# Sheriffdom of Tayside, Central and Fife at Forfar Under The Fatal Accidents And Sudden Deaths Inquiry (Scotland) Act 1976 Determination by Sheriff Alan D Miller

in

Inquiry into the circumstances of the death of

#### **Graeme Fraser Duthie**

Forfar, 2nd September 2009

The Sheriff, having resumed consideration of the cause, DETERMINES:

The death and the accident resulting in death: (in terms of sections 6(1)(a) and (1)(b) of the 1976 Act)

- 1. Graeme Fraser Duthie was born on 28<sup>th</sup> March 1968 and, at the time of his death in December 2007, was residing at 62 South Street, Kirriemuir.
- 2. On 10<sup>th</sup> December 2007 at 15:53 hours, within the yard at Orchard Timber Supplies, Orchardbank Industrial Estate, Forfar, Mr Duthie fell from the roof rack on top of his transit van, where he was attempting to position or secure timber supplies, onto the tarmac surface of the ground behind the van.
- 3. Mr Duthie died in Ninewells Hospital, Dundee, at 22:37 hours on 17th December 2007.
- 4. The primary cause of death was head injuries caused by blunt force trauma sustained as a result of the fall on 10<sup>th</sup> December. A secondary cause was early pneumonia developed while on constant ventilation in intensive care following the fall.

Reasonable precautions whereby death might have been avoided: (in terms of section 6(1)(c))

- 5. The accident would not have happened if Mr Duthie had not climbed onto the roof rack on his van.
- 6. There is a need for the Health and Safety Executive to devise and implement a strategy for improving the safety of loading and unloading operations involving vans, the principal elements of which would include a programme of education, a review of the design and installation of van roof racks, and regulation and guidance on safe loading and unloading practice with respect to vans.

7. The prior existence of such a strategy might have prevented Mr Duthie from following the practice of going up onto the roof of his van to position and secure loads.

Defects in any system of working: (in terms of section 6(1)(d))

8. No defects in any system of working contributed to Mr Duthie's accident on 10<sup>th</sup> December 2007 or to his death on 17<sup>th</sup> December 2007.

Any other relevant facts: (in terms of section 6(1)(e))

9. It is commonplace for tradespersons and others who use a van in the course of business to fit a roof rack to the van, and to go up onto the roof of the van in order to position or secure loads to be carried there.

#### NOTE

## Introduction

- (1) This fatal accident inquiry followed the death of Mr Graeme Duthie, a joiner and director of a joinery business. It was clear from the evidence that he was a hardworking man, who was friendly and well liked and respected locally in his line of business. I wish to extend my condolences to his family members, who have suffered his sudden loss in the midst of life.
- (2) The Crown was represented by Mrs Kennedy, Procurator Fiscal Depute. Mr Ireland represented Orchard Timber Supplies. I am grateful to both for their sympathetic but focused exploration of the evidence, as a result of which it was possible to hear all eleven witnesses, and closing submissions, in a single day on 28<sup>th</sup> August 2009.
- (3) The first witness was Mr Michael Wilson, who was Mr Duthie's business partner. Five members of staff from Orchard Timber Supplies gave evidence, both about the circumstances of the accident and about general practice. They were Isaac McDonald, storeman/driver; Michael Gach, fork-lift driver; Ronald Stephen, operations manager; Ian Gibb, storeman; and Scott McKinlay, managing director. PC Robert McCulloch also gave evidence on his analysis of the CCTV footage which offered a partial view of the van and the loading operation at the time of the accident. John McKiddie, paramedic, spoke to responding to the emergency call and to transferring Mr Duthie to Ninewells Hospital. Ms Clare Ireland, environmental health officer employed by Angus Council, gave evidence on her review of health and safety matters relating to the accident. Mr Eric Ballantine, consultant neurosurgeon, spoke to Mr Duthie's treatment at Ninewells and the complications that resulted in his death, while Dr Elizabeth Lim, consultant forensic pathologist, spoke to her post-mortem report.

(4)

### Evidence

- (4) There was no significant dispute as to any chapter of the evidence. Dealing first with the accident itself, Mr Duthie was a regular customer of Orchard Timber Supplies. On the day of the accident, he had called in to collect a pre-ordered supply of flooring timbers. It was quite late in the day. Mr Duthie wanted to collect the timbers quickly so that he could deliver them on site before the end of the working day.
- (5) The timbers were wrapped and banded, and quite heavy. The timbers were presented to his van roof-rack by a large fork-lift truck owned by Orchard Timber Supplies and operated by their employees. It was not, however, possible to drop the timbers from the fork-lift straight onto the roof rack as its side bar obstructed the fork-lift forks. Mr Duthie thus went up onto the roof rack, as he frequently did at such times, to help move the timbers. At some point he slipped on the rear roller bar and fell head-first onto the tarmac below. He briefly lost consciousness, and was confused and somewhat agitated when he regained consciousness.
- (6) The evidence of both Mr Wilson and the Orchard Timber Supplies staff demonstrated that the practice of tradespersons going up onto van roof racks to position or secure loads is very widespread. Almost immediately after the accident Mr McKinlay introduced a prohibition on van drivers following this practice on their premises. While local tradespersons (who are aware of the reasons for its introduction) have grudgingly accepted the prohibition, others have strenuously resisted it and some have taken their business elsewhere.
- (7) The accident resulted in severe injury to Mr Duthie's skull and brain. He was kept under anaesthetic, and on ventilation, while efforts were made to reduce the pressure in his brain to a level at which it would be safe to waken him. Unfortunately, rather than reducing, the pressure increased. Further, as commonly happens in patients under constant ventilation, a pneumonial infection developed, making it harder to ensure an adequate supply of oxygen to the brain. But increasing the oxygen content in the ventilator also contributed to increasing the brain pressure. By 17<sup>th</sup> December 2007 Mr Ballantine's view was that any further medical treatment would be futile. He and colleagues spoke with three family members and advised that ventilation would be withdrawn in order to allow a dignified death. Even had Mr Duthie's treatment been uncomplicated and successful, it was very unlikely that he would have made anything approaching a full recovery.
- (8) Perhaps of greatest significance to the purposes of this inquiry was Ms Ireland's evidence. She had been most surprised to find, in the course of her investigation, that there was nothing in health and safety guidance (either in 2007 or subsequently) about climbing on van roofs. Indeed, in contrast to what she described as extensive regulation and guidance about safe loading and unloading of large vehicles, she had found virtually nothing directed to the use of vans. Even new draft guidance issued days before this inquiry on the subject of loading and

- unloading vehicles made no mention of vans.
- (9) She considered the practice of climbing onto a van roof to be understandable: drivers felt they could best secure loads by pulling up on ropes or ties from above. But it was also inherently dangerous, particularly in the absence of any regulation of the design or installation of roof racks. In this particular case, the roof rack design was such that it simply would not have been possible for the fork-lift truck to deposit the timbers onto the roof rack. The practice was so widespread that a concerted programme of education would be required to change it. Regulation and guidance would also be necessary, but impossible to enforce in the absence of education.

## **Submissions**

(10) Submissions were brief and to the point. Mrs Kennedy submitted that formal findings under section 6(1)(a) and (b) of the 1976 Act could be made. The absence of guidance or regulations on the practice Mr Duthie was following at the time of his death was a matter that could properly be addressed as a reasonable precaution. Mr Ireland essentially concurred.

# <u>Issues</u>

- (11) Orchard Timber Supplies are to be commended for adopting a safety policy which appears to have put them at odds with several of their customers, not to mention their competitors. Their action was commendably quick and decisive, as was the aid and assistance they gave Mr Duthie immediately after the accident.
- (12) The medical staff, from the paramedics onwards, are also to be commended for their care of Mr Duthie. The severity of the injury and its consequences necessitated anaesthesia and ventilation. Unfortunately, the development of pneumonia which I accept is a common problem in such situations produced a catch-22 situation in which the very treatment required to ensure oxygen supply to the brain was also causing further increase in brain pressure.
- (13) What is most surprising is the apparent absence of health and safety guidance or materials on the safe loading or unloading of vans. It is within judicial knowledge or, indeed, the knowledge of any road user that tradespersons and small businesses frequently use a roof rack mounted on a transit-type van to carry materials. It is also common knowledge that such persons frequently mount up onto the roof rack to secure or unfasten such materials. No doubt there would be widespread resistance to any efforts to change this behaviour.
- (14) But the simple circumstances of Mr Duthie's fatal accident exemplify all too clearly the apparent need for the Health and Safety Executive, acting under its powers contained in the Health and Safety at Work etc Act 1974, to address this issue thoroughly. In doing so, as Ms Ireland suggested it seems inevitable that a programme of education will be required to undergird the effectiveness of more detailed regulation and guidance on safe loading and

unloading practice, and on the design and installation of roof racks. I have described this, in my formal findings, as a strategy since it seems evident that a long-term and planned approach will be required to reduce the risk of others suffering the same fate as Mr Duthie. The development of such a strategy would produce at least some lasting benefit from Mr Duthie's early demise.

(15)

Sheriff Alan Douglas Miller