

SHERIFFDOM OF LoTHIAN AND BORDERS AT EDINBURGH

[2017] FAI 13

2B209/17

DETERMINATION

BY

SHERIFF N A ROSS

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

into the death of

STUART JOHN WHITEHEAD

Edinburgh, 4 August 2017: The Sheriff, having resumed consideration of the cause, finds and determines as follows:

1. In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976 (the “Act”):

Stuart John Whitehead, whose date of birth was 7 May 1948 and who resided in Edinburgh, died at 01.15 hours on 11 August 2016 at the Royal Infirmary of Edinburgh, Little France Crescent, Edinburgh. His death was the result of an accident which occurred on 3 August 2016 in the course of his occupation as a self-employed aerial fitter. The accident occurred at approximately 14.50 hours that day at Clayknowes Place, Musselburgh.

2. In terms of section 6(1)(b) of the Act:

The cause of death was:-

1. (a) Left cerebral hemisphere infarction
 (b) Haemorrhage from superior mesenteric artery and ruptured spleen
 (c) Fall from height from a ladder
2. Severe left ventricular failure
 Left pneumonectomy for lung and pharyngeal cancer

The accident was a fall from height from a ladder, caused by a loss of balance by Mr Whitehead, caused in turn by both the ladder and him being blown by a gust of wind. This loss of balance caused Mr Whitehead to fall approximately 8 to 10 metres to the ground onto a concrete path.

3. In terms of section 6(1)(c) of the Act:

The accident and resulting death might have been avoided had the ladder been footed by another person, thereby preventing the ladder moving, or alternatively by affixing the ladder to a permanent structure on the building against which it was placed.

4. In terms of section 6(1)(d) of the Act:

The system of working was defective and unsafe in that it did not involve the securing of a ladder, whether by affixing or by footing by another, when working at height from the ladder. It is likely this contributed to the accident.

5. In terms of section 6(1)(d) of the Act:

There are no other facts relevant to the circumstances of Mr Whitehead's death.

And finds in fact as follows:

1. Mr Whitehead was a self-employed aerial fitter. He was very experienced in the use of ladders, having traded for approximately fifty years. He was a sole trader and worked alone. He was responsible for his methods of work and for supplying his own work equipment.
2. On 3 August 2016 he attended at an address in Clayknowes Place, Musselburgh, in order to install a television aerial on the gable end of a two-storey dwelling house. In order to install the aerial he required to access the top of the gable end, a height of approximately ten metres. A concrete pathway ran along the base of the gable end of the property. Next to the pathway was a two-metre high slatted wooden fence which separated the householder's property from the public pavement and roadway. The fence was separated from the public footpath by a strip of grass running parallel to the fence.
3. Mr Whitehead was equipped with a double-extension aluminium ladder, British Standard Type 1 Industrial Class. The ladder was of suitable construction and a suitable length to reach the height where he required to install the aerial. Mr Whitehead was dressed in jeans, shirt and rigger boots. He was wearing a tool belt with a thin leather strap. He was not wearing any safety harness. He was not wearing a helmet or other safety equipment. He was working alone, as was his custom.

4. In order to gain access, Mr Whitehead required to place the ladder at an angle against the gable wall. There was insufficient room between the wooden fence and the gable wall to allow the ladder to be placed at a stable angle. He required to erect the ladder with the base resting on the public grassed area, from where it crossed the fence and rested on the gable wall.
5. It was a bright, sunny day but noticeably windy.
6. Having placed the ladder against the wall, he returned to his vehicle to collect an aerial and electrical wire. At about 14.40 hours he climbed the ladder holding the aerial and wire under one arm. He was able to use both hands on the ladder.
7. Having climbed the ladder, he stood on the ladder for approximately one or two minutes as he worked on attaching the aerial. As he did so, a gust of wind caused him to lose his balance and fall from the ladder. He fell directly to the ground, landing on the concrete pathway beside the gable wall. He fell a distance of between approximately eight and ten metres. The ladder slid sideways in an arc to the ground, damaging the rone pipe at the end of the gable and the top of a slat of the fence.
8. Following the fall, Mr Whitehead lay on the ground next to the gable wall. A neighbour heard the sound of falling and attended in less than one minute. Mr Whitehead was conscious. He had a laceration on his head. The neighbour summoned an ambulance and engaged Mr Whitehead in conversation in order to keep him conscious. Mr Whitehead attempted to get up but was persuaded not to. He was able to talk and respond to questions.

9. An emergency call was placed to paramedics at 14.57 hours, and they arrived at the locus at 15.06 hours. They saw Mr Whitehead lying on concrete slabs next to the gable wall of the property. They required to gain access by climbing over the six-foot wooden fence. Mr Whitehead was conscious, and informed them that he had fallen from height from a ladder, having been blown over by a gust of wind. The aerial cord was attached to him, but did not present any medical issues and was cut away.
10. The two paramedics immobilised Mr Whitehead using a scoop stretcher, collar, head-huggers and straps. Oxygen was administered to him as part of trauma management protocol. At all times Mr Whitehead was conscious and lucid, and did not seem significantly distressed. He was placed in an ambulance and taken directly to Edinburgh Royal Infirmary. During the journey he posed no immediate acute concerns. The paramedics made a pre-alert call to the hospital, and on arrival he was seen by Accident and Emergency Department doctors without delay.
11. He was conscious on arrival. He informed staff that he had been standing on a 30 foot high ladder engaged in fitting an aerial when a gust of wind blew him over. He informed them that he had fallen approximately 30 feet to the ground.
12. On examination there was evidence of bleeding into his abdomen causing profound low blood pressure. He underwent an emergency laparotomy to stop the internal bleeding. He was thereafter brought to the Intensive Care Unit for life support treatment. He was in a medically-induced coma until 6 August 2016.

13. Upon removal of his sedative drugs on that date, he was not moving his right arm or leg. A CT scan of his brain revealed evidence of a new stroke. He received life support therapy for a further 48 hours.
14. On 8 August 2016, following discussion with Mr Whitehead's family, a palliative care approach was adopted. Mr Whitehead died at 01.15 hours on 11 August 2016. The primary cause of death was noted to be left cerebral hemisphere infarction, with haemorrhage from superior mesenteric artery and ruptured spleen, all resulting from a fall from height.
15. Mr Whitehead's medical history included the removal of his left lung in 2001 as a result of lung cancer. He also had pharyngeal cancer in 2007 which was treated and considered cured. He also suffered from chronic obstructive pulmonary disease and cardiomyopathy. None of these conditions was relevant to his accident. He had recently, on 28 July 2017, attended his general practitioner complaining of three separate episodes where he had lost vision in his left eye for two or three minutes. He was examined and, following specialist consultation, correctly diagnosed as having suffered a transient ischaemic attack. It was appropriately decided that corrective treatment was inappropriate due to passage of time and the risks of intervention. Mr Whitehead presented otherwise as suffering no impairment. This recent medical history did not cause or contribute to the accident.
16. The accident, and subsequent death, might have been prevented by securing the ladder to a permanent fixture on the gable wall, or by another person footing the ladder. These are the recommended precautions by the Health and Safety Executive.

There is no evidence of any available fixture on the wall which would have allowed Mr Whitehead to attach the ladder, so that precaution was not reasonably available to him. He worked alone and there was nobody working with him to foot the ladder. That precaution was not readily available to him either. Had the ladder been affixed or footed, it may be that, as an experienced ladder user, he would have been able to maintain his footing on the ladder.

17. Otherwise, the use of this ladder for the said task, and for tasks lasting thirty minutes or less, was appropriate and classified as low-risk. The Health and Safety Executive ('HSE') publish guidance on their website which is freely available to the public. It informs the public of all such factors, and provides comprehensive advice on the safe use of ladders when working at height.

Discussion

[1] This Fatal Accident Inquiry was held on 31 July 2017 at Edinburgh. The Crown was represented by Ms Bell. There was no other representation or appearance. The deceased's wife was present.

[2] Affidavit evidence was led from Mr Whitehead's general practitioner, Dr Wight; from one of the attending paramedics, Christopher Burns; and from a consultant in critical care, Dr Lone, under whose care Mr Whitehead remained. The use of such affidavit evidence was appropriate and did not result in any prejudice to the inquiry. Further oral evidence was led from a neighbour, David Wilson, who had witnessed Mr Whitehead at work; an investigating police officer, PC Sproat; and from a representative

of the Health and Safety Executive, Kim Munro. There is no dispute as to the factual background of Mr Whitehead's accident and subsequent death, and I was able to accept all the witnesses as credible and reliable.

[3] The central facts I have set out above. The death was directly attributable to injuries caused in a fall from height from a ladder. Mr Whitehead received timely, expert and appropriate medical care from the first attendance of the paramedics to the moment of his death. No other events are identified as causing or contributing to Mr Whitehead's death.

[4] It is a matter of regret that the evidence shows such work practices to be common, at least amongst self-employed people working on third-party premises. Ladders are commonly used by workers working alone and who do not have the means to secure a ladder to the structure from which they are working. Where a ladder is used for a task of no more than thirty minutes, and where it extends one metre above the point to be worked on, the HSE classify such use as low-risk. Mr Whitehead's task complied with these criteria. It is only the lack of securing which served to increase the risk. Ms Munro gave evidence that rubberised mats with a metal lip are available to place beneath the foot of a ladder. These are relatively cheap and portable, and will serve to some degree to prevent slippage of ladders when in use. The use of such a mat would seem to be sensible and practicable to reduce risk. There is no suggestion, in the present case, that the base of the ladder slipped. The ladder moved sideways as a result of the movement of Mr Whitehead and wind pressure, not as a result of slippage. The

further discussion and recommendation of use of such mats is therefore beyond the scope of this inquiry, as it would not have prevented the accident.

[5] Ms Munro also gave evidence that information about the use of ladders is freely available on the HSE website. The document 'Safe use of ladders and stepladders' dated January 2014 is available for inspection, and contains full information. It would have been available to Mr Whitehead. It is not suggested, however, that reading this guidance would have prevented this accident. There is no suggestion that Mr Whitehead did not follow the majority of the guidance, with the exception of failure to make sure the ladder was footed or secured to the gable wall. There is no reason to infer that, as an experienced ladder user, he was not aware of the benefits of securing or footing a ladder.

[6] Mr Whitehead's accident might have been prevented had the ladder been tied on at height to the gable. It is not possible to be more specific than this, as the precise mechanism of his fall went unwitnessed. Had the ladder been secured, it may be that Mr Whitehead would have been able to maintain his balance. The obvious problem is that temporary tasks like aerial fitting or window cleaning do not permit the adaptation of premises to suit. A gable wall would not ordinarily offer purchase to tie or affix a ladder. Ms Munro could only suggest that a hole be drilled for a tying point, a suggestion which she readily accepted was impracticable. Mr Whitehead cannot be faulted for failing to find or insist on installation of such a fixture. That would clearly be impracticable where the task was limited in scope, of short duration, and very infrequent.

[7] Mr Whitehead's accident may also have been prevented by a colleague footing the ladder and holding it steady. That would mean another wage for an employee. It is

not possible to say if this was economically workable, where Mr Whitehead would have to share his fee with another. To require the employment of another for such a limited task may render such a business economically unviable. Unless sole traders were forbidden by law to use a ladder without assistance, there is no practical method of ensuring such safe practices. The cost implications of forcing the engagement of another worker would most likely be highly significant. That would be a matter for the legislature. Ms Munro from HSE recognised this fact. She stated that in such circumstances she would give advice but would not enforce sanctions against a worker using such a system. She was unable to suggest a reasonable solution. I am equally unable to identify a reasonable solution, other than the foregoing.

[8] It is for these reason that I cannot identify any reasonable precaution, or change of work practice, which ought to be imposed on self-employed sole traders like Mr Whitehead, who require to carry out their trade on third-party premises over which they have no control. Suitable advice is already available on the HSE website. The use of such work practices by sole traders reflects the realities of their businesses. To enforce any further precautions would pose significant practical or economic difficulties. It appears to be an intractable problem. I can identify that tying or footing the ladder would have prevented the accident. I would accordingly recommend these work practices. Whether such practices ought to be demanded of sole traders working on third-party premises is a question which may have considerable economic and social consequences, and is properly beyond the remit of this inquiry.