SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT TAIN

[2019] FAI 12

Case ref: TAI-B76-18

DETERMINATION

BY

SHERIFF CHRISTOPHER DICKSON

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

in the death of

EVAN BRUCE CAMERON

Tain, 18 March 2019

Determination

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act"):

1. **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):**

   That the late Evan Bruce Cameron, born 23 May 1955, died at about 16.10 hours on 5 June 2018 below the B9176 public road between Fearn Lodge and Skiach at High Bridge by Easter Fearn.

2. **In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):**

   That the accident resulting in death took place between about 15.24 and 15.30 hours on 5 June 2018 on the B9176 public road between Fearn Lodge and Skiach at High Bridge by Easter Fearn.

3. **In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):**

That the cause of death was:

I (a) Multiple injuries

due to (or as a consequence of):

(b) Car collision with bridge parapet.

4. **In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):**

That the cause of the accident resulting in death was as follows:

(i) Mr Cameron safely negotiated the first section of the left hand bend into High Bridge.

(ii) Mr Cameron then, as a result of suffering some sort of medical episode, failed to negotiate the second section of the left hand bend into High Bridge and instead of maintaining his left turn, carried straight on, across the carriageway, and collided with the west parapet of High Bridge.

(iii) Mr Cameron's taxi then crashed through the west parapet of High Bridge and fell from High Bridge onto rocks approximately 15 metres below.

5. **In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):**

There are no precautions which could reasonably have been taken that might realistically have resulted in the death, or accident resulting in death, being avoided.

6. **In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):**

There were no defects in any system of working which contributed to the death.

7. **In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):**

   That there are no other facts relevant to the circumstances of the death.

Recommendations

1. **In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):**

   That there are no recommendations made.

NOTE

Introduction

[1] This inquiry was held into the death of Evan Bruce Cameron. Mr Cameron died on 5 June 2018 after the taxi which he was driving crashed through the parapet of a bridge, fell about 15 metres and landed on rocks below. The death of Mr Cameron was reported to the Procurator Fiscal (hereinafter referred to as "PF") on 6 June 2018. A preliminary hearing was held on 9 January 2019. The inquiry took place over a single day on 13 February 2019. Mr Main, PF Depute, represented the Crown. No other parties were represented. Mr Cameron's daughters were, however, present throughout the inquiry.

[2] The PF had prepared a substantial Notice to Admit which contained evidence that I was satisfied was uncontroversial. There were no objections to the Notice to Admit. I accepted the facts set out in the Notice to Admit. Also before the inquiry was an affidavit and statement from Dr Mark A Ashton, FRCPath, Consultant Pathologist, Raigmore

Hospital, Inverness. The combination of the Notice to Admit together with the affidavit and statement from Dr Ashton resulted in the need for oral evidence to be significantly reduced. I heard oral evidence from the following two witnesses:

1. Pc Karen Park, Road Policing Unit, Dingwall; and
2. Pc Christopher Eric Donaldson, Road Policing Unit, Dingwall.

Pc Donaldson was a qualified collision investigator and had prepared a detailed Collision Investigation Report. Pc Donaldson referred to that report during his evidence. The evidence of Pc Donaldson and Pc Park was not challenged in any way and I had no difficulty in finding their evidence to be credible and reliable. Findings in fact 1 to 4, 7 to 16, 18 and 22 to 23 are based on the Notice to Admit and associated undisputed evidence. Finding in fact 24 is based on the affidavit and statement of Dr Ashton. Findings in fact 5 and 6 are based on the evidence of Pc Park. Findings in fact 17, 19 to 21 and 25 are based on the evidence of Pc Donaldson when read together with his Collision Investigation Report.

The Legal Framework

[3] This inquiry was held in terms of section 1 of the 2016 Act. Mr Cameron died in the course of his employment or occupation, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2 of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter "the 2017 Rules") and was an inquisitorial process. The PF represented the public interest.

[4] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Cameron and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which

evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules).

[5] Section 26 of the 2016 Act sets out what must be determined by the inquiry. Section 26 of the 2016 Act is in the following terms:

> "**26 The sheriff's determination**
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
> (2) The circumstances referred to in subsection (1)(a) are—
> (a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) any precautions which—
> (i) could reasonably have been taken, and
> (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death,
> (g) any other facts which are relevant to the circumstances of the death.
> (3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—
> (a) if the precautions were not taken, or
> (b) as the case may be, as a result of the defects.
> (4) The matters referred to in subsection (1)(b) are—
> (a) the taking of reasonable precautions,
> (b) the making of improvements to any system of working,
> (c) the introduction of a system of working,
> (d) the taking of any other steps,
> which might realistically prevent other deaths in similar circumstances.
> (5) A recommendation under subsection (1)(b) may (but need not) be addressed to—
> (a) a participant in the inquiry,
> (b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.
> (6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[6] In this Note I propose, first, to set out the summary of the facts that I have found proved, second, to set out a brief summary of the submissions made by the PF and, third, to consider the circumstances identified in section 26(2)(a) to (f) of the 2016 Act and explain, with reference to the evidence led, the conclusions I have reached.

Summary

[7] I found the following facts admitted or proved:

1. That Evan Bruce Cameron was born on 23 May 1955 and resided in Inverness with his wife.
2. That Mr Bruce worked for Inverness Taxis as a taxi driver on a self-employed basis. Mr Bruce owned a Volvo S50 motor vehicle, registration number ST59 GWN, which he operated as a taxi when he was working.
3. That in order for a person to become a taxi driver in Inverness, he or she needs to complete an application form and submit it to Highland Council. There are two types of licence relating to taxis, namely a taxi operator's licence and a taxi driver's licence. A taxi operator's licence requires the vehicle being operated to be inspected by a garage. The taxi driver's licence relates to the individual. Any individual who wishes to drive a taxi must hold a licence. The taxi driver's licence conditions require the driver to declare any medical conditions and previous conditions. Generally, each licence will last for about three years. Thereafter the licence holder will require to apply to Highland Council for renewal.
4. That Mr Cameron held both a taxi driver's licence and a taxi operator's licence. Mr Cameron's initial taxi driver's licence was issued on 10 October 2000. His most recent taxi driver's licence was renewed on 7 October 2015 and was due to expire on

9 October 2018. Mr Cameron's initial taxi operator's licence was granted on 1 August 2010. His most recent taxi operator's licence was issued on 6 April 2018 and was due to expire on 3 August 2019.

5. That on 28 April 2016 Mr Cameron was sitting in a stationary motor vehicle in a supermarket carpark. Police officers approached his vehicle and found Mr Cameron to be slouched over the steering wheel whilst holding a lit cigarette. The tip of the lit cigarette was touching and burning the plastic stock for the window washer / indicator of his vehicle. The police officers did not consider that Mr Cameron was under the influence of drink or drugs but were concerned that he was having some sort of medical episode and summoned an ambulance. When the ambulance staff arrived they considered that Mr Cameron's symptoms were indicative of a possible stroke. Mr Cameron did not share the concerns of the emergency personnel and did not consider that he was unwell but agreed to being taken by ambulance to the Accident and Emergency Department at Raigmore Hospital, Inverness for investigations. Mr Cameron was subsequently examined at Raigmore Hospital. This examination included an ECG test. Nothing untoward was found during the hospital examination and he was discharged home later in the day.

6. That as a result of the incident set out in finding in fact 5 Police Scotland notified both the Highland Council Licensing Department and the DVLA that Mr Cameron had suffered a suspected stroke. The DVLA investigated this suspected stroke and required Mr Cameron to undergo an examination by his General Practitioner (hereinafter "GP"). Mr Cameron subsequently underwent an examination by his GP, Dr Russell, on 11 July 2016. The examination did not reveal any medical difficulties that would have prevented Mr Cameron driving. The DVLA

subsequently received a report from Mr Cameron's GP, dated 11 July 2016, regarding the examination he had conducted of Mr Cameron. Following sight of the GP report the DVLA advised Mr Cameron he could retain his driving licence.

7. That Inverness Taxis require their drivers to comply with, amongst other things, a "Driving and Road Risk Guidance Manual and Driver Handbook". The said Handbook provides at page 29:

> "If you have had, or currently suffer from a medical condition or disability that may affect your driving you must tell the Driver and Vehicle Licensing Agency (DVLA).
>
> You'll also need to provide details if you develop a new condition or disability or one that has become worse since your licence was issued. Failure to notify DVLA is a criminal offence and is punishable by a fine of up to £1000."

8. That Inverness Taxis require their drivers to comply with, amongst other things, a "Working Long Hours Policy" which provides, amongst other things, that:

> "Every 2 weeks you must take at least one period of 24 hours off duty"

9. That between 22 May and 3 June 2018, Mr Cameron's working hours were as follows:

(1) 22/05/18 – 07.52 to 16.05 hours;

(2) 23/05/18 – 07.00 to 16.00 hours;

(3) 24/05/18 – 07.46 to 17.33 hours;

(4) 25/05/18 – 07.54 to 16.34 hours;

(5) 26/05/18 – 07.55 – 16.45 hours;

(6) 27/05/18 – 07.38- 14.25 hours;

(7) 28/05/18 – 11.12 – 18.00 hours;

(8) 29/05/18 – 07.22 – 17.34 hours;

(9) 30/05/18 – 07.52 – 17.36 hours;

(10) 31/05/18 – 07.46 – 18.19 hours;

(11) 01/06/18 – 07.44 – 16.55 hours;

(12) 02/06/18 – 07.40 – 17.55 hours; and

(13) 03/06/18 – 07.55 – 15.31hrs.

On 4 June 2018, Mr Cameron, in line with the Working Long Hours Policy, had a day off.

10. That on 5 June 2018 at about 07.30 hours Mr Cameron left his home in Inverness in his Volvo motor vehicle (hereinafter referred to as "taxi") in order to commence work as a taxi driver. At that time Mr Cameron did not give any indication that he was feeling unwell.

11. That at 07.48 hours, on the same day, Mr Cameron logged on duty with Inverness Taxis. At 07.59 hours he was allocated his first job, which was a fare from Glenmoriston Hotel to Longman, Inverness. He cleared from that first job at 08.17 hours. Mr Cameron was then allocated the following fares:

(1) An 08.30 hours booking between Evan Barron Road and Merkinch Primary School, Inverness (he was allocated this job at 08.21 hours and cleared it at 08.48 hours);

(2) A fare between Harbour View and Johnny Foxes, Inverness (he was allocated this job at 08.48 hours and cleared it at 08.58 hours);

(3) A fare from the city centre to Mile End, Inverness (he cleared this fare on Leachkin Road at 09.20 hours);

(4) An 09.30 hours booking from Bruce Avenue to Kingmills Medical Practice, Inverness (he was allocated this job at 09.21 hours and cleared it at 09.39 hours);

(5) An 09.50 hours booking between Balloan Road and Raigmore Hospital, Inverness (he was allocated this job at 09.40 hours and cleared it at 09.59 hours).

(6) A fare from Redwood Avenue to Inverness city centre (he was allocated this job at 10.10 hours and cleared it at 10.34 hours);

12. That at 10.45 hours on 5 June 2018, Mr Cameron was allocated an 11.00 hours pickup from Raigmore Hospital Pharmacy, Inverness. The pickup was in relation to a package to be delivered to a house at Achfary, Lairg. Mr Cameron arrived at Raigmore Hospital, Inverness at 10.58 hours and collected the package which consisted of medication stored in a cooler. The package was to be delivered to Jonathon Amos at a particular address at Achfary, Lairg.

13. That at about 11.20 hours on the same day Mr Cameron's wife spoke to her husband on the phone. Mr Cameron said he was on the way to Lairg to deliver a package.

14. That at around 14.20 hours on 5 June 2018, Mr Cameron arrived in his taxi at the address in Achfary, Lairg to deliver the medication package. Mr Cameron seemed flustered, confused, quite unsteady on his feet and generally not right at all.
Mr Cameron did not smell of alcohol and there was nothing to suggest he was under the influence of alcohol or drugs. Mr Amos did not consider that he was in a fit state to be driving a taxi.

15. That in light of Mr Cameron's presentation Mr Amos lifted the cooler out of the boot of Mr Cameron's taxi, got the medication from within and lifted the cooler back into

the taxi. Mr Amos did so because he did not think Mr Cameron would have managed to do it himself.

16. That at around 14.25 hours or 14.30 hours, on the same day, Mr Cameron left the address in Achfary, Lairg. He did not mention feeling unwell.

17. That after leaving Achfary, Lairg, Mr Cameron was driving his taxi southbound along the B9176 public road between Fearn Lodge and Skiach. The B9176 road in that location, at that time, was a two way, undivided carriageway, with hazard warning lines in the centre of the carriageway to separate the northbound and southbound lanes. The speed limit was 60 mph. As the road approached High Bridge it changed to single track across the length of the bridge before returning to a two way undivided carriageway. For southbound traffic approaching High Bridge, the motorist would have negotiated a series of shallow left and right hand bends which climbed to a sharper right hand bend. The road then straightened for approximately 56 metres before entering a right hand bend. The said straight section contained two nearside warning signs which warned of: (i) the road narrowing from both sides; and (ii) a double bend. Upon entering the right hand bend at the end of the said straight section there were two further warning signs warning of: (i) the road narrowing at both sides; and (ii) a double bend. 42.5 metres south of the second set of warning signs were two further information signs with the first stating "Oncoming vehicles in the middle of the road" and the second stating "Reduce Speed Now". The road surface changed to bitumen macadam with a granite chip inlay 5.15 metres south of the information signs. The road layout changed to single track approximately 7 metres south of those information signs as the motorist approached a left hand bend. The width of the carriageway at this point was 5.38

metres and was no longer separated by centre white lines. The left hand bend passed over the Allt Fear Burn by way of a bridge known as High Bridge. The first section of this left hand bend was almost 90º. The second section of this left hand bend then tightened across High Bridge. The subtended angle of the entire left hand bend was approximately 105º and had a cross fall towards the east verge (or nearside verge) between 2.6 and 3º. Two chevron markers were located on the west verge (or offside verge) of the left hand bend to indicate a sharp deviation of route to the left for vehicles travelling south. High Bridge was approximately 29 metres in length and was constructed of stone blocks and mortar. The road surface on the bridge was 4.4 metres wide. The Allt Fear Burn ran approximately 15.4 metres below High Bridge. A concrete parapet bordered the east verge (or nearside verge) of the bridge. A stone and mortar parapet bordered the west verge (or offside verge) of the bridge.

18. That Inverness Taxis operate a GPS system which enables them to track the position of their taxis, including the speed the taxi is moving at. The said GPS system locates the position of a taxi about every minute depending on the signal.

19. That the last GPS connection Inverness Taxis had for Mr Cameron's taxi was at 15.24 hours and 13 seconds. At this time the location of Mr Cameron's taxi was on the B9176 approximately where the road surface changed 5.15 metres south of the said information signs. The GPS system recorded Mr Cameron's speed as being 32.3mph at that time. That was a reasonable speed for that part of the B9176 and would have allowed sufficient time to slow down for the left hand bend into High Bridge.

20. That the maximum speed which a southbound vehicle could negotiate the left hand bend into High Bridge was approximately 18 mph.

21. That between 15.24 and about 15.30 hours, on the same day, Mr Cameron reached High Bridge. At that time the weather was sunny and the B9176 was dry.

    Mr Cameron safely negotiated the first section of the left hand bend into High Bridge. Mr Cameron then failed to negotiate the second section of the left hand bend into High Bridge and instead of maintaining his left turn, carried straight on, across the carriageway, and collided with the west (and offside) parapet of High Bridge.

    Mr Cameron's taxi then crashed through the west parapet of High Bridge and fell from High Bridge with the taxi's nose pitching down as it fell. Mr Cameron's taxi fell approximately 15 metres and during the fall flipped over so that the taxi's roof was facing the large rocks below. Mr Cameron's taxi landed on its roof onto large rocks located on the west bank of the Allt Fear Burn. Mr Cameron's taxi, after landing on its roof, then rolled clockwise 180º and came to rest on its wheels, facing north, partially submerged in the Allt Fear Burn.

22. That at about 15.30 hours, on the same day, Graham Owen and Simon Dyer arrived at the scene of the accident. At that time Mr Cameron's taxi was in its resting place partially submerged in the Allt Fear Burn and the horn of his taxi was constantly sounding. Mr Owen and Mr Dyer made their way to Mr Cameron's taxi and found Mr Cameron within his taxi. Mr Cameron did not show any signs of life at that time.

23. That at about 15.55 hours, on the same day, Dr Richard Brown attended the scene of the accident. Ambulance staff and members of the public were already in attendance. Dr Brown went down to Mr Cameron's taxi with ambulance staff.

    Dr Brown found Mr Cameron in the driver's seat of the taxi. Mr Cameron had a significant head injury and no pulse. Dr Brown pronounced life extinct at 16.10 hours on 5 June 2018.

24. That on 6 June 2018, Dr Mark A Ashton FRCPath, Consultant Pathologist, undertook a post mortem examination of Mr Cameron at Raigmore Hospital, Inverness and prepared a post mortem report. Dr Ashton's conclusion of said examination was that:

> "Post–mortem examination showed severe head and chest injuries, either of which would have been fatal. The examination also showed that he was suffering from emphysema - a type of chronic obstructive pulmonary disease (COPD) – related to his cigarette smoking and significant coronary artery disease. There was marked narrowing of one of the major coronary arteries by atherosclerosis – a potentially serious condition where arteries become clogged with fatty substances called plaques or atheroma. This degree of narrowing may be associated with chest pain. Either of these events would potentially lead to loss of control of the vehicle and be a causative factor in this incident. A cardiac arrhythmia may lead to a drop in blood pressure, feeling faint or even loss of consciousness. Given the presence of atherosclerosis in the coronary arteries and distal aorta, it is also possible that he suffered a transient ischaemic attack (a mini stroke) due to a similar process within the carotid vessels leading to an embolic event obstructing a blood vessel in the brain. However, it is not possible to identify such a lesion from the examination that was conducted.
>
> The medical certificate of cause of death was completed as follows:
>
> "I (a) Multiple injuries
>
> due to (or as a consequence of)
>
> (b) Car collision with bridge parapet."

25. That at the time of the accident: (i) Mr Cameron's taxi did not have any mechanical faults that would have contributed to the accident; (ii) no other vehicles contributed to the accident; and (iii) no tyre marks were left on the road by Mr Cameron's taxi.

26. That the cause of the accident was due to Mr Cameron failing to safely negotiate the second section of the left hand bend into High Bridge. The reason for him failing to negotiate the second section of the left hand bend was due to him suffering some sort of medical episode.

Submissions

[8] The PF sought formal findings in respect of section 26(2)(a) to (c) of the 2016 Act. The findings sought were based on the uncontroversial evidence and my findings mirror those sought by the PF.

[9] As regards section 26(2)(d) of the 2016 Act the PF submitted that the cause of the accident was Mr Cameron failing to negotiate the left hand bend into High Bridge which resulted in his taxi crashing into the west parapet of High Bridge and falling to the burn below. The PF also contended that there was sufficient evidence to allow the inquiry to conclude that the reason why Mr Cameron failed to negotiate the left hand bend was due to him suffering some form of medical episode at the relevant time. In support of this contention the PF relied on the following factors: (i) Dr Ashton's findings at the post mortem examination; (ii) the presentation of Mr Cameron when dropping off the medication to Mr Amos shortly before the accident; (iii) the lack of any mechanical defects in Mr Cameron's taxi; (iv) the lack of any tyre marks on the road, which suggested that Mr Cameron either did not brake at all or only braked with minimal force; and (v) the medical episode that Mr Cameron appeared to suffer in his vehicle in April 2016.

[10] The PF did not seek findings in relation to section 26(2)(e) to (f) of the 2016 Act and did not invite the inquiry to make any recommendations.

Discussion and Conclusions

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[11] In this inquiry there was no dispute as regards when and where the death occurred. Therefore, I had no difficulty in determining from the undisputed evidence (see finding in fact 23):

That the late Evan Bruce Cameron, born 23 May 1955, died at about 16.10 hours on 5 June 2018 below the B9176 public road between Fearn Lodge and Skiach at High Bridge by Easter Fearn.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred)

[12] There was no dispute as regards when and where the accident resulting in death occurred. Therefore, I had no difficulty in determining from the undisputed evidence (see findings in fact 17 and 21):

That the accident resulting in death took place between about 15.24 and 15.30 hours on 5 June 2018 on the B9176 public road between Fearn Lodge and Skiach at High Bridge by Easter Fearn.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[13] There was no dispute as regards the cause or causes of death. On 6 June 2018, Dr Mark A Ashton FRCPath, Consultant Pathologist, undertook a post mortem examination of Mr Cameron at Raigmore Hospital, Inverness and prepared a post mortem report. Dr Ashton's conclusion of said examination was that:

> "Post–mortem examination showed severe head and chest injuries, either of which would have been fatal. The examination also showed that he was suffering from emphysema – a type of chronic obstructive pulmonary disease (COPD) – related to his cigarette smoking and significant coronary artery disease. There was marked narrowing of one of the major coronary arteries by atherosclerosis – a potentially serious condition where arteries become clogged with fatty substances called plaques or atheroma. This degree of narrowing may be associated with chest pain. Either of these events would potentially lead to loss of control of the vehicle and be a causative factor in this incident. A cardiac arrhythmia may lead to a drop in blood pressure, feeling faint or even loss of consciousness. Given the presence of atherosclerosis in the coronary arteries and distal aorta, it is also possible that he suffered a transient ischaemic attack (a mini stroke) due to a similar

process within the carotid vessels leading to an embolic event obstructing a blood vessel in the brain. However, it is not possible to identify such a lesion from the examination that was conducted.

The medical certificate of cause of death was completed as follows:

"I (a) Multiple injuries

due to (or as a consequence of)

(b) Car collision with bridge parapet."

[14] I considered that whilst it was possible that Mr Cameron had suffered some sort of medical episode on the approach to or on the left hand bend into High Bridge (on which see paras 20 to 21 below) it was clear that it was the injuries sustained as a result of the accident that had unfortunately proved fatal. In the circumstances I determined that the cause of death was as set out in the medical certificate.

Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death)

[15] The cause of the accident was carefully considered by Pc Donaldson in his Collision Investigation Report. Pc Donaldson had made detailed investigations at the scene of the accident. Pc Donaldson explained that Mr Cameron had been travelling southbound along the B9176 public road between Fearn Lodge and Skiach prior to the accident. Pc Donaldson provided a detailed explanation of the road layout for southbound vehicles approaching High Bridge (see finding in fact 17). He explained that there were three sets of warning signs. The first set of signs was two warning signs which warned of the road narrowing from both sides (with a qualifying plate stating "Single track road") and of a double bend. The second set of signs again warned of the road narrowing from both sides (with a qualifying plate stating "Single track road") and of a double bend. The third set of signs was two information signs which stated "Oncoming vehicles in the middle of the road" and

"Reduce Speed Now". Pc Donaldson considered that these warnings signs gave the southbound motorist clear notice of the need to reduce speed on the approach to High Bridge. Pc Donaldson explained that he conducted various calculations and had calculated that the maximum speed that a southbound vehicle could have negotiated the left hand bend into High Bridge was 18 mph (with a tolerance of plus or minus 10 per cent). Pc Donaldson explained he had had sight of a map which showed the last recorded GPS position of Mr Cameron's taxi. This GPS recording was timed at 15.24 hours and 13 seconds. At this time the location of Mr Cameron's taxi was on the B9176 approximately where the road surface changed 5.15 metres south of the final set of signs. The GPS system recorded Mr Cameron's speed as being 32.3mph at that time. Pc Donaldson considered that 32.3 mph was a reasonable speed for that part of the B9176 and that such a speed would have allowed Mr Cameron sufficient time to slow down for the left hand bend into High Bridge.

[16] Pc Donaldson explained that his investigation had revealed that Mr Cameron had safely negotiated the first section of the left hand bend into High Bridge. Mr Cameron had then, at the second section of the left hand bend into High Bridge, instead of maintaining his left turn, carried straight on, across the carriageway, and collided with the west (and offside) parapet of High Bridge. Mr Cameron's taxi then crashed through the west parapet of High Bridge and fell from High Bridge with the taxi's nose pitching down as it fell. Mr Cameron's taxi then fell approximately 15 metres and during the fall flipped over so that the taxi's roof was facing the large rocks below. Mr Cameron's taxi had then landed on its roof onto large rocks located on the west bank of the Allt Fear Burn. Mr Cameron's taxi, after landing on its roof, had then rolled clockwise 180º and came to rest on its wheels, facing north, partially submerged in the Allt Fear Burn.

[17] Pc Donaldson explained that the damage to the front end of Mr Cameron's taxi (which was red in colour) taken together with red flakes of paint and red staining left on the remaining damaged section of the west parapet supported his conclusion about how the collision with the west parapet had occurred. The damage to the roof of Mr Cameron's taxi, taken together with debris from the taxi found on the west bank of the Allt Fear burn, supported his conclusion about how the vehicle fell. The resting position of Mr Cameron's taxi, taken together with the damage to its nearside, supported his conclusion as regards how the vehicle rolled on impact with the west bank of the Allt Fear Burn.

[18] Pc Donaldson noted that at the time of the accident: (i) the weather was sunny and the B9176 was dry; (ii) Mr Cameron's taxi did not have any mechanical faults that would have contributed to the accident; (iii) no other vehicles contributed to the accident; and (iv) no tyre marks were left on the road by Mr Cameron's taxi. Pc Donaldson explained that the lack of any tyre marks on the road would allow a conclusion to be drawn that Mr Cameron did not brake, or only applied minimal braking, before colliding with the west parapet.

[19] Pc Donaldson did not consider that the reason for the accident could be determined from the marks left at the scene of the accident. However, he suggested that excessive speed, inattention or other driver error may have been contributory factors. Pc Donaldson accepted that there was no evidence to suggest that Mr Cameron had driven at excessive speed. Rather the evidence from the GPS system pointed to Mr Cameron travelling at a reasonable speed on the approach to High Bridge. Pc Donaldson noted that inattention could be a multitude of different things. He accepted that there was no evidence to suggest Mr Cameron had been distracted. He explained, given the three sets of warning signs, it would have to have been more than a momentary lapse of attention that caused Mr Cameron's taxi to collide with the west parapet. Pc Donaldson explained that he was not

aware of Mr Cameron's medical presentation in Lairg shortly before the accident occurring but accepted that a medical episode could have been the reason why Mr Cameron failed to negotiate the second section of the left hand bend into High Bridge.

[20] I considered that Pc Donaldson had conducted a thorough collision investigation and had clearly explained how the evidence found at the scene of the accident supported the conclusions he had arrived at (see para 17 above). In the circumstances I had no difficulty in accepting that the accident had occurred in the manner described by Pc Donaldson. The more difficult question was whether a finding could be made as regards the reason why Mr Cameron had failed to negotiate the second section of the left hand bend into High Bridge. The PF submitted that the reason was due to Mr Cameron suffering some sort of medical episode. In my opinion there was considerable force in that submission when the following factors are considered: (i) that Mr Cameron appeared particularly unwell when dropping off the package in Lairg a short time before the accident occurred; (ii) the conclusion of the post mortem report highlighting the underlying health conditions which could have led to a loss of control of the taxi / loss of consciousness / mini stroke at the time the accident occurred; (iii) the GPS recording of the speed of the taxi at 32.3 mph on the approach to High Bridge, which was reasonable in the circumstances; (iv) the absence of any tyre marks on the road, which points to minimal or no braking on the part of Mr Cameron immediately before the collision with the west parapet; (v) the lack of any evidence to suggest anything distracted Mr Cameron (such as a mobile phone); (vi) the lack of any mechanical defects with Mr Cameron's taxi; (vii) the lack of adverse weather; and (viii) that no other vehicle was involved in the accident. I did not consider the fact that Mr Cameron had appeared to have suffered some sort of medical episode in April 2016 supported the PF submission. However, when I considered the combination of factors set out in (i) to (vii)

above, I considered that it was more likely than not that the reason why Mr Cameron had failed to negotiate the second section of the left hand bend was because he had suffered some sort of medical episode.

[21] In all the circumstances I have determined that the cause of the accident resulting in death was as a result of Mr Cameron failing to negotiate the second section of the left hand bend into High Bridge on the B1976 due to him suffering some sort of medical episode.

Section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)

[22] Findings in fact 5 and 6 set out the reasons why the police were concerned about Mr Cameron's presentation on 28 April 2016 and the follow up action taken. Mr Cameron, after being spoken to by the police, was immediately taken to hospital by ambulance and was examined (with the examination including an ECG test). Nothing untoward was found. The Police, quite properly, notified the DVLA about what had occurred and the DVLA properly investigated the matter and required Mr Cameron to undergo a further examination by his GP. This further examination did not identify any reason why Mr Cameron ought not to be allowed to drive and the DVLA subsequently advised Mr Cameron that he could retain his driving licence. I considered that the Police, Mr Cameron and the DVLA all acted appropriately in the circumstances and that the medical information, at that time, fully justified the DVLA allowing Mr Cameron to retain his licence.

[23] The evidence heard at the inquiry did not identify any precaution which could reasonably have been taken which might realistically have resulted in the death, or the accident resulting in death, being avoided.

Section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)

[24] The evidence heard at the inquiry did not identify any defects in any system of working which contributed to the death or the accident resulting in death.

Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

[25] The evidence heard at the inquiry did not identify any other factors which were relevant to the circumstances of the death.

Recommendations

Section 26(1)(b) of the 2016 Act (recommendations (if any) 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances)

[26] The inquiry did not identify any matter which necessitated the making of a recommendation.

Postscript

[27] At the outset of the inquiry I extended my condolences to Mr Cameron's family. I was joined in those condolences by the PF. I wish to formally repeat my condolences to Mr Cameron's family in this determination.