DETERMINATION UNDER THE FATAL ACCIDENT AND SUDDEN DEATHS INQUIRY INTO THE DEATH OF STUART ROBERT HAMILTON

DETERMINATION

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY

(SCOTLAND) ACT 1976

BY

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SHERIFF PRINCIPAL OF

SOUTH STRATHCLYDE DUMFRIES AND GALLOWAY

INTO THE DEATH OF

STUART ROBERT HAMILTON

Held at STRANRAER from 29 April to 2 May 2002

STRANRAER: 19 June 2002

Stuart Robert Hamilton, who was born on 26 October 1980, lived latterly at 1A Forefield Court, Cairnryan Road, Stranraer. He died at Dumfries and Galloway Royal Infirmary at about 7.00 am on 22 July 2000. The causes of his death were internal blood loss resulting from rupture of his liver, which was severe, and of his right kidney. These ruptures were the result of a fall from a height.

During the evening and night of 21/22 July 2000 he attended various licensed premises, in at least some of which he drank alcohol. He and a friend, Gary Simpson, had been play fighting on and off during the evening. At about, or shortly before, 2.00 am he and his friend ascended a staircase onto the flat roof of a building between St Andrew Street and Castle Street, Stranraer. That staircase formed part of an access to a block of flats, via a passageway along the roof. The passageway was separated from the remainder of the roof by a wooden fence in which, close to the top of the staircase, there had formerly been a gate. That gate provided access to the remainder of the roof not occupied by the passageway. The gate had become rotten and had been removed. It was not replaced prior to 22 July 2000. It is not possible to say whether, if the gate had been replaced prior to 22 July, its presence would have made any difference to what happened. Part of the flat roof was used by residents in the flats as a drying area. Stuart Hamilton was on a part of the flat roof which did not form part of the passageway. He wanted to continue play fighting. He walked backwards, gesturing to his friend to come towards him. He did not realise how close to the edge of the roof he was. The edge of the roof has a parapet about 4

inches high and about 8 inches wide. When he reached the edge of the roof he lost his balance and fell about 14 feet from that building into the adjacent lane, which was dark and unlit. It was then between 2.00 and 2.15 am. As a result of the fall he sustained the injuries from which he later died. No other person caused or contributed to his fall.

An ambulance was called at about 2.18 am. It arrived at the scene at about 2.21. At that time Mr Hamilton was unconscious. He had abrasions to his abdomen and the right side of his chest up to his right shoulder. His pupils were fixed and dilated. He had a pulse of between 81 and 90 per minute. The ambulance crew were unable to detect blood pressure. His respiration was shallow and its rate at that time (3 per minute) was very low. A pharyngeal airway was inserted. He was given oxygen. His breathing was assisted by a mask and pump. A collar was put on him. His Glasgow Coma Scale was 3 - the minimum. That figure did not improve prior to his death. At 2.34 am the ambulance left for the Garrick Hospital, Stranraer. The ambulance arrived there about 3 minutes later. In the circumstances as they were known to the ambulance crew at the time, they were right to decide to take Mr Hamilton to that hospital. It was very close to the scene of the accident. It had better resuscitation facilities than were available to them in the ambulance. There was a doctor on duty there and a surgeon and an anaesthetist on call. It is possible to give a blood transfusion there.

At the Garrick Hospital Dr Balmer, who was joined shortly afterwards by Dr Coyle, an anaesthetist, attempted to raise his blood pressure using drips to which he had been attached. A blood sample was taken to group and cross-match his blood with a view to transfusion. After receiving fluids intravenously he was given O negative blood. He could and probably should have been given O negative blood sooner than he was. Initially his abdomen was not swollen but later it became swollen and his blood pressure dropped, indicating major blood loss. His airway was intubated with an endotracheal tube. He was given drugs so that he could tolerate the intubation.

Drs Coyle and Balmer acted as they did in an attempt to stabilise Mr Hamilton's condition as best they could, to improve his chances of surviving a transfer to Dumfries. While they were doing so they attempted to diagnose the nature and extent of his injuries. Dr Balmer began his examination at Mr Hamilton's head and worked down his body. It had been reported by the ambulance crew that Mr Hamilton may have suffered a fracture of his skull. Dr Balmer arranged for an x-ray examination to be carried out. A radiographer was called to the hospital and x-rayed his skull. A skull x-ray would not have shown if there was intra-cranial bleeding. In fact his skull was intact. However time was taken up gaining this information. The time taken by Drs Coyle and Balmer attempting to diagnose Mr Hamilton's injuries and to stabilise his condition, and x-raying his skull would not all have been spent by a doctor or surgeon of greater experience. The true cause of Mr Hamilton's symptoms was blood loss arising from the rupture of his liver and right kidney. In fact his condition could not have been stabilised. That was not appreciated as quickly as it should have been. He required very urgent and extensive surgical intervention. The only possible way to save his life, if it could be saved, was by his rapid and early transfer to Dumfries & Galloway Royal Infirmary for major surgery.

Dr Khan is a staff surgeon. She was on call and lives close to the Garrick Hospital. She should have been called soon after Mr Hamilton was admitted to the Garrick, i.e. soon after 2.37 am. She was not called until 4.00 am or slightly later. Dr Khan arrived at the hospital about 5 or 10 minutes after she was called. She immediately appreciated that Mr Hamilton was suffering from internal bleeding and that he required to be transferred to Dumfries and Galloway Royal Infirmary as soon as possible. She telephoned Mr Walls, the on-call consultant surgeon, and explained the situation to him. She also called Dr Peel, the on-call consultant anaesthetist, and the appropriate senior house officer or registrar. She made it clear to them that it would be necessary to carry out a major emergency operation. Having made these calls she was convinced that there would be a theatre team at the Infirmary awaiting Mr Hamilton's arrival. On his arrival there was no such team, though Dr Ballingall, a staff anaesthetist, examined Mr Hamilton very soon after his arrival and Dr Peel came soon after. Mr Walls did not go to the Infirmary in response to Dr Khan's call. There was no satisfactory explanation of his failure to do so.

Soon after these calls were made Mr Hamilton left the Garrick in an ambulance at 5.00 am. On the journey to Dumfries he was given blood which may have been blood which had been grouped and cross-matched. He arrived at Dumfries and Galloway Royal Infirmary at 6.25 am and died just over half an hour later.

Major emergency surgery is no longer carried out at the Garrick unless there is a consultant there at the time. Although Stuart Hamilton's best chance of survival involved the earliest possible transfer to a hospital where he could undergo a major operation to treat the ruptures to his liver and right kidney and to stem his blood loss, transferring him without stabilising his condition would have involved a material risk that he would die in transit. Since he survived until 7.00 am that day it is likely that, if he had been transferred to Dumfries and Galloway Royal Infirmary as soon as might reasonably have been expected after he arrived at the Garrick, he would have survived the journey. If Dr Khan had been called soon after Mr Hamilton arrived at the Garrick she might have arrived at the hospital by about 3.00 am. It would have taken some time thereafter for her to examine Mr Hamilton and make the telephone calls necessary to arrange for his admission to Dumfries and Galloway Royal Infirmary. He had a better chance of surviving the journey if his blood had been grouped and cross-matched before beginning his journey to Dumfries. It is understandable that those responsible for the decision to transfer him would have preferred to do so with a supply of such blood. At all events it is unlikely that he would have arrived at Dumfries and Galloway Royal Infirmary before about 5.00 am. Even if Mr Hamilton had arrived at the Infirmary at about 5.00 am and if he had been operated on very soon after that, it is very unlikely that his life could have been saved.

Mrs Yvonne Hamilton, Stuart Hamilton's mother, and her partner commented that when she eventually saw her son at the Garrick Hospital, nothing appeared to be being done for him. On the assumption that it was correct to attempt to stabilise his condition at the Garrick at that time there was little or nothing further that the doctors attending to him could have done which would have required activity on their part at the time when she visited her son. His condition was being stabilised as best it could be.

It was right to transfer him by ambulance from the Garrick to Dumfries by ambulance and not to attempt to do so by helicopter. It would have been necessary to find out if a helicopter was immediately available. A helicopter would have had to be flown to Cairnryan from Glasgow or, possibly, Prestwick. A helicopter transfer would have involved an ambulance journey to Cairnryan to board the helicopter. There would have been a further transfer from the helicopter to Dumfries and Galloway Royal Infirmary. It is at best very doubtful if the use of a helicopter would have resulted in a shorter journey time. If Mr Hamilton's condition had deteriorated while he was in the helicopter there would have been little that could have been done for him. In an ambulance it is possible to stop and render emergency assistance if it cannot be rendered on the move.

Ambulance crews based at the Garrick Hospital have been instructed to take all casualties to that hospital. That instruction was criticised during the Inquiry. There may be cases in which an ambulance crew picks up a casualty some distance from the Garrick and in the direction of another, more major hospital, such as Dumfries and Galloway Royal Infirmary. If that casualty is severely injured or is suffering from a potentially life threatening condition and if it is likely that he or she will have to be transferred to a major hospital, it may be prejudicial to the casualty to take him or her to the Garrick. A later transfer may have to be made, possibly past the point where the casualty was picked up. But the ambulance crew may not be able to determine the severity of the injuries to the casualty at the scene. A long transfer from the scene may not be in the interests of the casualty. The practical difficulties involved in changing the current instruction to ambulance crews to take all casualties to the Garrick include:

- the definition of the circumstances in which the ambulance crew should and should not take the patient to the Garrick Hospital.
- the definition of circumstances in which the patient should be taken to another specific hospital, which might be the Southern General Hospital, Glasgow if there are head injuries. (These circumstances might depend on whether or not a doctor was present at the scene.)

It is recommended that the instructions to ambulance crews to take all casualties to the Garrick Hospital be reconsidered and that consideration be given to establishing a protocol dealing with the circumstances in which a patient should be taken direct to a hospital other than the Garrick. In setting the criteria for direct transfer of a casualty to a hospital other than the Garrick, established triage criteria in use elsewhere should be taken into account.

It was said that there were insufficient ambulances based in Stranraer. There was not sufficient evidence to warrant any recommendation being made in relation to that matter. If there are insufficient ambulances based there, that insufficiency is likely to become apparent during daytime. It had no bearing on the events leading up to the death of Mr Hamilton. On both occasions when an ambulance was required to transport him one was immediately available.

The failure by Mr Walls to take any action after he was informed by Dr Khan of the condition and anticipated time of arrival of Mr Hamilton at Dumfries and Galloway Royal Infirmary is incomprehensible and appears to be inexcusable. He was, in

effect, told that a major operation would be required immediately on Mr Hamilton's arrival. He was the consultant on call. He had experience of carrying out operations to the liver and kidneys. He should have gone to the Infirmary and should have made sure that there was a theatre team ready when the ambulance containing Mr Hamilton arrived there. In fact Mr Walls remained at home. When the ambulance arrived at the Infirmary it appeared to the doctors and the ambulance crew that Mr Hamilton's arrival was not expected there. That should not have happened.

It is recommended that protocols be established in relation to the transfer of patients from the Garrick to Dumfries and Galloway Royal Infirmary with a view to improving communications and to ensure that incoming casualties are attended to by suitably qualified staff on arrival.

Because the resuscitation area to which he would normally have been taken was occupied at that time, he was taken to the Intensive Care Unit. It was appropriate to take him to that unit in these circumstances. That unit has facilities similar to those which would have been available in the resuscitation area had it not been in use.

Difficulty has been experienced recruiting and retaining surgeons in Stranraer. Of three staff grade posts there, one surgeon has left and another is soon to leave, with the result that Dr Khan will soon be the only surgeon in post there. Mr Burton, the A&E consultant based at Dumfries and Galloway Royal Infirmary attends the Garrick regularly. Other surgeons from Dumfries help to provide A&E cover from Monday to Friday during normal working hours. The quantity and difficulty of the surgical work required at the Garrick may not be sufficient to attract highly qualified surgeons to a full time appointment there. Rotation of suitably qualified A&E surgeons from Dumfries to the Garrick for periods may not be feasible. It is likely that, if A&E cover at the Garrick is to be improved, much of the improvement will have to come by upgrading the skills of those who work there full time.

Dr Balmer is a general practitioner in Stranraer. Along with other local general practitioners he helps to provide accident and emergency cover at the Garrick on a twenty four hour basis. Some of the general practitioners in Stranraer have attended an Advanced Trauma Life Support (ATLS) course in its full form, others in a modified form but probably about half of them have not attended any such course. ATLS training is regarded as an essential minimum level of training for medical and nursing staff involved in accident and emergency work. It is recommended that, as soon as is practicable, all those who provide A&E cover at the Garrick be given ATLS training. For the foreseeable future it is not likely to be practicable to stipulate that only those who have received such training may provide A&E cover. The present cover is provided to the level it is because local general practitioners have been willing to provide it, no doubt at considerable inconvenience to themselves and their families on occasion. The on-call doctor stays in the hospital overnight. If it were to be made mandatory to have undergone ATLS training, there may be times when A&E cover could not be provided at the Garrick at all. Some doctors could not provide A&E cover in that event. Those doctors who have received such training may not be prepared to take on all the A&E commitments there between them. Some might refuse to continue to provide cover though trained while others might be prevented from providing cover because they had not attended such a course. The

possibility of providing suitable and sufficient incentives to undergo training and provide such cover was not discussed at all at the Inquiry.

So far as the future of provision of A&E services in Stranraer by Dumfries and Galloway Acute and Maternity Hospitals NHS Trust is concerned the Trust, in November 1999, recommended as follows:

"Only the General Practitioners contracted by the Acute Trust, or doctors specifically approved by the Consultant in Accident & Emergency, should work in the A&E Department providing service outwith Monday to Friday office hours.

Clinical Governance implies that GPs working in A&E should undergo regular training in ATLS, ALS etc. but these issues remain under discussion.

A&E trained Staff Grade doctor(s) to cover A&E Departments; Monday to Friday - 9.00 am to 5.00 pm, supported by appropriately trained General Practitioners working on a sessional basis, as required.

Training of doctors working in the A&E Department must be formalised."

Shortly after the evidence in the Inquiry was concluded a review was due to commence of trauma services in Wigtownshire. The team carrying out that review is led by an A&E consultant from Plymouth who, with his colleagues, have experience of the provision of medical services in remote areas.

The regular training referred to above has not been instituted for GPs working in A&E at the Garrick as yet. Training of doctors working in the A&E department has not yet been formalised. No records are kept of the extent to which the GPs working at the Garrick have been trained nor of those who should be trained to reach the minimum desirable standard. All of these should be done as soon as they can be.