SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT ABERDEEN

[2026] FAI 60

ABE-B965-24

NOTE

BY

SHERIFF LESLEY JOHNSTON

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

into the deaths of

CHRISTOPHER STUCHBURY, DONALD DIGBY DINNIE and BRETT GEORGE MCCULLOUGH

29 September 2025

Background

[1] In advance of a preliminary hearing on 28 August 2025, the Rail Accident Investigation Bureau ("RAIB") lodged a detailed written submission in relation to the scope of evidence to be led in this inquiry. In short, the RAIB invited the court to consider adopting the approach taken in England and Wales in circumstances where an accident investigation branch ("AIB") has carried out an investigation and reported prior to the Coroner's Inquest. In that regard, the RAIB referred to three cases in which the principle was established, namely:

- *R (Secretary of State for Transport)* v *Her Majesty's Senior Coroner for Norfolk and another* [2016] EWHC 2279 (Admin) ("*Norfolk*")
- *HM Senior Coroner for West Sussex* v *Chief Constable of Sussex and others* [2022] EWHC 215 (QB) ("*West Sussex*")

- *R (Mid and West Wales Fire and Rescue Service)* v *HM Senior Coroner for Pembrokeshire and Carmarthenshire and another* [2023] EWHC 1669 (Admin) ("*Pembrokeshire and Carmarthenshire*")

[2] Taken together, the principle emerging from those cases ("the Norfolk principle"), is that in the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting a subsequent inquest should not consider it necessary to investigate again the matters covered by the particular AIB's investigation/report. The AIB's findings and conclusions should not be reopened.

[3] The RAIB's submission is supported by the following participants, namely ScotRail Trains Limited; Ove Arup Limited; and James Scullion.

[4] The Crown's position is that the Norfolk Principle has not been and should not be adopted wholesale into the system of Fatal Accident Inquiries in Scotland for, broadly the following reasons (i) the differences between an FAI and a Coroner's Inquest and in particular, the different purposes of the two systems and different statutory responsibilities of the sheriff/coroner in the two systems; (ii) that the Scottish courts' treatment of AIB reports in FAIs is well-settled and while the courts have had regard to the Norfolk principle, they have stopped short of fully adopting it. This is referred to by the Crown as "the Scottish approach".

[5] The Office of Rail and Road ("ORR") also opposes the approach proposed by the RAIB. It adopts the Crown's submission in relation to the differences between the system of FAI and Inquest and Scottish approach to the AIB reports to date. In addition, the ORR submits that wholesale adoption of the Norfolk principle would be contrary to what fairness requires in an in inquisitorial context and would be contrary to the public interest; and conflicts with the requirements of section 26 of the Fatal Accident and Sudden Deaths etc

(Scotland) Act 2016. In any event, the ORR's position is that the Norfolk principle, even if it was to be applied in this inquiry, is not engaged, because the issues on which the Crown and ORR submit that evidence should be led, do not challenge the RAIB investigation, its conclusions or recommendations.

[6] The following participants are neutral on the question, namely the Associated Society of Locomotive Engineers and Firemen; The National Union of Rail, Maritime and Transport Workers; Network Rail Infrastructure Ltd; Angel Trains Ltd; Amey OWR; Billy MacKay and Alasdair McIver; Owen Ferry and Karl Grewar; Alastair MacFarlane; Brian Mitchell; British Transport Police; the Scottish Ambulance Service; Scottish Fire and Rescue Service; Maritime and Coastguard Agency.

[7] To allow all parties who wished to do so to lodge written submissions on the question, and owing to the limited time available at the preliminary hearing on 28 August, I fixed a hearing on 24 September to be addressed in detail on the matter.

[8] In delivering this decision, I do not intend to repeat all of the submissions advanced by parties. However, I am extremely grateful to all parties for their detailed submissions.

Relevant legal principles

The law relating to Fatal Accident Inquiries in Scotland

[9] The law and procedure relating to Fatal Accident Inquiries in Scotland is set out in the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") Act and the accompanying rules contained in the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the rules").

[10] The purpose of an inquiry is to (a) establish the circumstances of the death and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances (section 1(3) of the Act).

[11] The procurator fiscal *must* bring evidence relating to the circumstances of the death to which the inquiry relates. A participant *may* bring forward such evidence. The sheriff *may* require the procurator fiscal or a participant in the inquiry to bring forward evidence about any matter relating to the circumstances of the death (section 20 of the Act).

[12] The sheriff has a statutory duty to make a determination, after the conclusion of evidence and submissions, on the matters set out in section 26 of the Act, namely –

> "**26 the sheriff's determination**
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out –
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2) and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) the circumstances referred to in subsection (1)(a) are –
> (a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) 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,
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death,
> (g) any other facts which are relevant to the circumstances of the death.
>
> (3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur-
> (a) if the precautions were not taken, or
> (b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are –
(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps
which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to-
(a) a participant in the inquiry
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

[…]"

[13] An inquiry is inquisitorial, not adversarial. It is to be progressed expeditiously and efficiently, with as few delays as possible. Taking into account the nature of complexity of the inquiry, the procedure at an inquiry is to be as flexible as appropriate and the manner in which information is presented is to be as efficient as possible (rule 2.2(1) to (3)).

[14] The sheriff may make any order necessary to further the purpose of an inquiry, including an order made to assist the sheriff to identify which issues are in dispute, such as an order of the nature set out in rule 2.6(a)(i) to (v) which includes, requiring participants to disclose the existence and nature of any information they hold relating to the inquiry; and requiring participants to lodge particular documents or other items or to lead particular witnesses, and an order restricting the documents or other items which a participant may present or the witnesses a participant may lead (rule 2.6).

[15] Preliminary hearings, taking place prior to the inquiry, are to ensure that the purpose of the inquiry is achieved when the inquiry takes place; to consider the scope of the inquiry and identify the issues which are in dispute; and consider the information likely to be presented at the inquiry and the manner in which it should be presented. The sheriff may order as many preliminary hearings to take place as is necessary to achieve that purpose

(rule 3.6). The matters to be considered at the preliminary hearing include considering the likely length, timetable and date for the start of the inquiry; the matters which are likely to be in dispute; the state of preparedness of participants and how information should be presented to the inquiry (rule 3.8).

[16] The sheriff also has wide ranging information management powers. The sheriff may make orders about the manner in which information is presented to the inquiry or about how the sheriff will reach conclusions, such as an order restricting the information presented to particular issues or particular sources; determining the manner which information is to be presented whether by oral presentation, written statement, the production of documents or other items, live link, video recording or otherwise and determining the manner in which the sheriff is to reach conclusions (rule 4.2).

The Rail Accident Investigation Branch

[17] The RAIB was established by the Railways and Transport Safety Act 2003 (as amended) (the "2003 Act"). It is one of the UK's Accident Investigation Branches ("AIBs"). It was established to investigate, amongst other things, serious railway accidents to try to determine what caused it, without consideration of, or determination of blame or liability, and with the aim of improving railway safety and preventing further accidents from occurring (sections 4 and 7 of the 2003 Act). Its investigations are independent from any other agency (regulation 5).

[18] The RAIB carried out an investigation into the derailment under and in terms of the Railways (Accident Investigation and Reporting) Regulations 2005 (as amended). Its investigation report in this case was published in March 2022.

[19] In terms of regulation 12, its recommendations are addressed to the relevant safety authority or body. In this case, the ORR.

[20] The specialist expertise of the RAIB was acknowledged by all participants.

The Norfolk principle

[21] There is no dispute as to what the "Norfolk principle" is. The only dispute is whether it does or indeed should form any part of Scots law. As I understand it, no other court in Scotland has been asked to consider at this stage in an Inquiry, whether the Norfolk principle should be applied in fatal accident inquiries. However, it is clear (as I shall later come on to examine) that previous inquiries have had regard to it at the stage of reaching a determination.

The English authorities

[22] In *Norfolk*, the question for the court was whether the Coroner had the power to order the Air Accident Investigation Branch to disclose certain evidence, namely the cockpit voice and flight data recorders. In answering that question, the court observed the following in relation to the conduct of inquests, where there has been an investigation by one of the AIBs:

> "49 Finally, in my view, it is important to emphasise that there is no public interest in having unnecessary duplication of investigations or inquiries. The AAIB fulfils an important function in that it is an independent body investigating matters which are within its expertise. I can see no good reason why Parliament should have intended to enact a legislative scheme which would have the effect of requiring or permitting the Coroner to go over the same ground again when she is not an expert in the field." (per Singh J at para [49])

[23] Lord Thomas CJ went further:

> "55. I consider it important to underline the significance of paragraph 49 of the judgement of Singh J in the light of the submission made to us on behalf of the coroner that she had a duty to conduct a full inquiry into the accident as a death had occurred during the accident. The submission reflected the tendency in recent years for different independent bodies, which have overlapping jurisdictions to investigate accidents or other matters, to investigate, either successively or at the same time, the same matter. On occasions each body considers that it should itself investigate the entirety of the matter rather than rely on the conclusion of the body with the greatest expertise in a particular area within the matter being investigated. The result can be that very significant sums of money and other precious resources are expended unnecessarily.
>
> 56. The circumstances of the present case provide an illustration of what in many cases will be the better approach. There can be little doubt that the AAIB, an independent state entity, has the greatest expertise in determining the cause of an aircraft crash. In the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting an inquest into a death which occurred in an aircraft accident, should not consider it necessary to investigate again the matters covered or to be covered by the independent investigation of the AAIB.
>
> […]
>
> 57. It should not, in such circumstances, be necessary for a coroner to investigate the matter de novo. The coroner would comply sufficiently with the duties of the coroner by treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident. There may be occasions where the AAIB inspector will be asked to give some short supplementary evidence… However, where there is no credible evidence that the investigation is incomplete, flawed or deficient, the findings and conclusions should not be reopened."

[24] In *West Sussex* the question before the court again concerned whether certain evidence, namely a cockpit video recording, should be disclosed to the Coroner for the purpose of the Inquests. In deciding that issue, the court said:

> "123. We accept that coroners' inquests are of great importance. However, whereas a criminal investigation fulfils a very different public interest to that of an AAIB investigation (being to establish blame and fault), a Coroner's investigation fulfils a similar and overlapping role to the AAIB, to consider the cause of an accident in order to answer the statutory questions (set out at para [47] of the court's judgment).

[…]

125. In our judgment, the starting point is therefore that there is no public interest in reinvestigation … An important and narrowly prescribed exception to this position is a situation where, as Lord Thomas CJ explained in Norfolk, there is credible evidence that the AAIB's investigation is incomplete, flawed or deficient…

[…]

126 It is clear why such a strict requirement is imposed: anything less would open the door to wasteful and duplicative reinvestigation by coroners. 'Credible evidence' is the condition precedent or gateway – it is an important control mechanism.

127. The situation postulated by the Norfolk test is intended to cover the rare case where there might be an obvious deficiency in an AAIB's investigation. We agree with the AAIB that it was not intended that, on a topic of complexity and technical difficulty, where different experts hold different views … that a coroner (who is 'not an expert in the field') would need to seek a range of independent expert opinion, based on material that she would obtain, in order to test whether the AAIB's conclusions were correct or incomplete. Rather, the Coroner should 'rely on the conclusion of the body with the greatest expertise in a particular area' (adopting the language used by the Lord Thomas CJ)."

[25] Whether an investigation is incomplete or flawed is a decision to be taken

"primarily on the basis of information available to the coroner, and with due regard to the specialist expertise of the accident investigation branch and a corresponding threshold to be applied to that decision-making. A coroner should be very slow to find credible evidence that an expert investigation was incomplete, flawed or deficient" (para [130]).

[26] Mere disagreement of experts as to the views reached by the AIB would not mean that there was arguably credible evidence that the AIB investigation was flawed (see para [133(2)]).

[27] In *Pembrokeshire and Carmarthenshire*, the court reiterated the approach taken in *Norfolk* and *West Sussex* as sound. Fairness and the requirements of natural justice did not justify a departure from the *Norfolk* approach. The court also noted the

opportunity for persons to make representations in respect of (in that case, an MAIB report) before publication (see Eyre J, paras [61] to [63]) (I note that the same provision exists in relation to RAIB reports (see Railways (Accident Investigation and Reporting) Regulations 2005, reg 13)). The court also noted that:

> "The judgments in Norfolk and West Sussex make it clear that the focus of attention is to be on the investigation rather than on the particular conclusions reached by the relevant [AIB]. As already noted the significant factors are the public interest in avoiding duplication and the specialist expertise of the [AIB]. The coroner is not be drawn into the exercise of considering whether the conclusions reached in the investigation are correct. If the [AIB] has conducted an investigation which cannot be said on the basis of credible evidence to have been incomplete, flawed, or deficient then the coroner is to approach matters on the footing that there has already been an investigation by the body best placed to come to a conclusion on the subject-matter of that investigation. It is not appropriate in such circumstances to seek to disentangle the conclusions and to accept some and not others. Such an approach would involve the coroner or a jury seeking to reach a conclusion on a matter in respect of which there had already been an investigation by a better qualified body and this would involve the duplication which was found in Norfolk and West Sussex to be contrary to the public interest (per Eyre J at para [70])"

[28] Minor criticism of the AIB's investigation or some of the conclusions reached would not amount to credible evidence that the investigation is incomplete, flawed, or deficient (per Eyre J at para [73]). The "all or nothing" effect of Norfolk meant that the Coroner ought to have been focussed

> "not on whether there was a disagreement with a particular conclusion [of the AIB report] but on whether there was credible evidence that the investigation was incomplete, flawed or deficient with an incorrect conclusion being potentially but not necessarily such evidence" (per Eyre J at paras [74] and [75]).

Norfolk in its context

[29] The Norfolk principle arose in the context of a Coroner's Inquest. The Crown and the ORR submitted that the differences between the Coroner's Inquest and the

fatal accident inquiry are such that the Norfolk principle should not be wholesale adopted in the latter. The RAIB and others acknowledged that the two systems are not the same. In essence, their position was that the differences are not so stark as to require a different approach to be taken in Scotland, and in any event are irrelevant when the policy underlying the Norfolk principle is considered, namely the public interest in avoiding lengthy inquiries involving the unnecessary duplication/reinvestigation of matters investigated and reported on by the AIB.

The Coroner's Inquiry

[30] The purpose of a coroner's investigation is contained within section 5 of the Coroners and Justice Act 2009 ("the 2009 Act"):

> "**5 Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain –
> (a) who the deceased was;
> (b) how, when and where the deceased came by his or her death;
> (c) the particulars (if any) required by the 1953 Act [Birth and Death Registration Act 1953] to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c.42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than -
> (a) the questions mentioned in subjection (1)(a) and (b) (read with subsection (2) where applicable);
> (b) the particulars mentioned in subjection (1)(c).
> This is subject to paragraph 7 of schedule 5."

[31] Paragraph 7 of schedule 5 of the 2009 Act states:

"**Action to prevent other deaths**

7(1) Where-

(a) a senior coroner has been conducting an investigation under this Part into a person's death,

(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c) in the coroner's opinion action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner."

[32] A "prevent future deaths" report is "ancillary to the inquest procedure and not its mainspring." (*Re Kelly* (1996) 161 JP 417 and *Takoushis* v *HMC Inner North London* [2006] 1 WLR 461 at 469E). They arise where a coroner is investigating a death and a matter giving rise to a concern is revealed by that investigation. There is no statutory duty to seek out or gather evidence regarding wider matters that might potentially generate a PFD report. Nor was it the intention of the 2009 Act that inquests should be lengthened, or their scope widened, for the purpose of hearing evidence or representations regarding PFD reports (Chief Coroner's Guidance No.5 at paragraph 14).

[33] Section 10 of the 2009 Act sets out what is to happen at the conclusion of an inquest:

> "**10 Determinations and findings to be made**
>
> (1) After considering the evidence given to an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –
> (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
> (b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.
>
> (2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of –
> (a) criminal liability on the part of a named person, or
> (b) civil liability.
> […]"

[34] The Coroners (Inquests) Rules 2013 sets out a formal "record of inquest" form (ROI) and provides for a record to be made of the following matters:

> "Part 1. Name of the deceased (if known)
>
> Part 2. Medical cause of death
>
> Part 3. How, when, where, and for investigations where section 5(2) of the 2009 Act applies, in what circumstances the deceased came to his or her death
>
> Part 4. Conclusion of the coroner/jury as to the death
>
> Part 5. Further particulars as required by the Births and Deaths Registration Act 1953 to be registered concerning the death."

[35] In most inquests the question of "how" (in part 3 of the ROI) will mean "by what means". The answer to "how" the deceased died may well go wider than the medical cause of death and encompass a description of the mechanism of death (see the Coroner's Bench Book, chapter 15, paragraph 27).

[36] In relation to paragraph 4, the conclusion as to the death, there is no requirement in law to use any particular formulation or particular number of words

in a conclusion. The Schedule to the Inquest Rules contains a list of "short-form" conclusions that *may* be adopted. The optional list includes nine conclusions – accident or misadventure, alcohol/drug related, industrial disease, lawful/unlawful killing, natural causes, open road traffic collision, stillbirth, and suicide.

[37] I am grateful to the Crown for its full submission as to the system of Coroner's inquest. It was not challenged by any other participant, although submissions were made as to the significance or otherwise of the differences between the two systems.

Scotland, AIB reports and Norfolk

[38] I was referred, by the Crown, to a number of determinations in fatal accident inquiries in which the specialist expertise of AIB investigations and reports has been commented upon. For the Crown it was submitted that from these determinations, I could conclude that the way in which AIB reports are treated in fatal accident inquiries is well-settled. For the RAIB and others, it was submitted that there was little to be taken from these determinations, because some of them pre-dated the Norfolk principle cases and in any event, because the courts were not considering the question posed in this inquiry, namely, whether the Norfolk principle should be applied at this stage of the inquiry and certain evidence excluded in terms thereof.

[39] I consider the Scottish cases are of assistance in answering the question before this court. The Scottish courts have, even in cases pre-dating the Norfolk line of cases recognised the specialist expertise of the particular AIB report.

The "Super puma" FAI

[40] In the *FAI into the deaths of John Barkley and others* [2019] FAI 5 (the "Super Puma FAI"), Sheriff Principal Pyle declined to set out his conclusions on the evidence by way of findings in fact. His reasons for doing so are set out at paragraph 7 of his determination and included his recognition of the specialism of the Air Accident Investigation Branch investigation and report into the accident. The AAIB report described most of the relevant facts which might otherwise be set out as findings in fact. Sheriff Principal Pyle considered that setting out findings in fact in his determination would be both a discourtesy to the careful work of the expert inspectors and also run the risk of lawyer's language inaccurately describing what was already set out in that report. The court was not concerned with the question being posed in this inquiry, and it would appear that evidence was led on matters already considered and reported on in the AIB report, but his determination at paragraph 7 is nevertheless helpful in demonstrating that, even before the Norfolk line of cases, the Scottish courts have recognised the expertise and specialism of the AIB reports in fatal accident inquiries.

The Clutha FAI

[41] The *FAI into the deaths of Gary Arthur and others* [2019] FAI 46 (the "Clutha FAI") came after Norfolk, but before the West Sussex, Pembrokeshire and Carmarthenshire cases.

[42] Again, that inquiry was not asked to consider the discrete issue before this court. However, as has happened in this inquiry, Sheriff Principal Turnbull (as he then was) ordered parties, at the outset of proceedings, to identify any matter contained within the AAIB report with which issue was taken. In that inquiry, it is noted at paragraph 132 of the

determination that the inquiry had the benefit of certain evidence not considered within the AAIB report.

[43] At paragraph 133 of the determination, Sheriff Principal Turnbull commended the approach taken by the court in *Norfolk*. He considered that it was entirely consistent with the approach taken by Sheriff Principal Pyle in the Super Puma FAI. Sheriff Principal Turnbull's assessment of the evidence led and submissions made at the inquiry was that there was no credible evidence to suggest that the AAIB investigation was incomplete, flawed or deficient. Accordingly, save to the limited extent set out in his determination, he concluded that there was no basis upon which the AAIB's findings and conclusions should not be adopted. However, as highlighted by the Crown in its submissions, that conclusion was reached following the leading of evidence at the inquiry. In addition, there were some matters on which the Sheriff Principal reached a conclusion that was different to the AAIB report.

Sumburgh FAI

[44] The *FAI into the deaths of George Thomas Allison and others* [2020] FAI 34 (the "Sumburgh FAI") took place after the Norfolk case and before the West Sussex, Pembrokeshire and Carmarthenshire cases. Sheriff Principal Pyle again acknowledged the specialism of, in that case, the Air Accident Investigation Branch investigation and report. In that case, all parties before the inquiry in general terms accepted the final report (referred to as an "impressive document") as an accurate description of what took place, where errors occurred and what recommendations should be made. Of note, is that further evidence was led before the inquiry which resulted in "some suggested changes to the text and the conclusions reached, although it did not materially affect the overall recommendations for

the future" (para [2]). Again, for that reason, Sheriff Principal Pyle declined to make findings in fact. In his determination, the Sheriff Principal discussed "evidence on the matters upon which differences of view from that of the report emerged" and his conclusions on that evidence (para [2]). So, the court in that case did hear evidence on discrete issues on which the AAIB had already investigated/reported.

The Louisa FAI

[45] The *FAI into the deaths of Paul Alliston, Martine Johnstone and Christopher Morrison* [2022] FAI 8 (the "Louisa FAI") took place after the Norfolk case and before the West Sussex and Pembrokeshire and Carmarthenshire cases.

[46] Again, Sheriff Principal Pyle recognised the extensive research and investigation by statutory independent bodies such as the AIIB or MAIB. In that inquiry, the MAIB made a submission about the status of their reports in the context of the coroner system in England and Wales. Sheriff Principal Pyle did not find it necessary to add to the comments he made in the first Super Puma Inquiry or the comments of Sheriff Principal Turnbull in the Clutha Inquiry. Sheriff Principal Pyle noted, as Sheriff Principal Turnbull had done in Clutha, that the system for investigation of deaths in England and Wales is "very different", and that:

> "In Scotland, the Crown is careful to lead evidence even on undisputed matters which are contained in the investigator's report, not least so that families have the opportunity of hearing the evidence first hand. I commend that approach" (para [27]).

[47] It is also clear from the terms of that determination, that the court did hear and consider evidence that conflicted with some of the conclusions reached by the MAIB.

The Edinburgh Trams FAI

[48] The *FAI into the death of Carlos Hernan Correa Palacio* [2025] FAI 22 ("Trams FAI") took place in April 2025, and therefore after the full Norfolk Principle line of authorities.

[49] A RAIB investigation and report into the circumstances of the accident preceded the inquiry. Again, in that inquiry, the participants were asked to identify any matter contained within the report with which issue was taken prior to commencement of the inquiry. There was only one issue identified, with the remainder of the report agreed. It seems clear from paragraph 51 of his determination, that the sheriff did hear evidence on that one issue. The approach taken by the sheriff in his determination, after hearing all the evidence and submissions, was to adopt the approach taken by Sheriffs Principal Turnbull and Pyle (outlined above). He considered there was no credible evidence to suggest that the RAIB investigation into the accident was incomplete, flawed, or deficient. There was no challenge to the evidence of the RAIB lead inspector. While other evidence was led on the "disputed" issue, he did not consider that it amounted to a challenge to the RAIB investigation, and in any event, he preferred the evidence of the RAIB investigator on the particular issue. The court accordingly adopted the RAIB's findings and conclusions in full.

[50] Reference was also made to the recent decision in the petition of *Greater Glasgow Health Board for Judicial Review* [2025] CSOH 12 in relation to what fairness requires in an inquisitorial context, and in particular para [33] of the court's opinion. No party sought to argue against what is outlined by the court regarding fairness in inquisitorial hearings. However, it was observed and I accept that the circumstances of that case were quite different to the question before this court, namely, that the inquiry under review in that case was the first opportunity for any inquiry into the particular circumstances. Whereas, in this

case, the RAIB has already carried out an investigation as to the circumstances of the accident.

Decision and reasons

[51] There was no dispute that fatal accident inquiries should be efficient and progressed expeditiously with as few delays as possible. That is reflected in the 2016 Act and the procedural rules thereto. The rules allow the sheriff to manage the inquiry to focus the relevant issues and the scope of the evidence to be led at the inquiry, including the manner in which information and evidence should be presented.

[52] There was also no dispute that the RAIB is a highly specialist and expert body, that has, in relation to this accident, conducted an investigation and produced a technical and highly specialist report. No participant takes any issue with the investigation.

[53] In that regard, while I accept that no Scottish court has required to consider the Norfolk principle at this stage in an inquiry, I consider that it is clear from the authorities to which I was referred that there is a "Scottish approach" to FAIs involving AIB reports. The Scottish courts have made clear the status afforded to AIB reports, and have reflected that status in the management of the inquiries referred to, by requiring parties to confirm at the outset of the inquiry any part of the RAIB report disputed by the participants; and by refraining from making findings in fact in respect of matters covered by the RAIB report.

[54] The orders made at the outset of this inquiry accord with that practice. They accord with the requirements already contained within the 2016 Act and procedural rules to ensure the inquiry is efficient and to consider the scope of the inquiry. They were made with the purpose of keeping the scope of the inquiry focussed and above all else, to avoid a

re-investigation at the inquiry of matters already thoroughly investigated by a highly specialist body.

[55] However, that is not to say that the Scottish approach is simply a "rubber stamping" exercise when there is an AIB report before the inquiry. Far from it. It is clear from the Scottish authorities referred to that the courts have allowed evidence to be led on particular issues, even in circumstances where the AIB involved has already investigated and reported on that issue. Indeed, it is also clear from the Scottish authorities that on occasion, inquiries have reached conclusions on certain issues different to those reached by the AIB. Doing so has not resulted in a reinvestigation or an unnecessarily lengthy inquiry duplicating all that the AIB has already concluded. It is also clear that the courts have had regard to the Norfolk principle and assistance derived from it, at the stage of assessing the evidence in the case.

[56] The question then is whether this inquiry should go a step further, and decide at the stage of a preliminary hearing, to exclude evidence on certain issues unless there is credible evidence that the investigation was incomplete, flawed, or deficient. This is, as described by the Crown in its submission, as a wholesale adoption of the Norfolk principle.

[57] I am not persuaded that the Norfolk principle should be applied in this way. The Norfolk principle developed in the context of the Coroner's Inquest. The two regimes are very different. The statutory responsibilities of the Coroner, and the matters on which the Coroner requires to reach a decision are narrower in scope than the Scottish fatal accident inquiry. Section 26 of the Act contains a far wider range of matters on which the sheriff requires to reach a determination. While both systems consider the circumstances of the death (the "who, what, where and how"); the sheriff in an FAI is also obliged to consider any reasonable precautions which might realistically have resulted in the death being avoided as well as any defects in any system of working which contributed to the death and

any other facts relevant to the death (section 26(2(e) to (g)). The purpose of an FAI is also to consider what steps (if any) might be taken to prevent other deaths in similar circumstances (2016 Act, section 1(3)). Accordingly, the sheriff is required to reach a determination on the matters set out in section 26(4) of the 2016 Act.

[58] I do not consider that the differences are narrowed when paragraph 7 of schedule 5 of the 2009 Act is considered (as was suggested by the RAIB). Paragraph 7 contains a duty of the coroner to report the matters contained within that paragraph (a "PFD report") if anything is revealed by the investigation. However, there is no positive obligation on the coroner to investigate, seek out or gather evidence on the matters contained within that paragraph. Indeed, PFD reports are ancillary to the inquest procedure. There is no positive obligation to investigate any wider implications that the circumstances of the death has for the safety of the public and prevention of future deaths, and no requirement to make recommendations in that regard.

[59] All of that accords with Sheriffs Principal Turnbull and Pyle's observations as to the differences between the two systems. For that reason, I do not consider that Norfolk should be "wholesale adopted" in the manner suggested by the RAIB and others.

[60] In any event, I do not consider it necessary to do so. The policy underlying the Norfolk principle is, in my view, common to both systems of inquiry and therefore the courts in Scotland have rightly had regard to Norfolk, found it to be instructive, and had regard to it at the stage of reaching a determination. Standing the way in which Scottish inquiries have treated the AIB reports and our domestic law and procedure relating to management of inquiries, it is not necessary for it to be applied here in the same way as in England and Wales. It is already a requirement of the fatal accident inquiry that it proceed expeditiously and efficiently. A desire to avoid a repetition of the AIB's investigation is

already firmly rooted in our domestic law, procedure and the practice developed by the Scottish inquiries where such reports are involved.

[61] For that reason, I do not consider that this will give rise to any material difference in the treatment or status of accident investigation branch reports north and south of the border, standing the way in which the Scottish jurisprudence has developed in FAIs involving AIB reports namely, as I have already outlined, the recognition of the specialist and technical nature of the report, and the procedural management of inquiries following AIB investigations and reports.

This inquiry

[62] The question posed by the RAIB and others in this inquiry, has arisen for two reasons. First, during discussions regarding draft joint minutes of agreement of evidence, it was felt that some of the detail of the joint minutes did not reflect the content of the report. Obviously, I have not seen those joint minutes. They remain in draft form. However, I understand that this issue has now resolved and the way in which the RAIB evidence might be presented to this inquiry is a subject of continued discussion and on which there shall be further agreement. However, at this stage, it appears to be anticipated that the RAIB report would in principle, and subject to the court's decision on the matters raised by the ORR, be agreed with one or more of the AIB inspectors giving evidence to the inquiry.

[63] Second, the issue arose as a result of the rule 3.7 notes intimated by the ORR. The ORR has continually stressed that it does not dispute the RAIB report or its conclusions, and does not seek to argue that the investigation giving rise to the report was, to borrow the words in Norfolk, incomplete, flawed, or deficient. Despite that assurance, there is a concern on the part of some participants that the evidence they seek to lead may

nevertheless do that. Parties wish to avoid a re-investigation or repeat of the RAIB report during this inquiry.

[64] The ORR has raised three matters on which it proposes evidence should be led, namely: (i) climate change and drainage resilience and how the design and construction of drainage in steep upland areas such as Carmont can be improved to avoid a repetition of the incident. In that regard, the Crown proposes to lead evidence from an expert ("Dr Nettleton") who prepared a report **after** the RAIB investigation; (ii) Extreme Weather Action Teleconferences (EWATs) and the industry response following the incident regarding the prediction of convective storms in order to plan preventive and mitigating measures; and (iii) High Speed Train (HST) crashworthiness and consideration of the work undertaken by the industry in response to the RAIB recommendation 19 in that regard.

(i) Drainage

[65] The ORR does not disagree with the conclusion of the RAIB report that, had the drainage system been installed in accordance with the design it is highly likely to have safely accommodated the flow of surface water on 12 August 2020. The ORR's position is that Dr Nettleton's report considers how the design and construction of drainage in steep upland areas such as Carmont can be improved to avoid a repetition of the tragedy. The ORR's position is that the applicability of his observations and insights becomes more pressing in the context of climate change bringing more frequent and severe instances of extreme weather, and that these are relevant considerations in light of section 26 of the 2016 Act. This evidence is said to be of assistance to the court in determining how well the industry has addressed issues arising from failure of the drain.

(ii) EWATS

[66] It would appear to me that the ORR's position in relation to the issue of EWATs has changed over time. For example, in its revised rule 3.7 note of 17 June 2025, the issue was described as "whether convening an EWAT might have made a difference to the sequence of events". In its submissions for the hearing last week, it was submitted (at paragraph 34 of the submission) "ORR accept most of RAIB's reasoning in its report, but believe there are additional factors that may have led to a different outcome". In its revised updated 3.7 note lodged shortly before the hearing last week, the issue is again expressed differently, namely "the importance of EWATs and the response of the industry following the incident in order to predict the incidence of convective storms in order to plan preventive and mitigating measures…" I can understand that the ORR's position on this issue may have changed over time, owing to discussions regarding the agreement of evidence with other participants. However, it would be of assistance to the court to better understand the final position of the ORR and whether or not the RAIB report on EWATs is disputed in any way.

(iii) HST Crashworthiness

[67] In relation to HST crashworthiness, the ORR propose that evidence is led to provide context to the industry response to the accident. In that regard, the ORR would wish to lead evidence by way of the crashworthiness report produced by the industry working group for the RAIB's rolling stock recommendations (Crown prod 1691). The focus is, in the ORR's submission, what has been learned following the RAIB investigation and report. That evidence is said to be relevant in judging how to prevent deaths in similar circumstances.

[68] It strikes me that while the ORR has provided further specification as to why these issues are relevant to the inquiry, it remains unclear how these issues interface with the

RAIB report and the extent to which any evidence may duplicate (if at all) matters already investigated by the RAIB. I can therefore understand the concern raised by the other participants to the inquiry, that it is unclear whether or not, or to what extent the issues raised might conflict with the RAIB's investigation and conclusions, although I do not consider that any of the evidence proposed to be led on these three issues would have the effect of "lifting the lid off the tin" of the RAIB report. Nor do I consider that is the intention of the ORR or the Crown. The ORR has repeatedly stated that these three issues are "forward looking" and relevant to the inquiry's consideration of recommendations which might realistically prevent other deaths in similar circumstances.

[69] All parties agreed that there is no public interest in having a reinvestigation of matters already investigated and reported on by the RAIB. It is common ground among all participants that the RAIB report will be the starting point of the evidence led in this inquiry. Accordingly, I would like greater clarity on exactly how the issues, responsibly raised by the ORR, interface with the RAIB report. Put another way, if there is no challenge to the RAIB report on these issues, the conclusions of the RAIB on these issues will be the starting point and it will be necessary for the ORR to develop with greater clarity why additional evidence on these matters is relevant to the matters to be determined at this inquiry.

[70] The stage at which parties had reached prior to the RAIB raising the issue of the Norfolk principle was discussion of agreement of evidence. As I indicated at the hearing on 28 August 2025, that has been an important exercise in narrowing the scope of this inquiry from an estimated 12 weeks to around 4 weeks. It became apparent during the hearing last week that there was scope for further discussion among the participants on the issues raised by the ORR. For example, both the ORR and Ove Arup made submissions to the effect that they had reached out to each other for such a discussion on the matter of Dr Nettleton's

report, and that there remained the possibility that there was scope for the agreement of evidence in that regard. In addition, in relation to the issue of EWATs, it strikes me that there should be further clarification of the ORR's position on EWATs, whether or not the ORR disputes the RAIB's report/conclusion in that regard, and in particular discussion between the agent for James Scullion and the ORR. Following these discussions, it would be my hope that the ORR could specify with greater clarity, the relevance of the issues raised; and the extent to which (if at all) any evidence led on these issues conflicts with the RAIB report/its conclusions.

[71] Accordingly, in order to progress matters and so that the court may consider whether or not and to what extent the matters raised by the ORR require evidence to be led at this inquiry having regard to the need for the inquiry to be carried out expeditiously and avoiding unnecessary duplication of matters already investigated and reported on by the RAIB, I will make further orders.

[72] In doing so, I note that the ORR has indicated that it does not intend to lead evidence, but is instead relying on the Crown leading evidence in respect of the issues raised by the ORR. That explains the structure of the following orders. There will necessarily require to be further discussion between the ORR and the Crown. In addition, the following orders are informed by the fact that all other participants have confirmed that no issue is taken with the RAIB report or its conclusions; and have had had lengthy discussions on the agreement of evidence:

1. For the Crown to lodge a final updated list of the issues it proposes should be addressed at the inquiry; and to lodge a List of Witnesses (with corresponding witness summaries and an indication of the manner in which it is proposed the witness shall give their evidence) and a List of Documents (relating to each

issue) to be relied upon in the inquiry, all within 14 days of today's date (13 October);

2. For all other participants to confirm by way of updated rule 3.7 note, whether any issue proposed by the Crown is disputed; whether they intend to lead evidence and if so, to lodge a List of Witnesses (with corresponding witness summaries and an indication of the manner in which it is proposed the witness shall give their evidence) and a List of Documents (relating to each issue); all within 14 days thereafter (27 October);
3. A further preliminary hearing to take place as soon as possible thereafter and in any event, not later than the week commencing 17 November 2025, on a date to be afterwards fixed;
4. The joint minute of agreement(s) to be lodged not later than 7 days prior to the preliminary hearing;
5. An updated list of disputed issues to be lodged by the Crown not later than 3 days prior to the continued preliminary hearing.
6. Meantime, fixes the inquiry to commence on 26 January to 13 February; and 23 February to 27 February 2026 to take place in person at a venue to be confirmed.

[73] At the preliminary hearing on 28 August 2025, the representatives for the emergency services intimated that they intended to raise at the hearing on 24 September, whether it was appropriate for the inquiry to consider the response of the emergency services to the derailment, and that there would be further discussion between the representatives for the emergency services and the Crown on this issue. Prior to the hearing on 24 September 2025, I was informed that discussions were ongoing on this matter, and that parties would not be

addressing it at the hearing. The timetable above allows those discussions to continue. I expect to be addressed on this issue at the next hearing.

[74] Finally, I wish to stress again my commitment to this inquiry being progressed as efficiently and expeditiously as possible. In light of the number of participants involved, work to comply with the timetable outlined above, including any further discussions requiring to take place among the participants, should be commenced at pace. Standing the good work that has been achieved already among the participants in the discussions relating to the agreement of evidence, I do not anticipate that should cause a difficulty.