Renfrewshire Council

Item 9

To: **LEADERSHIP BOARD**

On: **17 FEBRUARY 2016**

Report by: **JOINT REPORT BY DIRECTOR OF COMMUNITY RESOURCES AND DIRECTOR OF FINANCE & RESOURCES**

Heading: **THE GLASGOW BIN LORRY CRASH – RECOMMENDATIONS FROM FATAL ACCIDENT INQUIRY**

1 Summary

1.1 The purpose of this report is to provide the Leadership Board with a summary of the potential implications to the Council in carrying out certain functions as a Local Authority, following the release of the determination of the Fatal Accident Inquiry into the Glasgow Bin Lorry Crash of December 2014.

1.2 A determination was released on 7 December 2015 by Sheriff John Beckett QC, following a Fatal Accident Inquiry into the death of six people who died on 22 December 2014 when a bin lorry mounted a pavement in Glasgow City Centre. The vehicle collided with a number of pedestrians after the driver suffered an episode of neuro cardiogenic syncope (fainting), causing him to temporarily lose consciousness so that he was unable to control the movement and direction of the vehicle.

1.3 As a Local Authority running similar services and vehicles, it is essential that the Council takes cognisance of the Sheriff's findings in this Fatal Accident Inquiry and considers these recommendations in a Renfrewshire context.

1.4 The Sheriff indicated eight reasonable precautions which could have prevented the crash, which all related to the driver's health and in particular to a previous loss of consciousness in April 2010 and his subsequent failure to disclose true and accurate information about his medical history in later health questionnaires and assessments.

1.5 The Sheriff also made 19 recommendations in his determination which, if followed, may reduce the chance of a recurrence of such an accident. The recommendations covered possible legislative changes, disclosure of medical information and implicated the DVLA, Glasgow City Council and other Local Authorities in general.

1.6 In relation to current employee processes and operational arrangements within the Council's refuse collection activities, these have been examined in the context of the Sheriff's 19 recommendations. Albeit the Council has detailed and robust employee processes and operational practices in place there are areas that will require to be considered and addressed in line with the Sheriff's recommendations. The particular areas as immediately identifiable for addressing and potential additional controls being:

- refuse collection vehicles, heavy fleet (gross vehicle weight of over 7.5 tonnes) having autonomous braking systems or lane departure warning systems fitted for new vehicles and considering what adaptations are possible, if any, to existing fleet;

- strengthening and additional checks within the Council's recruitment and absence management processes. In particular:

    - sharing of information as held by GPs, for existing and new employees. Information which would prevent an employee / potential employee from driving and any declarations as made to the DVLA.;

    - more detailed and more regular health checks on all drivers as employed by the Council (Heavy goods vehicles / public service vehicles); and

    - introduction of mandatory pre-employment health questionnaire as specific to posts that require driving.

1.7 For the reasons set out earlier in paragraph 1.3 and above in paragraph 1.5 above the Sheriff's recommendations require to be considered in a Renfrewshire context. As set out later in this Report, paragraphs 2.1(i) and 5.1, a short life multi-disciplinary task group has

been established to review current employee and operational arrangements and processes and to develop an action plan in respect of the Council's activities and duties with regard to the recommendations from this Fatal Accident Inquiry.

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2 Recommendations

It is recommended that the Board notes that:

2.1 A short term multi-disciplinary task team has been set up, service led by Community Resources in conjunction with officers having specialist legal and operational / technical knowledge including Refuse Collection, Transport, HR (recruitment and health and safety), Legal, Finance and Renfrewshire Community Health Partnership.

2.2 The task team will consider the findings of the Inquiry and develop an action plan which will address the recommendations made by the Sheriff in so far as it relates to our function as a Local Authority.

2.3 A further report will be brought forward on the details of the action plan, including any financial implications, to a future meeting of this Board.

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3 Background

Legal Framework for the Fatal Accident Inquiry

3.1 The underlying purpose of a Fatal Accidental Inquiry is to establish what happened, and how it came to happen, with a view to trying to ensure that the same circumstances do not avoidably recur.

3.2 Section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the 1976 Act) provides for the holding of an inquiry under the Act where:

"it appears to the Lord Advocate to be expedient in the public interest…that an inquiry under this Act should be held into the circumstances of the death on the ground that it was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern."

3.3 The application in this instance gave notice of certain objectives, namely:

"To publicly establish the circumstances of the deaths to include in particular -

(i) examination of the medical assessments and DVLA review process of Henry Clarke's fitness to hold an LGV and PCV driving licence;

(ii) examination of whether any design feature of the motor vehicle or other measures or intervention could have been in place to bring said motor vehicle to a controlled stop after control had been lost;

(iii) examination of the safety of the refuse collection route undertaken by said motor vehicle."

3.4 Section 6(1) of the 1976 Act provides that the purpose of a Fatal Accident Inquiry is for the Sheriff to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction:

(a) where and when the death and any accident resulting in the death took place;
(b) the cause or causes of such death and any accident resulting in the death;
(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided;
(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death;
(e) any other facts which are relevant to the circumstances of the death.

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4 Key Findings of the Fatal Accident Inquiry

4.1 Sheriff Beckett found that there were reasonable precautions which could have been taken whereby the accident might have been avoided. His determination is critical of the driver (Harry Clarke), stating that the crash might have been avoided had he not lied about his medical history. In his report he concluded that the most effective measure to prevent such an occurrence would be to seek to avoid drivers becoming incapacitated at the wheel. It should also be noted that responsibility in relation to this specific issue lies with drivers themselves and Driver and Vehicle Licensing Agency (DVLA).

4.2 He indicated eight reasonable precautions which could have prevented the crash which all related to the driver's health and in particular to a previous loss of consciousness in April 2010 and his subsequent failure

to disclose true and accurate information about his medical history in later health questionnaires and assessments.

4.3 Sheriff Beckett made a total of 19 recommendations in his determination which, if followed, may reduce the chance of a recurrence of such an accident. The recommendations covered potential legislative changes, disclosure of medical information, the DVLA, Glasgow City Council and other Local Authorities in general.

4.4 In his conclusions the Sheriff intimated that it may well be that the single most useful outcome of this inquiry would be to raise awareness of the dangers involved in driving if subject to a medical condition which could cause the driver to lose control of a vehicle.

4.5 The key findings arising out of the Fatal Inquiry into the death of six people who died on 22 December 2014 when a bin lorry mounted a pavement in Glasgow City Centre are as follows:-

4.5.1 Affecting Local Authorities

- When a doctor is advising an organisation employing a driver as to that driver's fitness to drive following a medical incident whilst driving, that organisation should provide all available information about the incident to the doctor and the doctor should insist on having it prior to giving advice to the organisation and the driver.

- The Council should not allow employment of a driver to start before references have been received. Councils and other operators of large vehicles should put in place systems to make sure drivers are fit to drive on appointment, and that they remain so for the duration of their employment.

- The Council should carry out an internal review of its employment processes with a view to ascertaining potential areas for improvement in relation to checking medical and sickness absence information provided by applicants, for example by having focussed health questions within reference requests for drivers and obtaining medical reports in relation to health related driving issues from applicants' GPs.

- The Council should provide its refuse collection operators with some basic training to familiarise them with the steering and braking mechanisms of the vehicles in which they work.

- From the age of 45, a group 2 licence only has to be renewed every five years and much could change in a driver's state of health in that time. Annual medicals should be considered.

- Glasgow City Council should seek to identify routes between refuse collection points which, so far as is reasonably practicable, minimise the number of people who would be at risk should control be lost of a refuse collection lorry. The potential for the presence of exceptional numbers of pedestrians at particular times should be taken account of as part of route risk assessment in refuse collection.

- Local Authorities and any other organisations which collect refuse, when sourcing and purchasing refuse collection vehicles which are large goods vehicles, should seek to have autonomous emergency braking system (AEBS) fitted to those vehicles wherever it is reasonably practicable to do so.

- Local Authorities and any other organisations which collect refuse and which currently have large goods vehicles without AEBS but to which AEBS could be retrofitted, should explore the possibility of retrofitting with the respective manufacturer.

- Sheriff Beckett stated in the future a type of pedestrian protection sensor, which is available on some cars, could provide a more reliable protection than AEBS alone. He also intimated that some form of "facial recognition" technology could be integrated with AEBS at some stage in the future.

4.5.2 Affecting Local Health Partnerships - Legislative and Non Legislative

- Occupational Health Doctors acting on behalf of employers may choose to seek independent confirmation from the applicant's GPs of the accuracy of what an applicant for a drivers post (LGV) tells them. This would increase the burden on GPs and might involve duplication, so a better system should be developed.

- Doctors generally should make sure medical notes are kept in a way which maximises their ability to identify repeated episodes of loss of consciousness in the case of patients who are drivers.

- The Sheriff said the DVLA's task was complex and difficult but there were weaknesses in the current system of self-reporting.

- He asked for more clarity on its "at-a-glance" guidance over "loss of consciousness/loss of or altered awareness". The "at-a-glance" guidance should consider giving more weight to loss of consciousness if the symptoms are non-specific and also if they occur at the wheel of a vehicle.

- The Sheriff said the DVLA should change its policy on notification from third parties so that relevant fitness-to-drive information from reliable sources, such as the police, can be investigated whether or not it comes in written form.

- DVLA should increase its efforts to raise awareness of the implications of medical conditions for fitness-to-drive among the medical profession.

4.5.3 Affecting Other Organisations

The specific recommendations associated with the future avoidance of a similar accident which are outwith the Local Authorities remit are summarised below.

Doctors

- Doctors generally, and general practitioners in particular, should take steps to ensure that medical notes are made and kept in such a way as to maximise their ability to identify repeated episodes of loss of consciousness, loss of or altered awareness, in the case of patients who are or may become drivers.

Drivers and Vehicle Licensing Agency

- The Driver and Vehicle Licensing Agency (DVLA) should satisfy itself as to precisely what the categorisation is intended to mean and to achieve in the loss of consciousness/loss of or altered awareness section of the guidance contained in its “At a Glance Guide to the Current Medical Standards of Fitness to Drive.”

- Having done so, DVLA should then ensure that the meaning is made clear to those who apply the guidance in practice.

- DVLA should consider if a flow chart could be provided to guide doctors through the categorisations contained in the loss of consciousness/loss of or altered awareness section of “at a glance.”

- DVLA should consider whether the section of “at a glance” on loss of consciousness/loss of or altered awareness gives sufficient weight to the absence of prodrome given its significance for road safety.

- DVLA should consider whether the section of “at a glance” on loss of consciousness/loss of or altered awareness gives sufficient weight to a medical event occurring at the wheel of a vehicle and its consequences.

- DVLA should change its policy on notification from third parties so that relevant fitness to drive information from ostensibly reliable sources, such as the police, can be investigated whether or not it comes in written form.

- DVLA should redouble its efforts to raise awareness of the implications of medical conditions for fitness to drive amongst the medical profession.

UK Secretary of State

- The Secretary of State for Transport should instigate a consultation on how best to ensure the completeness and accuracy of the information available to DVLA in making fitness to drive licensing decisions with a view to making legislative change.

- Part of this exercise should involve considering increasing the penalties and altering the mode of prosecution for contravention of section 94 of the Road Traffic Act 1988.

- The Secretary of State for Transport should instigate a consultation on whether it is appropriate that doctors should be given greater freedom, by the General Medical Council, or an obligation, by Parliament, to report fitness to drive concerns directly to DVLA.

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5 Implications for the Council

5.1 In order to consider the findings of the Fatal Accident Inquiry and develop a detailed Action Plan in respect of Council’s activities & duties a short life multi-disciplinary task group has been set up involving Transport, HR (recruitment and health and safety), Legal and Finance, and Renfrewshire Community Health Partnership. A detailed Action

Plan for the group will be presented at a future meeting of this Board.

Implications of the Report

1. **Financial –** Financial Implications are anticipated from the action plan, as currently being developed, in relation to potential vehicle modifications and potential increased vehicle specifications when procuring new refuse collection vehicles. Some increased costs could emerge from changes as may arise in relation to recruitment and other HR / employee processes...

2. **HR & Organisational Development** – in the development of the action plan the task group will consider current recruitment and employment processes and employee training in relation to the recommendations arising from the Fatal Accident Inquiry.

3. **Community Planning –** none

4. **Legal** – note that future legislative changes may result, following the recommendations of the Fatal Accident Inquiry.

5. **Property/Assets** – none.

6. **Information Technology** – none.

7. **Equality & Human Rights** – in the development of the action plan the task group will consider current health & safety processes and requirements (public, employee and vehicle related) in relation to the recommendations arising from the Fatal Accident Inquiry.

8. **Health & Safety** – This report supports and demonstrates the council's commitment to ensuring effective health and safety management.

9. **Procurement** – in the development of the action plan that task group will consider the specifications of vehicles in relation to the recommendations arising from the Fatal Accident Inquiry.

10. **Risk** – In the development of the action plan the task group will consider risks and any potential to the Council's Risk Management Plan. In the development of the action plan, the task group will identify and consider any associated risks and ensure these are included within relevant risk registers, for appropriate management and

monitoring.

11. **Privacy Impact** – none.

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