INQUEST into the death of WILLIAM HENRY ROSS

18th February 2016

1. Good morning. I am sitting as coroner today to open the inquest into the death which was reported to me as being that of William Henry Ross and as having occurred on 22nd August 2015 at King Edward VII Memorial Hospital in Stanley.

2. The proceedings today are conducted under the Coroner's Act 1988 (of England) as it applies in modified form in the Falkland Islands, and the Falkland Islands' own Coroner's Rules 1995. I would remind everyone that this inquest is a fact-finding exercise and, like all other inquests, is an inquiry; no one is on trial, least of all the deceased.

3. For this inquest, as in every coroner's inquest conducted in the Falkland Islands, the question "how" is limited to finding out by what means a person came by his or her death. The aim is to ascertain the simple facts of what actually happened and the inquiries are focused on the direct cause of death. An inquest is not a trial and it is not a method of apportioning guilt or blame nor is it an opportunity to examine the broader circumstances in which the death occurred. The role of the Coroner is to examine the evidence to find answers to the four questions. The purpose of the inquest is to find answers to four limited but factual questions:

    - Who was the person?
    - How did he die?
    - When did he die?
    - Where did he die?

    My conclusion will form the formal verdict.

4. I have been assisted in my inquiries by Police Constable Timothy Wilson who has acted as Coroner's Officer and attends today.

5. If there are any legal representatives or other interested parties, please will they identify themselves now.

6. I have given notice of my intention, under rule 33 of the Coroner's Rules 1995, to admit documentary evidence in the form of written statements provided by witnesses to the circumstances of Mr Ross's death and extracts from Mr Ross's medical records held at King Edward VII Memorial Hospital. I do not intend to call any of the witnesses to give oral evidence as some witnesses are not

resident in the Falkland Islands and are not able to attend this inquest and others, although they are resident in the Falkland Islands, would give evidence which, in my opinion, is not likely to be disputed. Notice was given to Mr Ross's daughters and they have not raised any objection. The documentary evidence for which I gave notice was as follows:

- Unsigned and undated document in the form of a statement prepared for Lieutenant John MASON (from HMS Clyde) in which an account is given of an incident when a vehicle with a single male occupant (later identified as Mr Ross) skidded across the road, rolled over and landed in a ditch at the side of the Stanley to Darwin road. Lt Mason called the emergency services.

- Unsigned and undated document in the form of a statement prepared for Lieutenant William John DURBIN (from HMS Clyde) giving a further account of the same incident and also saw a vehicle skid across the road, roll over and land in a ditch. He gave assistance to the vehicle occupant until the emergency services arrived at the scene.

- Statement made on 28th June 2013 by Police Constable Phillippe TESTOR to whom it was reported that there had been a vehicle accident on the Stanley to Darwin road near to the Mount Kent turning and who went to the scene with Police Constable Normann Ford.

- Statement made on 23rd June 2013 by Police Constable Normann FORD who attended the scene of the accident and was present when the vehicle driver was identified as William Henry Ross and he was removed from the vehicle.

- Photographs of the vehicle and scene taken by PC Normann FORD.

- Extracts from records provided by the Command Secretariat, British Forces South Atlantic Islands, relating to the medical assessment and actions taken by the RN and RAF Search and Rescue team that attended the scene.

- Statement made on 27th October 2015 by Nurse/Midwife Mandy Gail HEATHMAN of King Edward VII Memorial Hospital confirming Mr Ross's admission to hospital following the vehicle incident and producing his medical records.

- Extracts from medical records of William Henry Ross held by King Edward VII Memorial Hospital Stanley relating to his diagnosis, prognosis, treatment and care between 22nd June 2013 and his death on 22nd August 2015. These records cover his periods in hospital in the Falkland Islands, Chile and England.

7. In addition to the documentary evidence for which I have already given notice I now give notice that I also intend to admit the following documentary evidence:

    - Report prepared by Gerard Jaffray, Station Officer, Falkland Islands Fire and Rescue Service in which he sets out the actions taken by the Fire and Rescue Service and the actions taken by other rescue services at the scene of the incident on 22nd June 2013. 12 photographs of the scene are attached to the report.

    - Statement made on 4th September 2015 by Dr Narendra Pranlal DAVE who gave a short summary of the medical treatment received by Mr Ross between 22nd June 2013 and his death on 22nd August 2015. Dr Dave was directly involved in Mr Ross's treatment and care in the months prior to Mr Ross's death and issued the medical certificate of cause of death.

    Is there any objection to the admission of this documentary evidence or any request to see it before it is admitted?

8. There being no objections and no requests to see copy documentary evidence, I shall read aloud the statements and extracts from the medical records so that they form part of the record of the inquest.

[Statements and extracts read]

Summary

9. I shall now give a summary of my reasons for my conclusions. I have considered all the evidence carefully but I shall not repeat the detail from each statement. I shall confine myself to what I am satisfied are the most important elements needed for the formal inquisition.

10. The deceased was William Henry ROSS who was born in the Falkland Islands on 14th July 1955 and was a shepherd by occupation. At approximately 15.25 on 22nd June 2013 he was driving his Landrover along the Stanley to Darwin road, heading towards Stanley and was about 1.5 miles west of the Bluff Cove turn off when the vehicle went into a skid. The vehicle rolled over and landed the right way up but in the roadside ditch. It was a gravel section of road and the driving conditions were poor as there was a light covering of snow on the ground. The event was witnessed by Lt John Mason and Lt William John Durbin who were in a vehicle going in the opposite direction (i.e. towards Mount Pleasant). Mr Ross was alone in the vehicle and was not wearing a seat belt. Lts Mason and Durbin went to his assistance and summoned the emergency services. Emergency medical treatment was given at the scene by the crew of the RN and RAF Search and Rescue team who attended. Mr Ross was taken by the Search and Rescue helicopter to KEMH and arrived there at

5.00pm. He was fully examined an found to have several injuries, the most serious being to his cervical spinal. He was stabilised in KEMH and taken to the Clinica Aleman in Chile for further medical assessment and treatment. Thereafter he was sent to the Queen Elizabeth National Spinal Injuries Unit in Glasgow for rehabilitation but sadly his injuries had rendered him quadriplegic. He also had permanent respiratory and cardiovascular problems and required a pacemaker.

11. He returned to the Falklands in July 2014 and remained resident in KEMH as an in-patient. His health deteriorated and he ultimately developed a fatal bout of bronchopneumonia. Although the bronchopneumonia was the direct or immediate cause of his death the underlying cause was the tetraplegia which had resulted from the vehicle accident on 22nd June 2013.

CONCLUSION

12. I fully accept Dr Dave's opinion that there was nothing anyone could have done to prolong Mr Ross's life further. I have seen the medical files and the reports and I am satisfied that he received appropriate care and treatment after the accident on 22nd June 2013 and up to his death.

13. I must also mention the result of the breath test for alcohol taken on 22nd June 2013. This was not a result that would have been accepted as evidence in a criminal court. Mr Ross was not prosecuted. I take the view that there is insufficient evidence to be sure whether or not Mr Ross had consumed alcohol before the accident and whether or not it had any effect on his driving. I have to discount the smell of alcohol without proper evidence that it was connected to Mr Ross's drinking. I draw no conclusion that alcohol played a part in causing him to lose control of the vehicle. I am in no doubt that the driving conditions were poor because of the weather conditions (snow) and the gravel road and were significant factors and that no other vehicle was involved. I am sure that, so far as the serious injuries sustained in the accident are concerned, the fact Mr Ross was not wearing a seat belt was a significant factor.

Thanks

14. My thanks go to bystanders who assisted and the rescue services, police and medical staff: Lts Mason and Durbin, "Clare" who we think was a teacher, RN and RAF Search & Rescue R25 team, Fire service and RFIP at the scene and to all who cared for him and treated him after the accident until his death.

Condolences

15. I offer my sympathy and condolences to Mr Ross's two daughters, his mother and his wider family and friends.

Verdict

16. The formal finding of this inquest is:

1. *Name of the deceased*: William Henry Ross

2. *Injury or disease causing death* :

1A Bronchopneumonia

1B Tetraplegia

1C Injuries sustained in a motor vehicle accident

3. Time, place and circumstances at or in which the injury was sustained: *At approximately 15.25 hrs on 22nd June 2013 the deceased drove his Landrover on the Stanley to Darwin Road in snowy conditions and on a gravel section of road about 1.5 miles west of the Bluff Cove turn off . The car skidded, rolled over and landed in a ditch. The deceased was not wearing a seat belt and sustained serious injuries. His cervical spine was fractured and he was rendered incurably tetraplegic despite medical treatment. He also suffered from continuing respiratory and cardiovascular complications.*

4. Conclusion of Coroner as to death: *William Henry Ross died as a result of an accident*

Date of Death	**Name & Surname**	**Sex**	**Age**	**Rank or Profession and Country**	**Cause of death**
20.30 on 22nd August 2015 in King Edward VII Memorial Hospital, Stanley, Falkland Islands	*William Henry ROSS*	M	*60 years (dob 14th July 1955)*	Shepherd Falkland Islands	1A Bronchopneumonia 1B Tetraplegia 1C Injuries sustained in a motor vehicle accident.

This inquest is now closed.

18th February 2016

Clare Faulds
Her Majesty's Coroner for the Falkland Islands
Stanley,
Falkland Islands