INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 FOR v. GORDON SCOTT NIVEN

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND)ACT 1976

SECTION 1(1)(a)

SECTION 1(1)(b)

DETERMINATION by EDWARD F BOWEN QC, Sheriff Principal of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on Monday on the Fifteenth to Nineteenth days of February Nineteen Hundred and Ninety Nine into the death of GORDON SCOTT NIVEN.

GLASGOW, 5 March 1999. The Sheriff Principal having considered all the evidence adduced DETERMINES: in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 section 6(1):

(a) That Gordon Scott Niven aged 16 years who resided at 35 Regwood Street, Glasgow, died at the Southern Gene ral Hospital, Glasgow at 11.30 hours on 25 September 1997 as a result of injuries sustained in an accident which occurred in Tantallon Road, Glasgow, at about 17.00 hours on 23 September 1997;

(b)That the cause of death was a head injury sustained when he was projected over the handlebars of a pedal cycle ridden by him that had stopped suddenly at the top of a makeshift ramp, and fell to the ground striking his head directly on a hard surface;

(c)That the death might have been avoided by the wearing of an appropriate protective cyclist's helmet;

(d)That the said accident and subsequent death were not caused or contributed to by any defect in a system of working;

(e)That the following facts are relevant to the circumstances of the death:

1Gordon was riding his bicycle on a building site in Tantallon Road, Glasgow at about 17.00 hours on 23 September 1997. He and a number of other boys had constructed a ramp out of pieces of

wooden shuttering. They were using it to cycle over at speed. Gordon fell off when his front wheel suddenly jammed.

2Following the accident a nearby resident summoned an ambulance which arrived at the scene at 17.14 hours. The ambulance attendants found Gordon standing. He had a swelling to the front of the head. He appeared slow to react and was drowsy. He was conveyed by ambulance to the Victoria Infirmary, Glasgow, where his admission was timed at 17.33 hours.

3On admission Gordon was seen almost immediately by Dr Long, a Senior House Officer, who found him to be fully conscious Dr Long noted bruising and swelling around the right eye. Although the right eye could not be opened the left eye was normal and reacted to light. Dr Long asked Gordon if he had been drinking to which he gave conflicting replies. He rapidly became abusive, violent and difficult to manage. It was impossible for Dr Long to examine his ears. Attempts were made to hold him down but he became more violent, attempted to strike members of nursing and medical staff, and succeeded in striking Sister Michelle Emery. At about that time Mr Ritchie, the Accident & Emergency Consultant on duty became aware of Gordon's presence. Mr Ritchie instructed that he be left to see if he would calm down. He did not do so. As a result of his conduct a decision was taken to call for police assistance.

4Two police officers, Constables Buchanan and Wilson attended at the casualty department. Gordon was lying on a trolley when they arrived. When they approached he immediately became abusive. He began to lash out. His mother who had been in attendance at the hospital from an early stage was asked to enter the resuscitation room. When she did so Gordon became increasingly and crudely abusive. Mrs Niven became very upset. She commented that she had never before seen Gordon behave in that manner.

5Some discussion took place amongst the medical staff and the police officers as to what could be done. Mr Ritchie suspected that Gordon had taken alcohol or drugs and did not consider that his behaviour was caused purely by his head injury. He requested, or at least authorised, his arrest. The police officers were told that he could be returned to the Infirmary if his conduct improved. They were given no particular instruction that he should be observed.

6Gordon was removed from the Victoria Infirmary and was conveyed to Aitkenhead Road Police Station where his detention was timed at 18.22 hours. He did not smell of alcohol and was recorded as "sober". He was uncooperative but not aggressive. He was placed in cell 7, which is not an observation cell. He was observed by the turnkey on duty at 19.15 and at 19.50 hours and responded on each occasion.

7Police Inspector Haggerty, the duty inspector, became aware of his presence at about 18.35 hours and saw him about thirty minutes later. Gordon was in a kneeling position and appeared to be confused. Inspector Haggerty decided to have him examined by a police casualty surgeon and

arranged for the attendance of Dr Hay, a very experienced police surgeon, who arrived at about 20.20 hours. When the cell door was opened Gordon was standing, having been leaning against the inside of the door. He was removed to the shower area where Dr Hay examined him.

8Dr Hay noted that Gordon was confused and had two large periorbital haematomae. His eyes were closed and examination of the pupils was not possible. Dr Hay noted "This boy looks as if he has a frontal skull fracture and needs returning to hospital". He was returned to the Victoria Infirmary by police car at about 21.30 hours. At that stage the upper part of his body was bare, his upper clothing having been removed earlier in the casualty department.

9In the meantime Mrs Niven had contacted Jonathon Crossan and had gone to the Victoria Infirmary with him. He was questioned, in particular by Sister Emery, as to whether Gordon had been drinking or had "taken anything". Jonathon was, however, able to confirm that he had fallen from a height and this was relayed to Mr Ritchie who telephoned Aitkenhead Road Police Station to enquire as to Gordon's condition. He was informed that arrangements were already being made for his return.

10On return to the casualty department at the Victoria Infirmary, Gordon was seen again by Dr Long at about 21.45 hours. Dr Long noted that both eyes were closed; but that he was much easier to examine, his reflexes were normal and that he obeyed "commands". Dr Long noted as his impression "basal skull fracture" and arranged for a skull X-ray which revealed a right frontal fracture. After discussions with neurosurgeons at the Southern General Hospital a CT (computerised tomography) scan was carried out. This showed an extra dural haematoma over the right frontal region, contusions along the inferior surface of the right frontal lobe, and an intercerebral haematoma. After intubation and ventilation he was transferred to the Neurosurgical Unit of the Southern General Hospital at about midnight.

11After examination at the Southern General Hospital and review of the CT scan it was decided that the only possible course was to keep Gordon under sedation and continue with ventilation and monitoring of intra-cranial pressure. Despite attempts to control it, his intra-cranial pressure continued to rise and by 12.50 hours on 24 September had reached a level that was incompatible with life. ICP monitoring was discontinued at 13.40 hours. Death was pronounced at 11.30 hours on 25 September after appropriate brain death criteria were established.

12Dr Andrew Davison carried out post-mortem examination within the Southern General Hospital on 30 September 1997. The findings revealed that death had resulted from pressure effects within the skull of swelling of the brain due to the development of intracerebral haematoma caused by a complicated skull fracture in the right frontal side. Death was certified as caused by "Head injury due to fall from height".

13The aggressive and irrational behaviour, which Gordon exhibited at the time of his initial admission to the Victoria Infirmary, was caused by cerebral irritation as a result of injury to the brain and was not caused by the consumption of alcohol or drugs.

14The severity of the injury sustained by Gordon at the time of his fall was such that he was unlikely to survive. No treatment was appropriate other than ventilation and control of intra-cranial pressure as was carried out at the Southern General Hospital. If he had remained at the Victoria Infirmary instead of being taken to Aitkenhead Road Police Station it is unlikely that treatment would have commenced any earlier than it did. If treatment had commenced earlier it would not have affected the eventual outcome and would not have prevented his death.

NOTE:

This Fatal Accident Inquiry arises out of the death of a sixteen-year-old boy who was injured in a relatively simple cycling accident at about 5.00 pm on the afternoon of 23 September 1997. His death occurred in the neurosurgical department of the Southern General Hospital two days later, although he had deteriorated to a condition described as "incompatible with life" some 24 hours before death was pronounced. In the relatively short period between the accident and that point he had been admitted to the Accident and Emergency Department of Victoria Infirmary where he was ultimately arrested and conveyed to Aitkenhead Road Police Station where he spent some time in a cell before being returned to the Infirmary. It is clear with the benefit of hindsight that the behaviour which precipitated his arrest was caused by injury to the brain which he suffered in the accident and that he should not have been removed from hospital. With that background of events it is difficult to express adequately one's feelings of sympathy for the distress felt by his parents at losing their son in such circumstances. Although it is now quite clear that the injuries which Gordon Niven sustained were of such a severe nature that no medical intervention would have avoided the fatal outcome, there is at least one area of concern which, if addressed, might serve to prevent other relatives suffering the same distress in similar situations.

Before turning to that I wish to comment on certain more general matters. In the first place I have made a finding that the use of a protective helmet might have avoided this death. I make that finding - and indeed do so at the forefront of my findings - in the knowledge that the use of such a helmet does not necessarily eliminate the possibility of serious head injury in severe bicycle accidents, and indeed might not have done so in this case. I also acknowledge that Gordon's parents may well have done all that they reasonably could to persuade him to wear a helmet but met with the usual resistance which people of all ages put forward to being encumbered in this manner. This case, however, demonstrates just how easily a cyclist may sustain a fatal head injury. Gordon was not on a public road. He was probably not travelling at great speed. No motor vehicle was involved. He was simply playing as boys do on a makeshift ramp when a sudden stop propelled him over the handlebars onto hard ground. If the widespread publicity that this case has attracted highlights that danger as much as the more sensational aspects the inquiry will have been of value for that reason alone.

The second general matter I feel compelled to comment upon is this. Gordon was removed from the Accident and Emergency Department of the Victoria Infirmary because his conduct was violent and disruptive. On the evidence led before me it is plain that hundreds of people are removed from the casualty departments of major hospitals annually for similar behaviour. The overwhelming majority of them are under the influence of alcohol or drugs. Those who have so behaved, and who read of the circumstances of this case, might pause to reflect that it is because of their behaviour, leading to a situation where drunken and disorderly conduct has become such a regular feature of life in casualty hospitals, that a case where disruptive behaviour has a genuine medical cause is all too easily missed. They have a great deal more to answer for than simply the immediate danger and distress caused to those who have to deal with them

With these general observations, I turn to deal with the circumstances of Gordon's initial admission to the Victoria Infirmary, the events that took place there including his removal to the police station, and his subsequent return to the Infirmary. At the time of Gordon's fall a friend, Jonathon Crossan, accompanied him. There were about three other younger boys present who witnessed what occurred. It was obvious that the fall was violent and that Gordon had sustained a severe blow to the head. Any loss of consciousness was, however, at worst momentary, and he was standing when an ambulance arrived at the scene at 17.14. The ambulance attendant was able to obtain some information from those present, and in due course it was entered in the appropriate Ambulance Report Form that "Patient fell off push bike sustaining haematoma to the eye and front of head. Witness said he was not ko'd". This information was duly passed on, both verbally and by means of the written report, on arrival at the Victoria. It was stressed in the course of evidence that it is important for Accident & Emergency staff to have as much information as possible regarding the mechanism of a head injury, and there was a hint of criticism that a more detailed description of Gordon's accident might have led to an earlier realisation that his injury was likely to be severe. In my judgement it would be unfair to anyone involved to suggest that the information which was passed on as to the circumstances of this accident was inadequate. The ambulance technician who gave evidence acknowledged the importance of obtaining a full history at the scene of an accident and I have no reason to doubt that ambulance crews are well aware of that. But it is very difficult to expect them to be able to record events in much detail in situations which must often be emotionally charged and confusing when their first responsibility is care of the patient. Beyond observing that the fullest report possible at the scene of an accident ought to be obtained particularly in cases of head injury I do not consider it appropriate to make any further comment or recommendations

The most sensitive area with which the Inquiry was concerned related to the decision to arrest Gordon and take him to Aitkenhead Road Police Station. I have recorded at findings 3, 4 and 5 above an outline of the sequence of events which led to this. It is perhaps worth recording a number of observations of the witnesses regarding his behaviour. Staff Nurse Cameron, who had about three years experience, said she had only been involved in one incident that was more violent. Dr Long the Senior House Officer described Gordon as probably the most violent patient he had had to deal with in 18 months experience of Accident & Emergency work. PC Buchanan, an officer of sixteen years service spoke to making several attempts at calming him down without success, but indicated that "his actions seemed to me strange - not what I would have expected of a Saturday night drunk". The other officer, PC Sharon Wilson, who was a very junior officer at the time, noted that Gordon became even more objectionable when his mother appeared and said of his behaviour "I had the

feeling it was something to do with his head injury". Unfortunately Sister Emery, who was apparently heavily involved in dealing with Gordon and in communicating with his mother, was unable to attend the Inquiry due to being involved personally in a serious accident.

I have to say that I have every sympathy with nursing and medical staff who are required to deal with obstreperous patients. It must be extremely difficult to draw a distinction between those whose conduct might be affected by the underlying pathology of their injuries and those cases where it clearly is not. In the present case I have no doubt that the view of the medical staff at the time when Gordon was removed was that he was under the influence of alcohol or drugs. It was accepted all round that it was inappropriate to despatch a patient to police custody if he was thought to be suffering from a head injury and I do not consider that Gordon would have been arrested on the instructions of the medical staff if they had thought that. I am satisfied, however, that in this case the circumstances as known to the medical staff were such as ought to have led them to conclude that Gordon's behaviour was likely to have been caused by his head injury. This was a sixteen-year-old boy who had fallen off a bicycle. He was admitted in the afternoon, not late in the evening. He did not smell of alcohol. Apart from his behaviour the only indications of intoxication were certain remarks which he made himself which were contradictory and indicative of a state of confusion. Perhaps most significantly, some of his remarks were lewd and inappropriate, particularly in the presence of his mother, behaviour that, on her account was entirely out of character. In conjunction with the site of his injury, that particular behaviour pointed to frontal lobe injury. Upon that view the decision to have him arrested and taken to a police station in my judgement was wrong and, in the circumstances, insensitive.

In making that criticism I have a number of points to make. First, I express no view on the matter of whether the decision was one that no reasonably competent medical practitioner would make in the exercise of ordinary care. It would be wholly wrong to do so. This observation is, however, necessary in the light of a submission that I could not level any criticism at any doctor unless it was shown that his conduct could be so regarded. That submission is obviously derived from part of the test for a successful action based on medical negligence as set out in the well-known case of Hunter v Hanley 1955 SC 200. I reject the submission without difficulty. As the Lord President pointed out in Black v Scott Lithgow Ltd 1990 SLT 612 the sheriff is given no power by section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 to make a finding as to fault. For that reason, and others, a Fatal Accident Inquiry is not the appropriate forum for consideration of issues of fault of the type that might provide the basis for an action of damages. The court is entitled to examine much wider issues, including areas of practice generally, and is entitled to direct criticism in such terms as seem appropriate if satisfied upon examination of the facts that it is right to do so. The making of such criticism has no necessary implication for any other proceedings in which issues of professional standards may be properly focused.

In the second place I am satisfied that removal of Gordon to the police station and his detention there for a matter of three hours did not make any significant difference to his subsequent treatment and did not alter the course of events which led directly to his death. Had he remained at the Victoria Infirmary the best that could have been done was a period of observation. Any attempt to move him would have resulted in more violence and agitation in turn leading to increased

pressure on the brain which was the very cause of his death. Observation would have revealed exactly what was noticed by Dr Hay within about two hours of his arrival at Aitkenhead Road - namely periorbital haematoma or "racoon eyes", a classic sign of frontal skull fracture.

That leads to the third comment, namely that although I am satisfied that the decision to have Gordon taken into custody was wrong it is hard to be too critical of it because of the lack of any clear alternative. Whilst a period of observation was appropriate, it is difficult to say where this could have been carried out. The resuscitation room in the casualty department was hardly the place to keep a patient in a violent condition, as it might have been required at any moment for a fresh patient requiring urgent treatment. Attempts by hospital staff to move Gordon to a general ward within the hospital would have been very difficult, and, as indicated above, would have had a potential for harm. To have sedated him would, on the evidence adduced, be much more difficult that might be popularly perceived. It would have involved considerable physical restraint for insertion of a drip, and the effect of the administration of powerful drugs on a patient whose underlying condition was uncertain. There are potential side effects including a danger of re-gurgitation of stomach contents into the lungs. A more drastic alternative, namely the administration of paralysing drugs followed by ventilation, calls for considerable resources and is a major intrusive procedure which would not be contemplated for someone displaying Gordon's level of consciousness.

It might be suggested that what was lacking was a facility for observation within the Accident & Emergency department, and there was evidence that such a facility does exist, for example, in Glasgow Royal Infirmary. Opinion amongst A & E specialists was, however, divided on whether the existence of such a facility was desirable and whether "observation" was an appropriate role for A & E staff. Moreover, the possibility of providing observation facilities has resource implications that cannot be properly addressed in the context of a Fatal Accident Inquiry. This case does, however, raise what must be a regular and acutely difficult problem for A & E staff, namely, how and where to deal with a violent patient whose conduct may be caused by head injury. I accordingly recommend that the issue should be addressed as a matter of priority by those bodies having professional interest, in particular The Faculty of Accident and Emergency Medicine and the Society of British Neurological Surgeons. The latter have recently been involved in the preparation of guidelines for the initial management of head injuries; they may consider it appropriate to make representations in relation to resources available for the management of the type of case that this Inquiry has highlighted.

That is the only recommendation that I am disposed to make. I do not consider it appropriate to suggest, as I was invited to do, that in casualty departments violent and aggressive behaviour in a patient with a head injury should always be assumed to be caused by the underlying pathology. It is plainly wise to make that general assumption, but there will inevitably be cases where it is perfectly clear that such behaviour has other causes. I make no criticism of the actings of any of the police officers involved except to say that it was thoughtless for Gordon to have been returned to hospital with no upper clothing at a stage where it was fairly clear that he had a fractured skull. That criticism I understood to be accepted. Otherwise the police officers who took Gordon into custody did so because no alternative was available, and he was treated as well as could be expected at the police

station. Prompt action was taken to obtain medical attention for him as soon as his condition became the subject of concern. I am also satisfied that Mr Ritchie, the consultant who must bear the responsibility for Gordon's arrest, took steps to check on his condition as soon as he heard that the fall had been a serious one. Although both Mrs Niven and Jonathon Crossan felt that on their return to the Victoria Infirmary they did not make much headway in allaying the suspicion of staff that Gordon had "taken something", there was clear corroborated evidence that their visit prompted Mr Ritchie to telephone the police station. I have no doubt that this was in the light of better information regarding the fall.

I have only to add that the evidence adduced indicated that the treatment given once Gordon returned to the Victoria, and on his subsequent transfer to the Southern General, was entirely proper.