SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT STIRLING

[2022] FAI 12

STI-B66-21

DETERMINATION

BY

SHERIFF DEREK J HAMILTON

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

into the death of

JOYCE GARDINER

Stirling, 25 January 2022

The Sheriff having considered the evidence, the written and oral submissions presented at the inquiry, the productions and the terms of the joint minute, finds and determines in terms of Sections 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the 2016 Act) that Joyce Gardiner, born 13 April 1958, lately of Scone, Perthshire, died on 16 January 2019, on the A90 dual carriageway close to the slip road at St Madoes, Perthshire, and;

(i) In terms of Sections 26(2)(a) of the 2016 Act, Joyce Gardiner, born 13 April 1958, died on 16 January 2019, on the A90 westbound dual carriageway, about 530 metres west from its junction with St Madoes, Perthshire. Her life was formally pronounced extinct at 1249 hours, and followed a road traffic collision analysed to have occurred at approximately 1148 hours.

(ii) In terms of Sections 26(2)(b) of the 2016 Act, the accident resulting in Joyce Gardiner's death took place at approximately 1148 hours on 16 January 2019, on the A90 Dundee to Perth westbound dual carriageway, about 530 metres west from its junction with St Madoes Perthshire.

(iii) In terms of Sections 26(2)(c) of the 2016 Act, the cause of Joyce Gardiner's death was multiple injuries, specifically;

a. craniothoracic injuries;

b. blunt force trauma;

as a result of a road traffic collision in which she was the driver of one of the two vehicles involved.

(iv) In terms of Sections 26(2)(d) of the 2016 Act, the accident was caused by the vehicle which was driven by Joyce Gardiner, a Ford Tourneo motor vehicle registered number SP17 UJW, stopping suddenly on the A90 dual carriageway and then being struck to the rear by another vehicle, a Renault Heavy Goods Vehicle, flatbed lorry registered number PX17 LHH, operated by RJ & I Monkhouse Ltd, and driven by Andrew Kirkpatrick.

(v) Makes no findings in terms of sections 26(2)(e) and (f) of the 2016 Act.

(vi) In terms of Sections 26(2)(g) of the 2016 Act, there are no other facts which are relevant to the circumstances of the death.

Recommendations

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

NOTE

Introduction

[1] A fatal accident inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 into the death of Joyce Gardiner, who died on 16 January 2019. She was at the time of her death employed by Dundee City Council as a social care officer/support worker at [Address redacted] Dundee, for adults with learning disabilities, and her death was the result of an accident which occurred in the course of that employment. In terms of Sections 2(3) of the 2016 Act, an inquiry was required to be held into the circumstances of her death.

[2] The Procurator Fiscal first received notice of Ms Gardiner's death on 17 January 2019, and issued notice of the inquiry on 29 July 2021. The first order was granted on 10 August 2021. A preliminary hearing was held at Stirling Sheriff Court on 24 September 2021. That hearing was continued to 26 November 2021. The inquiry, where evidence was led, was held on 12 and 13 January 2022. I then continued matters until 24 January 2022, for written submissions to be lodged. The written submissions were expanded upon at the hearing on 24 January 2022. At all hearings Ms Whyte, Procurator Fiscal Depute, appeared for the Crown, Mr Boyle, solicitor, for Dundee City

Council (Ms Gardner's employer) and Mr Graham, QC for both Mr Andrew Kirkpatrick (driver of the other vehicle) and RJ & I Monkhouse Ltd (Mr Kirkpatrick's employer). Members of Ms Gardiner's family were present at all hearings. All hearings were conducted via the medium of WebEx facility in accordance with guidelines issued under the present Covid-19 pandemic restrictions.

[3] Much of the evidence for this inquiry was not in dispute and was capable of agreement. A Joint Minute of Agreement between the Crown and the participants in the inquiry was tendered to the inquiry. That greatly assisted the inquiry and reduced the oral evidence that required to be heard. At the inquiry the Crown led five witnesses;

(i) Robert Booth, fellow employee and front seat passenger in Ms Gardiner's vehicle

(ii) Andrew Kirkpatrick, driver of Renault Heavy Goods Vehicle, flatbed lorry registered number PX17 LHH

(iii) Christine Walsh, eyewitness

(iv) Police Constable Ian Cattrell, co-author of the Road Policing Collision Investigation Report

(v) Gerard Bowlt, Critical Concern Manager, Ford UK, author of report on vehicle, Ford Tourneo motor vehicle registered number SP17 UJW

[4] Each of the witnesses had provided statements or had prepared a report, and each of them adopted same as part of their evidence. The other parties did not lead any witnesses. A number of productions were lodged, which included a Road Policing Collision Investigation Report, vehicle inspection reports and a book of photographs.

The legal framework

[5] This inquiry was held under Sections 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 her statutory duty to do so. The purpose of an inquiry under Sections 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 Sections 1(4) of the Act, it is not its purpose to establish civil or criminal liability.

Discussion and Conclusion

Discussion

[6] Joyce Gardiner was employed by Dundee City Council as a Social Care Officer/Support Worker at [Address redacted] Dundee, for adults with learning disabilities. On 16 January 2019, she was driving a Ford Tourneo minibus, registration number SP17 UJW in the course of her employment with Dundee City Council. In the vehicle was a front seat passenger colleague, Robert Booth, and an adult whom they cared for in the course of their employment. That adult was secured in a seat in the row behind Ms Gardiner and Mr Booth.

[7] At approximately 1145 hours on 16 January 2019, Ms Gardiner was driving the vehicle westbound on the inside lane of the A90 Dundee to Perth road close to the slip

road at St Madoes, Perthshire. She was at a point approximately 530 metres west from the A90 junction with St Madoes, Perthshire. Travelling immediately behind Ms Gardiner was a Renault Heavy Goods Vehicle, flatbed lorry, registered number PX17 LHH, driven by Andrew Kirkpatrick in the course of his employment with RJ & I Monkhouse Ltd. Ms Gardiner's vehicle suddenly slowed/stopped on the inside carriageway. It was then struck to the rear by the vehicle driven by Andrew Kirkpatrick. The force of the collision caused Ms Gardiner's vehicle to be pushed forward some distance. The rear of Ms Gardiner's vehicle was extensively damaged. Ms Gardiner was almost immediately assisted by a passing doctor who had stopped, but tragically she could not be saved and she died at the scene. Neither of the other passengers in her vehicle, nor Andrew Kirkpatrick, sustained serious injury.

[8] The first issue to consider is the cause of the sudden slowing/stopping of Ms Gardiner's vehicle. I say slowing and/or stopping, as the evidence suggested that if the vehicle was stationary at the point of impact, it was so for the briefest of period, perhaps a half second or so.

[9] Robert Booth was a front seat passenger in Ms Gardiner's vehicle. He is a non-driver. He did not notice anything unusual in Ms Gardiner's driving. He did not observe any dangers or anything unexpected. He was aware of the vehicle suddenly slowing and dipping at the front. The only thing he observed as this happened was a look of confusion on Ms Gardiner's face, and he heard her say "oh". He then felt and heard the collision impact.

[10] Andrew Kirkpatrick was driving his vehicle within the speed limit for the road, at approximately 50mph. He had just passed the "on" slip road of the A90 junction with St Madoes. Mr Kirkpatrick did not observe any dangers or anything untoward as he drove along. He checked both mirrors as he drove past the slip road. He spoke of a glint of sunshine in his nearside wing mirror but it did not appear that the glint of sunshine was a relevant factor. As he again looked forward he saw Ms Gardiner's vehicle suddenly slowing under what he believed was heavy braking. Mr Kirkpatrick immediately and forcefully applied his brakes, but that did not prevent him colliding with the rear of Ms Gardiner's vehicle. Mr Kirkpatrick was unsure as to what vehicles had been around him just before the impact, and he had not noticed Ms Gardiner's vehicle before this moment. Mr Kirkpatrick gave various estimates as to how far behind Ms Gardiner's vehicle in front he was travelling. I was of the view that Mr Kirkpatrick was doing his best to assist in this, and his own estimates in fact suggested he might have been driving closer to Ms Gardiner's vehicle than was recommended or was safe.

[11] There was available to me data from Mr Kirkpatrick's vehicle's tachograph and data from Ms Gardiner's vehicle's Restraints Control Module (RCM). An RCM receives data from various sensors around the vehicle that might indicate a collision is about to occur. The RCM then triggers various restraints as required, for example airbags and seat-belt pre-tensioners. The RCM data showed the time taken for Ms Gardiner's vehicle to slow suddenly to a stop just before impact. That was approximately three seconds. The HGV's tachograph showed the distance likely travelled by Mr Kirkpatrick's vehicle over a similar period. The information for each vehicle is independent of the other.

Whilst it cannot be shown with certainty what Mr Kirkpatrick's vehicle was doing during the same three seconds it took for Ms Gardiner's vehicle to stop, the evidence was such that Mr Kirkpatrick's vehicle slowed suddenly, and to a stop, during a similarly short period.

[12] Christine Walsh was driving westbound on the A90 around the time of the collision. She was passing both Mr Kirkpatrick's and Ms Gardiner's vehicles just before the collision. As she was about to pass Ms Gardiner's vehicle, she saw its brake lights come on suddenly. She did not observe any obstruction on the roadway or other reason for that to happen. As she passed Ms Gardiner's vehicle she looked in her mirrors and saw that it was not moving forward, and then heard the bang of the collision.

[13] Crown Production number 9 is a report from Scottish Police Authority Forensic Services dated 3 April 2019. This followed an examination of the rear brake lights of Ms Gardiner's vehicle, and concluded that at the time of the collision to the rear of the vehicle, both brake lights were illuminated.

[14] Crown Production number 4 is the Road Policing Collision Investigation Report for the incident. PC Ian Cattrell spoke to that report. He concluded that around the point of the collision Ms Gardiner's vehicle either slowed dramatically or stopped before being struck from the rear by the Renault motor lorry. There was nothing at the scene to suggest a different conclusion. No defects had been found to exist on either vehicle prior to impact.

[15] Crown Production 5 is a Vehicle Investigation Report of Ms Gardiner's vehicle, following an investigation of the vehicle by Ford UK engineers in to whether there was

any evidence of an error state within the vehicle engine which could have caused the vehicle's engine to shut down or stall prior to the collision. A number of Diagnostic Trouble Codes (DTC) were read from the Powertrain Control Module (PCM). The conclusion was that there were seven DTCs present on the PCM, however none of these showed any evidence of an error state in the engine prior to collision, and that no fault was recorded that would have resulted in vehicle failure.

[16] Crown Production number 6 is a report prepared by Ford UK on the vehicle driven by Ms Gardiner, Ford Transit Custom 310L M1, Registration number SP17 UJW. Crown Production number 7 is a report prepared by Veoneer France on the data downloaded from the Restraint Collision Module (RCM) from the vehicle. The data from that report was used in the preparation of the Ford UK report. Gerard Bowlt, Critical Concern Manager, Ford UK, gave evidence and spoke to the report which he had authored. Ford UK had been asked to examine and report on Ms Gardiner's vehicle because it had come to the attention of the authorities that a similar accident, where a Ford transit minibus had stopped suddenly on a motorway and had been struck to the rear by an HGV resulting in a fatality, had occurred in the year preceding Ms Gardiner's accident. Mr Bowlt explained that whilst the vehicles were both Ford Transit vans, they were in fact quite different. They were of a different age and had different engines. The earlier accident had involved a vehicle with rear wheel drive, whereas Ms Gardiner's vehicle had front wheel drive. There appeared to be nothing to link the two accidents.

[17] The powertrain was removed from Ms Gardiner's vehicle and put into a donor vehicle. After being put through several tests, no issues were observed from the

powertrain testing which could explain why Ms Gardiner's vehicle came to a stop. An inspection of the vehicle did not disclose any defects.

[18] Mr Bowlt in his evidence went through the data from the Restraints Control Module (RCM) in Ms Gardiner's vehicle. The data showed that the vehicle's brake had been applied for three seconds and the vehicle had been brought to a standstill 0.5 seconds prior to the collision. Mr Bowlt explained that the RCM was a measure of brake pedal input, and the data showed that the brake pedal had physically been applied (rather than there being any other explanation for the braking). The ABS operation indicated that there had been a high level of braking. The vehicle had been in the same gear before braking and during braking and it had stalled half a second before the collision, indicating that the clutch had not been depressed.

Conclusion

[19] The evidence from Mr Kirkpatrick was that Ms Gardiner's vehicle had slowed/stopped suddenly in front of him. Mr Booth said he was aware of the vehicle suddenly slowing and dipping at the front. Ms Walsh said that when she was passing Ms Gardiner's vehicle she saw its nose dip as if "the brakes had been anchored", and she saw the brake lights coming on. The brake lights being on at the point of impact was also confirmed by the report from Scottish Police Authority Forensic Services. The brakes being applied sharply by Ms Gardiner was confirmed by the data from the Restraints Control Module (RCM) in Ms Gardiner's vehicle. There was no evidence from the various inspections on Ms Gardiner's vehicle that there was any other cause for

the vehicle to slow suddenly/stop. I am satisfied that the cause of the accident was the sudden slowing/stopping of Ms Gardiner's vehicle as a result of Ms Gardiner applying the brakes sharply. It cannot be said why she did so.

[20] As a result of the sudden braking and slowing/stopping of Ms Gardiner's vehicle, the HGV Renault flatbed lorry being driven by Mr Kirkpatrick immediately behind Ms Gardiner's vehicle, could not stop in sufficient time to avoid colliding with the rear of Ms Gardiner's vehicle. The data produced by the tachograph in Mr Kirkpatrick's vehicle was discussed in evidence and submissions at some length. Although the time taken for Mr Kirkpatrick's vehicle to stop, and the distance travelled during that time, can be seen from the tachograph, it cannot be said with any accuracy how long after Mr Kirkpatrick applied his brakes he then struck Ms Gardiners' vehicle. That is because, after striking Ms Gardiner's vehicle Mr Kirkpatrick's vehicle did not come to an immediate stop, but continued forward for some distance. I heard evidence from PC Cattrell that after the vehicles collided they would have travelled forward together. I also noted the terms of and the photographs contained within Crown Production 4. They showed that Mr Kirkpatrick's vehicle had travelled some distance after the point of impact. Whilst PC Cattrell was prepared to agree some calculations put to him regarding stopping times and distances, he was not prepared to conclude on the basis of those calculations, the distance separating the two vehicles prior to Ms Gardiner's vehicle suddenly slowing down/stopping. Having considered this data, I am unable to conclude whether or not Mr Kirkpatrick was driving behind Ms Gardiner's vehicle at a distance that was recommended or was safe.

[21] Ms Gardiner sadly died as a result of the injuries sustained in the collision.

[22] Robert Booth was the only witness who knew Ms Gardiner. He described her in very affectionate terms. He described Ms Gardiner as kind, caring, enthusiastic and, notwithstanding the significant age difference between them, an easy colleague to speak to. He also described her as interesting, and a unique character who was quite adventurous. This inquiry was held because Ms Gardiner died during the course of her employment. Mr Booth said Ms Gardiner was a person who loved her job, was good at her job and had good relations with her clients.

[23] It is clear Ms Gardiner's death will be a great loss to many. All parties involved in this inquiry offer their sincere condolences to Ms Gardiner's family, friends and work colleagues.