

**SHERIFFDOM OF GRAMPIAN,HIGHLANDS AND ISLANDS AT WICK
DETERMINATION**

by

**SHERIFF ANDREW BERRY,Esq, Sheriff of Grampian,Highlands and Islands
at Wick**

in Inquiry into the circumstances of the death of

**John Sutherland (27.06.1945), late of 16, Shore Street,Thurso,
under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976**

For the Crown, David Barclay, Procurator Fiscal

Wick, 1st April 2010.

My determination is:-

- (1) Following upon an accident a few minutes before 12.18 on 23rd June 2009 at 4 Ord Terrace, Thurso, John Sutherland died at Caithness General Hospital, Wick, at approximately 17.30 on 30th June 2009.
- (2) The cause of death was due to a pulmonary thromboembolism secondary to a calf vein thrombosis, caused by Mr Sutherland having fallen from a ladder and suffering a head injury.

Sheriff Andrew Berry

NOTE.

This Fatal Accident Inquiry took place before me at the Sheriff Court in Wick on Wednesday 31st March 2010. No party was formally present or represented at the Inquiry.

In broad terms Mr Sutherland, while helping a friend, Michael William Miller, to put felt on a new garden shed at 4, Ord Terrace, Thurso, fell from a ladder whereby he sustained a serious head injury. Mr Miller called 999 and in a few minutes an ambulance with two paramedics arrived, attended to Mr Sutherland and conveyed him

to Caithness General Hospital where he was treated for his injuries. One week later Mr Sutherland's condition suddenly deteriorated and as arrangements for his transfer to Aberdeen Royal Infirmary were about to be implemented he died.

I heard evidence from:-

- a) Detective Constable Derek Fraser who, following upon Mr Sutherland's death took photographs of the locus of the accident and of the deceased at Caithness General. His involvement in the case did not cause him to think there would be a need for a criminal investigation of any kind.
- b) Michael Sinclair who is the owner of the house at 4, Ord Terrace, Thurso and with Mr Miller had constructed a garden shed in his garden and after going to work offshore became aware of the accident at his home in a telephone conversation with his wife. He therefore had no knowledge of the circumstances of the accident but the ladder referred to was his and had been in good working order up to and including the day before he went offshore.
- c) Hamish Robertson was one of the paramedics who attended to Mr Sutherland and it is clear that he and his colleague acted very properly in the assistance they gave to the deceased and in particular in the way they attended upon him and conveyed him to hospital with admirable speed.
- d) Michael William Miller is a self employed joiner of great experience who had known Mr Sutherland for many years and had sought his assistance in felting the shed roof which required a second person to assist with the felt as it was rolled out. At the time of the accident Mr Sutherland's role was complete with Mr Miller on the roof completing the exercise. The deceased did not need to be on the ladder but was seen to be so with Mr Miller sitting astride the apex of the roof and Mr Sutherland facing him at the front of the shed. Mr Miller could see his friend from just below his shoulders. It appeared to Mr Miller that it was as if something had been pulled from under Mr Sutherland who fell. Mr Miller got no response from shouting to his friend and came down from the roof to find Mr Sutherland injured on the ground, tangled up in the ladder and bleeding from perhaps his right ear. He called 999. Mr Miller did not think that he would have done anything different in the way he carried out this job.
- e) Paul Fisher is a Consultant Surgeon who had not cared for Mr Sutherland but on 30th June was called out at about 02.00 due to a deterioration in the patient's health. As the day progressed and following upon consultation with colleagues in Aberdeen, arrangements were made to transfer Mr Sutherland there by plane. As the patient was about to be taken to the airport he died. In evidence the witness perused the medical records of the deceased and felt that the treatment of the patient was correct throughout and that the conclusions of the pathologist (below) were entirely consistent with his and his colleagues' thoughts after the death. He was not sure if it was he or a colleague who had pronounced life extinct.
- f) Peter Black is an inspector with the Health and Safety Executive of 30 years experience. The Executive became involved as the accident had occurred in a course of employment. He had taken photographs of the locus and of the ladder, at Thurso Police Office, and had spoken to, amongst others, Mr Miller. Mr Black did not feel that the way in which the job had been carried out was to be faulted to any material extent nor that the circumstances of Mr Sutherland's fall could have been avoided by a different approach to the job.

He spoke to the obvious damage, now, to the ladder but thought it to be a well maintained ladder capable of being safely used. He did not have the expertise to say if the damage to the ladder could have been caused in the fall. When asked if he had any thought that there might have been a matter worthy of prosecution in this accident he replied “certainly not”.

After the leading of the witnesses the Procurator Fiscal read out an affidavit by Dr Mark A Ashton, Consultant Pathologist admitting into evidence his Postmortem Report which covered the history of the deceased, the accident, his views (post mortem) and his summary and conclusion “that death was due to a pulmonary thromboembolism secondary to a calf vein thrombosis....predisposed to by (his) head injury leading to immobility in bed”.

In his submissions Mr Barclay asked me, based on the evidence, to reach the views which I have in my determination, in relation to where and when Mr Sutherland died and the cause thereof in terms of section 6 (1)(a) and (b) of the Act and to conclude that there were no reasonable precautions which might have avoided the accident happening, nor defects in the system of working which contributed to the death and that there were no other relevant facts relevant to the circumstances of the death in terms of section 6(1)(c)-(e).

I agree with the Procurator Fiscal’s submissions and in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 find:-

Section 6.

(1) (a) Following upon an accident a few minutes before 12.18 on 23rd June 2009 at 4 Ord Terrace, Thurso, John Sutherland died at Caithness General Hospital, Wick, at approximately 17.30 on 30th June 2009.

(b) The cause of death was due to a pulmonary thromboembolism secondary to a calf vein thrombosis, caused by Mr Sutherland having fallen from a ladder and suffering a head injury.

(c),(d) and (e) I make no finding.

It is clear that John Sutherland’s death, caused by a fall from a ladder, was a tragic accident while he was helping a long standing experienced friend to complete the felt roofing of a recently well constructed garden shed. It is not at all clear why Mr Sutherland was on the ladder as his part in the day’s work was complete. There is nothing to suggest the ladder was to any extent defective and it is clear that the death was not caused or contributed to by any other person or a defective system of work. Following upon the accident it is clear that Mr Miller, the paramedics and all those at Caithness General acted speedily, appropriately and with care in assisting and caring for the Mr Sutherland.

I was greatly assisted by the measured presentation of the case by Mr Barclay.

May I express my personal condolences to the family and friends of John Sutherland.

