SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2017] FAI 15

PER-B127-17

DETERMINATION

BY

SHERIFF WM WOOD

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

in respect of the Fatal Accident Inquiry into the death of

SCOTT CHRISTOPHER McCALLUM

At Perth, 31 August 2017

The sheriff, having considered the cause, determines:

a) in terms of section 6(1)(a), Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976 ("the 1976 Act") that Scott Christopher McCallum, born 18 March 1979, formerly residing in Glasgow, died on 26 May 2015 at a time officially recorded as 1532 hours following a road traffic collision that occurred at a layby on the A90, Dundee to Perth road, approximately 750 metres east of the unclassified Walnut Grove to Perth road at Kinfauns, Perth.

b) In terms of section 6(1)(b) of the 1976 Act, the cause of death was (a) thoracic injuries; (b) blunt force trauma; (c) vehicular collision (driver).

c) There was no evidence before the court that would allow any further findings in terms of section 6(1)(c), (d) or (e) of the 1976 Act.

Note

The Evidence

[1] Evidence in this inquiry was led on 13 July 2017. The Crown was represented by Mr Saddiq, senior procurator fiscal depute, Dundee; Ms Anderson, solicitor, represented Optimal Cleaning Solutions Limited, the deceased's employer at the time of his death. There was no representation by or on behalf of any other interested party. I was advised that the deceased's mother, Mrs Jacqueline McCallum, had been his only near relative and that the deceased was otherwise single, with no dependents.

[2] The Crown led evidence from Denise Anne McKeown (forensic toxicologist, Glasgow); Dr Kerri Neylon (the deceased's medical general practitioner at the time of his death); and Police Constable Kevin Wilkie. There was no other parole evidence. There was a substantial Inventory of Productions produced for the Crown; in the course of the inquiry these were supplemented, without objection, by a letter from the deceased's psychiatrist of 30 April 1997 produced by Ms Anderson and a police witness statement prepared by PC Wilkie.

[3] In terms of a Joint Minute agreed by the represented parties (to which I have added small explanatory adjustments in parentheses), it was accepted that:

(a) Scott Christopher McCallum ("the deceased") was born on 18 March 1979. At the time of his death on 26 May 2015, he resided in Glasgow and

he was in employment as a cleaner with Optimal Cleaning Solutions, Glasgow. The business deals in industrial and commercial cleaning.

(b) In the days leading up to the incident, the deceased had been working in Inverness and Aberdeen. According to the deceased's timesheets held by his employers, he worked for 6 hours on 23 May 2015 and 6 hours on 24 May 2015, both shifts being in Inverness. After his shift on 24 May 2015, the deceased drove from Inverness to Aberdeen with a colleague. On 25 May 2015 he worked for 9 ½ hours and on 26 May 2015 he worked for 1 hour, both shifts in Aberdeen, before receiving a call from his employers informing him that his [usual] van was ready for collection from the repair garage and instructing him to return the [Mercedes Sprinter] hire van [he had been using for his work in Aberdeen and Inverness] to Glasgow that day. The hours worked by the deceased on the days leading up to the date of the incident were within statutory limits for safe working and driving.

(c) The locus of the incident is a large layby on the A90 Dundee to Perth road about 750 metres east of the unclassified Walnut Grove to Perth Road [at Kinfauns]. The road is a dual carriageway with 60 miles per hour speed limit for vans. The road is a long straight leading into a long right hand bend. The layby is situated to the nearside with a pavement, crash barrier and large fence separating the layby from the train line that runs adjacent.

At the time of the incident the weather conditions were dry and sunny with clear visibility.

(d) At or about 1440 hours, Tuesday 26 May 2015, witness Neil Firth Clarke had been driving his vehicle a MAN HGV tractor unit SK62 GZA with a large trailer with a metal container attached to same. At this time he stopped in the layby next to the A90 just before Perth for a 30 minute break. He had been sitting in the driver's seat with his seatbelt off, reading a book. About 5 minutes before the end of his break he became aware of an impact to the rear of his vehicle and a crashing noise. He saw a van coming to rest at the front nearside of his vehicle. The van was extensively damaged.

(e) Mr Clarke observed the driver of said vehicle strike the dashboard of the van and slump towards the passenger side of the vehicle. He made his way to the front of the van where he found the driver had received major injuries including a large head wound. He shouted over but received no response. Mr Clarke believed him to be dead and called 999, requesting police and ambulance assistance.

(f) An ambulance crew arrived and examined the deceased. It was immediately apparent that the driver of the van had died and life was pronounced extinct at 1532 hours. It was noted that the deceased had major injuries and that his right arm was missing. This was found near to the initial point of contact towards the rear of Mr Clarke's trailer.

(g) From the deceased's vehicle, the police recovered a prescription for methadone and two bottles of methadone. One bottle of 210mls was labelled "09 April 2015" and the other, of 140mls, was labelled "18 May 2015". The deceased had failed to declare his methadone use to his employers, who were not aware that he had been prescribed methadone.

(h) The deceased was registered at Gairbraid Medical Centre [Maryhill, Glasgow]. He had been prescribed methadone since 2012. On 20 May 2015, the deceased had contacted the said medical practice, stating that he was going to Inverness for two weeks and that he would therefore be unable to obtain his prescribed methadone from the pharmacy. He advised staff at the [medical centre] reception that he would start using "street drugs". Dr Kerri Neylon spoke with the deceased on 21 May 2015 and arranged a prescription to cover Tuesday, Wednesday and Thursday [(that is, 26 to 28 May 2015)] at Aberdeen. The prescription was issued to commence on Tuesday, 26 May 2015.

(i) DVLA records show that the deceased had not reported any medical conditions to them. Specifically, the deceased had not declared his methadone use.

(j) On 28 May 2015, Dr Helen Brownlow, forensic pathologist, carried out an autopsy examination on the body of the deceased and certified the cause of his death as:

I. (a) thoracic injuries

(b) blunt force trauma

(c) vehicular collision (driver).

The results of said examination are accurately recorded in the Final Report dated 28 May 2015 (Crown production no 1) and the contents of said report are agreed to be true and accurate.

(k) Toxicology analysis revealed the presence of methadone and diazepam in the deceased's blood. Both of these drugs produce sedative effects. However, at the low therapeutic concentrations detected, the degree to which these drugs may have contributed to the collision, if at all, cannot be estimated with any degree of accuracy.

(l) Crown production no 7 is a disk containing CCTV footage from Mr Clarke's vehicle namely MAN HGV tractor unit SK62 GXA. The said footage was captured at or around 1500 hours on 26 May 2015, whilst the said vehicle was parked at a layby at the said locus.

(m) Investigations by VOSA revealed no defects to Mr Clarke's vehicle – the MAN HGV tractor unit – that were considered contributory to the incident. The findings of the VOSA investigator are that the vehicle and trailer were most likely in a roadworthy condition, pre-collision. The van driven by the deceased SF13 NZK was extensively damaged as a result of the collision but no defects were identified which were considered contributory to the incident. Crown productions numbered 2 and 3 are VOSA investigation reports for the said vehicles.

(n) Crown production no 4 is a Collision Investigation Report prepared by Constable Craig McNeill and Sergeant Steven Manson, both officers of the Police Service of Scotland. They noted that it was unlikely that the deceased had fallen asleep because he had stopped for 30 minutes at a service station shortly before the collision. It is likely that the deceased's view of the HGV (Mr Clarke's vehicle) would have been at least partially obscured by [a] motor lorry ahead of him in lane 1. From the information available it is impossible to know whether the deceased entered the layby deliberately or due to a loss of concentration, however, once within it he would have had little or no time to react [before the collision].

(o) Crown production no 8 is a book of photographs taken on Tuesday, 26 May 2015 at the locus by witness Neil Coupar, Scene Examiner and a member of the Scottish Police Services Authority, Forensic Services, Scene Examination, Dundee. The said book of photographs contains the following:

1. General view showing the position of the HGV, facing west in a layby on the A90, Dundee to Perth road.
2. View showing the rear of the said HGV; it has been screened off due to the deceased being visible.

3-4. Further views showing the position of the HGV.

5. View showing the positon of the HGV; hatching line is the edge of the main dual carriageway.

6. General view looking towards the rear of the HGV, showing apparent damage.

7. View to the rear of the HGV, on removal of the screening, apparent damage is clearly evident. Debris from both vehicles lies scattered upon the carriageway. Number markers had been placed under the direction of the said Crash Investigators.

8-9. Closer views of damage and debris.

10. View showing the nearside of the HGV, the crash barrier and high fence evidence. The Mercedes van driven by the deceased has, following the initial collision, passed between the crash barrier and the HGV, leaving a trail of debris until becoming wedged up by the HGV cab.

11. Further view of the rear of the HGV.

12. View looking east along the layby carriageway. Both vehicle fronts can be seen with the Mercedes van wedged between the HGV cab and the crash barrier.

13. A closer view of the vehicles. Extensive damage is clearly evident to the Mercedes van.

14. General view showing the final resting positon of both vehicles within the layby at the locus.

15. View looking from the rear of the Mercedes van, eastwards.

16. General view looking towards the debris, situated on the nearside of the HGV between the vehicle and the crash barrier. A yellow bag has been placed over a human limb.

17. Closer view of the said human limb.

18-21. General views showing Mercedes Sprinter van, with the position of the deceased within the same. These photographs were recorded from the offside of the said vehicle.

22. General view looking into the passenger door (nearside) of the said Mercedes van, showing the position of the deceased.

23-29. General and close-up views showing numbered markers 1-4 highlighting areas of interest, to the rear of the HGV.

30-32. As part of the crash investigation it was noted that the HGV had been shunted forward by the force of the collision, and these photographs highlight this finding.

33-35. General views looking towards the rear of the Mercedes Sprinter van, showing the extensive damage sustained to it during the collision.

Submissions

[4] In submissions, the parties were agreed on the findings in terms of section 6(1)(a) and section 6(1)(b) in respect of the cause or causes of death. I was invited to find that it was not possible to determine the cause of the collision or whether the deceased had at any stage lost control.

The Evidence

[5] The evidence in the present inquiry gave no rise to any dispute. Witnesses were subject only to extremely limited cross-examination, at most. I found all of the witnesses to be credible and reliable.

[6] **Denise Anne McKeown** is a forensic toxicologist at the University of Glasgow. She holds an MSc in forensic and analytical chemistry and has 14 years of analytical experience and 7 years as a reporting toxicologist. She spoke to the terms of the Toxicology Report at pages 6 and 7 of the Inventory of Productions. She confirmed that the deceased's blood had been found to contain methadone (0.56 mg/L), diazepam (0.23 mg/L) and metabolites (desmethyldiazepam, oxazepam and temazepam). She explained that "metabolites" were often produced by the body following ingestion of other drugs (such as methadone or diazepam), although not necessarily so. In the concentrations found, the metabolites were most likely to have come from diazepam use. Although both diazepam and methadone might have a sedative effect, the concentrations found would come within the "therapeutic range" and therefore the actual effect would depend on individual tolerance. From the concentrations found, it

was not possible to identify the quantity consumed and it was not possible to "back calculate" to arrive at any reliable figure. Blood concentrations of diazepam would normally peak between 30 minutes to 2 hours following consumption/ingestion although it could take anywhere between 20 to 100 hours before it disappeared from blood completely. It was likely that the deceased had ingested both methadone and diazepam and there was nothing to suggest that he had ingested or otherwise taken any other substance. It was not possible to say whether any sedative effect would be increased through the ingestion of both methadone and diazepam, although it was possible. The tolerance of an individual to the effects of a drug does not affect the concentrations found in their blood and the body still processes the drugs within the same time range. It could take a number of days for all traces of the ingested drugs to reduce to nil.

[7] **Dr Kerri Neylon** spoke to the medical records held about Mr McCallum (Crown production 9). A qualified doctor, she has been a general medical practitioner ("GP") since 2003, having initially trained as a general surgeon for three years before that. The deceased had been a patient of hers when she worked at the Gairbraid Medical Practice in Maryhill, Glasgow. She remembered the deceased and that she had been responsible for prescribing him methadone. From the medical notes, she confirmed that the deceased had been prescribed 280mls of methadone on 23 April 2015, representing four daily doses of 70mls. On 7 April 2015, he had been prescribed zopiclone tablets to help him sleep. She recalled that the deceased had frequently requested these, although she had often declined to prescribe them. Although she knew that the deceased was in

work, she could not recall being aware of the nature of his employment. She explained that methadone would normally be prescribed to a patient who had previously been a user of either heroin or diazepines. A patient would be started on a relatively low dose in order assess opiate tolerance. Methadone could cause drowsiness and/or nausea, so a prescription would always be accompanied by discussions regarding the presence of children at home, whether a patient was working or driving and safety issues in general. Advice from the DVLA was to contact them directly in relation to drugs prescribed to a driver. As prescription of opiates could also affect vehicle insurance, patients would also be told to contact their insurers. Drowsiness is a well recognised side effect, but the extent to which a patient will be affected depends on their opiate tolerance. A former heroin user is likely to have a higher tolerance.

[8] Dr Neylon explained that she would normally see a patient prescribed methadone every two months and that the patient would see a drugs counsellor in between times. If she was aware that such a patient was a driver, she would make a point of following up with him whether the DVLA had been contacted and, if need be, ask him to provide evidence. If that was not forthcoming then she would get in touch with DVLA herself. From her recollection, the deceased had assured her that he was not driving. She would have asked that specifically, because he asked for "takeaway" prescription quantities. The deceased had told her that he was going to Inverness for three or four days with work and that he would be unable to access a pharmacy as he had no transport. He had told her that he was not driving. As such discussions were a routine part of her consultation, these were not recorded discretely in the notes. Since

learning of the deceased's death, however, she was now fastidious about documenting any driving advice given and she and the addictions team now used a new "drug user computer template" which helped to record or document those discussions. In the past, albeit in a different situation, she had contacted DVLA about a drug user patient. She believed that, for larger methadone prescriptions, one dose would normally be dispensed to be taken by a patient on the day, in the presence of the pharmacist; additional doses would be dispensed for other days. How that would be done – that is, whether in individual or multiple dose containers – was a matter for the pharmacist.

[9] Dr Neylon identified Crown labels 1 and 2 as being bottles of 140mls and 500mls respectively, both of which were just under half full. The smaller bottle appeared to have been dispensed on 18 May 2015, and the other on 9 April 2015. She surmised that one probably contained 70mls and the other 210mls, in accordance with the prescription. She explained that the deceased would have had to have attended at the pharmacist on Tuesdays and Fridays for a supervised dose but he would otherwise have been responsible for self-medicating on Wednesdays, Thursdays, Saturdays, Sundays and Mondays. As a safeguard, urine checks are carried out monthly to ensure that a patient is not also using illicit substances. She confirmed having issued the deceased with a prescription to commence on Tuesday 26 May 2015 to cover the period the deceased was due to be away and working in Aberdeen.

[10] Dr Neylon could not say whether or not the deceased would have taken any of the methadone prescribed to him on the day of his death. While urine was checked regularly for methadone patients, this does not indicate the quantities of any drugs

taken, only the type used. This was a normal level of trust for an effective working relationship. If it was discovered that a patient was not taking methadone as prescribed then, depending on the reasons, the dose could be reduced or arrangements could be made for all doses to be taken under supervision, but this could lead to working difficulties. Dr Neylon was unable to comment on the presence of diazepam in the appellant's blood, as this had not been prescribed by her or her practice. Similarly, she could not comment on the existence of metabolites. Similar to methadone, the likely effects of diazepam would include possible drowsiness or reduced reactions and patients would be advised not to drive or operate machinery; although there could be increased tolerance if a patient had been using it for some time. If using both methadone and diazepam, then there was an increased risk of side effects, which would also happen if alcohol was taken.

[11] Cross-examined, Dr Neylon confirmed that the deceased had been prescribed methadone up until around October 2013, when it had stopped for a period, restarting in or about April 2014. She recalled that the deceased had requested medication regularly for claimed sleep issues and he had said that he had used dihydrocodeine prescribed to his aunt. Following a detoxification programme in or about February 2014, he had been reviewed and methadone had been recommenced with effect from April 2014. By reference to a letter from Dr Wylie, consultant psychiatrist, Woodilee Hospital, Lenzie of 30 April 1997, she confirmed that the deceased had been involved in poly-drug misuse from around age 11, including opiates and heroin and that he had purchased methadone, too. She accepted that the deceased had an extensive drug misuse history.

She clarified that she had been responsible for running the specialist methadone clinic at Gairbraid Practice and that she had acquired some expertise in relation to the prescription of methadone and drug abuse in general. She confirmed that the deceased could be described as "stable" on the methadone programme. Pressed on the issue of discussions with the deceased regarding his driving, she recalled that he had always insisted that he was driven to jobs by others and that she had been surprised to learn that he had been driving on the day of his death. She thought it odd that the deceased still had the prescription of 9 April 2015: if the deceased was using illicit drugs, then she would have expected him to have sold it. If methadone is used for some time, it does create greater dependence, although it does create a greater tolerance of the effects.

[12] If a patient decided to stop using methadone, it was likely that they would develop side effects or withdrawal symptoms within 48 hours, becoming agitated, feeling sweaty, suffering leg cramps, nausea and anxiety. Drowsiness was not normally a withdrawal symptom. If that happened, a patient would be expected to take the methadone in order to alleviate the symptoms. She confirmed that the deceased had not reported any recent problems with the dosage and she recalled that on 7 April 2015, he had told her that he was "doing better". Although there was a possibility that the deceased was ingesting methadone that had not been prescribed, she could not say why he would choose to do that. It was unlikely that anyone else would have prescribed the deceased diazepam without contacting her practice, so she assumed that it had been obtained illicitly. She confirmed that if diazepam and methadone were taken at the same time, there was an increased risk of drowsiness.

[13] **PC Wilkie** is 41 years of age with 22 years police service. He is part of the Trunk Road Policing Group, based in Perth. He had been responsible for investigating the road traffic accident and resulting death of the deceased. He and a colleague had been on duty at or about 1507 hours on 26 May 2015 when they received a call instructing them to attend at a serious road traffic incident on the A90 near Kinfauns. As they made their way there from Perth, they had to pass the incident on the opposite carriageway before turning and returning to it on the westbound carriageway. He had observed a white "Sprinter" van on the front nearside of a lorry cart following a collision. On their return to the locus, they stopped behind the incident and deployed cones and road signs. They saw that the van's single occupant had been "thrown about" and that he was "practically sitting" on the steering wheel, with no obvious sign of life. Ambulance crews had attended and pronounced "life extinct" shortly after that. They had erected screens where appropriate. The person in the van turned out to be the deceased, Scott McCallum. Thereafter, PC Wilkie and his colleague made routine enquiries and examined the locus. They identified the deceased's detached right arm to the rear of the HGV, which they covered. They searched for identification of the deceased and reported the outcome of the investigations. A senior investigating officer was appointed to take control and to direct enquiries.

[14] Further enquiries revealed that the police had been called regarding the driving of the deceased's vehicle two days earlier (on 24 May 2015) by a Mr and Mrs Connolly. They had been driving on the A96, travelling eastwards near Nairn and they had been unhappy with the way in which the vehicle had pulled out of a layby in front of them,

causing them to brake. They were so concerned with the way in which the vehicle was being driven, they had taken video footage of it weaving from side to side in front of them. They had called the police. The video footage formed Crown production 6. Commenting on the footage, PC Wilkie observed that the driver of the vehicle appeared to be weaving from side to side within the single lane, which would be a cause for concern: there was a possibility of the driver being under the influence of alcohol, drugs or otherwise distracted. Possible distractions would include other parties in the vehicle; using a mobile telephone; or other, outside distractions. His inquiries disclosed that the deceased had been stopped by the police and required to undertake the roadside breath test, although this had been with a negative result. The deceased had said that his passenger had been blocking his view of the nearside of the vehicle of the car so he had been distracted at the time. It was an explanation that may have seemed plausible at the time but the investigating officers had no reason for any further concerns and therefore they took no further action.

[15] PC Wilkie's enquiries also disclosed that, on the day of the deceased's death, a Witness McNaughton had called the police making a complaint about a white van. She had been driving down the A90 dual carriageway from Aberdeen to Dundee when the van had drifted out while she was overtaking before drifting back to the nearside carriageway. Further down the road, the same van had overtaken her; while doing that, it had drifted left towards her before drifting back to the outside lane. She had last seen it pulling into the Shell filling station on the Kingsway in Dundee but she was only able to provide a partial registration as beginning with "SF"; she described it as "a van with a

box", a description consistent with the deceased's vehicle. PC Wilkie assessed that the approximate distance from the Shell garage on the Kingsway to the locus would be around 16 miles; the call from Ms McNaughton had been reported around 1345 hours; it was a matter of agreement that the HGV driver had taken a break at 1440 hours; it would take approximately 15 to 20 minutes to drive from the Shell garage to the locus. The van had been reported as being in the garage for around 40 minutes. It would appear that nothing was done in relation to Ms McNaughton's call because there was insufficient information. The driver had been described subsequently as being "slim, male, 40". Although he could not be sure, it was likely that the vehicle reported by Ms McNaughton was following the same route as the deceased's.

[16] PC Wilkie identified Crown production 7 as being a recording from the dashboard camera of the HGV that had been parked at the locus. He explained that impact would trigger the recording, and he described the mechanics by which the deceased's vehicle ended up, after the collision, on the front nearside of the HGV between the tractor unit and the fence. Recording had commenced at 1503 hours.

[17] The deceased's vehicle was not required to have a tachograph as this was only required for vehicles exceeding 3,500 kilogrammes in weight. There was no legal requirement to maintain a record of driver's hours, but enquiries disclosed nothing untoward. He confirmed that both vehicles had been examined by VOSA and the collision investigators had prepared a report, all of which had been produced. He identified the photographs, which he confirmed were an accurate depiction of what he had seen and found at the locus. No other witnesses to the incident had been found.

[18] Cross-examined, PC Wilkie confirmed that there was no need to record driving hours if driving was secondary to another occupation and if a vehicle was less than 3,500 kilogrammes in weight. He had obtained the deceased's timesheets from his employers and there was no evidence that the deceased had been working or driving excessively. Enquiries had revealed that the deceased's vehicle had visited the Shell garage on the Kingsway in Dundee. The deceased had spoken to someone in the forecourt of the garage, but that witness had not thought that the deceased had given any indication of being under the influence of alcohol. The 40 minutes he spent at the garage had been due in part to the fact that he did not know the PIN for his employers' fuel card, as a result of which he had had to phone them. The deceased had also visited the toilet. By reference to his witness statement (prepared on 15 June 2015 from his own notebook), PC Wilkie confirmed that the deceased had been recorded entering the forecourt of the Shell garage from the A90 at 14:14:28 hours and leaving at 14:40:05 hours: the distance and time were consistent with the likely duration of the journey to the locus and consistent with the time of the collision.

Determination

[19] In light of the evidence that I heard in this inquiry, very few conclusions can be accurately drawn. Clearly, Mr McCallum died quickly as a result of thoracic injuries sustained through a blunt force trauma occasioned by a road traffic collision in which he was the driver. Notwithstanding that Mr McCallum was well-established on a methadone programme there is no evidence that the quantities of methadone – or, for

that matter, the diazepam – found in his blood caused or materially contributed to his death. Indeed, while it is impossible to be certain one way or another, it seems to me that a man such as Mr McCallum, who had struggled with drug abuse from a remarkably early age (11 years old) had possibly developed a tolerance to the extent that his functioning might not have been affected to any material extent by his substance use (or misuse). I certainly do not doubt that Dr Neylon, being a GP of some experience who managed a specialist methadone clinic, made the proper enquires of Mr McCallum regarding his activities and the likelihood of him driving. As she has since recognised, the recording of some detail of those discussions might have been helpful in her notes.

[20] While there is some evidence of Mr McCallum's driving being – at times – somewhat erratic (both when driving between Inverness and Aberdeen and then between Aberdeen and Dundee) there appears to be no evidence that would enable me to make any findings in relation to the cause of the fatal collision.

[21] Finally, I should like to extend my sympathy to Mr McCallum's family, to whom his traumatic passing, at a time when he was stable on a methadone programme and in gainful employment, must have come as a severe shock.