SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT STRANRAER

[2026] FAI 36

STR-B74-25

DETERMINATION

BY

SHERIFF GARRY A SUTHERLAND

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

into the death of

BRIAN MCCOLM

STRANRAER, 10 July 2026

The sheriff, having considered all the evidence presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 that:

1. Brian McColm was born on 27 February 1955

2. In terms of section 26(2)(a), his death occurred on 9 January 2024 at 1900 hours within the Garrick Ward, Galloway Community Hospital, Stranraer.

3. In terms of section 26(2)(b), an accident resulting in his death occurred on 5 January 2024 at some point prior to 1300 hours at Awhirk Farm, Ardwell, Stranraer.

4. In terms of section 26(2)(c), the causes of his death determined at a post-mortem examination at Dumfries and Galloway Royal Infirmary on 16 January 2024 were:

    1a. Subdural haematoma

1b. Traumatic brain injury

1c. Bronchopneumonia

II. Epilepsy, Guillain Barre syndrome, ischemic heart disease, chronic obstructive pulmonary disease.

5. In terms of section 26(2)(d), the cause of the accident that resulted in the death is incapable of being identified.

6. In terms of section 26(2)(e), there were no precautions which (i) could reasonably have been taken, and (ii) had it been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided.

7. In terms of section 26(2)(f), the defect in any system of working which contributed to his death or any accident resulting in his death was that Mr McColm was working alone with plant and equipment in a remote rural location. There was no system in place to alert another person in the event of his becoming injured or incapacitated during his work.

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

Recommendations

There are no recommendations to make under section 26(1)(b). There are no (a) reasonable precautions to be taken; (b) improvements to any system of working to be made; (c) systems of working to be introduced; or (d) other steps that could be taken which might realistically prevent other deaths in similar circumstances.

NOTE

Procedural history

[1] On 12 May 2026, at Stranraer Sheriff Court a public Inquiry was held remotely via the Webex platform into the death of Brian McColm (hereinafter referred to as "Mr McColm"). The Crown was represented by Ms Lewis.

[2] Preliminary hearings were held at Stranraer Sheriff Court remotely via the Webex platform on 13 January, 24 February and 24 March 2026. The Crown was represented at each hearing by Ms Lewis.

[3] No party other than the Crown entered appearance.

[4] The inquiry was held in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016.

[5] The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry) Rules 2017.

[6] In terms of sections 1(3) and (4) of the 2016 Act, the purpose of the inquiry was to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the Inquiry was not to establish civil or criminal liability.

[7] In terms of subsections (1)(a) and (2) of the 2016 Act, in relation to the death to which the inquiry relates, the sheriff's findings must be as to (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, and (g) any other facts which are relevant to the circumstances of the death.

[8] The inquiry was raised by the Crown as a mandatory inquiry under section 2(3) of the 2016 Act on the basis that the accident that resulted in the death of Mr McColm occurred whilst he was acting in the course of his employment or occupation.

The information/evidence before the inquiry

[9] The following was before the inquiry by virtue of a notice to admit information dated 8 May 2026:

> ***Facts***
>
> [9.1] That Brian McColm, born 27 February 1955 (hereinafter referred to as Mr McColm) lived and worked on Awhirk Farm, Ardwell, Stranraer, with his wife Joy McColm. They had two children, Zoe Marshall and Ben McColm. Following Joy's death in May 2021, Mr McColm resided alone on the farm. He was a self-employed farmer and often worked alone, although would sometimes get help from witness William Alexander Barry. Witness Barry was not formally employed by Mr McColm and never took monetary payments for helping on the farm.

[9.2] Mr McColm had a medical history including epilepsy, hypertension and Guillain Barre syndrome.

Epilepsy

[9.3] Mr McColm is noted to have suffered with his first epileptic seizure in 1972. In the years prior to Mr McColm's death, he did not appear to always be forthcoming about his epileptic seizures, therefore it is impossible to say how frequently he would have an epileptic seizure.

[9.4] On 11 June 2000, Mr McColm's driving licence was revoked by the Driver and Vehicle Licensing Agency (hereinafter referred to as the "DVLA"), following an epileptic seizure on 13 December 1999. In August 2008, Mr McColm reapplied to the DVLA for his driving license and advised the DVLA that he had been seizure free for over 7 years. The DVLA issued a driving licence valid until 26 February 2025. There does not appear to be any further self-notifications to DVLA, to report epileptic seizures.

[9.5] On 7 December 2011, Mr McColm suffered a tonic-clonic seizure. He was taken to Galloway Community Hospital Accident and Emergency Department (A&E) and discharged, however suffered another seizure almost immediately and was returned to A&E. Mr McColm was made aware by hospital staff that he had to notify the DVLA. The hospital informed Mr McColm's GP. Mr McColm subsequently had an epilepsy review with his GP on 14 December 2011. It is recorded in his GP records that during this review, Mr McColm informed his GP

that he had had no seizures for years, until the previous week. Mr McColm had an upper respiratory tract infection and may have missed his medication. He also advised that the farm was being inspected and had felt unwell for 5 days prior to the seizures. Again, he was advised to contact the DVLA.

[9.6] Mr McColm engaged with epilepsy reviews at his GP practice. These occurred on 15 January 2013, 11 March 2014, 30 December 2015, 23 March 2018 and 27 November 2019. On each of these reviews, Mr McColm reported being seizure free for over 12 months. During the appointment on 23 March 2018, he was challenged by the GP on whether he was complying with his medication, as the last prescription was ordered in June 2017. Mr McColm was adamant that he was taking his medication and was using old stock.

[9.7] On 21 December 2021, Mr McColm was witnessed having a seizure. He appeared to close his tractor door and collapse. This seizure lasted 6 - 7 minutes. He was initially admitted to Galloway Community Hospital A&E Department where he had a further seizure prior to being transferred to Dumfries and Galloway Royal Infirmary. Mr McColm was informed that he should not drive and inform the DVLA. Mr McColm's GP practice was made aware of this hospital admission.

[9.8] On 21 May 2022, Mr McColm was brought to Galloway Community Hospital following a head injury. Mr McColm thought he had fallen in the kitchen, but it is noted that there was blood outside his house. He was found in bed by his daughter and had no recollection of the events of the fall. He was

transferred to Dumfries and Galloway Royal Infirmary and subsequently discharged on 25 May 2022. The transfer paperwork queries a possible seizure. Whilst in Dumfries and Galloway Royal Infirmary, Mr McColm was noted to have sustained a severe head injury, facial fractures, 8th and 9th rib fractures and an intracranial bleed. Mr McColm was advised not to continue working with cattle and not to drive for 1 month. It is unclear if this was the result of a fall or a seizure.

[9.9] On 24 June 2022, a letter was sent to Mr McColm's GP, advising that he had been contacted by the community occupational therapy team. They had raised concerns about Mr McColm continuing to drive and operate heavy machinery. Mr McColm had an appointment with his GP, Dr Charlotte Ross on 27 July 2022 where he was asked about the letter from occupational therapy and the concerns they had raised. It is recorded in his medical notes that:

> "given seizure indece he (Mr McColm) knows he is not able to drive and he agrees to that… Suggested that he liaise with insurance and the police. Brian tells me he will do that and get help with driving until 12 months after last seizure".

[9.10] On 12 January 2023, Mr McColm was admitted to Galloway Community Hospital A&E Department following a witnessed seizure. Mr McColm fell face down into slurry and may have aspirated on the slurry. The seizure lasted 4 minutes. At this time, his last seizure was recorded as being in December 2021. The discharge letter was sent to Mr McColm's GP.

[9.11] On 23 August 2023, Mr McColm attended his GP practice for an epilepsy review, amongst other things. It is recorded that Mr McColm had no reported seizures and was seizure free for over 12 months. There is no mention of his hospital admission from January 2023.

[9.12] Mr McColm had no further epilepsy reviews or seizure related hospital admissions prior to his death.

[9.13] The General Medical Council (GMC) website advises that where a patient has a condition or is undergoing treatment that could impair their fitness to drive, the driver is legally responsible for telling the DVLA. A GP should: Explain this to the patient and tell them that they have a legal duty to inform the DVLA; tell the patient that they (GP) may be obliged to disclose any relevant medical information about them, in confidence, to the DVLA if they continue to drive when they are unfit to do so; make a note of any advice they (GP) have given to a patient about their fitness to drive in their medical record.

If a GP becomes aware that a patient is continuing to drive when they are not fit to do so, the GP should make every reasonable effort to persuade them to stop. If the GP does not manage to persuade the patient to stop driving or discovers that they are continuing to drive against GP advice, the GP should consider whether the patient's refusal to stop driving leaves others exposed to a risk of death or serious harm. If the GP believes that it does, they should contact the DVLA or DVA promptly and disclose any relevant medical information, in confidence, to the medical adviser.

Before contacting the DVLA or DVA, the GP should try to inform the patient of the intention to disclose personal information. If the patient objects to the disclosure, the GP should consider any reasons they give for objecting. If the GP then decides to contact the DVLA or DVA, they should tell the patient in writing once they have done so and make a note on the patient's record.

[9.14] There is nothing within Mr McColm's medical records to suggest that his doctor believed he was still driving after they had explicitly told him not to drive, and to report himself to the DVLA.

[9.15] Had Mr McColm reported his seizure on 12 January 2023 to the DVLA, it is likely that his driving licence would have been revoked at the date of his death on 9 January 2024.

[9.16] Even if Mr McColm had self-reported to DVLA, and had his licence revoked, there is no requirement to have a driving licence to drive a tractor on private land.

Circumstances of accident

[9.17] At approximately 1300 hours on 5 January 2024, William Barry attended at Awhirk Farm to eat lunch and grab some sockets that he had left there. Mr McColm was not in the farmhouse. William Barry was about to leave the farm when he noticed Mr McColm's red Case maximum 5130 tractor sitting down the lane that runs parallel to the silage pit on his farm.

[9.18] He headed towards the red tractor believing Mr McColm may be there. He then noticed that another tractor, a blue New Holland/Ford 7840 was down a banking as if it had come off the lane. William Barry noted that it was a steep drop.

[9.19] Mr McColm was climbing up the banking from the tractor and had blood running down the left side of his face. He had a large gash on his face. William Barry intended to take Mr McColm to hospital, but he became stroppy and was determined to get the blue tractor out of the ditch by using the red tractor. William Barry looked at the tractor and advised it could not be removed without seriously damaging it. Mr McColm was going on and on about moving the tractor and mentioned getting another farmer to help. Mr McColm appeared to be agitated.

[9.20] William Barry advised Mr McColm that he could get on with it, and he was taking nothing to do with it. Following this, he asked for his socket set and drove back to the house, expecting Mr McColm to follow but he did not. William Barry did not want to enter the house without Mr McColm so returned to the tractors.

[9.21] Upon his return, William Barry noticed that Mr McColm was on the ground and having a seizure. He called 999 and requested an ambulance. Initially the call handler was unable to hear William Barry and could not establish the address resulting in William Barry hanging up the phone. Scottish Ambulance Service (SAS) call handler was able to call back William Barry and

establish the farm address. Advice was given to put firm pressure on Mr McColm's wound to try and control the bleeding until an ambulance arrived.

[9.22] Crown Production 9 contain the transcripts of these calls.

[9.23] Following the initial call to SAS, William Barry had contacted a neighbour, Rosemarie McGibney, to get her to contact SAS given the call handler could not understand him. Rosemarie McGibney attended at Awhirk Farm immediately.

[9.24] Rosemarie McGibney was on the phone to SAS around the same time as William Barry received the call back. She was able to provide the address and went to the road end to meet ambulance crews.

[9.25] Crown Production 12 contains a transcript of this call.

[9.26] At approximately 1400 hours on 5 January 2024, Dr Ian McGinley received a call from the SAS, advising that there had been an accident and asked him to attend as a first responder. An ambulance was already enroute.

[9.27] At approximately 1400 hours, paramedic John Watson was working alongside a student when they received a call relating to a traumatic injury involving a tractor. They attended at Awhirk Farm. Dr McGinley and another ambulance crew arrived shortly after. The second ambulance crew was made up of paramedic Tanya Ellis and ambulance technician, Shona McMillan.

[9.28] Dr McGinley checked Mr McColm's airway and noted that there were no immediate injuries requiring treatment. Mr McColm had lacerations to his head,

and his face was covered in blood. Dr McGinley then placed a neck brace on him.

[9.29] At this time the blue tractor was down the embankment, pressed against the slurry tanks. The red tractor had a chain attached to it as if it was attempting to pull the blue tractor out.

[9.30] At approximately 1410 hours, Police Constables David Packer and Sean Hannah were on duty when they received a call to attend a road traffic collision involving a tractor at Awhirk Farm. They attended immediately and arrived at the locus at approximately 1424 hours. Mr McColm was already receiving medical attention at this time. PC Packer assisted paramedics by holding Mr McColm steady whilst they administered treatment.

[9.31] At the same time, Police Sergeant Ross Williams also received a request to attend at the locus. He noted the position of both the Case tractor and the Ford tractor. An initial check of the locus revealed nothing of a suspicious nature.

[9.32] Mr McColm's clothing was removed to allow IV access. He was given 1000mg of tranexamic acid over a 10-minute period. At this time, Mr McColm was conscious and breathing and thought to have a Glasgow Coma Scale (GCS) of 14. Mr McColm was placed in the back of an ambulance using an orthopaedic stretcher and trolley bed due to the trauma that he had been through. A top-to-toe survey was then carried out in the ambulance. Mr McColm had facial trauma to the right side of his face, good bilateral air entry on his chest examination, although was slightly tender when his abdomen was

palpated. His pelvis appeared stable and he had pain in his right knee. Paramedic John Watson fed this information back to the talk group and had a conversation with someone on the critical care desk. He was advised to transfer Mr McColm to Galloway Community Hospital in Stranraer to allow for a trauma CT scan to be carried out and to stabilise Mr McColm. Mr McColm was subsequently transferred to Galloway Community Hospital. The ambulance departed the locus at 1512 hours.

[9.33] At 1532 hours Mr McColm was triaged by nurse Russell McQuaker. Mr McColm was able to provide a history of having an accident whilst driving his tractor. He sustained a head injury, although when first assessed had a GCS of 15. There was evidence of a facial injury, some tenderness to his chest wall and he was complaining of abdominal pain.

[9.34] At 1629 hours, Mr McColm was taken for a CT scan which showed a right sided subdural haematoma. At this point, Dr David Pedley made efforts to contact the Queen Elizabeth University Hospital (QEUH), to refer Mr McColm to the neurosurgical unit. Dr Pedley believes he first tried to contact the neurosurgical team at approximately 1645 hours but had difficulty in contacting them. Dr Pedley recalls it taking between 30 to 45 minutes to contact the on-call consultant neurosurgeon, after being unable to contact the on-call registrar. It is acknowledged that neurosurgery is a very stretched area of health care in Scotland, and the West Coast in particular have very limited resources given the size of the population.

[9.35] This referral was made because Mr McColm needed high level monitoring and critical care input and would need to be in a high dependence or critical care unit. He also potentially needed immediate surgical intervention and that could not be done at Galloway Community Hospital.

[9.36] Whilst trying to contact the QEUH neurosurgical team, Dr Pedley was also making efforts to contact the Emergency Medical Retrieval Service (EMRS). Every transfer of a patient needs to be reviewed on its own merits. The EMRS deals with transfers from rural hospitals. Generally, contacting EMRS and the receiving hospital are done in parallel within minutes of each other.

[9.37] Contact was made with the EMRS at approximately 1701 hours. At this time, Dr Nicola Littlewood who was on duty with the EMRS was advised by Dr Pedley that he could not contact neurosurgery at this time and informed Dr Littlewood of Mr McColm's situation and likely need to be transferred. A plan was put in place, despite the receiving hospital (the QEUH) not yet accepting Mr McColm's transfer. A discussion was had with the air ambulance co-ordinator, who was also on the call, about the current position of Helimed 5. Helimed 5 was just landing in Arran to collect a patient and transfer them to Crosshouse. The plan was for Helimed 5 to convey a patient to Crosshouse and then go directly to Galloway Community Hospital to collect Mr McColm.

[9.38] It is recorded in the SAS run sheet that the EMRS were made aware that the neurosurgical team had accepted Mr McColm's transfer at approximately 1810 hours.

[9.39] At approximately 1740 hours, PC Liza Murdoch and PC Stuart Home attended at Galloway Community Hospital to speak with Mr McColm. At this time, he stated that the shaft broke on the tractor and caused the crash, however he was in too much discomfort and pain for a full statement to be taken at this time.

[9.40] Whilst in Galloway Community Hospital, Mr McColm was subject to regular checks and observations by medical staff. These were carried out at 1545 hours, 1610 hours, 1655 hours, 1735 hours, 1805 hours and 1850 hours. These checks assessed his score on the Glasgow Coma Scale, respiratory response, limb movement, oxygen saturations, blood pressure, pulse, consciousness and temperature. Mr McColm appeared well and was conscious and alert at 1545 hours, 1610 hours, 1655 hours and 1735 hours. At 1805 hours Mr McColm was noted to have significantly deteriorated and was recorded as being unconscious and not responding.

[9.41] A repeat CT scan was carried out at 1845 hours which showed a dramatic deterioration with significant progression of the subdural haematoma, significant oedema on the right hemisphere, haemorrhagic dramatic contusions on the left temporal and parietal cortex, small volume of blood into the ventricles (fluid reservoir of the brain) and significant compression of the ventricle with herniation of the brain. The updated CT scan was shared with the neurosurgical team at the QEUH, but given the extent of deterioration, it was thought that any

further intervention would be futile to save Mr McColm's life or produce a good neurological outcome.

[9.42] Mr McColm was no longer fit for transfer to the QEUH and was to be given palliative care. He was moved to the Garrick Ward within Galloway Community Hospital, where he was kept comfortable until he passed away on 9 January 2024. Life was pronounced extinct at 1900 hours by Dr Nikki Duncan.

Timings of Helimed 5

[9.43] Helimed 5 was the helicopter that was due to transfer Mr McColm from Galloway Community Hospital to the QEUH. At approximately 1651 hours Helimed 5 was allocated a job in Arran. There was a delay in mobilising because the helicopter needed cleaning from a previous mission. At approximately 1737 hours, Helimed 5 landed on Arran and left at approximately 1800 hours. It landed at Crosshouse at approximately 1820 hours (at which point Mr McColm had already deteriorated). At approximately 1847 hours, Helimed 5 was cleared from the Crosshouse job.

[9.44] Following Helimed 5 departing Crosshouse Hospital, it was unable to travel straight to Stranraer as it needed to return to Glasgow to refuel first. Despite this, Mr McColm had already deteriorated at this point and no longer required the transfer.

[9.45] Had Helimed 5 been available straight away where it is based in Glasgow, it would have taken approximately 40 minutes to travel from QEUH to

Stranraer. There would then be a turnaround time which is normally at least 30 minutes, to transfer the patient to a stretcher and load them into the helicopter. The return time from Stranraer would have been approximately 40 minutes, with an additional 10 minutes to unload the patient at QEUH. This total time would have been approximately 120 minutes. Even if Helimed 5 was available at 1629 hours when Mr McColm went for his first CT scan, and he was accepted immediately by the QEUH neurosurgical team, he would not have made it to the QEUH before deteriorating. Similarly, if Mr McColm had been transferred by an emergency road vehicle, it is likely this would have taken at least 2 hours, and he would have deteriorated enroute.

Post-mortem

[9.46] A post-mortem examination was carried out on 16 January 2024, by consultant pathologist Dr Krsty Nale. The cause of death was recorded as:

1a. Subdural haematoma

b. Traumatic brain injury

c. Bronchopneumonia

2. Epilepsy, Guillain Barre syndrome, ischaemic heart disease, chronic obstructive pulmonary disease.

The autopsy showed a collection of freshly clotted blood in the subdural space most likely caused by traumatic brain injury. The bridging veins transverse subdural space and are prone to tearing due to trauma. The displacement of the

brain also occurs in trauma and can tear the veins at the point where they penetrate the dura, causing bleeding in this space. A subdural haematoma is most common over the lateral aspect of cerebral hemispheres as in this case.

Vehicle inspection

[9.47] On 11 May 2024, Police Constable Ryan Fingland and Police Constable Chris Kirkpatrick carried out a vehicle examination of Mr McColm's blue New Holland/Ford 7840 tractor, registration S223 ULS.

[9.48] This examination revealed that the steering system in place, was a hydrostatic power steering system which operated on the front wheels and was attached via nearside and offside ball joints. The vehicle had a front-mounted tie rod, whose function is to keep the front wheels parallel. This was attached to the front of the steering knuckle via nearside and offside ball joints. Examination of the point of attachment at the offside wheel showed that the tie rod had failed at the ball joint housing. It was not possible to tell if this failure occurred prior to, or as a result of the collision. The steering action was tested, and the nearside and offside hydraulic rams were found to operate correctly, however the absence of the tie rod caused the front wheels to toe-in and-out.

[9.49] The report concludes that the officers were unable to determine if any mechanical defects would have been a contributory factor in the collision, as it was not possible to tell if the failure of the front tie rod occurred prior to, or as a result of, a collision.

Galloway Community Hospital transfer policy

[9.50] All patients at Galloway Community Hospital who require a major trauma neurosurgical referral are referred to the QEUH.

[9.51] There is no one set policy or procedure for initiating a patient transfer from Galloway Community Hospital to another hospital. This is because every patient must be assessed on a case-by-case basis. The steps that should be followed are:

a. Recognising that the patient is unwell and requires transfer to another hospital. A prompt assessment is key.
b. Seeking advice from senior clinicians at Dumfries and Galloway Royal Infirmary and the specialist receiving units.
c. Get early support from EMRS.

EMRS generally will not accept a transfer unless the patient has been accepted at the receiving hospital, however there is a level of discretion available to initiate transfer if it is felt that the patient cannot stay in their current location.

[9.52] The EMRS team operating from Glasgow covers retrievals for critically ill patients for remote and rural Scotland in the West, from Stornoway to Stranraer, including community hospitals, isolated GP/nursing practices and district generals such as Fort William. Within this EMRS Team, there are two rapid response vehicles and a helicopter based at Glasgow Airport (Helimed 5). There is one helicopter in Inverness, one in Aberdeen and one in Perth. These can be

used if required but are further away and may not be available. EMRS can also request assistance from Search And Rescue (SAR) in certain circumstances. There is one helicopter within the SAR team based at Prestwick Airport, which can be considered for life or limb emergencies but requires authorisation from the Scotstar general manager. This also takes this resource away from potential search and rescue missions.

Health and Safety Executive (HSE)

[9.53] The Health and Safety Executive were made aware of Mr McColm's accident and subsequent death. As Mr McColm was a self-employed farmer, on his own land, using his own equipment, with no other employees and no ongoing risk, the HSE advised that they would not be investigating the matter further.

Productions

[10] A number of Crown productions were lodged and before the court by virtue of the notice to admit information dated 8 May 2026. Those consisted of medical records, expert reports, statements and affidavits, amongst other relevant documents. Where those were a document or copy document, they were incorporated into the information/evidence before the court without having to be spoken to by a witness. Where those are a statement, they were deemed to be admitted into evidence in their entirety and to be taken as the information/evidence of the person who gave the

statement in this inquiry. Where that witness also swore an affidavit that was lodged, any statement was taken to supplement the affidavit.

Treatment of information/evidence

[11] The notice to admit information dated 8 May 2026 provided that, save to the extent that evidence to the contrary had been heard or it was otherwise agreed, it was presumed that:

a. All copy productions are true and accurate copies of the originals and shall be treated as such;

b. All productions and label productions are what they bear to be;

c. All documents bearing a date were prepared on or about the date they bear;

d. All letters or other written communications addressed to or intended for another person or persons were sent by the person by whom they bear to have been sent by, to the person or persons to whom they are addressed, on or about the date they bear; and

e. All clinical records are admitted into evidence without the need to be spoken to by a witness.

Further, that all affidavits, statements, productions and reports could be taken into consideration by the court as information/evidence before the inquiry.

Findings on the information/evidence

[12] It is clear that Mr McColm had suffered from medical conditions that caused him to take seizures over a number of years. He had engaged with general practitioners during that time regarding those. It also seems to be clear that latterly, presumably of necessity, he required to work on in running his farm notwithstanding those and cope as best he could. Whether or not he complied with advice from his general practitioners not to drive and to liaise with DVLA regarding his driving licence is perhaps not directly relevant to the issues to be resolved by this inquiry. He did not need such a licence to drive tractors on his farm. Further, of necessity, he almost certainly would have required to drive tractors at the farm as part of his day to day working life in running and maintaining it. Other than the occasional assistance of William Barry, in years recent to his death, Mr McColm was alone in that regard.

[13] It is against this backdrop that Mr McColm came to be driving his tractors on 5 January 2024. William Barry appears to have by chance encountered him shortly after an accident. From what he describes, it appears that the blue New Holland/Ford tractor had driven down the embankment and collided with the slurry tank. Only Mr McColm could have been driving it when that collision took place. Mr McColm had then been trying to retrieve that tractor with his red Case tractor. That collision was the accident that ultimately resulted in Mr McColm's death. When the New Holland/Ford tractor was later examined by the police experts it was found to have sustained damaged to the front steering system, but it was impossible for the officers to determine whether that was a cause of the collision or a result of it. Accordingly, the court is also unable to

determine that. It seems that the two most likely possibilities of the cause of the collision are the steering system failing in that manner or Mr McColm having suffered a seizure when driving the tractor, causing him to lose control of it. No finding can be made as there is no information/evidence available to indicate which is more likely.

[14] There was thereafter some delay in the emergency services being called and arriving on scene. The reasons for those delays are understandable. It is not clear how much time had passed between the accident occurring and William Barry arriving on the scene. Logic would suggest at the very least long enough for Mr McColm to recover sufficiently to retrieve his other tractor from elsewhere on his farm, drive it to the site of the collision, and hook it up to the crashed tractor with a chain. William Barry did not perceive the full extent of the injuries to Mr McColm who was both mobile and talking to him when he was initially encountered. When William Barry then did call the emergency services, there were difficulties with the call no doubt due to a combination of factors to include poor mobile telephone signal, the relatively remote location and William Barry's accent. In any event, once those difficulties were overcome and emergency services arrived, following upon assessment of him there was no immediate indication that Mr McColm's life was in danger to the medical staff on the scene. The time lost ultimately had no impact on his death.

[15] Upon arrival at hospital, Mr McColm was more thoroughly assessed and given appropriate treatment. There was no reason at that stage for medical staff to suspect that his life was at risk. It was only after passage of time that his condition deteriorated,

and further assessment identified the complications with his head injury that disclosed the need for urgent assessment and treatment by a neurologist at QEUH.

[16] Initially it might appear that delays in Dr Pedley being able to contact the appropriate medical practitioner at QEUH, despite his best efforts to do so should be a cause for concern. Furthermore, the consequent delays in authorisation to transfer may be seen to have resulted in Helimed 5 not being despatched as quickly as it might to retrieve Mr McColm and transfer him to QEUH. These points were raised with the Crown at preliminary hearings for investigation as they were deemed to be germane to the court's consideration of the questions of reasonable precautions, defects in systems and potentially recommendations. Upon further investigation by the Crown and relevant information/evidence being ingathered however it became apparent that ultimately even if none of those delays had occurred, Mr McColm would not have been able to have been transferred to QEUH in sufficient time for treatment that could have saved his life. Unavoidable external factors pertaining to the operation of Helimed 5 would have prevented it from effecting the transfer any more quickly even if that had been approved and instructed almost immediately. Furthermore, even if that had been possible, it is not clear whether any treatment was available that could have saved Mr McColm's life if he had been transferred more quickly.

[17] As a result of the earlier accident, despite there initially being no signs of it, Mr McColm developed and suffered from subdural haematoma and traumatic brain injury. That was the cause of death that he succumbed to at Galloway Community Hospital on 9 January 2024 at 1900 hours after receiving palliative care. There was no

treatment available to save Mr McColm's life following upon the deterioration of his condition on 5 January 2024.

Position

[18] The Crown's position was that no findings should be made by the court under the following sections of the 2016 Act:

1 In terms of section 26(2)(e) any precautions which (i) could reasonably have been taken, and (ii) had it been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

2 in terms of section 26(2)(f), whether there were defects in any system of working which contributed to his death or any accident resulting in his death;

3 in terms of section 26(2)(g) any other facts which are relevant to the circumstances of the death.

[19] Further, it was the Crown's position that the court should refrain from making any recommendations in terms of section 26(1)(b). Each of these shall be addressed in turn.

Reasonable precautions

[20] The test to apply is that laid out in *Sutherland* v *Lord Advocate* 2017 SLT 333, namely:

> "In determining whether the death might have been avoided by a reasonable precaution, the appropriate test has been described as that of a '*lively possibility*'. Such a description is entirely apt and is consistent with the language of 6(1)(c). According the provision its ordinary meaning, certainty or probability are not relevant considerations in determining whether the death might have been avoided. Further, given the nature of the process as I have described it, in considering whether a precaution is reasonable, foreseeability has no part to play. The question falls to be determined with the benefit of hindsight, and a finding that the death might have been avoided by the application of a reasonable precaution carries no implication that the failure to take the reasonable precaution was negligent or unreasonable. Whether or not a precaution was reasonable does not depend on foreseeability of risk, or whether at the time the precaution could or should have been recognised."

[21] Applying this test, it is difficult to conceive of any reasonable precautions that could have been taken. Whilst it might be thought to be stating the obvious to suggest that in his condition and with his medical history Mr McColm should not have been working alone in running a farm nor driving tractors, as I have indicated already, his circumstances appear to have left him with no choice in that regard. It is not a reasonable precaution to simply stop operating the farm for a number of reasons. I accordingly concur with the Crown on this point.

Defects in systems

[22] It logically flows from the foregoing however that there was a defect in the system of work on Awhirk Farm. It is in a relatively remote location. There was one person only, most of the time it would appear, tending to all aspects of the running of it on a self-employed basis. That person had a number of health difficulties, most concerning of which in that environment was a tendency to suffer seizures. From all the information/evidence it appears that quite apart from there being no management

structure for obvious reasons, there was no system in place for Mr McColm to alert any other person in the event of his suffering a seizure and/or being involved in an accident in the course of his work. It seems apparent that the most basic of health and safety systems and precautions were not in place. I accordingly do not concur with the Crown on this point, although it may be moot, and make a finding to that effect.

Other facts which are relevant to the circumstances of the death

[23] There are no other facts which are relevant to the circumstances of Mr McColm's death. I concur with the Crown on this point.

Recommendations

[24] It was not possible to determine the cause of the accident that ultimately resulted in Mr McColm's death. The factual situation was a unique one that is very unlikely to occur again elsewhere. Whilst it was possible to identify a defect in the system of work at Awhirk Farm under Mr McColm, that appears to have been attributable to that unique situation. Accordingly, I concur with the Crown in that there are no recommendations to make under section 26(1)(b). There are no (a) reasonable precautions to be taken; (b) improvements to any system of working to be made; (c) systems of working to be introduced; or (d) other steps that could be taken which might realistically prevent other deaths in similar circumstances.

Conclusion

[25] I would wish to record the court's thanks to Ms Lewis for the exemplary manner in which she conducted matters for the Crown throughout the preliminary hearings and inquiry. Her thorough investigations, preparations and skilful submissions were of great assistance.

[26] Whilst I was unable to identify the cause of the accident that resulted in Mr McColm's death, I was able to carefully scrutinize the steps that were taken after that accident by the emergency services and medical staff in assisting him. In doing so it is clear that there is nothing that could have been done or done more quickly that would have saved Mr McColm's life in the circumstances. I would hope that his family and friends, who have my deepest condolences, can take some measure of comfort from that.