SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2021] FAI 31

HAM-B312-20

DETERMINATION

BY

SHERIFF DANIEL KELLY QC

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

into the death of

ROBERT McMILLAN

HAMILTON, 17 May 2021

DETERMINATION

(1) The Sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

a) When and where the death occurred

In terms of section 26(2)(a) the death of Robert McMillan occurred between about 10.05 am and 10.20 am on Thursday 17 January 2019 at Mount Cameron Drive North, East Kilbride.

b) When and where any accident resulting in the death occurred

In terms of section 26(2)(b) an accident resulting in the death of Mr McMillan occurred at about 10.05 am on Thursday 17 January 2019 at Mount Cameron Drive North, East Kilbride.

c) The cause or causes of the death

In terms of section 26(2)(c) the primary cause of the death was **mechanical asphyxia** due to a **motor vehicle incident (pedestrian).** A potential contributing cause was **ischaemic heart disease**.

d) The cause or causes of any accident resulting in the death

In terms of section 26(2)(d) the cause of the accident resulting in the death was the deceased becoming trapped under the front nearside wheel of Mercedes Econic motor vehicle registration number SJ65 FZN as he lay prone on the roadway, likely having collapsed, directly in front of the vehicle which was travelling north and then stopped.

e) Any precautions which could reasonably have been taken and which might realistically have avoided the accident or the death

In terms of section 26(2)(e) there are no precautions which could reasonably have been taken and which might realistically have avoided the death or the accident.

f) Any defects in any system of working which contributed to the death or accident resulting in the death

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

g) Any other facts which are relevant to the circumstances of the death

In terms of section 26(2)(g) there are no other facts and circumstances which are relevant to the death.

Recommendations

(2) In terms of Section 26(1) and (3), it is necessary to make a determination setting out such recommendations (if any) as considered appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps, which might realistically have prevented other deaths in similar circumstances. I have no recommendations arising from this inquiry to make.

NOTE

Introduction

(3) A fatal accident inquiry was held at Hamilton Sheriff Court on 20 and 21 April 2021 into the death of Robert McMillan.

(4) Parties agreed evidence in a Joint Minute and initially proposed that the case proceed solely on the basis of that along with submissions. However, there were a number of issues relating to the circumstances of the death of Robert McMillan which called for fuller investigation. Mr McMillan was working as a refuse collection loader. In particular, his visibility to the driver of the lorry as he walked down its side and in front of it called for exploration in the course of oral evidence. Therefore, I required the procurator fiscal to bring forward evidence about the following matters:

a) the significance of the presence or absence of scuff marks on the underside of the refuse collection vehicle registration number SJ65 FZN;

b) the path that the deceased would have taken from when he was observed at the rear of the said vehicle to when he was at its front nearside;

c) his visibility in moving there; and

d) the obstruction of the central blind spot mirror by the sun visor.

Thereafter, a hearing was fixed at which the following witnesses gave evidence:

(i) Daniel Eaglesham,

(ii) PC David Murdoch,

(iii) PS Stuart Bell, and

(iv) PC Stuart Paterson.

The driver of the lorry did not give evidence at the hearing. He provided statements and professed great anxiety at attending and his attendance was not insisted upon.

The Legal Framework

(5) The inquiry was held under section 1 of the 2016 Act which, under section 2(3), was mandatory since the death of Mr McMillan was the result of an accident occurring in the course of his employment. Fatal accident inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the 2016 Act and of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

(6) In terms of section 1(3) of the Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps if any may be taken to prevent other deaths in similar circumstances. Section 26 requires the sheriff to make a determination which in terms of section 26(2) is to set out factors relevant to the

circumstances of the death, in so far as they have been established to his satisfaction. These 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 could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided; (f) any defects in any system of working which contributed to the death or accident; and (g) any other facts which are relevant to the circumstances of the death. In terms of section 26(1)(b) and 26(4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances. The procurator fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The determination must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish civil or criminal liability.

Summary

(7) Robert McMillan (born 19 November 1963) was employed by South Lanarkshire Council as a bin loader uploading food and garden waste onto a refuse collection vehicle. He had been employed in this role since 25 May 2015. Three members of South Lanarkshire Council staff worked together, namely a driver and two bin loaders.

(8) As a bin loader the deceased travelled on foot alongside the refuse collection vehicle, retrieving bins which had been left out for collection from the side of the road or from garden grounds where occupants were unable to take their bin out for collection. The bins were loaded onto the refuse vehicle to be emptied and then returned to the side of the road.

(9) On 17 January 2019 the deceased was working for South Lanarkshire Council, Facilities, Waste and Grounds Services, 18 Forrest Street, Blantyre. He accompanied Robert Shaw, the driver of the refuse vehicle Mercedes Econic registered number SJ65 FZN, and Daniel Eaglesham, a fellow bin loader. Together, they carried out their daily uplifts from an established route in the East Kilbride area. The three had worked together for a period of around 18 months covering the East Kilbride and Hamilton areas, rotating each area on a weekly basis.

(10) At about 10.00 am the refuse vehicle was travelling north on Blacklaw Drive where it turned left westbound onto Mount Cameron Drive North. A left southbound turn took it into Mount Cameron Drive North. This street is a cul-de-sac, with the end of the road being used as a large parking and turning area. Robert Shaw reversed the vehicle up this part of Mount Cameron Drive North with the deceased and Mr Eaglesham acting as reversing assistants. Once the vehicle had reached the end of the road the deceased and Mr Eaglesham began collecting and emptying the refuse bins. Mr Eaglesham collected bins from the refuse vehicle's offside and the deceased collected those from its nearside.

(11) Having emptied the bins at the end of the cul-de-sac, Mr Shaw drove forward to enable two bins to be loaded, one from either side, by Mr McMillan and Mr Eaglesham. Mr Eaglesham was emptying the bins on the offside of the vehicle before returning them to the side of the road and walking down towards the entrance to the street. Mr Shaw moved the refuse vehicle slowly forwards towards two unemptied bins on the nearside of the vehicle before stopping and applying the handbrake. It had only travelled a short distance at what is likely to have been walking speed. Noticing that some bins on the nearside which Mr McMillan was dealing with had not been emptied, Mr Eaglesham went to look for him. Not having seen the deceased either, Mr Shaw asked Mr Eaglesham out of his window from a stationary position if he had seen Mr McMillan. Mr Eaglesham walked around the front of the vehicle, from offside to nearside, where he observed the deceased lying on the roadway trapped underneath the front nearside wheel. Mr Eaglesham shouted to Mr Shaw to advise him of this. Mr Shaw exited the vehicle via the passenger side door and immediately contacted an ambulance to attend. Mr Eaglesham called his superiors.

(12) At about 10.07 am paramedic Anthony Lithgow was dispatched in a fast response ambulance to attend. On arrival he observed the deceased positioned on his back with the right side of his chest underneath the front nearside wheel of the refuse vehicle. His head was facing towards the front nearside of the vehicle, his legs towards the rear offside. Mr Lithgow noted that the injuries to the deceased's chest were unsurvivable and determined that no emergency medical treatment could be provided. He pronounced life extinct at 10.20 am.

(13) A number of divisional and road traffic police officers arrived at the scene as well as employees from South Lanarkshire Council. Neither the deceased nor the refuse vehicle had been moved. Police Sergeant Stuart Bell took on the role of Senior Investigating Officer. Police Constables Calum McKinlay and Stuart Paterson attended in their capacity as Collision Investigators. PC David Murdoch, a road patrol officer, was also in attendance and carried out a visual examination but was not one of the officers who compiled the investigation report.

(14) Mr Shaw was required under Section 6 of the Road Traffic Act 1988 to provide a specimen of breath for the purposes of a roadside breath test, which was negative.

(15) A visual examination of the refuse vehicle was carried out by Sergeant Bell and Constables McKinlay and Paterson. It was identified that there was no significant evidence on the front or nearside of the refuse vehicle that indicated that the deceased had been struck by and knocked over by the vehicle as it moved. There was some evidence in the form of four small horizontal cleaning marks at the very bottom of the front valance which may have been consistent with finger marks, possibly gloved.

(16) At about 12.25 pm Russell Berry and Ashley Fallis, Inspectors for the Health and Safety Executive, attended.

(17) On 24 January 2019 in a mechanical examination carried out on the refuse collection vehicle by George Mcintyre, vehicle examiner, in the presence of Constable Simon Reilly no mechanical defects were found other than the rear auxiliary amber beacons and rear work lamp being inoperative.

(18) On 25 January 2019 following a post mortem examination conducted at the Queen Elizabeth University Hospital, Glasgow, Consultant Forensic Pathologists Dr Julia Bell and Dr Gemma Kemp recorded the cause of death as indicated in paragraph (1)c).

(19) The Health and Safety Executive carried out its own inquiry and, in a Report dated 21 February 2020, concluded that the scenario was consistent with Mr McMillan already being on the ground when he was hit by the front wheel of the vehicle.

(20) Parties submitted that only the mandatory formal findings should be made but that no further findings or recommendations were called for.

Discussion and Conclusions

(21) A key area explored at the hearing was the visibility of the deceased to the driver of the lorry. Whether the driver ought to have seen Mr McMillan move from the back and nearside of the lorry to its front was explored in depth with the witnesses at the hearing. Mr McMillan was wearing a high-visibility vest over his working clothes. Three specialist road traffic police officers gave evidence and a fourth co-authored a collision investigation report. One of them, Sergeant Stuart Bell, was among the most senior collision investigators in the west of Scotland at the time. All of them concluded that it was possible for Mr McMillan to have walked around the front of the lorry and dropped to the roadway without the driver having seen him. They were of the view that whether the driver would have seen the deceased walk round would have

depended upon him looking in the relevant mirror at the particular time, which would likely have lasted for only a matter of seconds.

(22) The collision investigators found that Mr McMillan must have been lifeless as the lorry passed over him. Had he been conscious he would have been expected to have shouted and moved when this happened. There were no cleaning marks on the front of the lorry other than four marks on the bumper. The absence of marks on the front of the lorry was indicative that Mr McMillan had not been upright when the lorry advanced. Cleaning marks on the front of a vehicle resulting from when someone was knocked down on impact were generally readily identifiable.

(23) The small marks on the bumper had a straight edge and were consistent with being created by the fingers of Mr McMillan's left gloved hand as the lorry passed over him. The left glove was found nearby as if it had been pulled off. Its rubberised surface would have been sufficient to have pulled it off. There were also limited cleaning marks on the underside of the lorry. Marks on the heatshield were consistent with the toe ends of Mr McMillan's boots hitting the underside of the lorry as it passed over him. Marks on the inside rim of the front nearside wheel likely occurred as it rolled against the right side of his chest. The marks were consistent with Mr McMillan having fallen to the ground and the lorry passing over him, with one of his hands brushing against the bumper and with his boots creating cleaning marks on the underside. Had Mr McMillan been conscious or moving, the collision investigators would have expected more marks to have been caused from him touching the lorry.

(24) The driver of a Mercedes Econic refuse vehicle has an elevated seating position which would be higher than that of a car but lower than that of a tipper truck. There was a blind spot for the driver extending to 3.9 metres from the front nearside of the lorry. The vehicle had six mirrors. Two on each side faced rear and covered the sides of the vehicle. A fifth above the passenger door covered the area beneath that door and the front nearside wheel. A sixth mirror fitted centrally to the windscreen covered the area directly in front of the lorry and below the windscreen. Even despite the mirrors, there were a number of areas or blind spots around the lorry into which the driver would not have been able to see.

(25) Although the central mirror allowed the driver to see the area directly in front of the lorry and below the windscreen, when the sun visor was extended it blocked out this mirror, with that area reverted to being a blind spot. The sun visor, which was capable of extending down from the top of the windscreen for 65 cm, was being utilised that day. It was operated electronically from a panel on the inside of the driver's door. As it was sunny and the sun was low in the sky, the collision investigators did not criticise the use of the visor, even although the sun would not have been in front of the lorry for all of the time. However, its use had the consequence that the position where Mr McMillan was lying would not have been visible to the driver when within a proximity to the lorry of 3.9 metres.

(26) While it would have been unusual for a bin loader to walk in front of a lorry, no explanation emerged for Mr McMillan having done so. Moreover, the reason as to why Mr McMillan would have been prone on the roadway remains elusive, with one of the

road patrol officers saying that this question had been on his mind for the intervening years. Factors such as the narrowness of the footpath and the finding of his phone were considered but discounted. Had Mr McMillan fallen from the footpath he would most likely have struck the side of the lorry. As his phone was crushed under the front nearside wheel, it was not possible to determine if it was being used during this time, but he had not been seen using it. Had he been trying to retrieve a dropped phone it was unlikely that there would not have been any mark on the vehicle, such as one caused by him placing a palm on it while doing so. With either of these explanations there would have been expected to have been some banging or shouting from the deceased. The most likely explanation to emerge from the police road traffic unit investigation, expressed most clearly by Sergeant Bell, was that some substantial medical episode occurred, resulting in Mr McMillan collapsing onto the roadway in front of the lorry and not moving as it passed over him. That such an episode occurred is consistent with the post mortem report, which concluded that Mr McMillan had significant ischaemic heart disease, which was of a severity that it could have caused sudden death at any time and which could have played a part in his death by potentially being a factor that had led to collapse prior to being run over.

(27) It may be concluded, therefore, that Mr McMillan has fallen to the roadway in front of the lorry, likely having collapsed. In the short time that Mr McMillan walked down the nearside of the lorry, in front of it and collapsed, the collision investigators concluded that it was possible for him to have done that without the driver having seen him. Mr McMillan would have been lifeless on the roadway as the lorry passed over

him, resulting in him coming under its front nearside wheel, which has resulted in his death.

(28) Where the death involved a pedestrian being in front of and then underneath a refuse lorry, it was important to explore fully with the witnesses whether any precaution ought to have been taken or whether any recommendation should be made which might realistically prevent other deaths in similar circumstances. Ultimately, while no definitive answer emerged from the evidence as to why Mr McMillan came to be placed where he was, the witnesses at the hearing were at one in ruling out that that any precaution should have been taken or that any recommendation be made. I, therefore, make no findings as to precautions and make no recommendations.

Condolences

(29) Finally, I extend my sincere condolences to the family of Mr McMillan.