SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FORFAR

[2022] FAI 25

FFR-B96-22

DETERMINATION

BY

SHERIFF JILLIAN MARTIN-BROWN

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

into the death of

DARIUS ZAMYLKO

Forfar, 24 June 2022

The sheriff, having considered the information presented at an inquiry on 14 June 2022 and the written submissions received on 14 June 2022, under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, finds and determines that:

Findings

Section 26(2)(a)

Darius Zamylko died at 13.22 on 28 April 2021 in the Intensive Care Unit at Ninewells Hospital, Dundee.

Section 26(2)(b)

Darius Zamylko's death was as a result of an accident on 21 April 2021 at around 16.10 outside his garage premises at Unit 2, Ferry Road, Montrose.

Section 26(2)(c)

The cause of Dariusz Zamylko's death was entrapment beneath a motor van resulting in hypoxic brain injury and traumatic asphyxia.

Section 26(2)(d)

The immediate cause of the accident resulting in Dariusz Zamylko's death was the deceased starting the engine of a van whilst lying under it, causing the van to move forward, dragging him underneath.

Section 26(1)(e)

Compliance with the precautions set out by the Health & Safety Executive in HSG261 "Health and safety in motor vehicle repair and associated industries" was reasonable and might realistically have prevented Dariusz Zamylko's death, in particular:

(i) Engines should only be started by someone sitting in the driver's seat with their legs in the vehicle, with the handbrake on and the vehicle in neutral gear.

(ii) Brakes should be applied.

(iii) Wheels remaining on the ground should be securely chocked.

(iv) The starting control should be removed from the vehicle and retained by the worker gaining under-vehicle access (i.e. the keys should be removed from the ignition).

(v) A vehicle ramp should be used in a workshop.

Section 26(2)(f)

There were no defects in any system of working which contributed to his death.

Section 26(2)(g)

There are no other facts which are relevant to the circumstances of Mr Zamylko's death.

Recommendations

Section 26(4)(a)

There are no recommendations as to the taking of reasonable precautions which might realistically prevent other deaths in similar circumstances.

Section 26(4)(b)

There are no recommendations as to the making of improvements to any system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(c)

There are no recommendations as to the introduction of a system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(d)

There are no recommendations as to the taking of any other steps which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] This was a mandatory inquiry held under section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act").

[2] A preliminary hearing was held on 24 May 2022. The inquiry was held on 14 June 2022. Written submissions were received on 14 June 2022. Both hearings took place by way of WebEx.

[3] Mr Sadiq, procurator fiscal depute, represented the Crown. Mr Logue, solicitor, represented Aviva Insurance Limited, motor and public liability insurers of Dariusz Zamylko.

[4] Police statements and productions were lodged on a single pen drive. An extensive joint minute of agreement was entered into by the parties.

Facts and circumstances

[5] All of the facts were agreed between the parties and were contained in an extensive joint minute.

[6] Darius Zamylko ("the deceased") lived in Montrose. He was generally regarded as keeping in good health and was not known to suffer from any significant medical conditions.

[7] The deceased was a self-employed motor mechanic trading as W Motors from garage premises at Unit 2, Ferry Road, Montrose, DD10 8DX. There were no persons employed by the deceased. The deceased was an experienced mechanic, who had traded as W Motors since approximately 2014.

[8] On Wednesday 21 April 2021, the deceased's customer Mark Steven arranged for a white Citroen Relay van, registration LD17 HCA, to be dropped off at the deceased's business premises because there had been an issue starting the van. The deceased diagnosed a problem with the starter motor initially. The van was left with the deceased to carry out the repair.

[9] At around 16.10 on 21 April 2021, Christopher Lyons was driving north on Ferry Road, Montrose. Peter Morton was in a separate vehicle travelling north behind him. They both became aware of a van moving slowly diagonally across Ferry Road towards a parked blue Ford Transit minibus, registration MW55 UUC.

[10] Mr Lyons sounded his horn to alert the driver but on getting closer noticed that there was no one within the driver's seat of the van. Mr Lyons stopped his vehicle when

the van came to rest against the parked blue Ford Transit minibus. Mr Lyons then noticed that the deceased was trapped underneath the van.

[11] Mr Lyons got out of his van and immediately went over, crouched down and tried to speak with the deceased but received no response. Mr Lyons contacted the emergency services to report the incident and then checked for signs of life. He could feel a pulse from the deceased.

[12] Mr Morton also got out of his vehicle and went over to the van. He could see that the deceased was trapped under the van. He tried to administer first aid to the best of his ability with the deceased still being trapped. The deceased was unconscious and in a contorted position underneath the front axle of the van.

[13] Mark Steven received a phone call about the incident involving his van. He immediately attended and saw the deceased under the van. Mr Steven removed the keys from the ignition of the van.

[14] Scottish Fire and Rescue Service attended to assist with the recovery of the deceased from under the van using airbags. Watch Commander Kenneth Mackie went round to the driver's door of the van and opened it. He did not touch the gear stick and did not know if the van was in gear. He looked for the handbrake between the driver and the passenger seat but it was down the right side of the driver's seat at the driver's door. He saw that the handbrake was up and put his hand on to check it. He was satisfied the handbrake was engaged before he touched it. The ignition was not on. There were no lights on the dashboard and the engine was not running.

[15] The deceased was in cardiac arrest when the ambulance crew arrived. Cardiopulmonary resuscitation was administered. The deceased's vital signs improved. When stable, the deceased was conveyed by road to Ninewells Hospital, Dundee by ambulance, where his condition was described as being critical. An air ambulance was at the locus but the decision was taken to transport the deceased by road due to the risk of the deceased going into cardiac arrest again. There was more room in the ambulance to treat a patient in cardiac arrest.

[16] The deceased had been working underneath the van, which was parked half on a pedestrian footpath and half on the road, about 20 yards down the road from his business premises at Unit 2, Ferry Road, Montrose. That allowed the deceased enough space to gain access underneath the van to carry out the work. The deceased was lying under the van, working within the engine compartment, with the van in gear and the parking brake applied. The deceased started the engine of the van whilst lying under it.

[17] The van moved forward off from the kerb, dragging the deceased underneath. There were scratch / drag marks on the road indicating the van's path. A torch and set of leads were recovered from the path of the van.

[18] Later that day at around 15.50, the deceased's brother, Kamil Zamylko, and the deceased's partner, Marta Pokorzynska, identified the deceased to PC Ferrie and PC Butter. At that time, the deceased was in an induced coma within the intensive care unit at Ninewells Hospital, Dundee.

[19] On Monday 26 April 2021, the van was taken to a garage for examination by PC Stewart Coupland and PC Michael Guild. The parking brake required a reasonable

amount of travel in order to apply the brake. When the van was not running, the handbrake was adequate in preventing it from rolling away. The van's starter motor had fresh cleaning marks on it consistent with it recently been worked on. Partial engagement of the parking brake to the "8 clicks" position was sufficient to hold the van in position. However, when the van's engine was running and the vehicle was in first gear, partial application of the parking brake was not sufficient to hold the van in position. Further tests revealed that when the parking brake was fully engaged to the "12 clicks" position, it was sufficient to hold the van in position when the engine was running and the van was in first gear.

[20] The garage premises had three vehicle lifts which were capable of lifting vehicles up to 3 tonnes each. The premises were full with approximately 12 vehicles.

[21] On Tuesday 27 April 2021, the deceased's life support was switched off because his condition was considered as not being compatible with life. At around 13.22 hours on Wednesday 28 April 2021, Matthew Casey pronounced life extinct within the intensive care unit at Ninewells Hospital, Dundee.

[22] The deceased was conveyed to the Police Mortuary in Dundee. On 30 April 2021, Dr Helen Brownlow carried out an autopsy examination on the body of the deceased. An external examination did not reveal any marks of injuries on the body which could be regarded as suspicious or give rise to concerns. Dr Brownlow certified the cause of his death as: I (a) hypoxic brain injury; (b) traumatic asphyxia; and (c) entrapment beneath motor van.

[23] Toxicology analyses of ante mortem blood gave negative results. CCTV footage of the incident was available.

[24] Inspector Michelle Gillies of the Health & Safety Executive carried out an investigation into the accident. In her report dated 12 July 2021, she concluded that cause of the accident was the deceased starting the engine of the van whilst lying under it, causing the van to move forward, dragging him underneath. She also concluded that the accident would not have occurred if the deceased had followed guidance issued by the Health & Safety Executive in HSG261 "Health and safety in motor vehicle repair and associated industries", in particular:

(i) Engines should only be started by someone sitting in the driver's seat with their legs in the vehicle, with the handbrake on and the vehicle in neutral gear.

(ii) Brakes should be applied.

(iii) Wheels remaining on the ground should be securely chocked.

(iv) The starting control should be removed from the vehicle and retained by the worker gaining under-vehicle access (i.e. the keys should be removed from the ignition).

(v) A vehicle ramp should be used in a workshop.

[25] HSG261 highlights that failure to follow these procedures, for example operating the starter motor from outside the vehicle, has resulted in fatal injuries due to the vehicle falling from a lift, running over a worker beneath it or crushing someone as an open door passes a support pillar, adjacent vehicle or other fixed object.

Submissions

[26] The procurator fiscal submitted that both the cause of the deceased's accident and the relatively simple precautions which might realistically have prevented it were set out in the HSE investigation report. This was an unfortunate accident and no findings in terms of section 26(2)(f) or (g) were sought.

[27] Aviva submitted that complacency may have had a part to play in the accident and the accident was a reminder of the importance of ensuring that even experienced workers follow safety precautions in garages to prevent similar accidents in the future.

Legislation

[28] The Health and Safety at Work Act 1974 imposes duties upon self-employed persons as well as employers. Section 3(2) provides:

> 3. General duties of employers and self-employed to persons other than their employees.
>
> …
>
> (2) It shall be the duty of every self-employed person who conducts an undertaking of a prescribed description to conduct the undertaking in such a way as to ensure, so far as is reasonably practicable, that he and other persons (not being his employees) who may be affected thereby are not thereby exposed to risks to their health or safety.

[29] Self-employed persons are defined in section 53(1) as follows:

> 53. General interpretation of Part 1
>
> (1) In this Part, unless the context otherwise requires-
>
> …
>
> "self-employed person" means an individual who works for gain or reward otherwise than under a contract of employment, whether or not he himself employs others;

Findings and recommendations

[30] Having considered all of the evidence in this inquiry, my findings are in line with the conclusions of the HSE investigation. This was a tragic accident, caused by the deceased starting the engine of a van whilst lying under it, causing the van to move forward, dragging him underneath.

[31] The deceased, as a self-employed person, was under a legal duty to conduct his garage business in such a way as to ensure, so far as is reasonably practicable, that he was not exposed to risks to his health or safety.

[32] The precautions set out in the guidance issued by the Health & Safety Executive in HSG261 "Health and safety in motor vehicle repair and associated industries" were reasonably practicable and would have prevented his accident. HSG261 highlights that failure to follow these precautions, for example operating the starter motor from outside the vehicle, has resulted in fatal injuries due to the vehicle running over a worker beneath it.

[33] There was no evidence that the deceased *routinely* failed to follow such precautions. His garage premises had three vehicle lifts which were capable of lifting vehicles up to 3 tonnes each. There was therefore no evidence to suggest a defect in his system of working. Unfortunately, this inquiry serves as a reminder of the importance of such safety precautions on *every* occasion, even for experienced mechanics.

Conclusions

[34] I am grateful to the solicitors involved for their professionalism in investigating matters without delay, seeking agreement of evidence and preparing detailed written submissions.

[35] Finally, I wish to express my sincere condolences to Mr Zamylko's family and friends, which were echoed in the submissions made by both parties.