SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

[2025] FAI 8

INV-B61-24

DETERMINATION

BY

SHERIFF IAN HAY CRUICKSHANK

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

into the death of

CHLOE RACHEL MORRISON

For the Crown: Mr Dickson, Solicitor Advocate for the Procurator Fiscal, Inverness.
For Glenevin Limited (in administration): Mr Anderson KC, instructed by Clyde & Co, Solicitors, Aberdeen.
For John O'Donnell: Mr Graham KC, instructed by DAC Beachcroft, Solicitors, Glasgow.

Inverness, 16 January 2025

DETERMINATION

The Sheriff having considered the information presented at the inquiry determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act") that:

(1) In terms of section 26(2)(a) of the 2016 Act Chloe Rachel Morrison ("Chloe Morrison") died whilst walking along a foot path adjacent to the north side of the A82 at Kerrowdown, approximately 0.7 miles north of Drumnadrochit, at or about 1336 hours on 25 October 2019.

(2) In terms of section 26(2)(b) of the 2016 Act, a collision at the above locus resulting in the death of Chloe Morrison occurred shortly prior to the time of her death on 25 October 2019.

(3) In terms of section 26(2)(c) of the 2016 Act the cause of death was:

I. (a) multiple injuries due to (or as a consequence of)

(b) pedestrian struck by lorry.

(4) In terms of section 26(2)(d) of the 2016 Act the cause of the accident resulting in the death of Chloe Morrison was that, as she walked along the pavement with her mother, Chloe was walking nearest to the road. A large goods vehicle ("LGV") owned and operated by Glenevin Limited was at that time being driven by John O'Donnell in the course of his employment. The LGV approached Chloe from behind. The nearside outrigger, being part of a crane mounted on the LGV, was fully extended horizontally and locked in that position. The nearside outrigger extended 1.3m over the pavement. The nearside outrigger struck Chloe Morrison from behind and caused the injuries she sustained.

(5) In terms of section 26(2)(e) of the 2016 Act, a number of precautions could reasonably have been taken. Had these precautions been taken, they might realistically have resulted in death, or any accident resulting in death, being avoided. The precautions which could reasonably have been taken were;

1. Glenevin Limited should have been aware of the absence of a "not stowed" warning system in relation to the outriggers on the LGV driven by

John O'Donnell albeit there was no legal obligation on the Company to have such a safety device fitted to the LGV involved in the collision.

2. Glenevin Limited, whilst having instructed John O'Donnell not to operate the lorry loader during loading or unloading operations, should have taken steps to ensure that John O'Donnell was trained, as part of daily walk around checks, to ensure that the outriggers were secure and safely stowed prior to commencement of the journey.

(6) In terms of section 26(2)(f) of the 2016 Act, there were no defects in the system of working which contributed to the death or the accident resulting in the death.

(7) In terms of section 26(2)(g) of the 2016 Act, there were no other facts relevant to the circumstances of death in this case.

RECOMMENDATIONS

In terms of section 26(1)(b) of the 2016 Act the court makes the following recommendations. In the particular circumstances of the death of Chloe Morrison these are recommendations which can properly be made in relation to the matters referred to in terms of section 26(4)(d) of the 2016 Act. The following recommendations are made:

1. That the operators of any LGV, or heavy goods vehicle ("HGV"), which is fitted with outriggers should take steps to ensure that any driver operating such a vehicle be trained to ensure that outriggers are safely stowed prior to the commencement of any journey.

2. That the operators of any LGV or HGV fitted with outriggers ensure that drivers make checks, and record these checks, as part of their daily walk around of the vehicle on the daily defect form used for that purpose.

3. That the UK Government, through the Secretary of State for Transport, give consideration to the introduction of statutory provisions to the effect that all LGVs and HGVs fitted with outriggers must be fitted with an audible and visible warning system and/or an immobiliser for the purpose of giving warning whilst the vehicle is in motion that the outriggers are not secure or safely stowed.

4. That the UK Government, through the Secretary of State for Transport, ensure that any such statutory provisions introduced should be retrospective in effect so that the requirement to fit the warning and/or immobiliser systems as stated above shall apply to all LGVs and HGVs fitted with outriggers regardless of their year of manufacture or year of installation.

NOTE

Introduction

[1] This is a discretionary Fatal Accident Inquiry in terms of section 4 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act"). In terms of section 4(1)(a) of the 2016 Act the inquiry is being held as it has been considered that the death occurred in circumstances which may give rise to serious public concern. It has been decided by the Lord Advocate that it is in the public interest for an inquiry to be held.

[2] The death of Chloe Morrison was reported to COPFS on 25 October 2019 or shortly thereafter.

[3] The date of the preliminary hearing in relation to this inquiry was 18 April 2024. The preliminary hearing was, in the first instance, continued to 24 June 2024. Thereafter the preliminary hearing was continued administratively on a number of occasions. The court assigned 13 and 14 November, together with 5 and 6 December, all 2024 for the purposes of hearing evidence. This was assigned as an "in person" hearing at Inverness Sheriff Court. As it transpired, given the level of agreement of evidence, not all of these days were required.

[4] The Crown was represented at the inquiry by Mr Dickson, Solicitor Advocate for the Procurator Fiscal. Glenevin Limited (first participant), the Company who owned and operated the lorry involved in the incident, was represented at the inquiry by Mr Anderson KC. At the time of the inquiry the Company was in administration. Mr John O'Donnell (second participant), the driver of the lorry involved in the collision, was represented by Mr Graham KC. No other interested parties were present or represented.

[5] In the course of the inquiry the parties helpfully entered into three Joint Minutes of Agreement. This assisted greatly in the presentation of evidence and led to the number of witnesses required to give oral evidence to be substantially reduced.

[6] As a result of the above procedures, the inquiry had before it the following evidence, and in the following format:

1. Oral evidence given by Douglas Edward Potter.

2. Oral evidence given by Darren Van der Boon.

3. Oral evidence given by John O'Donnell.

4. Statements of Jamie Davies and Nina Day.

5. Various reports the terms of which were agreed.

6. Various photographs and CCTV footage the terms of which were agreed.

7. A victim impact statement by the parents and sister of Chloe Morrison.

[7] The Crown lodged 69 productions which included the evidence referred to in 4-6 above. The productions were in various formats. The terms of a large number of these productions were agreed for their various terms. No productions were lodged on behalf of either participant.

[8] The inquiry commenced with the reading of a victim impact statement which had been prepared by Chloe's parents, Robert and Karen Morrison, and Chloe's sister, Jodi Morrison-Napier. Whilst I will not repeat the terms of that statement, this was a powerful and thought provoking contribution to the inquiry which reinforced the tragedy and sadness still felt by the friends and family of Chloe.

The Legal Framework

[9] This inquiry was held under section 1 of the 2016 Act. As I have already stated, the inquiry was a discretionary inquiry in terms of section 4 of the 2016 Act.

[10] The inquiry and relevant procedure are further governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[11] In terms of section 1(3) of the 2016 Act, the purpose of this inquiry is to establish the circumstances of the death of Chloe Morrison, and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. Section 26 of the 2016 Act sets out what must be determined by the inquiry. This requires the sheriff to make a determination setting out various circumstances surrounding the death. A sheriff's determination must also set out such recommendations (if any) as to any of the matters mentioned in section 26(4) as the sheriff considers appropriate. The matters outlined in that subsection include such recommendations as to the taking of any steps which might realistically prevent other deaths occurring in similar circumstances.

[12] A Fatal Accident Inquiry is an inquisitorial process, and it is not the purpose of the inquiry to establish civil or criminal liability.

[13] The manner in which evidence may be presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information.

SUMMARY

[14] I found the following facts to be admitted or proved:

Chloe Rachel Morrison

1. Chloe Rachel Morrison ("Chloe Morrison") was on born 17 May 1993. She resided with her parents and older sister in Drumnadrochit.

2. Chloe Morrison was 26 years of age at the time of her death. She was employed full time as an Early Years Teaching Practitioner at Holm Primary

School, Inverness. Chloe loved life and enjoyed spending time with friends and family. She had been with her partner for three years. She enjoyed walking and also driving to visit various beaches, her favourite beach being at Achmelvich.

3. Chloe is hugely missed by her family. They continue to feel great sadness following her death. Chloe's family were overwhelmed by the support they received from their local community.

Glenevin Limited

4. On 11 February 2013, Glenevin Limited was incorporated with company number 08397690 and company name Glenevin Construction Ltd. On 16 March 2023, Glenevin Construction Limited changed its name to Glenevin Limited. On 6 September 2024 Glenevin Limited entered administration.

5. In early October 2019, Glenevin Limited appointed external road transport consultants to review certain of its internal procedures. On or around 15 October 2019 the consultants advised Glenevin Limited that they had identified the absence of a formal induction process to inform new drivers of rules, regulations or company-specific expectations. The consultants advised Glenevin Limited to implement certain formal processes. These were to include pre-employment licence checking, the issuing of a driver handbook and confirmation of knowledge of rules and assessment of skills, which drivers should themselves sign-off to confirm. As of 23 October 2019, the date upon which John O'Donnell entered their employment, Glenevin Limited was in the

process of considering the advice it had been given and was in the process of developing a plan to implement it. The Company implemented their plans in this respect by December 2019.

Scania lorry, registration M25 NEW

6. The mechanically propelled vehicle driven by John O'Donnell on 24 and 25 October 2019 was a Scania P270 "beaver tail" flat bed large goods vehicle ("the LGV"). Fitted to the LGV was a Palfinger PK15500 lorry loader crane ("the lorry loader"). The registration number of the LGV was M25 NEW.

7. The LGV was owned by Glenevin Ltd. The Company had acquired the LGV on 1 October 2019. The LGV had a valid MOT certificate which had been in force since 18 June 2019. The lorry loader was already fitted to the LGV when the vehicle was acquired by the Company.

8. Crown Production 4 is a book of photographs taken on 28 October 2019 at Elgin Truck and Van Centre, 38 Carsegate Road, Inverness. It contains images of the LGV and the lorry loader. In particular, the photographs show the following:

a. Photographs numbered 2-3 show views of the LGV;

b. Photographs numbered 4-5 show views of the nearside outrigger of the lorry loader;

c. Photographs numbered 10-12 show views of levers and positioning on the nearside of the LGV;

d. Photograph numbered 13 shows views of the nearside outrigger;

e. Photographs numbered 19-20 show views of the nearside wing mirror of the LGV from the driver's seat.

9. The lorry loader was fitted with outriggers to aid stability when in use. There was a two-stage process to manually unlock the outriggers from their stowed position. A primary lock required to be pulled back and disengaged. Thereafter a secondary lever required to be turned anticlockwise. This raised and disengaged the secondary lock. When the secondary lock was disengaged a yellow warning "collar" on the secondary lever would become visible. The yellow warning collar was approximately 4 inches in width.

10. The outriggers could be extended vertically to ground level and horizontally outwards from the lorry loader and therefore also horizontally outwards from the LGV. Both processes were capable of independent operation. The outriggers could be extended vertically whilst locked in the stowed position. When fully extended horizontally the outrigger would lock in that position. Once locked in that position, the outrigger arm could not be retracted without further operator input.

11. In order to safely stow the outriggers after horizontal extension, the operator would require to reverse the unlocking procedure.

12. The LGV was not fitted with an audible alarm, visual warning aid or immobiliser. Such fitments would alert a driver in the event that they attempted to move the LGV when either outrigger was not in the safely stowed position.

The fitments would also alert a driver if either outrigger became insecure during transit.

13. Due to the year of manufacture of the LGV involved in the collision there was, and remains as at the date of these proceedings, no legal requirement that the LGV be fitted with any such device.

John O'Donnell and employment with Glenevin Limited

14. On 23 October 2019, John O'Donnell commenced his employment with Glenevin Limited. He was a lorry driver and held a valid Irish driving licence. He further held an Irish qualification card which authorised him to drive vehicles, including the LGV, on UK roads. Mr O'Donnell held an in-date Certificate of Professional Competence.

15. On 23 October 2019 John O'Donnell received an induction from Glenevin Limited's Health and Safety Advisor Darren Scott Van der Boon. At that time Mr Van der Boon held a National Examination Board in Occupational Safety and Health (NEBOSH) NVQ Level 6 qualification in occupational health and safety. Mr Van der Boon commenced his employment with Glenevin Limited sometime between December 2017 and January 2018.

16. The induction given by Mr Van der Boon included the checking of Mr O'Donnell's qualifications and certification. It further included both being involved in a "walk around" of the LGV.

17. John O'Donnell had no training which entitled him to operate lorry loaders. It was not part of his employment with Glenevin Limited that he would operate the lorry loader. In relation to the journeys undertaken on 24 and 25 October 2019, John O'Donnell was instructed by Mr Van der Boon not to operate the lorry loader. John O'Donnell was competent to carry out pre-journey walk around checks of the LGV and to action any issues identified. He was not trained to carry out pre-journey checks of the lorry loader outriggers or to action any issues identified.

18. Prior to the journeys undertaken on 24 and 25 October 2019, Glenevin Limited did not give John O'Donnell any information, instruction or training concerning pre-journey checks of the lorry loader outriggers which would ensure that they were safely stowed prior to transit.

19. Crown Productions 12 and 13 is documentation held by Glenevin Limited in respect of John O'Donnell.

20. Crown Production 67 contains Glenevin Limited vehicle defect reports relating to the LGV, completed by John O'Donnell and dated 24 and 25 October 2019.

21. Darren Van Der Boon was familiar with lorry loaders from past experience elsewhere. He was aware that some vehicles which carried lorry loader cranes were fitted with audible alarms and/or immobilisers to warn a driver should they try to move the vehicle when an outrigger leg was not securely stored. Mr Van Der Boon could have enquired as to whether such

devices were fitted to the LGV. He did not do so. He was unaware whether or not any such devices were available to John O'Donnell for the tasks he was to carry out during the course of his employment.

Journey of 24 October 2019

22. On 24 October 2019 Mr Van der Boon instructed John O'Donnell to drive the LGV to Inverness to collect bales of pipes and to deliver them to Skye. The load consisted of 4 bales. Each bale contained 110 pipes which were 6m in length. John O'Donnell was instructed not to use the lorry loader, but to seek the assistance of other Glenevin Limited employees for the unloading operation when he reached Skye.

23. In the course of his journey John O'Donnell drove the LGV on various roads or other public places, including the A82, A887, the A87, and the A855. This was in the course of a journey between premises occupied by Glenevin Limited at Oldmeldrum, Aberdeenshire and Inverness. Thereafter the journey included driving through Drumnadrochit, Invermoriston, Portree and Duntulm on the Isle of Skye.

24. During the journey on 24 October 2019, both the nearside (passenger side) and offside (driver side) outriggers of the lorry loader were locked in the safely stowed position.

Journey of 25 October 2019

25. Between 24 October 2019 at 16.24 hours, at the Loch Ness Clansman Hotel, Brackla, Loch Ness-side, Inverness and 25 October 2019, at 10.55 hours, at the Central Filling Station, Main Road, Kyle of Lochalsh the outriggers on the LGV became unlocked. These unlockings must have involved manual operation of the locking mechanisms.

26. On the morning of 25 October 2019, the LGV was unloaded on Skye. During the unloading operation the nearside and offside outriggers were in the unlocked position. The outrigger legs were deployed vertically.

27. Following the unloading operation, the outrigger legs were raised. The outriggers were not locked in the safely stowed position prior to departure from Skye.

28. John O'Donnell commenced his return journey from Skye with the outrigger legs raised and horizontally retracted. The outrigger legs remained retracted horizontally throughout the journey.

29. John O'Donnell drove the LGV on various roads or other public places, namely the A855, the A87, A887 and the A82, during a journey between Kilmuir Cemetery, Kilmuir, and the Co-operative Petrol Station, Portree Road, Broadford, both Isle of Skye, a layby between Invermoriston and Alltsigh, Loch Ness, Drumnadrochit and Kerrowdown. During the course of this journey the collision occurred.

30. Crown Production 14 is a map which shows the routes taken by John O'Donnell on both 24 and 25 October 2019.

31. Crown Production 15 is a map showing the route taken by John O'Donnell on 25 October 2019. This map shows the locations of CCTV systems from which images were recorded and subsequently downloaded on to Crown

Label 7 and 16.

32. Crown Production 16 is a map showing Drumnadrochit and surrounding area. This map shows the locations of the CCTV systems from which the recorded images were obtained for Crown Label 14, 15 and 16.

33. The first point at which CCTV captures the nearside outrigger to be extended on the LGV is at Drumnadrochit. This CCTV footage was captured 0.9 miles prior to the collision. At this point, the outrigger is partially extended.

The collision locus

34. The collision occurred on the A82, approximately 0.7 miles north of Drumnadrochit near to Kerrowdown.

35. At the locus the A82 is a 2-way undivided carriageway approximately 6.1m in overall width. Hazard warning lines separate both lanes which are of equal width. A footpath, 1.44m wide, was on the north side of the carriageway. The footpath was raised approximately 0.15m from the road surface.

36. The A82 carriageway at Kerrowdown is governed by the national speed limit which, for the LGV, was 40 mph. When the collision occurred, the LGV was travelling at 49 mph. Speed was not a factor in the collision.

37. When the collision occurred the weather at the scene was dry, bright, and sunny. Visibility for road-users at the time was excellent.

The collision

38. Chloe Morrison was walking with her mother, Karen Morrison, on the pavement on the north side of the A82 at Kerrowdown. Chloe Morrison was walking nearest to the road. The LGV was being driven along the A82 and approached Chloe Morrison from behind. When it did so, the nearside outrigger was locked in the fully extended position. The nearside outrigger extended 1.3m over the pavement. The nearside outrigger struck Chloe Morrison from behind on the area of her upper back and did further drive over her right leg.

39. Following the collision, Chloe Morrison was thrown along the pavement for a distance of 35 metres before coming to rest. Chloe Morrison sustained severe injuries as a result of the collision.

40. Following the collision, members of the public, including a nurse, stopped at the scene to render assistance to Chloe Morrison. The nurse was unable to detect a pulse. The emergency services were contacted and attended promptly.

41. At or around 13.32 hours, paramedics and an on-duty Intensive Care Consultant arrived at the scene.

42. Chloe Morrison was pronounced deceased at the scene at 13.36 hours.

Post-mortem examination

43. On 29 October 2019 a post-mortem examination took place at Raigmore Hospital, Inverness. Chloe Morrison was found to have sustained multiple injuries to her head, chest, abdomen and pelvis. These included multiple bruises and abrasions, a fracture to the base of the skull, a fracture to the vertebrae, fractures to eighteen ribs, and a transection of the brainstem. These injuries were all sustained as a result of the collision with the LGV.

44. Cause of death was recorded as;

1(a) multiple injuries due to (or as a consequence of)

1 (b) pedestrian struck by lorry.

Investigations following upon the collision

45. Police Officers, including Collision Investigators, attended the locus.

46. John O'Donnell complied with the requirements of section 172 of the Road Traffic Act 1988. He provided negative readings for the presence of alcohol or drugs.

47. A Collision Investigation was carried out by Police Constables Tonner and Housby. As a result of their investigations the police officers concluded that:

(a) The deceased and the LGV were both travelling in the same direction when the collision occurred. Unless the deceased had looked behind her, she would not have been aware of the approaching LGV and the extended outrigger arm. The deceased was on the pavement when she was struck.

(b) The outrigger was mobile for at least 0.9 miles prior to the collision as the LGV travelled through the village of Drumnadrochit and towards the locus. On becoming fully extended it locked in that position. Using the aforesaid distance of 0.9 miles, it was calculated that the minimum amount of time that the outrigger was mobile and visible to the driver was 1 minute and 6 seconds.

DVSA examination of LGV and lorry loader

48. On 31 October 2019, the LGV and the lorry loader were examined by the Driver and Vehicle Standards Agency ("DVSA"). As a result of the examination, it was concluded by DVSA that:

(a) There was no defective or faulty vehicle component which was likely to have contributed to the collision.

(b) The locking mechanism used to secure the outriggers in the stowed position functioned without fault.

(c) There was no evidence that either outrigger had experienced component failure. The extended state of the nearside outrigger at the time of the collision was due to human intervention.

49. Pages 9 to 14 inclusive of Crown Production 11 show photographs of the outriggers on the LGV, taken by DVSA during their examination on 31 October 2019. These photographs have been correctly annotated.

Association of Lorry Loader Manufacturers and Importers ("ALLMI")

50. ALLMI is the United Kingdom's leading trade association concerned with the design, manufacture, application and use of lorry loaders. It was formed in 1978. ALLMI has three defined objectives:

1. To promote the safe use of lorry loaders.

2. To ensure that the Association is involved in the formulation of legislation that affects the industry's interests, and

3. To promote compliance with the training requirements embodied in current legislation.

51. Crown Production 62 comprises the relevant parts of a report, dated 22 March 2024, by ALLMI Technical Manager Keith Sylvester. The report concerns the circumstances of the death of Chloe Morrison. Mr Sylvester's opinion included the following conclusions:

(a) The outrigger on the LGV should have been fully extended out and down during loading operations.

(b) The collision would almost certainly have been avoided if the lorry loader had been fitted with a stabiliser not-stowed warning system, providing that it was maintained and checked as working at the start of the working day or shift as part of documented pre-use checks.

(c) There was no requirement for the lorry loader to have had a stabiliser-not-stowed warning system fitted at the time of manufacture or installation.

52. Mr Sylvester's report contained the following the opinion that there was a buoyant second-hand market for lorry loaders in the UK. The average life of a loader crane could be around 8 to 10 years, but this could fluctuate greatly. As a consequence, it was very difficult to accurately assess the overall size of the UK lorry loader industry or how many lorry loaders were on the roads without stabiliser "not stowed" warning systems installed. His belief was that a great many lorry loaders were still on UK roads without warning systems installed. At page 24 of his report Mr Sylvester states:

> "In all cases ALLMI strongly advocates the fitting stabiliser and crane not stowed warning systems…The system is typically relatively cheap and can be integrated into the existing crane-not-stowed warning system on most lorry loaders…I have been advised the cost for retrofitting a stabiliser-not-stowed warning system for a lorry loader with manual stabilisers varies from around £250 to £1000."

Health and Safety Executive Reports

53. Crown Productions 63 and 64 are the respective statements of Jamie Davies, HM Principal Inspector of Health and Safety (Mechanical Engineering), and Nina Day, Senior Policy Adviser, Transport and Public Services Unit, both employed by the Health and Safety Executive. These statements are agreed and accepted for their terms.

54. In terms of the agreed statement of James Davies, he was asked to comment on the matter of loader cranes and if there is a retrospective requirement to fit stabiliser leg not stowed warning systems to older cranes where there was no requirement to do so. He answered that there was no requirement to bring older equipment up to current standards. Mr Davies further expressed the view that fitting a "leg not stowed" detection and warning system would be an inexpensive addition and would not compromise the safety of the original design. Such a system, if installed, would not warn the driver of the vehicle if in motion but it would do so if observed by the driver. Such a system, if installed, would ensure that the driver would not forget to stow the stabiliser legs prior to starting the journey. The "crane not stowed" warning is mandated by existing legislation. The "leg not stowed" warning is not mandated by legislation but only in the product standard applicable to when the crane was manufactured.

55. In terms of the agreed statement of Ms Day, she was asked to comment on the requirements for driver training and awareness in relation to lorry

mounted lifting equipment. She confirmed that vehicle operators operating vehicles fitted with additional equipment and machinery must ensure that the equipment is fit for purpose, maintained, and operated only by the people trained to do so. A lifting operation using vehicle mounted equipment on a work site was a work activity to which Lifting Operations and Lifting Equipment Regulations ("LOLER") and Provision and Use of Work Equipment Regulations ("PUWER") applied. The journey to and from a work site was not a work activity to which either LOLER or PUWER applied. As such there was no requirement for the driver to be trained to operate the lifting equipment if that was not part of their job. The lifting equipment on site could be operated by a suitably trained person without any involvement from the driver. Drivers should be provided with information and suitable training on how to check and secure all parts of the lifting equipment and accessories to prevent injury to any person.

Various productions

56. Crown Label 2 comprises footage of a demonstration held at Elgin Van and Truck, 38 Carsegate Road, Inverness on 31 October 2019 by Crown witness Douglas Potter of the operation of the outriggers on the LGV.

57. Crown Label 26 is a disc which contains two compilations consisting of (a) digital recordings of images of events captured by a CCTV system at premises of Glenevin Construction Ltd at Barra Business Park, Mounie Drive,

Oldmeldrum, Aberdeenshire on 24 October 2019; digital recordings of images of events captured by a CCTV system comprising multiple CCTV cameras at Co-op Filling Station, Broadford, Isle of Skye, showing views of the A87 and the filling station forecourt on 25 October 2019 between the times of 10.23 hours and 10.36 hours; digital recording of images of events captured by a CCTV system at Great Glen Gifts, 2 Victoria Buildings, Drumnadrochit, showing views of the A82 on 25 October 2019 and digital recordings of images of events captured by a CCTV system at House of the Highlands, Bank of Scotland Buildings, Drumnadrochit showing views of the A82 on 25 October 2019 respectively and (b) moving footage showing images of events captured at Elgin Van and Truck, 38 Carsegate Road, Inverness on 31 October 2019 being a demonstration by Crown witness Douglas Potter of the operation of the nearside and offside outriggers of the LGV and digital recording of images of events captured by a dashcam system from a police car during a journey on the A82 between a location to the south of Drumnadrochit, through Drumnadrochit to Kerrowdown approximately 0.7 miles north of Drumnadrochit on 29 December 2019 respectively.

The Department of Transport

58. The Department for Transport of the UK Government and its executive agency DVSA does not hold data for the number of LGVs fitted with lorry loader cranes whether or not fitted with outriggers and whether or not fitted with not-stowed warning alarms or immobilisers.

Prosecution of John O'Donnell

59. On 7 September 2022, in the High Court of Justiciary John O'Donnell was convicted after trial of a contravention of section 2B of the Road Traffic Act 1988. The charge of which he was convicted was in the following terms:

> "on 25 October 2019 on roads or other public places, namely the A855, the A87, A887 and the A82, in the course of a journey between Kilmuir Cemetery, Kilmuir, and the Co-operative Petrol Station, Portree Road, Broadford, both Isle of Skye, a layby between Invermoriston and Altsigh, Loch Ness, Drumnadrochit and Kerrowdown, you JOHN JOSEPH O'DONNELL did cause the death of Chloe Morrison, born 17 May 1993, c/o Police Service of Scotland, Bridaig, Dingwall by driving a mechanically propelled vehicle, namely large goods vehicle registered number M25 NEW with a Palfinger PK15500 lorry loader attached carelessly and you did (i) drive said motor vehicle whilst both said nearside and offside outrigger legs were not locked securely in their stowed positions; (ii) at the co-operative petrol station, Portree Road, Broadford, Isle of Skye and a layby between Invermoriston and Altsigh, Loch Ness, Drumnadrochit fail to observe that said nearside and offside outrigger legs were unlocked and insecure; and (iii) and on the A82 at Kerrowdown, having failed to observe that the said nearside outrigger leg was fully extended, locked in position and was protruding outwards over the pavement, he did cause said nearside outrigger leg to strike said Chloe Morrison, a pedestrian walking on the pavement and did drive over her leg whereby she was so severely injured that she died: CONTRARY to the Road Traffic Act 1988, Section 2B"

60. On 26 October 2022, John O'Donnell was sentenced to a Community Payback Order requiring him to carry out 100 hours of work. He was disqualified from holding or obtaining a driving licence for a period of 12 months from that date.

DVSA guidance

61. The Driver and Vehicle Standards Agency ("DVSA") issues guidance on maintaining roadworthiness of commercial goods and passenger carrying vehicles.

62. As at 24 and 25 October 2019, the guidance in force was the Guide to Maintaining Roadworthiness, Commercial Goods and Passenger Carrying Vehicles. This was issued in November 2018. That Guidance is Crown Production 68. Appendix 3A of Crown Production 68 is an example of a driver's vehicle defect report (goods vehicles). The vehicle defect reports contained in Crown Production 67, being the daily defect reports signed off by John O'Donnell on 24 and 25 October 2019, conform to appendix 3A of Crown Production 3A. Appendix 3A of Crown Production 68 does not prompt a driver to check ancillary equipment.

63. Since 2018, the DVSA guidance has been updated periodically. Crown Production 69 is the current version of the guidance, entitled Guide to Maintaining Roadworthiness. This outlines the regulatory requirement and industry best practice for Commercial Goods and Public Service Vehicles. This updated guidance was issued in October 2024. Appendix 3C of Crown Production 69 is an example of a driver's vehicle defect report. Appendix 3C prompts a driver to check ancillary equipment which, having regard to what is stated at paragraph 5.16 of the guidance, would include lifting equipment.

The Office of the Advocate General for Scotland

64. Crown Production 65 is a letter from the Office of the Advocate General for Scotland dated 11 April 2024. On behalf of the UK Government the letter advised that they did not intend to participate in this Fatal Accident Inquiry. The letter further confirmed that the UK Government had no plans at present to make changes to the regulatory framework in respect of the requirement to have stabiliser "not stowed" warning systems fitted retrospectively to vehicles with the proviso that the UK Government would consider any recommendations addressed to them in the sheriff's determination.

Submissions

[15] Mr Dickson, for the Crown, provided me with detailed written submissions. Mr Anderson and Mr Graham, for Glenevin Limited (in administration) and John O'Donnell respectively, provided relatively brief written submissions but this on the responsible basis that neither took issue with the submissions for the Crown. I am very grateful to all parties for their efforts in this respect.

[16] The circumstances which all parties invited me to find in my determination were similar in most respects. All parties agreed on the circumstances which required to be determined in relation to section 26(2)(a) – (d) of the 2016 Act. Based on the evidence as presented I found the circumstances established in line with the parties' respective submissions.

[17] In relation to the circumstances to be determined in terms of section 26(2)(e) of the 2016 Act, Mr Dickson invited me to find that there were two reasonable precautions which could have been taken by Glenevin Limited. These were as follows:

1. To have been aware of the absence of a "not stowed" warning system in relation to the outriggers on the LGV, albeit that there was no legal obligation or requirement to have fitted such a device on the particular LGV, and

2. To have ensured that Mr O'Donnell was trained to check that the outriggers were secure as part of his walkaround checks and, if fitted, to have been trained to have awareness of an alarm system.

[18] In relation to the circumstances to be determined in terms of section 26(2)(f) all parties submitted that there were no defects which had been identified in any system of working which contributed to the death or any accident resulting in death. Based on the evidence heard I agreed with these submissions.

[19] In terms of the circumstances to be found in terms of section 26(2)(g) of the 2016 Act, being any other factors relevant to the circumstances of death, none of the parties proposed that any findings should be made. I also agree with these submissions.

[20] On the matter of recommendations to be made in terms of section 26(1)(b) of the 2016 Act, with reference to the matters mentioned in section 26(4)(a) and (d), Mr Dickson invited me to consider making two recommendations. These recommendations were in the following terms:

1. That operators of LGVs and HGVs fitted with outriggers should ensure that drivers operating such vehicles are trained to be satisfied that outriggers are

safely stowed and that this should be achieved as part of daily pre-journey walk around checks.

2. That it should be recommended to the UK Government, via the Secretary of State for Transport, that consideration be given to the introduction of a statutory requirement that all LGVs and HGVs fitted with outriggers, regardless of their year of manufacture, should be fitted with an audible and visual warning system and/or an immobiliser to indicate if, whilst the vehicle is in motion, an outrigger is safely stowed.

[21] With particular reference to the second proposed recommendation, Both Mr Anderson and Mr Graham were in agreement. For Glenevin Limited (in administration) it was submitted that the Company would welcome the making of such a recommendation to the effect that the UK Government consider legislating for the mandatory retrofitting of such devices to relevant vehicles not covered by existing legislation. An opportunity was seen for road haulage industry bodies and government to work collaboratively in this regard with a view to enhancing safety. For Mr O'Donnell it was submitted that a recommendation to the UK Government be made to consider legislating for the mandatory retrofitting of immobilising systems to vehicles fitted with cranes such as to prevent the disengagement of the parking brake if outriggers are not stowed and for this to be enforced via the present annual vehicle testing system. Alternatively, the recommendation should be to mandate the retrofitting of audible and/or visual in-cab warnings to all relevant vehicles not covered by existing legislation.

Discussion and Conclusions

[22] The evidence led before this inquiry leads to the determination I have made in relation to the death of Chloe Morrison. It is based on that evidence, and what it supports in fact, that I have reached my findings in relation to the various circumstances as listed in section 26(2)(a) -(g) of the 2016 Act.

[23] The majority of the evidence led at this inquiry was in agreed terms. I will not repeat the various sources of evidence which led to the findings-in fact that I have made. I will proceed to review the conclusions reached on the circumstances listed in section 26(2) of the 2016 Act.

Section 26(2) (a) of the 2016 Act (when and where death occurred)

[24] In this inquiry there was no dispute as to when and where the death of Chloe Morrison occurred. Chloe Rachel Morrison died at approximately 13.36 hours on 25 October 2019 at the A82 at Kerrowdown approximately 0.7 miles north of Drumnadrochit.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred)

[25] Again, there was no dispute in relation to this matter. The collision involving the LGV driven by John O'Donnell and resulting in the death of Chloe Morrison occurred shortly prior to the time of her death on 25 October 2019.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[26] As a result of the collision Chloe Morrison suffered severe injuries which led to her death. The cause of Chloe Morrison's death was certified as being (a) multiple injuries due to (or as a consequence of), (b) a pedestrian struck by a lorry.

Section 26(2) (d) of the 2016 Act (the cause or causes of any accident resulting in death)

[27] The LGV driven by John O'Donnell commenced its journey with the destination being on the Isle of Skye. Between commencement of that journey at Oldmeldrum and reaching the destination at Kilmuir, Isle of Skye, both outriggers forming part of the lorry loader were secured in a safely stowed position. During the unloading operation the outriggers were deployed. When John O'Donnell commenced his return journey the outriggers were raised and horizontally retracted. The LGV travelled from Skye to Kerrowdown with both outriggers neither safely stowed nor secure.

[28] The nearside outrigger was first observed to be partially extended 0.9 miles away from where the collision occurred. The nearside outrigger would have been free moving over this distance and remained so for 1 minute and 6 seconds prior to the collision. The LGV was being driven along the A82 and approached Chloe Morrison from behind. When it did so, the nearside outrigger was locked in the fully extended position. The nearside outrigger extended 1.3m over the pavement. The nearside outrigger struck Chloe Morrison from behind and caused the injuries she sustained.

Section 26(2)(e) of the 2016 Act (any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)

[29] The Crown in submissions invited me to conclude that there were two reasonable precautions which could have been taken by Glenevin Limited. Neither participant invited me to find otherwise. Having reflected on the evidence I agree with the submissions for the Crown.

[30] It was not expected that Mr O'Donnell would operate the lorry loader including deployment or storage of the outriggers. There was no evidence presented to the inquiry that would allow a finding that Mr O'Donnell operated these systems. Whereas there was agreement that the unlocking of the outrigger would have required human intervention, it remains unknown who was responsible for that. I accept the submission that had the outriggers not been unlocked then the collision would have been avoided.

[31] The LGV was not fitted with a "not stowed" warning system. Given the age of manufacture of the lorry loader there was no legal obligation for one to be fitted. With that acknowledged, the industry was aware of the issue of retrospective fitting of such systems. As confirmed in the extremely comprehensive report of Mr Sylvester, ALLMI has advocated the fitting of stabiliser and crane not stowed warning systems. The system is relatively cheap to install. The cost for retrofitting a stabiliser-not-stowed warning system for a lorry loader with manual stabilisers varies from around £250 to £1000.

[32] Accordingly, with reference to the above observations I conclude that Glenevin Limited could have taken two reasonable precautions which, if taken, might realistically have resulted in the death, or any accident resulting in the death, of Chloe Morrison being avoided. These precautions were:

1. Glenevin Limited should have been aware of the absence of a "not stowed" warning system in relation to the outriggers on the LGV driven by John O'Donnell albeit there was no legal obligation on the Company to have such a safety device fitted to the LGV involved in the collision.

2. Glenevin Limited, whilst having instructed John O'Donnell not to operate the lorry loader during loading or unloading operations, should have taken steps to ensure that John O'Donnell was trained, as part of daily walk around checks, to ensure that the outriggers were secure and safely stowed prior to commencement of the journey.

Section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or accident resulting in death)

[33] Neither the Crown, nor either participant, submitted that circumstances should be found to have existed under these circumstances. I agree on that point.

Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

[34] In terms of section 26(2)(g) of the 2016 Act I am entitled to make findings in relation to any other facts which are relevant to the circumstances of the death. All parties invited me to make no findings on this matter. I agree that there are no other facts relevant in this respect.

Recommendations

Sections 26(1)(b) and 26(4) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of work, (c) the introduction of a system of working and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances)

[35] No words can adequately describe the tragic loss of Chloe Morrison in the circumstances of the collision which led to her death. There is no doubt in my mind that her death occurred in circumstances which give rise to serious public concern. Without rectification of certain requirements relating to the installation of safety systems relating to lorry loaders there remains a possibility that similar circumstances could arise again. I have concluded that steps could be taken which might realistically prevent deaths in similar circumstances.

[36] In submissions the Crown has advanced two recommendations for my consideration. These are supported by both participants to this inquiry. Having

reflected on all relevant considerations I agree that recommendations akin to those advanced by the parties should be made as part of this determination.

[37] The recommendations I make fall into two categories. The first category, which is covered by the first two of the four recommendations I have made, relates to what might be regarded as best industry practice. This relates to the matter of ensuring that drivers, whether or not they are trained to operate and deploy lorry loaders, are suitably trained to ensure that outriggers are safely stowed prior to commencing any journey. The necessary training should allow each driver as part of pre-journey checks to ensure that outriggers are safely stowed. In this inquiry it has been identified that there are regulations which cover the use and operation of lorry loading equipment on site which does not apply to journeys to and from sites. During those journeys it must remain the responsibility of the driver to ensure that such equipment is safely stowed and therefore locked to prevent outriggers extending away from the vehicle and causing an obvious and exceptionally dangerous hazard. I accept some evolution in practice has already taken place here given the updating of the Guidance issued by DVSA as outlined above.

[38] In relation to the above category, I consider the recommendation should be made to, and best addressed by, the operators of relevant vehicles. I recognise that might be a broad homogeneous group. Promulgation of such training may be assisted by representative bodies in this respect. Whether formal regulation is required would be a matter to be considered generally by those involved in transport safety and enforcement.

[39] The second category of recommendation relates to the need for potential legislative change. Road Traffic Law is a matter reserved by the UK Parliament. It is for

that reason that my third and fourth recommendations are directed to the UK Government via the Secretary of State for Transport.

[40] An important point has been identified in this inquiry which relates to current statutory requirements for lorry loading equipment. There are regulations which relate to cranes as part of this equipment. As has been explained to this inquiry, "crane not stowed" warning systems are mandated by existing legislation. The "leg not stowed" warning system is not mandated by legislation but is only in the product standard applicable to when the crane was manufactured.

[41] It was an agreed fact in this inquiry that due to the year of manufacture of the LGV involved in the collision there was, and remains as at the date of these proceedings, no legal requirement that the LGV be fitted with any such device. It was further agreed that neither The Department for Transport of the UK Government nor its executive agency, DVSA, held data for the number of LGVs fitted with lorry loader cranes whether or not fitted with outriggers and whether or not fitted with not-stowed warning alarms or immobilisers. Mr Sylvester provided his skilled opinion in terms of the report he prepared in which he concluded that the collision would almost certainly have been avoided if the lorry loader had been fitted with a stabiliser not-stowed warning system provided that was maintained and checked.

[42] Mr Sylester, whose opinion I accepted, also stated that there was a buoyant second-hand market for lorry loaders in the UK. The average life of a loader crane could be around 8 to 10 years, but this could fluctuate greatly. As a consequence, it was very difficult to accurately assess the overall size of the UK lorry loader industry or how

many lorry loaders were on the roads without stabiliser "not stowed" warning systems installed. His belief was that a great many lorry loaders were still on UK roads without warning systems.

[43] The evidence before this inquiry was to the effect that the cost of the retrospective fitting of warning systems was relatively low. It would appear to be a proportionate cost balanced against the real likelihood that the warning systems outlined could prevent further such incidents occurring.

[44] What I conclude from the above is that no one can say for certain how many vehicles remain on UK roads without stabiliser "not stowed" warning systems installed. As a result, it is difficult to assess the level of risk of a similar collision occurring in the future. If Mr Sylester's opinion is correct, and there a great many lorry loaders still on UK roads without warning systems, then the risk is potentially high. In such circumstances, the taking of these steps might realistically prevent other deaths in similar circumstances. These steps would include the introduction of statutory provisions with the purpose of ensuring that all LGVs and HGVs fitted with outriggers must be fitted with an audible and visible warning system and/or an immobiliser for the purpose of giving warning whilst the vehicle is in motion that the outriggers are not secure or safely stowed. To properly reduce the risk of such a collision and death recurring any such legislation should be retrospective in effect so that the requirement to fit the warning and/or immobiliser systems as stated above shall apply to all LGVs and HGVs fitted with outriggers regardless of their year of manufacture or year of installation.

[45] It is not the purpose of this inquiry to legislate. This inquiry is only entitled to make recommendations. My recommendations anent the introduction of statutory provisions are therefore made to the UK Government where the power to introduce such legislation lies.

[46] Having reviewed and considered the evidence, based on the conclusions I have reached, I recommend:

1. That the operators of any LGV, or heavy goods vehicle ("HGV"), which is fitted with outriggers should take steps to ensure that any driver operating such a vehicle be trained to ensure that outriggers are safely stowed prior to the commencement of any journey.

2. That the operators of any LGV or HGV fitted with outriggers ensure that drivers make checks, and record these checks, as part of their daily walk around the vehicle on the daily defect form used for that purpose.

3. That the UK Government, through the Secretary of State for Transport, give consideration to the introduction of statutory provisions to the effect that all LGVs and HGVs fitted with outriggers must be fitted with an audible and visible warning system and/or an immobiliser for the purpose of giving warning whilst the vehicle is in motion that the outriggers are not secure or safely stowed.

4. That the UK Government, through the Secretary of State for Transport, ensure that any such statutory provisions introduced should be retrospective in effect so that the requirement to fit the warning and/or immobiliser systems as

stated above shall apply to all LGVs and HGVs fitted with outriggers regardless of their year of manufacture or year of installation.

Publication and distribution of this determination

[47] Section 27(1)(a) of the 2016 Act provides that The Scottish Courts and Tribunals Service ("SCTS") must publish, in such manner as it considers appropriate, each determination made under section 26(1). In terms of section 27 (1)(b) of the 2016 Act, SCTS must give a copy of each such determination to:

(i) The Lord Advocate,

(ii) Each participant in the inquiry,

(iii) Each person to whom a recommendation is addressed, and

(iv) Any other person who the sheriff considers has an interest in a recommendation in the determination.

[48] Accordingly, a copy of this determination will be published as SCTS considers appropriate, including publication on their website. Furthermore, SCTS will give a copy of this determination to the Lord Advocate and the participants of the inquiry. I consider that a copy of this determination should be given to the Office of the Advocate General for Scotland. Separately, a copy of this determination will be provided to the Secretary of State for Transport of the UK Government. Finally, a copy of this determination is to be given to ALLMI given it is the leading trade association concerned with the design, manufacture, application and use of lorry loaders.

Postscript

[49] Mr Dickson, Mr Anderson and Mr Graham extended their condolences during the inquiry and in their written submissions. I also wish to record my condolences to all who have been affected by the sad loss of Chloe Morrison. She was a young lady who loved her job and loved life. The circumstances surrounding Chloe's death are unbelievably tragic. The loss to her family is immeasurable.