on 4 August 2020.

[3] It became clear at the preliminary hearing that there was scope for the lodging of a Notice to Admit Information in terms of Rule 4.12. Having had regard to its terms and to the terms of the productions lodged I was satisfied that the scope and extent of the inquiry could be thereby limited and no witnesses were called to give evidence.

[4] This inquiry is held under section 1 of the 2016 Act and governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (SSI 2017/103). The inquiry was initiated by the procurator fiscal, who represents the public interest, in accordance with his statutory duty to do so. The purpose of an inquiry under section 1(3) of the Act is (a) to establish the circumstances of the death and (b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The inquiry is an inquisitorial

process and, under section 1(4) of the Act, it is not its purpose to establish civil or criminal liability.

Summary and conclusion

[5] The mechanism and circumstances of the accident are not disputed. No oral evidence was led. The deceased, Hetal Lallubhai Patel, was Company Director, sole shareholder and sole employee of a private limited company, 24/7 H Couriers Limited which had a registered office in Bilston, United Kingdom and which provided delivery services for a number of client companies. His role as delivery driver was to collect and deliver goods on behalf of company clients and in doing so was engaged in pick up and deliveries throughout mainland UK. As a self-employed driver he was subject to no formal supervision of his working hours or conditions by those who employed his services. He was solely responsible for compliance with those GB domestic driving hour rules which applied to him.

[6] To fulfil the services he offered clients, he hired a Mercedes Sprinter van, registration number BT67 ZDK on a repeat short term contract basis from One Stop Van Hire Rental. Inspection of the van in the aftermath of the accident confirmed it to have had no mechanical defects at the time. The van was fitted by its owners with a Ctrack Is130-s2 telematics unit together with online software door monitoring solutions. Accordingly it has been possible, having regard to the information thus provided, to track the deceased's driving record continuously throughout the period from 26 April 2018 at 0234 hours until 0834 hours on 30 May 2020 when the incident occurred. Perusal

of that record indicates that Mr Patel had been engaged in work-related activities throughout that period, had on twenty occasions driven for more than 10 hours a day, on 14 of those days exceeding 14 hours driving, had failed to take breaks as required by the Working Time Directive and GB domestic rules and had failed to take appropriate rest and off duty periods as required by the applicable regulations. On the day of the collision he had already driven for 7 hours and 18 minutes with an overnight rest period lasting approximately 1 hour 20 minutes. Accordingly, he had been driving, loading or with his vehicle throughout the 28 hours prior to the accident with only short breaks, the longest extending to less than 3 hours. He was in breach of GB domestic drivers' hours rules as they apply to goods vehicles. He had failed to ensure he got adequate rest of sufficiently long and continuous periods to ensure he did not harm himself or others.

[7] The A 702 is the main Edinburgh to Dumfries trunk route. At the locus it is a two-way undivided carriageway with one lane for traffic in each direction, extending generally northeast and southwest. The lanes are separated by solid double white lines preventing vehicles from overtaking. The A702 is bordered to the east by a raised kerb and grass verge and to the west by a raised kerb and footway leading to a grass verge in which are situated a series of reflective marker posts indicating the edge of the verge. Approaching the locus from the north, having negotiated a right hand followed by a left hand bend, a driver enters the village of Lamington where speed is restricted from 60 mph to 40 mph with an area of red enhanced surface dressing upon the carriageway and hazard warning lines along the centre of the carriageway. A "SLOW" sign is painted upon the carriageway with two white arrows instructing drivers to return to

their own lane as they are warned of a left hand bend and cross-roads ahead. The hazard warning lines are then replaced by solid double white lines. Approximately 98 metres north of the locus there is a second area of red enhanced surface dressing reinforcing the 40 mph limit and a further "Slow" sign painted upon the carriageway with solid double white lines along the centre of the carriageway. The road surface was in a good state of repair and was dry with all road markings clearly visible. There were no adverse weather conditions. A southbound driver has an unobstructed view towards the locus as he approaches on a relatively straight section of carriageway with a slight downhill gradient, extending to a maximum of approximately 697 metres towards the locus.

[8] Dashcam footage retrieved from the cab of an HGV motor vehicle travelling north along the A702 and approaching the locus at the time of the accident reveals the deceased's vehicle failing to negotiate a left hand bend, leaving the carriageway on its offside and striking a tree and electricity pole at the locus. The footage confirms that no attempt has been made by the driver to negotiate the bend or to brake. Ctrack data shows he was travelling at 41 mph at the time of the collision.

[9] Emergency services, including a trauma specialist from the air ambulance unit attended. Mr Patel was removed from the vehicle and resuscitation was attempted. His breathing was laboured but his condition rapidly deteriorated and he had cardiac arrest at 1022 hours.

[10] At post-mortem he was found to have sustained a large comminuted skull fracture associated with subdural and subarachnoid haemorrhage, contusion over the

surface of the brain, blood in the ventricular system and multiple small haemorrhages throughout the white matter of the brain. These severe head injuries would account for his death. He also sustained multiple rib fractures, which could in all or in part be associated with the result of cardiopulmonary resuscitation attempts. Albeit there was post-mortem evidence of cardiac disease which potentially could have caused him to lose control of the vehicle, there were no identifiable unequivocal acute changes and no cardiac related incident was recorded as being either a primary or secondary cause of death.

[11] Analysis of post mortem blood revealed the presence of cannabis, together with Alfentanil an analgesic which may well have been administered by medical staff but can also be a drug of abuse. Alcohol was also detected in blood and urine samples.

[12] Police Collision Investigators attended the scene of the incident at approximately 1140 hours on 30 May 2018, the locus having been closed to preserve evidence. They prepared a Collision Investigation Report based upon their examination of the scene and of the vehicle involved, together with the Dashcam footage and Ctrack movement data referred to above and reconstruction of the accident.

[13] They concluded as follows: that the deceased failed to negotiate a left hand bend whilst travelling at approximately 41 mph. He makes no attempt to brake or to steer the vehicle which continued in a straight line, crossing from the south-bound lane across the solid double white centre lines into the opposing carriageway. All 4 wheels of the van mount the west kerb and the vehicle continues south whereby the nearside of the vehicle strikes the electricity pole at the locus before colliding with a mature tree causing an

extensive intrusion into the passenger compartment. The deceased has been projected forward, colliding with the windscreen. Given the minimal intrusion into the driver's compartment of the vehicle had he been wearing a seatbelt at the time of the collision, he may have survived it.

[14] The conclusions of the Crash Investigators are supported by the terms of their report and the uncontested facts set out in the Notice to admit information. The toxicology report reveals the presence of cannabis in the blood of the deceased. The quantity of cannabis and alcohol ingested by the deceased and the likely affect upon him are not known and therefore no conclusion can be arrived at in respect of any causal relationship with the accident. The post mortem report raises the possibility of a cardiac arrhythmia giving rise to the deceased's loss of control of the vehicle but there is no other evidence supporting such a conclusion. The Ctrack data confirms that the deceased had undertaken a punishing regime of working extremely long hours without significant breaks in the form of rest periods or days off and had been so working for a period of at least 28 hours immediately prior to the accident. He had not had adequate sleep or breaks from driving to ensure he was an alert and safe presence on the road. As a self-employed driver of the vehicle in question the statutory schemes designed to ensure that professional drivers of specified vehicles work and drive for limited hours, take regular specified break periods, limit the working day and take specified daily and fortnightly specified rest periods do not apply. The reasons why he chose to not follow safe driving practices by failing to take adequate breaks and rest periods and to fail to comply with the terms of section 14 of the Road Traffic Act 1988 relating to the

compulsory wearing of a seat belt and the existence or otherwise of any pressure which may have been felt by him to maximise his hours of work to the prejudice of his ability to drive safely and fully refreshed have not been and cannot be explored in the absence of available testimony. The protection of a requirement to report any unreasonable demands being made with regard to working hours by employers does not apply to self-employed couriers. I am satisfied, as submitted by the parties, that only findings in terms of paragraphs (a), (b), (c) and (d) should be made.