# AN INQUIRY UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS (SCOTLAND) ACT 1976 INTO THE SUDDEN DEATH OF JOHN JAMES McKELVIE

**DETERMINATION**

by

IAN DUNCAN DUNBAR, Esquire, Sheriff of Tayside Central and Fife

In the Inquiry

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Into the death of

JOHN JAMES McKELVIE

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I heard evidence in this Inquiry on 21, 26 and 27 September, 21 October and 2 December 2005. I thereafter received written submissions and there was a hearing on submissions on 26 January 2006. It is unfortunate that the Inquiry took so long to conclude but there were a number of reasons for this, not least of which was the difficulty in getting all the witnesses available on particular dates. I hope that it has not added to any distress felt by the family of the late Mr McKelvie, to whom I offer my sympathies.

What happened factually is fairly straightforward and not, to any great extent, the subject of dispute. Mr McKelvie was heard to fall within the Silver Tassie public house, Main Street, Lochgelly. He was taken to Queen Margaret Hospital. He was to be discharged into the care of his family but would not go. He was therefore taken into police custody. Having been placed in an observation cell it became apparent later the following day that he was unwell and he was returned to Queen Margaret Hospital. A CT scan was taken and this disclosed a significant bleed in Mr McKelvie's brain. He died two days later.

I propose to deal with the circumstances under a number of separate headings and thereafter make a formal determination.

The fall

The deceased was a single man of 69 and was someone who drank regularly and probably quite frequently to excess. He was a regular customer of the Silver Tassie public house in Lochgelly where he drank Guinness. Mary Armstrong the barmaid indicated he usually had enough to get merry but was not in himself a merry person.

On Friday 26 March 2004 he had gone into the bar at around opening time of 11 am and had stayed there all day. Medical notes suggest he had drunk ten pints of Guinness. At about 5.30 pm he got up from the stool at the bar to walk towards the toilet which is located through a door leading to a corridor. He had gone through the door when Mrs Armstrong and Robert Biegala, another customer in the bar, heard a loud thump which both described as like someone falling. They went through the doors and found the deceased on the floor. He was on his back and they helped turn him on to his side. Mrs Armstrong thought his eyes were closed but Mr Biegala thought they were open or opening and closing. He did not speak but was described as making noises like snoring. Mr Biegala tried to rouse him but there was no response. An ambulance was called by means of a 999 telephone call. The ambulance arrived three minutes after the call was received and left for hospital ten minutes later.

Ralph Smith the ambulance technician described finding the deceased lying on his back conscious, but staring and trying to get up. He seemed agitated and was not speaking to the ambulance crew. Mr Smith carried out a check for bumps or bangs but the deceased kept pushing him away. There was no sign of blood and no apparent bump to the head. No-one said he had ever lost consciousness. He was removed to the hospital by means of chair secured by a belt which he was trying to pull off.

First admission to Queen Margaret Hospital

Mr Smith said that he knew the deceased who had been his father's best man and was aware that the deceased was a regular drinker. He did not regard his behaviour as normal for him. He said that he was "a bit wary" and told the nurse that there may have been more wrong with the deceased than simply alcohol. The patient report form prepared by Mr Smith either in the few minutes after arrival at hospital or just before arrival, records under "history and additional comments" the following:-

*"ASI (emergency call). Male patient has been drinking heavily since 1100 hours today and was found lying in hallway of public house. Patient conscious on arrival but not capable of answering any questions. Patient not allowing any examination to be done and kept pushing us away."*

In other words there was no mention of there being anything else involved other than alcohol. There was no expression of fear of any underlying head injury which Mr Smith said was in his mind. The only nurse who gave evidence could not remember ambulance staff saying anything about possible brain related injury and nothing was noted in the admission record nor in the ambulance notes. Dr Shanks overheard the handover by ambulance staff and recalled nothing being said about there being anything involved other than excessive alcohol consumption.

At the hospital, triage was carried out by staff nurse Catherine Monaghan who noted the deceased was "not very co-operative" and was speaking in confused sentences. He was faecally incontinent but initially refused to allow his coat to be removed to enable a blood pressure reading to be taken. He refused to lie in bed and would not let nursing staff change his clothes or clean him up. As she was doing the handover to the nightshift, the deceased came out of the cubicle, staggered and fell to the

ground. He was returned to the cubicle but just as she was leaving the ward he again came out, staggered and had to be returned to the cubicle. Neither fall was apparently recorded in the notes or on an incident report form which should be completed as a matter of routine if a patient has a fall. It has to be said however the falls did not appear to have been dramatic and were probably more in the nature of staggers or crumples to the ground.

Dr Catherine Shanks was the doctor on duty and she saw him at 1925 hours. She carried out a full examination and this is recorded on page 1 of production 6. She had overheard the handover by ambulance crew to nurses and there was nothing said to suggest that he was anything other than intoxicated. She had no information about a possible head injury when she examined him. He said to her he was just drunk. His speech was slightly slurred and he smelled of alcohol.

She carried out a full examination including a neurological examination. She did that because the deceased had taken a lot of alcohol and was vague and she wanted to exclude head injury. She recorded his Glasgow Coma Scale as 14 and his vital signs were reasonably normal. He was very drunk and she was happy that he be discharged but not on his own. An attempt was made to find a relative to keep an eye on him. Dr Shanks felt that he answered questions appropriately and understood commands during examination. He said he had not hurt himself.

An ECG was taken and this was normal. His presentation was attributable to alcohol and there was no history or sign of head injury. There was nothing which would have warranted a CT scan at that time. She could not have authorised a CT scan and she felt it was very unlikely that a senior doctor would have authorised one given the findings in her assessment.

While I will comment later on the general standard of care, I would say that the notes on admission including Dr Shanks' notes are competent, reasonable notes dealing with all relevant matters given the presentation of the deceased and the history.

Contact was made with Mrs Patricia Coyne, the deceased's sister. When she arrived at the hospital with her son, she spoke to Dr Shanks and asked if there was anything other than alcohol involved. Dr Shanks felt that she had reassured Mrs Coyne that there was not. She intended to take him to his own home and then check on him in the morning but Dr Shanks did not feel that was sufficient and she wanted someone with the deceased overnight as he was drunk and unsteady. She did say that if she had been told of a five-minute lapse into unconsciousness that would have resulted in the deceased being admitted to hospital. Further if she had been told that the ambulance man knew the deceased that may also have been something to consider. She was not however told either of these matters. If that had happened he would have been observed for several hours before a CT scan would have been considered and there would have to have been a deterioration in his condition.

There was CCTV video tape at the outside of the hospital when the deceased was leaving and Dr Shanks was shown this video tape. She commented that he looked awake and not particularly drowsy. He rose from the chair without assistance and seemed to understand what he wanted to do. This tied in with her experience of him

at examination when he did not object to what she asked and responded appropriately.

Some time later a policeman called at the hospital and asked if Dr Shanks had any concerns other than alcohol. She responded that she thought it was just alcohol. It was not common practice to admit to hospital patients who were simply drunk. There are no facilities in the Accident and Emergency department for observation beds. Admission of the deceased would have depended on whether or not there was a head injury. There would then have been a discussion with a senior doctor who would have taken any decision to admit. In the present case there was no indication of any head injury. She commented on the Glasgow Coma Scale in the ambulance report which was ten but that would signify a markedly reduced consciousness level which did not tally with the deceased being conscious on arrival, answering questions or resisting treatment.

Discharge from hospital and arrival in police custody

Two staff nurses, Trewaves and Morgan were involved in getting the deceased from Accident and Emergency to the door, where it was intended that he be transferred into the care of his sister. Staff nurse Trewaves spoke of the deceased wandering about Accident and Emergency and entering into other cubicles, refusing to lie in bed or sit in a chair and being agitated and aggressive. He was speaking at times, usually swearing. Her impression was he was intoxicated. Nurse Morgan also confirmed that he was wandering about being abusive, aggressive and using foul language.

They wheeled him outside and tried to get him to go into his sister's car but he was resisting. He was aggressive to staff nurse Morgan and hit her and nipped her with the result that she drew away. A security guard, William Makin, had been observing this on CCTV and, having locked a camera on to the car and the people at the door, he went outside to assist. Police were called at about this time.

The deceased was making it clear he was not getting into his sister's car. Mr Makin is seen on the tape to hold the deceased's arm by way of restraint. When the police arrived there was discussion and the deceased seemed to understand what was required of him. He got up unaided from the wheelchair and got into the car. There then followed a discussion involving Mrs Coyne and the police officers. It is not clear what was said but either she said she could not cope with him or she maintained that she would have to put him into his own house which was unacceptable to the hospital. A decision was therefore taken to arrest him for being drunk and incapable and he walked with assistance to the police van. He was thereafter taken to the police station.

Mrs Coyne was quite clear that she thought she had said to a doctor that her brother was ill. She described her brother as a talkative drunk and on this occasion he was very quiet. She was however content that he was in the care of the police. She also said that while she knew her brother, if someone did not know him it would be easy to think he was just drunk.

The deceased in police custody

The deceased walked with assistance to the police van and was placed on rubber matting on the floor. He was monitored from the front of the van. It was about a five minute drive to the police station. He got out of the vehicle with a lot of assistance and was taken inside the police station. It was decided not to process him at the charge bar as he would not have understood but to take him straight to a cell. The CCTV from the police station shows him going past the charge bar on his feet but being assisted by two police officers. The image then shows him being placed in a cell where he was searched. This was about 9.40 pm according to the records. A decision was taken very quickly to transfer him to the observation cell which was next door and this was done at 9.45 pm. The transfer was effected by the deceased being dragged on a mattress from one cell to the other all of which was done with reasonable care. He may in fact have been asleep when this was done.

When he was being checked over by police officers they noted ECG pads on his chest and accordingly Sergeant McKelvie instructed PC Sneddon to return to the hospital to check what had been done. PC Sneddon confirmed that on checking the deceased there were no sign of injury. The check had included a check of his head.

The observation cell is nearest to the barred gate entry to the cell area. The door had a glass panel. The custody care room is immediately beside that entry and it is possible to see into the observation cell from that area. A cell file record was generated upon which there is listed the number of visits to the cell. There were 24 visits between 2145 on 26 March and 1332 on 27 March. The person designed as custody officer would be the person making the check and the supervisory officer would also check who was in custody at least twice per shift. The purpose of the check is to make sure a prisoner is well, does not have injuries and is not ill. There should be a response and if there is none the door should be unlocked to enable there to be some form of interaction.

Guidelines indicate that a prisoner who is drunk and incapable would be a special risk and should be checked every 30 minutes. In this case the gaps are sometimes greater and sometimes less. Custody care attendants would do most of the checking. When Sergeant McKelvie who was the station officer on duty on 26 March checked personally he could see the deceased apparently awake, either scratching himself or moving his limbs. The plan was that he was to be released in the morning when sober and clean clothing had been obtained, but when Sergeant McKelvie came back on duty the following afternoon he was surprised he was still in the cell. At that stage an ambulance had been called.

Sergeant McKelvie was shown a commentary taken from the custody officer course from the Scottish Police College containing an observation checklist. The deceased had fallen into a category which required such a checklist and he was happy that it was observed.

Sergeant Ian Anderson was the duty sergeant on the morning of 27 March and he checked the deceased at 0737. He was lying in the recovery position on the mattress and he could see his face. He did not try to rouse him as he would be woken shortly for breakfast. A meal was delivered at 0855 but it was not eaten. That in itself was not uncommon. At 1122 he visited again with Sergeant Williamson and observed the

deceased was snoring deeply. There was no verbal response but he moved an arm. He had no undue concern at that time.

Some time in the afternoon, possibly between 12.30 pm and 1 pm it was decided to feed the deceased prior to his being discharged but he could not be roused. The fact that the deceased had been in hospital and had been deemed fit to be in police custody seemed to give the police some comfort, even if the deceased was not rousing. The sergeant conceded that he never saw the deceased awake but said he saw him moving and once he lifted an arm as if to acknowledge him.

Paramedics were called and they arrived at 1343. The cell smelled bad as the deceased had soiled and wet himself. The video tape in fact shows officers using fresh air spray over a period of about 20 minutes and the paramedics changing into full protective clothing and face masks. One of them is also seen to rush out of the cell seeking air. The deceased was eventually brought out of the cell on a mattress and lifted on to a stretcher. He was moving at the time and could be seen drawing a blanket over himself.

There was a question as to whether or not Sergeant Anderson was aware that the deceased had been sick. He had seen him wipe what he described as mucus from his face but no-one had mentioned sickness as a result of an observation. He was aware that vomiting could be associated with head injuries.

Sergeant Gordon Williamson was also on duty on 27 March and took part in the supervisory visit at 1122. He tried to engage the deceased in conversation but the only response was incoherent along with a movement of the arms. He decided to leave him until lunch time and then release him in the afternoon.

When the paramedics attended they found the deceased making incomprehensible noises. He was not conscious but was also not deeply unconscious. He was not opening his eyes. When a blanket was placed over him he pulled it up. The smell was overpowering and he was covered from head to toe in excrement, vomit and urine.

David Stark, one of the paramedics assessed the Glasgow Coma Scale of nine. The deceased was taken back to Queen Margaret Hospital. Detective Inspector Neil Kerr was responsible for the care of custodies at Dunfermline police station at the relevant time. He spoke to the routine of formal and informal observations and the recording of them. He also looked in on the deceased twice. On one occasion he got a response which was the raising of the hand.

He had no particular cause for concern when the meal wasn't taken and had seen drunk persons remain unconscious for many hours. It was when he returned from visits to other police stations that he realised all was not right. He had been slightly more assured because the deceased had come from hospital but there was nothing uncommon in his presentation compared with others coming in drunk. There was no sign of an injury.

Sergeant Steven Collingwood was on duty on 27 March and tried to waken the deceased to give him a meal. The deceased brushed it off with his arm which he

described as a common reaction as if to say "leave me alone". There was no verbal communication but his eyes were slightly opened. He saw him later from the custody care room and he was moving his arms. There had been a police surgeon in the building but he did not feel it necessary for the deceased to be seen. He did however begin to become concerned at about 1300 largely due to the lapse of time. He should have been sober enough by then and therefore steps were taken to rouse him. There was some response but it was decided to call an ambulance.

Second admission to Queen Margaret Hospital

Dr Peter Currie is a consultant anaesthetist who is also qualified to deal with trauma cases and he was the consultant on call on 27 March. He was called to see the deceased and his first note of this is at 1720 hours. He recalled some time between 4 and 5 pm being presented with an unconscious patient with no significant injuries. He arranged for a CT scan of the head and this confirmed an intra-cranial problem. There was an obvious large amount of white material signifying a significant degree of bleed in the brain. Queen Margaret Hospital has an electronic link to the Western General Hospital in Edinburgh and the details were sent there. There was a discussion with the consultant on call and also with registrar in neuro-surgery at the Western General. It was agreed this was a severe injury and little could be done surgically to deal with the problem. He described the injury as unsurvivable.

Dr Currie was aware that the deceased had been in hospital on the Friday night and he spoke to nurses who had seen him then. It was apparent he had a relatively minor fall and was probably inebriated. He had been in accident and emergency for a number of hours before being discharged either to the care of his relatives or, in this case, being passed to the police. The A & E notes comprised a complete examination and the conclusion reached was a reasonable one.

Dr Currie spoke to Mrs Coyne the following day and the impression he got was that she had not felt able to cope with her brother in the state he was in, drunk, having defecated in his underwear and generally being difficult to deal with.

Dr Currie had never seen a head injury of this type which presented late. The amount of damage would suggest that the patient would have been unconscious. He would not have been able to talk if he had had that level of bleed on the Friday when being admitted on the Friday evening. It was clear his head had rattled within his skull and this must have been a significant bang to the head. Dr Currie was confused about what happened between the collapse and when he came to hospital on the Saturday evening from the police station.

Head injuries can present late and there can be lucid intervals but that usually happens when there are subdural injuries. There were signs of injury to both sides of the brain therefore there was significant force. The injury would not normally happen simply from falling to the floor. It would have to have been hard enough to, for example, have knocked him out. There should also have been some sort of external evidence of a blow of that severity.

Dr Currie was quite puzzled by this presentation because his view was that the bleed as seen by him on the CAT scan should have been immediate if it had happened as

a result of the fall in the public house. However, had he been on call on the Friday night he would not have been informed that Mr McKelvie was in. If he had been called he would have done exactly what Dr Shanks did which was to observe him for three to three and a half hours, although the practice should have been for four hours. She left him some time after 9 pm in the care of a responsible individual. There was no indication to do a CT scan on the Friday night. From the description it was not a dramatic fall. It was perfectly reasonable for Dr Shanks to think that she did not have a head injury patient. He was arguing and being difficult, whereas if there had been a head injury he would have tended to have become quiet or unconscious. Nurses were very quick to pick up signs of change in a patient. He remained of the view that he had never seen anything develop into this type of injury over that period of time.

The observation guidelines relate to possible head injury patients and it is to allow medical staff to look for signs.

Miss Lynn Myles is a consultant neuro-surgeon at Western General hospital, Edinburgh and has responsibility for the day to day management of neuro-surgical conditions for the whole of south east Scotland and this includes links with many other hospitals. She was on call when the deceased was admitted to hospital on 27 March and saw the scans as they were faxed through. By looking at the various productions she was able to refresh her memory although she had not seen the medical records before. The CT scans of the head showed very extensive bleeding in the frontal lobe to the left and temple lobe to the left. There was a lot of swelling which had pushed the brain and therefore caused a lot of pressure. It was the sort of bleed common after head injuries as a result of falls or road traffic accidents. In an older person, especially if that person was a drinker, the brain shrinks slightly and a simple fall and hit of the head on a hard surface could have caused this sort of damage. It is difficult to age the injuries but they were less than a week old and probably two to three days old.

By reference to the Accident and Emergency records, Miss Myles said that after the fall the presentation appeared variable. In an older person there was more space round the brain and it could therefore accommodate such a fall longer before showing symptoms. The initial bleed would not have shown on the scan. It was not uncommon for there to be lucid intervals but there would be a deterioration with the blood clot causing pressure and brain swelling then the shifting of the brain.

She was asked a number of questions about assessment of a patient with head injury and she suggested that if the Glasgow Coma Scale was less than 15 there should perhaps be a CT scan taken. If it was 14 it may call for observation then a scan if there was deterioration. The four hour period gives a chance for alcohol to wear off. She then said that if a scan had been done initially the bleed could have been detected and if it had been treated or treatable he could have survived but she could not say he would have survived. Heavy drinkers often have more bleeding from an injury. She maintained that he possibly should have been admitted to hospital at least to observe his progress to see if the Glasgow Coma Scale was going down.

In the course of cross examination she conceded that certain categories of people, including older people do less well in recovery from brain injuries. The odds were stacked against Mr McKelvie. The fact that he may have vomited in custody and was doubly incontinent might have been signs that the brain was injured. At all events his prognosis was not great at any stage due to his age and alcohol consumption.

She assumed when she got the history that there was a head injury but to the first person seeing him (Dr Shanks) it may not have been entirely clear that he had a head injury. Miss Myles did however say that she should assume the worst that he did hit his head.

With reference to the TV pictures from the police van she did not think the deceased had a Glasgow Coma Scale of 14 at that stage and suggested it was 13 or less. That should have meant he should have been observed for a minimum of four hours.

Mr McKelvie did not recover and died on 29 March.

Expert evidence

Apart from Dr Shanks and Dr Currie the inquiry head from Dr Myles, the consultant neuro-surgeon. She was a witness to fact but also attempted to give some expert evidence in relation to the treatment received at Queen Margaret hospital. Evidence was also given by Dr Brodie Paterson, a consultant in Accident and Emergency at Ninewells Hospital at Dundee and Dr Kranti Hiremath who is a forensic medical consultant with Fife Constabulary.

In assessing the evidence of Dr Myles I have to bear in mind that she is a consultant neuro-surgeon and she seemed to approach her opinion on the basis that the deceased had a head injury. Clearly he did have such an injury but the question is whether or not at the time of his first attendance at the hospital such an injury was either obvious or should have been suspected. She was of the view that if the Glasgow Coma Scale was less than 15 that would suggest that a CT scan should be taken, but if it was 14 it might be appropriate to observe and then scan if there was deterioration. Reference was made to "SIGN" guidelines from which I understand there is a recommendation that a patient with a possible head injury be observed for at least four hours. While I can accept from the evidence given by various doctors that these guidelines exist, I cannot comment further because they were not part of the productions in the case.

Dr Myles was critical of the approach followed at the hospital, pointing out that someone who was drunk could probably not give a full history. She still felt observations should have been carried out.

It is worth mentioning at this point that Queen Margaret Hospital does not have beds in Accident and Emergency to which patients can be admitted. Whether or not a hospital should have such beds is not, in my view, an issue for this inquiry.

Dr Paterson had also prepared a report to which he referred. Ninewells Hospital has a short stay ward which can be used by Accident and Emergency. It is common to

see a lot of patients who have taken a lot of alcohol and head injuries are a significant part of work in his department.

Dealing with the first attendance at the hospital, Dr Paterson thought that the Glasgow Coma Scale score was better than 10 recorded by the ambulance staff and was at that stage likely to be 11 or 12. He cast some doubt upon whether or not the mention of loss of consciousness for five minutes, which appeared in a witness statement, was in fact something said at the time or something said as an afterthought.

On looking at the notes prepared by Dr Shanks and particularly the neurological examination, he indicated that the notes gave a good impression of a proper examination being done, albeit they are recorded in a shorthand manner. She has done it correctly but the recording is a little scanty. There was no story of a head injury, assault or fall but instead the deceased was saying he was only drunk. She had looked for medical signs and looked for head injury and found none.

Dr Paterson had seen the video at Accident and Emergency and his presentation was consistent with someone who had consumed alcohol. He said in fact he found the vide enlightening because the witness statements from those who were in the car park varied at lot as to how the deceased had presented in the car park. The doctor could now actually see what he was like.

The question arose as to whether a doctor in A and E should assume the worst and assume a head injury. Dr Shanks had what information was available to her and she had to take responsibility and make important decisions. It would have been a different matter if the deceased had had a head wound or a history of hitting his head or the like. She had looked for appropriate things and looked for the worst things such as heart attacks, stroke or head injury.

There is also the question of whether or not a patient with a Glasgow Coma Scale of less than 15 should be CT scanned. Once again Dr Paterson referred to the "SIGN" guidelines on dealing with head injury patients and he seemed to say that if the patient is under the influence of alcohol with a possible head injury, then the patient should be observed then scanned. He also however, said that they only apply where there is a head injury and they had no applicability on the night in question. The guidelines go on to state that where there is a history of head injury such as someone being knocked out but they then present as being fit and well they would not need a scan. The guidelines can be described as the best advice of things to do in different circumstances. He emphasised that they did not relate to someone in Mr McKelvie's position and there was no suggestion of head injury.

When asked to comment about any history of unconsciousness his impression was that the ambulance staff did not get that information. He feels this may have been mentioned as an afterthought in a witness statement. Having read the witness statements and then seen the video the deceased looked much more mobile than he had suspected from the statements.

It was unlikely in his view that Mr McKelvie would have survived. The guidelines do not say that a drunk person cannot be sent home.

It was clear however that if Mr McKelvie had been kept in hospital his deterioration could have been noticed earlier and therefore a CT scan could have been taken slightly earlier. Whether this would have made any difference is difficult to say.

Dr Hiremath was responsible for the production of the guidelines on medical care of prisoners and spoke of the indications which police officers should look for in people suspected of having head injuries.

A large number of people come into police custody under the influence of alcohol. If one cannot walk or talk then the doctor has instructed in the past that the person should be taken to hospital. It was more common for people to come to police custody via the hospital partly because of the zero tolerance policy regarding behaviour to hospital staff.

There is now a memorandum of understanding between the police and hospital authorities about people found in a state of intoxication. Paramedics decide after assessment if the person should go to the police station or hospital. Thereafter the police doctor would become involved depending on how long the person was being kept in custody.

She did not regard the police station as a safe place for a person in the state that Mr McKelvie was in. He needed a lot of help. Having seen the video from the police van his speech was not clear and his breathing did not seem normal. The police were clearly concerned since they went back to the hospital but were reassured he was fit for custody.

In assessing the expert evidence I have to bear in mind that Dr Myles was looking at matters from the point of view of a neuro-surgeon and she seemed to assume that Dr Shanks should have been aware of a possible head injury. I have no difficulties whatsoever with Dr Myles' conclusions based on the fact that there is a possible head injury. The difficulty is that there is no evidence at all that Mr McKelvie displayed any sign of a possible head injury when he first went to hospital.

It seems clear from the evidence of Dr Paterson and also Dr Currie at an earlier stage that Dr Shanks has carried out a full, proper and thorough examination of Mr McKelvie. She has tried to exclude major matters such as heart attack, stroke or head injury. While she was aware that Mr McKelvie had fallen to the ground she was never given an indication that he had hit his head on anything or that he had ever been unconscious. I do not doubt that Mr Smith, ambulance technician felt that he did say that there had been an unconscious period but I wonder if that has come as an afterthought. He is an experienced technician and had that been mentioned I am certain he would have placed it in his ambulance notes. Equally had it been mentioned to the nurses at handover, then one of them or Dr Shanks would have remembered and it would have been noted. No nurse remembered such comment being made and there is no note in the hospital notes. I have to conclude therefore that the comment was not made at the time Mr Smith thought it was made.

Returning to Dr Shanks' examination and notes, the only criticism coming from Dr Paterson is that the notes are somewhat scanty. Be that as it may, all those reading the notes were able to identify what had been done and what the result of the

examination was. It was clear there had been a neurological examination. Dr Myles had a slightly different opinion on the interpretation of the findings but that was no doubt as a result of her expertise in her particular discipline. From the point of view of Accident and Emergency, Dr Paterson can find no criticism of Dr Shanks and in the circumstances neither do I.

Conclusions

In her submissions, the procurator fiscal depute asked that I should consider if the absence of an observation ward within Queen Margaret Hospital might have been significant. I do not regard this Inquiry as having been about such issues and I do not feel it appropriate to comment on them. Clearly such wards are available in certain hospitals, usually much larger hospitals, but their provision is a matter of resource and is a question for the hospital authorities. The procurator fiscal depute also asked that I consider the effectiveness of the Scottish Ambulance Service report form. I have no comment to make on the form itself. Placing of information on the form is clearly important and should obviously be done before the patient is handed over to medical staff. In this case, the information on the form is factually accurate. There is an issue as to whether or not there was additional information at the time and, as I have indicated, I cannot be sure that Mr Smith made any mention at all of a lapse into unconsciousness. I cannot therefore comment on this as a contributory aspect.

The final point raised by the procurator fiscal depute is whether the deceased's chances of survival would have been greatly increased had he been observed within a ward and checked on hourly, so that the deterioration would have become evident earlier. There is no doubt that had the deceased been admitted, his deterioration would have become more obvious. The point is that Dr Shanks had no evidence of head injury and therefore no reason to admit a person who was, apparently, simply drunk. It is not therefore appropriate that I make any finding in that regard.

Mr Stewart raised a number of issues in his submission. The first of these was that it had been suggested that when Dr Shanks considered all the factors, Namely Mr McKelvie's condition on admission to A & E, comments allegedly made to her by Mrs Coyne, that should have resulted in admission to hospital. He asked that I disregard that and I agree that I cannot accept there is anything in such a proposition. As indicated, the deceased presented as a drunk person and the history seemed to confirm it. While I have no doubt Mrs Coyne was trying her very best to be truthful in the course of the Inquiry, I have some doubt about what she might have said and to whom she may have said it. For example she said that she spoke to a doctor outside A & E and it was quite clear on the video that this could not have been Dr Shanks and indeed there was no doctor present. The second proposition which he sought to have rejected was whether, in effect, any intoxicated person suffering from a fall must be admitted for observation on the basis that it is impossible to exclude the possibility of hitting their head on the way down. In the present case there was no visible sign of a fall. Dr Paterson was strongly of the view that the "SIGN" guidelines did not apply and in any event they are guidelines not directions. Dr Myles was quite clear that in her view Mr McKelvie should have been admitted but she cannot speak to his clinical presentation at A & E and was looking at matters from the point of view of a neuro-surgeon considering the notes and scans. Once again I cannot accept the proposition and agree with Mr Stewart. Indeed, if it was accepted, given what Dr

Paterson had to say about the volumes of people in A and E under the influence of alcohol, there would be a huge strain on resource, possibly to the detriment of others with a greater need.

Might an earlier CT scan or admission to hospital have prevented death? It seems likely that even if such a scan had been carried out on the Friday night and Mr McKelvie transferred to Edinburgh at the same time, there was no chance of a full recovery and it was difficult to say whether he would have survived at all. Having considered Mr McKelvie's age and drinking habits along with the scans it did appear that the odds were stacked against him. Dr Paterson did not think a patient who had suffered such injury could have survived and he had not experienced any survivors from such injuries. Dr Wyatt, who had submitted a report but was not a witness, had felt that even if admission to hospital had taken place at an earlier date it was certain the outcome would have been the same. Therefore it is difficult to say that an earlier CT Scan would have affected the position.

Miss Turnbull for Fife Health Board suggested that I should make no findings under Sections 6(1)(c) or 6(1)(d) and in her submission she goes into detail about why that should be the case. I have dealt with most of the points raised in her submission up to this point. The matter of comment under Section 6(1)(e) is one of discretion.

Finally Mr Munro for the Chief Constable has made a number of suggestions in his submission. One of these relates to suggestions that there might be defects in the completeness of the ambulance reports and the quality of the handover briefing. I have commented on this earlier in this note. The notes stated what information seemed relevant. If other information is given at handover that should be noted somewhere. If, as I was told, the ambulance notes are sometimes written up after the actual handover and admission it is all the more important that all relevant information is inserted. Here I suspect that some of what was said to have been said at handover was an afterthought.

He also suggested that Mr McKelvie's discharge from Queen Margaret Hospital was in breach of the national guidelines. As I understood the evidence these guidelines applied to people with head injuries. There was no indication of head injury at the time of discharge. It is going too far to suggest that the possible installation of short stay wards at the Victoria Hospital in Kirkcaldy is an admission on behalf of the authorities that the current system is not ideal or defective.

His final suggestions relate to the care of intoxicated persons coming into custody. It is quite clear that the police have concerns about having to care for such people and training is given to custody care attendants. Dr Hiremath said that a police cell was not the place to care for someone who is drunk and in an ideal world that is probably true. It is equally true that drunkenness may mask an injury or other condition. However in the real world it would not be practical for every person arrested under the influence of alcohol to be taken to hospital. The new procedure in place whereby ambulance technicians assess whether a person should go to custody or hospital appears to be worthy of a trial. It is also the case that there are specific places of safety in certain parts of the country, particularly Aberdeen to which intoxicated people are taken until they sober up. That may well be a good idea worthy of

consideration. Had such a facility been in place it would seem unlikely that the outcome as far as Mr McKelvie is concerned would have been different.

Dr Shanks acted perfectly correctly when presented with Mr McKelvie. She was briefed by the triage nurse and read the notes. She had overheard the ambulance handover. All the evidence suggested that she was being presented with someone who had fallen when drunk. She had carried out a full examination and excluded a number of serious conditions. She had carried out a neurological examination and found no trace or evidence of a head injury. She concluded, having been able to converse with Mr McKelvie, that he was simply drunk and needed to go home in the care of a relative. While Dr Paterson suggested her notes were a little scanty there is no room for criticism of her action or diagnosis on the night.

If she had been told that there had been a period of unconsciousness that may have made a difference to her decision to discharge but I accept that she was not told this. Dr Paterson's view was that this was a piece of information only and would not necessarily have changed the course of events. There was clearly discussion with Mrs Coyne within the A & E ward. Mrs Coyne expressed the concern that there was something more than intoxication and Dr Shanks felt that she had reassured Mrs Coyne. Both Mrs Coyne and her son said that for someone who did not know Mr McKelvie they could simply have assumed that he was drunk. That unfortunately is the position in which most of the medical staff found themselves. He appeared drunk; he was resistant; he was wandering around making a nuisance of himself. None of that paints a picture of someone with a head injury.

The decision to take Mr McKelvie into police custody was, in the circumstances, the correct one. He needed to be in the care of someone and his nearest relative was not able to provide the level of care the Doctor felt was appropriate. She may well have found it difficult to manage him given his condition and the mess he was in and she cannot be criticised for that. The video of what was happening outside the A & E entrance was quite illuminating since it did show the deceased was moving around unaided and appeared at times to be quite animated. This is in stark contrast with the evidence that had he had the injury which eventually showed on the CT scan he would have been unconscious and immobile. It was also in contrast with some of the evidence. I found Dr Paterson's comment on the video as against the witness statements quite helpful. It was quite clear that if the fall caused the injury then the subsequent bleed was a very slow bleed and that, at the time he was being discharged from A & E, there were few, if any, obvious signs that he had a problem other than the fact that he was intoxicated. His presentation is, therefore, perfectly consistent with the view expressed by Miss Myles that in an older person there is more space in the brain and the brain can, therefore, accommodate such a fall longer before showing symptoms. In all probability that is what has happened here.

The police have acted more or less conform to the appropriate guidelines. The noted rates of observation are slightly outwith the guidelines but I accept that the custody care officers from their position would be able to look into the observation cell quite frequently. There were signs of life and movement by the deceased. Such signs would, of course, all contribute to masking what was happening. Having been sent to the police station from the hospital and the duty sergeant having been reassured by

the hospital that it was simply a case of drunkenness they were quite right to assume that they should leave him to sleep it off.

Perhaps steps should have been taken to waken him earlier than lunch time on the Saturday, especially when his breakfast remained untouched. Having said that, had such steps been taken at that time it would have made no difference to the eventual outcome.

By the time Mr McKelvie was re-admitted to Queen Margaret hospital there was little or no hope of survival.

Mr McKelvie's death was unfortunate but was not, in my view, preventable. No precautions could have been taken within the system as it operated at the time which would have prevented the death.

Clearly the new protocol between the Health Board and the police about the treatment of drunks is a step forward. If ambulance personnel can assess whether that person should go to hospital or police custody that will assist for the future.

A halfway house where intoxicated persons can be taken to, in effect, sleep off their state would be a good idea and if such is planned in the Fife area then that can only be a good thing. Such a place would need to have a proper observation regime and, possibly, trained medical presence as well as those responsible for the "custody" aspect. Whether such would have made any difference here is impossible to say. If such facilities are not planned it would do no harm to have at least a feasibility study since it seems clear from the general body of the police evidence that it is a fairly frequent occurrence that people under the influence of alcohol are in custody, often for their own safety rather than because they have committed a crime.

It would be neither appropriate nor practical to treat all persons admitted to hospital under the influence of alcohol and/or drugs as if they may have had a head injury. It is reasonable that steps are taken by the examining doctor to ascertain if there is any history or evidence which might lead to the conclusion that there is a possible head injury. Only then would consideration be given to a CT scan.

One issue not raised in submission but which I consider merits some mention and consideration is whether or not there should be a more defined role for a police surgeon when persons under the influence of alcohol are being detained at a police station. It is clear that Dr Hiremath was in the police station to see another prisoner at some time on 27 March. It is not clear what time she was there but Mr McKelvie was in custody when she was there. She was not asked to see Mr McKelvie who fell into the category of vulnerable person as defined by Dr Hiremath in her guidelines for the police. Mr McKelvie had been in custody for some time and had never been sufficiently awake or sober to give his details.

The question arises as to whether the police surgeon should be informed that there is a vulnerable person in custody and if so at what stage should he be informed? To have every vulnerable person taken into custody reported to the police surgeon would be unnecessary and impractical. However, "SIGN" guidelines suggest four hours of observation for head injury patients. The police said in evidence that drunk

persons tended to sober up or wake up for a meal after a few hours. Should a police surgeon be informed that a vulnerable person is in custody either after an appropriate period in custody or at a specific time of the day? There appears to be nothing in guidelines about any requirement to inform a police surgeon. Given the view of Dr Hiremath that a cell is not a place for such people, there perhaps should be. Different considerations may well apply if the prisoner has come from medical care. It is clear that the whole issue is one which has received attention and there is a new protocol but it does appear to me that this is a potential loose end which might merit some examination.

Having said that, it should not be interpreted as being critical of the actings of the police in this case.

Determination

Having resumed consideration of the inquiry, the Sheriff Finds and Determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Section 6(1) as follows:

1. In terms of Section 6(1)(a) John James McKelvie, who was born on 19 December 1934 and lived at 109 Navitie Park, Ballingry, Lochgelly, Fife died in Queen Margaret Hospital, Dunfermline on 29 March 2004.

2. In terms of Section 6(1)(b) the causes of death were

1) craniocerebrel trauma,

2) blunt force trauma,

3) presumed backwards fall while intoxicated.

3. In terms of Section 6(1)(c) there were no reasonable precautions whereby the death could have been avoided.

4. In terms of Section 6(1)(d) there were no defects in any system of working which contributed to the death or any accident resulting in death.

5. In terms of Section 6(1)(e) the following are relevant to the circumstances of death.

a. Consideration should be given to the provision of supervised accommodation to which persons arrested or detained under the influence of alcohol might be admitted. Such provision would require to have a degree of medical supervision and be subject to a regime of checking or observation similar to that which currently exists for dealing with vulnerable patients in custody.

b. Consideration should be given to defining circumstances when the police should inform a police surgeon that a vulnerable person is in custody.

c. Where it is possible, all relevant information should be recorded in an Ambulance Report Form. Where it is possible to do so that form should be completed before the handover of a patient to admitting hospital staff. Where the handover is urgent or emergency medical treatment has to take priority, such information may require to be given verbally. In such cases it is important when the Form is completed after the event that all information given verbally is included.