

**SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY  
AT LANARK**

**[2024] FAI 23**

LAN-B112-22

DETERMINATION

BY

SHERIFF ADRIAN COTTAM

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

into the death of

**BOGDAN-GEORGE POPA**

LANARK, 31 May 2024

The Sheriff, having resumed consideration of the evidence led, productions, the terms of the joint minute and the written and oral submissions presented at the inquiry,

Finds and Determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016:

(1) When and where the death occurred (In terms of section 26(2)(a)):

Bogdan-George Popa, date of birth 18 August 1989, died on Saturday 29 January 2022 on the northbound carriageway of the M74 Motorway, approximately 1.5 miles north of Junction 11. His life was formally pronounced extinct at 08.15 hours.

(2) When and where any accident resulting in death occurred (In terms of section 26(2)(b)):

The accident resulting in Mr Popa's death took place at approximately 07:45 hours on Saturday 29 January 2022 on the carriageway of the M74 Motorway, between junctions 10 and 11, approximately 1.5 miles north of Junction 11.

(3) The cause of death (In terms of section 26(2)(c)):

The cause of death was head injuries following a road traffic collision in which Mr Popa was a driver.

(4) The cause or causes of any accident resulting in the death (In terms of section 26(2)(d)):

The accident was caused by Mr Popa's curtain sided articulated lorry being struck by a strong gust from an already strong side wind. The wind caused Mr Popa to lose directional control as the vehicle began to roll onto its offside. Mr Popa had no opportunity to regain control. The lorry tipped over fully onto its offside before crossing the metal barrier into the southbound carriageway and struck an oncoming vehicle.

(5) Any precautions which, (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided (in terms of section 26(2)(e)):

- a Mr Popa could have slowed his vehicle down to approximately 20 or 30 mph, through the area where cross wind warnings had been highlighted, thus potentially allowing him an opportunity to recover from the gust.
- b Mr Popa could have stopped his journey at a safe place when he first felt that the impact of the wind was affecting the steering and control of his lorry.

(6) No findings in terms of sections 26(2)(f) of the 2016 Act.

(7) Any other facts which are relevant to the circumstances of the death (In terms of section 26(2)(g))

- a The accident took place during a period of time covered by a yellow weather warning.
- b The company could have provided clearer information to drivers on the impact of stopping or postponing a journey due to high winds or other weather conditions in respect of pay or rest days.

**Reasons for Section 26(2)(e) findings:**

- a. There was insufficient evidence to establish an exact speed at which the wind could not, as a matter of certainty, have affected the lorry. However, the evidence led strongly suggested that a combination of a lower speed and the skill of the driver could have given an opportunity to regain control after the unexpected cross wind hit the lorry. There is no evidence however that Mr Popa was driving at excessive speed. It is reasonable for a driver to slow down from an otherwise “normal” speed, having observed the cross winds

warning signs and knowing through training how winds can affect the type of vehicle being driven.

- b. There was evidence that showed at least one safe stopping place for lorries after the time that the cross winds began to affect the control of the vehicle and after the additional road signs / overhead gantry warnings (Mr Popa's knowledge being shown by the WhatsApp exchange). While of course an unexpected strong gust could have occurred at any time at any place it is plain that had the lorry stopped in advance of the area of the accident then the collision would not have occurred at that time and place.

**Reasons for comments in terms of Section 26(2)(g):**

- a. A yellow weather warning is the lowest level of warning and relates to the least severe weather. The consideration of the whole facts and circumstances must be read in that context, as opposed to different considerations had an amber or red warning been in place. It is therefore important to record this as a fact.
- b. From the evidence led there was a clear tension between a. drivers taking heed of warnings/training about the impact of wind and b. the desire to fulfil their duties and deliver on time. It was not possible on the evidence to ascertain exactly the information provided to Mr Popa, but the impression left was that drivers in general may not be entirely comfortable waiting for weather to pass.

Different companies may have different policies but it should be made clear exactly what will happen to pay and, if appropriate, future shifts or rest days if stopping means the delivery is “late”. The impact on pay and conditions, according to company policy, of any delay caused by a decision to pull up due to weather conditions could be made clear and drivers reminded of it by way of ongoing training/refreshers. Simply doing this at induction or by provision of written material may not be effective. No driver should be left wondering about docked pay or missing rest days when contemplating safety.

There is no finding that the information was not available to Mr Popa, but equally no finding that he was certain of any impact of a decision to stop, hence the reason for this being a section 26(2)(g) comment.

**Other recommendations sought but not made (and reasons)**

Section 26(2)(e)

(i) It would have been a reasonable precaution for the employer company XDP not to send out a lightly loaded vehicle during extreme weather conditions with high winds and gusts expected.

Reason:

The weather cannot on the evidence led be described as “extreme”. This was a yellow weather warning and drivers have the skills and knowledge to mitigate risks. The warning does not suggest that vehicles of any type should not travel.

This recommendation can therefore not be made on the evidence agreed and led.

(ii) It would have been a reasonable precaution for the employer company XDP to postpone the delivery of flat pack furniture until Monday 31 January 2022, or alternatively to delay the commencement of the journey to 4 pm on Saturday 29 January 2022 when weather conditions were expected to improve.

Reason:

It is correct to state that had Mr Popa not been on the exact stretch of road at the exact time the gust hit the lorry then the accident would not have occurred. It is speculative to consider if another gust at another point on the road may have had the same effect. Therefore had the journey been delayed the death is extremely unlikely to have occurred.

The precaution however is not reasonable in terms of the Act when considering the wider implications for transport companies. In considering the reasonableness of a precaution, the Inquiry has to consider suitability and practicality of the solution offered. To suggest in effect that every delivery in this type of vehicle be delayed every time there is a yellow weather warning would have an unreasonable impact on business and the economy.

That is not to say business is more important than safety and lives. This recommendation may be reasonable for extreme weather or where a warning advises against travel. The use of other safeguards such as training and the findings made above are practical in the circumstances of this particular tragic accident.

(iii) It would have been a reasonable precaution for XDP to monitor weather conditions on 28 January 2022; to advise employees driving from Skelmersdale to Cleland, of the Met Office Yellow Weather Warning Wind in force from 04.00 until 15.00 on Saturday 29 January 2022, and issued at 10.24 on 28 January 2022; and changing to an Amber Weather Warning Wind for between 07.00 to 15.00 on Saturday 29 January 2022 and updated at 04.04 on Saturday 28 January 2022. Crown Productions 14 and 15. (Note the Amber Warning relates to east of Scotland, but strong winds also crossing Scotland.)

Reason:

There was insufficient evidence to allow the Inquiry to find that even had drivers been reminded of the warning the journey would have ceased. The findings made already are the precautions which may have prevented the accident. There was evidence that drivers were aware of the possible travel conditions, and other road warnings were in place as well as the WhatsApp exchange.

The amber warning did not cover the location of the journey and is irrelevant in the particular circumstances.

(iv) It would have been a reasonable precaution to remind drivers of exposed areas on routes such as the M74 at the accident locus, which may present dangers of rollover, It would have been reasonable for XDP to remind drivers to slow down significantly at these locations.

Reason:

Journey specific information did not appear to be a practical or reasonable solution on a consideration of the evidence. All drivers must be assumed and trusted to follow their training and guidance and utilise their experience. It is impractical to remind every driver of every risk on every road and every circumstance when driving. There must be trust and reliance on knowledge and skills of the drivers who have passed the necessary enhanced tests to be able to drive HGVs. Other warnings such as road signs and gantries exist.

(v) It would have been a reasonable precaution to advise drivers that if they felt their vehicle was being adversely affected by wind that they should pause their journey, park up until conditions improved, and that they would suffer no penalty financial or otherwise in those circumstances.

Reason:

This reflects the finding in terms of section 26(2)(g). It was not made in these exact terms, as there was insufficient evidence to find as a fact that the company policy was such that there would be no penalty had the journey been delayed. It is not for the inquiry to regulate driver's terms and conditions but the section 26(2)(g) finding should be taken as suggesting that no penalty for staying safe is best practice.



Section 26(2)(f)

(i) Although the employers XDP did have a risk assessment current at the time of the fatality, it was not suitable and sufficient in terms of the Management of Health and Safety at Work Regulations 1999. In January 2022 XDP did not have a safe system of working.

Reason:

There was insufficient evidence to establish that the nature of the risk assessment documentation in place led to a defect in the system of working. The context of the accident was a relatively routine transport journey. The system of work is in effect to get products from A to B. The safety and system of loading and unloading is not a matter for the inquiry, although this is part of a system of work where risks will require to be identified and managed. Once driving the risks are in connection with weather, other road users and the conduct of the driver. I was satisfied that the training, education and information provided was sufficient, subject to the recommendations made.

The overall tenor of the expert evidence and suggestions was to expect an impractical and unreasonable set of requirements in context. Again safety is more important than business, but realistically hauliers are driving in the knowledge of the risks every day like every other driver. They have enhanced skills having passed tests and induction. They must be expected to follow the rules of the road and drive to mitigate risks. Save for the recommendations

made Mr Popa always did this. He was aware of the weather and knew the impact it could have. He was properly trained and qualified.

There was insufficient evidence to find that the lack of the same information that drivers should already be aware of was a defect leading to the accident.

- (ii) It would have been reasonable for XDP to have put in place a system of monitoring of weather conditions, such as the Yellow Weather Warning on 28 January 2021; to advise drivers of the Met Office Weather Warnings where they impact on the routes; during times of high winds, to remind drivers of exposed areas on routes which may present dangers of rollover, and to advise drivers to reduce speed in those localities during times of high winds.

Reason:

This suggested recommendation has been dealt with. It does not form part of a defect in a working system.

- (iii) It would have been reasonable for XDP to have a hands free comms system for each driver, and to communicate any Met Office Weather Warnings to drivers enroute.

Reason:

On a practical and pragmatic basis there is merit in this suggestion simply as it would be helpful for drivers. However there is no evidence that is was a. a defect in a system of work and b. a defect that contributed to the death.

- (iv) It would have been reasonable for the XDP employer to carry out induction and refresher training to drivers on the dangers of driving curtain sided vehicles during conditions of high winds. Such training should have contained advice that drivers

should pull over and park if at any time the driver experienced instability caused by wind. Such training should have emphasised that drivers would not suffer financial penalty or otherwise if such a decision is taken.

Reason:

This recommendation has been adapted to some extent above. I am not satisfied that it forms part of a defect in a system of work or, if it was, that it contributed to the death. There was no evidence that Mr Popa was inadequately trained. He had in fact completed his CPC very recently. The ministry of transport set the standards required to pass the enhanced test and drivers are trusted to maintain their knowledge and levels of skills. It cannot be said on the evidence that as far as Mr Popa is concerned additional training would have prevented this tragic accident as he was recently qualified both here and in Europe.

**Note**

[1] On a personal level, and on behalf of the Court, I express my deepest sympathy to the family of Mr Popa. The grief and continued pain of losing a loved one in a tragic accident is immeasurable. I would like to recognise Mrs Popa's strength in not only attending the Inquiry but participating and giving her evidence as she did.

[2] The court also recognises and thanks the parties for their preparation and presentation of all the issues before the Inquiry.

## **Proceedings**

[3] After relatively substantial preliminary procedure, evidence was led in the Inquiry at Lanark on 24 November 2023, 1 December 2023 and 19 January 2024.

Submissions were heard by way of video conference on 28 March 2024.

[4] There were some accommodation issues in finding a date for the Inquiry to begin due to High Court sittings in Lanark and building problems in Airdrie. The court recognises the impact all delays would have had on the bereaved family. It should be noted however that the parties were actively progressing the case and were well prepared to deal with preliminary issues and the Inquiry itself.

## **Summary**

[5] Mr Popa was employed by XDP Limited as a skilled and qualified Class 1 HGV driver. On Saturday 29 January 2022 he was to drive an articulated curtain sided lorry from Skelmersdale in West Lancashire to Cleland, near Motherwell, in North Lanarkshire. He was delivering a relatively light load of flat pack furniture. This was a route he had driven on numerous occasions. The road is known at parts to be affected by cross winds and permanent triangular warning signs are in place where appropriate. The overhead gantry warning signs on the day also noted the risk of high winds.

[6] On the day of the accident a yellow weather warning was in place for much of the route. This warning was for strong westerly winds especially in the morning which could bring some disruption. It included reference to gusts of 50 to 60 mph. The

warning also suggested likely delays for high-sided vehicles on exposed routes and bridges.

[7] At approximately 07:45 hours on the northbound carriageway of the M74 motorway between Junctions 10 and 11, 1.5 miles north of Junction 11 near Lesmahagow, as the vehicle exited a banked grass verge area, a very strong gust of wind struck the side of Mr Popa's lorry. The gust was estimated to be between 39 and 48 mph. The gust, hitting the relatively light trailer's curtain side (the curtains were drawn), resulted in Mr Popa losing control of the lorry's direction. The vehicle started to roll onto its driver's side and Mr Popa had no chance to regain control. The lorry continued to roll over and ended up fully on the driver's side, then crossed the metal barrier in the middle of the road. The vehicle, on its side, made its way into the opposing southbound carriageway and collided head on with a Land Rover Discovery.

[8] Various people stopped to try to assist Mr Popa and the other driver. Tragically, Mr Popa had suffered significant injuries and when paramedics attended the scene his life was formally pronounced extinct shortly thereafter.

### **Evidence**

[9] The facts of the tragic accident were clear and therefore it is not necessary to rehearse the evidence in detail. The findings and reasoning above cover my consideration and conclusions. However it is helpful to note the following summary of evidence.

[10] A detailed joint minute was prepared by parties and it was of considerable assistance in setting out and establishing the facts.

*Lacrimona Popa*

[11] Mrs Popa is also an HGV driver. She shared her life and previously a business with her husband in Romania before they both moved to the UK. She confirmed that she had not participated in the CPC training in the UK but is trained to the equivalent standard in Europe. She gave evidence that this included training on driving in adverse weather. She confirmed that she was aware of the need to adjust speed and driving style in high winds. She was used to the road, aware of the winds there, as was her husband. She was aware of the difference the loading makes especially to a curtain sided vehicle and recognised a lighter vehicle is at more risk. She had been due to carry out the same journey on the day of her husband's death but as the company only had one trailer she was stood down. Whilst not knowing what each colour signified, she had driven in a yellow weather warning scenario before. She confirmed the driver's communicated by WhatsApp.

*PC Ian Nish*

[12] PC Nish gave evidence detailing his full collision investigation report. He confirmed his factual findings and a detailed description of the location of the accident. He described the impact of the wind even on him trying to carry out his investigation. He advised that the tachograph was damaged in the collision so the only estimate of

speed was to take the distance from depot to the collision site, then calculate the time between leaving and the accident itself. Using  $\text{speed} = \text{distance}/\text{time}$  the average speed over the whole journey was approximately 54 mph. He advised on the contents and guidance of the Highway code which includes reference to slowing down and pulling over for high sided vehicles if the wind is impactful.

***Barry Carle***

[13] Mr Carle has driven HGVs since 2008. He has sat his CPC. His evidence was that it covered loading and also adverse weather. He was driving a flatbed trailer lorry behind Mr Popa prior to the accident. The wind was affecting Mr Popa's vehicle more than him. He recollected driving at a speed of between 50-55mph. He was pulling a flatbed trailer. He saw Mr Popa manage to correct steering on a couple of occasions as they approached the location of the collision and could see the wind was affecting him. He watched the accident occur and stopped to try to offer assistance.

[14] He commented that he knew that if wind was impacting on his control he would pull over and let the conditions calm down. He worked for a different employer from Mr Popa.

***James Foreman***

[15] Mr Foreman was employed by XDP at the time of Mr Popa's accident.

Mr Foreman was based at the Cleland depot. On the day of the accident he was driving the same type of vehicle as Mr Popa. He drove empty to Carlisle and travelled back

north loaded. He described an empty curtain sider “like driving a sailing ship”. He passed an accident which he later learned was Mr Popa’s. He decided he did not wish to continue with his journey. He contacted his own depot manager at XDP and terminated his journey. He had to return to work on the Monday, which was his day off, and complete the delivery. He was not paid extra for this nor any extra time off.

[16] He knew to slow down in adverse weather conditions including high winds. At some points he had slowed down to a speed of 20mph on the day of the accident. He agreed that the handling of the vehicle is indicative of its weight and that drivers should be able to tell from its handling whether its load is heavy or light. He accepted that the only precautions open to a driver once on the road are to slow down or stop and that he was aware of this.

*Karen McNeill*

[17] Ms McNeill is a qualified Health and Safety consultant. She gave opinion evidence in that capacity. Her qualifications and experiences are set out in her report. She gave evidence which led to the suggested findings submitted by the solicitor for the family. Whilst her evidence was full and detailed it can be summarised by her conclusions:

- a. “The revised assessment is more comprehensive however, it still places the onus on the driver to devise a safe plan. In my opinion, there must be a combined approach to driving in adverse weather conditions. There ought to be discussions with the driver, including good route planning that tries to avoid such risks.



b. After all, the Risk Assessment process is the starting point for developing procedures. The employer should implement the control measures identified in the assessment (for example, through developing procedures, training and communication) as the assessed risk rating is dependent on the listed measures being in place, adhered to and monitored.

c. When considering HGVs, weather and wind ought to be included in the planning, especially where weather warnings exist. This would include consultation on the planned route and whether detours were necessary to avoid hazardous areas (like open stretches of motorway). Consideration as to wind conditions and how that would affect the vehicle, including all legs of the journey (when loads would differ).

d. It should be ensured that there is good communication, and that staff are checking/receiving weather forecasts and in communication throughout the route. It ought to be advised which are the most appropriate channels to be monitoring.

e. Once out driving in windy conditions there are a limited number of things a driver can do, apart from slow down and/or park up. Staff should be told clearly of company policy to park up if safe to do so, as part of the company's policy to protect staff (highlighting the information contained within the driver handbook). Changing from enclosed to open stretches of road may not allow the driver the opportunity to park up once on the motorway. From reading the witness evidence, primarily the evidence of the driver from the HGV vehicle travelling behind, Mr Carle, Mr Popa took reasonable care by slowing down to the conditions faced on the motorway. This would be in line with his driver's training (including the Highway Code)".

[18] Ms McNeil confirmed that her evidence was not that a risk assessment would have meant that the vehicle Mr Popa was driving would not be allowed to continue with the journey in the circumstances which existed at the time. She also confirmed that had the weather warning not been in place it may not have been necessary to give advice about wind or advice on what to do. She referred to a grid which could be used to assess the risk, suggesting that there may be a combination of circumstances where the duty would be on an employer to tell a driver to turn round and come back. This might

be the case if the Met Office issues a red weather warning as it in effect prohibits driving. She agreed, having considered the terms of a red weather warning, that somewhere there must be a set of rules regarding the wind speed as instructions will be given to close bridges or roads in particular to high sided vehicles. Finally, she confirmed she was unable to say that even IF a risk assessment took place, in the circumstances presented this would have resulted in a control measure of stopping him driving.

*Alfred Stalker*

[19] Mr Stalker is the manager of the depot at Skelmsdale. He confirmed Mr Popa had been through an induction programme and handed a copy of the XDP handbook. The handbook included advice on driving in winds. He was a driver himself. He confirmed that the WhatsApp group was used daily for real time information to be shared between drivers and managers including updates on weather or road conditions. He was not aware of any prescriptive guidance that could be followed or applied in relation to potential wind speeds, weights of loads or and driving speeds. In his experience all drivers knew they should slow down in conditions of high wind or if necessary pull over until conditions improve. He said he reiterated this periodically to drivers, albeit it not in a formal training session. It was not practice to delay journeys even in the knowledge of a yellow warning. He did recognise the dangers of lightly loaded curtain siders and with hindsight would have preferred a heavier load. He confirmed Skelmsdale drivers are paid if they have to delay their journey due to wind or weather.

[20] Under examination from Mr Conway, Mr Stalker stated that again with hindsight he would not have sent Mr Popa out. However that comment appeared to be predicated by a misunderstanding of the weather warning, with Mr Stalker discussing the impact of an amber warning. It is also clear his comment was tainted by hindsight and fact the tragic accident occurred and he naturally felt that had Mr Popa not gone out he would still be alive. This was not an admission of fault.

### **Conclusion**

[21] My overall impression of the evidence led me to make the recommendations I did. It also allowed me to consider in detail the evidence led by Mr Conway and in particular Miss McNeill's analysis. There are different considerations for the court sitting as a Fatal Accident Inquiry, as opposed to one assessing employment law or health and safety legislation. There are obvious cross overs, but the requirements for section 26 have to be the focus. The evidence here related to a tragic accident, which, in essence was caused by the gust of wind. It was helpful to hear of a wider picture and it provided a context. My findings have to be limited to those I made in terms of the Act.

[22] That is not to say I felt restricted or that I feel there are wider implications but simply to explain the framework in which I gave full consideration to all the evidence.

[23] I am again grateful to parties for their conduct of the enquiry and reiterate by deepest condolences.