**OUTER HOUSE, COURT OF SESSION**

**[2025] CSOH 17**

**A127/22**

OPINION OF LORD YOUNG

In the cause

LYNDA O'NEILL and OTHERS

Pursuers

against

SCOTTISH AMBULANCE SERVICE BOARD

Defender

**Pursuers: L. Sutherland KC, H Masters; Drummond Miller LLP**
**Defender: A. Bergin, J. McGowan; NHS Scotland Central Legal Office**

11 February 2025

**Introduction**

[1] The Carbeth Hutters Community grew from an initiative shortly after the end of the First World War when the then landowner granted camping rights to returning soldiers. Overtime, individual huts were constructed on land to the north of Milngavie, and a Community Company was formed to manage the site. These huts remain "off grid" in the sense that there are no connections to the usual service utilities.

[2] Brian O'Neill was visiting his hut no. 111 over the weekend of the 26-28 June 2020. On the evening of 27 June 2020, he suffered a fall which caused a laceration to his head which bled copiously. He was attended by a number of fellow "hutters" including a visitor

who was medically qualified. On the morning of the 28 June 2020, Brian O'Neill was found unconscious and was subsequently pronounced dead. This case raises the question of whether his death was, to any extent, the fault of the Scottish Ambulance Service for their failure to transport him to hospital following a 999 call made on his behalf. This action is brought by Mr O'Neill's family against the Scottish Ambulance Service.

**Proof before answer**

[3] I heard evidence and submissions in this case over 5 days. The pursuers led evidence from Dr Leanne Rae, Ms Elaine Noden, Mr Michael Jackson and Dr Stephen Hearns. The defender led evidence from Professor Charles Deakin. Witness statements were lodged on behalf of Dr Rae and Ms Noden. Expert reports were lodged on behalf of Mr Jackson, Dr Hearns and Professor Deakin. In addition, parties entered into four joint minutes agreeing a large amount of evidential material including the quantification of the individual claims.

**Agreed or uncontroversial facts**

[4] Brian O'Neill was aged 59 at the time of his death. He was married and had three children and three grandchildren. His previous medical history included a stroke. He was on a number of prescription medications including the anti-platelet medication, Clopidogrel.

[5] On Friday 26 June 2020, he was dropped off by his brother at Carbeth Huts where he planned to spend the weekend. On 27 June 2020, Mr O'Neill had been drinking alcohol with others at one of the huts. At some point, he fell while outside the hut and struck his head which caused an L-shaped wound to the scalp. His fall was not witnessed.

[6] Dr Leanne Rae was also spending the weekend at the Carbeth Huts. She was staying with a friend. This was her first visit to the Carbeth Huts. During the evening, Dr Rae and her friend had gone for a walk. On their return from the walk, they got into conversation with three men in a neighbouring hut and joined them for a social drink. Dr Rae consumed a couple of beers over the course of the evening. Late in the evening, as Dr Rae and her friend were about to leave the group, a younger man came to tell the group that Brian O'Neill had injured himself in a fall. Dr Rae went with the group to see if she could help. Dr Rae had not previously met Mr O'Neill before attending at his hut.

[7] Brian O'Neill was in his hut when Dr Rae and the others arrived. There was no electric light in the hut so it was pitch black inside. They used their phone torches to check on him. A towel had recently been put on the wound. He had blood on his shirt. Dr Rae saw a small wound to the head which was bleeding when the towel was removed. Dr Rae was told at some point that Brian O'Neill had previously had a stroke. She was also made aware that he had been drinking alcohol. After viewing the wound, she told Mr O'Neill that the wound was still bleeding and she needed to call for assistance. He was happy for her to do so.

[8] A 999 call was made at 2324 hours (the "first 999 call"). This was made on the mobile phone of one of the other men in the group. He placed the call on loud speaker. One of the defender's call handlers, Claire Maguire, dealt with that first call. Ms Maguire took details of the injury and the mode of injury. She was told by Dr Rae that blood was pouring out of the wound whenever pressure was removed from the wound. Ms Maguire categorised the call as a "green category" which would be the subject of further triage and remote consultation. It is accepted by both parties that the "green" categorisation was correct. The first 999 call was recorded and was played in evidence.

[9] The further triage was to be carried out by Elaine Noden, a trainee advanced paramedic practitioner. She called back at 2341 hours and spoke with Dr Rae ("the second 999 call"). There are important differences between Elaine Noden and Dr Rae regarding the content and tone of that call back. However, some aspects of the second 999 call are not in dispute. During the call, Dr Rae told Ms Noden that Mr O'Neill had suffered a head injury and had been consuming alcohol. Dr Rae also told Ms Noden at some point before the end of the call that the bleeding from the wound had stopped. Ms Noden told Dr Rae that there would be a 2-3 hour wait for an ambulance and she asked whether Mr O'Neill could attend hospital by taxi. The second 999 call ended at 2344 hours. No ambulance was sent to transport Brian O'Neill to hospital. The second 999 call was not recorded.

[10] Ms Noden allocated a stop code "CSDSELF CSD Self Care Advice" at the end of the second 999 call. Other potential stop codes available for an advanced paramedic to use included "CSD Cancelled by Dr/Nurse", "CSD Cancelled by Caller", "CSD Patient Making Own Way" and "Patient Refused Transportation".

[11] Mr O'Neill was left unsupervised overnight in hut 111. On the morning of 28 June 2020, he was found lying on the floor of his hut. A 999 call was made at 0922 hours advising that Mr O'Neill was not breathing ("the third 999 call"). Dr Rae was informed and she ran to hut 111 and took over the giving of CPR. Two ambulances were dispatched to Carbeth Huts. The ambulances arrived at 0951 and 0953 hours with CPR continuing until 1017 hours when Mr O'Neill was pronounced dead. Dr Rae provided a statement to the police that morning. The third 999 call was recorded and part of it was played in evidence.

[12] A post mortem was carried out on 30 June 2020. External examination identified a full thickness laceration of crescent shape over the posterior parietal scalp surrounded by an

area of red abrasion. The cause of death being determined as "head injury (haemorrhage from a scalp laceration) and ischaemic heart disease."

[13] The defenders carried out a Significant Adverse Event Review ("SAER") in October 2020 following concerns raised by Mr O'Neill's family.

**Disputed evidence in relation to the second 999 Call and the import of that call**

***Dr Leanne Rae***

[14] Dr Rae gave her evidence by way of a signed witness statement supplemented by oral evidence. Dr Rae gave her oral evidence by a live link from Hamilton, New Zealand where she works as a psychiatrist. Dr Rae obtained her medical degree from the University of Edinburgh in 2012. Her medical training did not include any time working in accident & emergency but she had spent a 4 month period in acute medicine. After completion of her foundation training, she undertook specialist psychiatric training and commenced a series of locum psychiatric posts. At the time of the events which we are concerned with, she was in the 4th year working as a psychiatrist.

[15] Dr Rae described Mr O'Neill as being under the influence of alcohol. She confirmed that in her police statement she had described him as "steaming" and she felt that remained a fair description. She described him as "pleasantly drunk and not bothered by the fact that he was bleeding from his head". She was asked in chief whether she felt he was able to give a detailed and reliable history to which she replied "No, not detailed. He could appropriately answer questions and was able to follow directions and commands". By reference to the recording of the first 999 call, she agreed that his speech was slurred on account of being drunk. She asked him where he had fallen and what he had struck his head on but Mr O'Neill was unable to give precise answers to these questions. After looking

at the laceration and the continued bleeding, she considered that he needed medical assistance and investigation.

[16] While they waited for the call back after the first 999 call, Dr Rae continued to monitor and assess Brian O'Neill as best she could allowing for the limitations presented by the remote location and lack of medical equipment. She carried out an assessment by looking into his eyes with the light of a phone and by testing the tone in his upper limbs. She noted a right sided weakness but he was able to tell her that was a consequence of his previous stroke. She said that Brian O'Neill was alert and orientated but his speech was slurred and he did not offer much in the way of spontaneous conversation. She kept the pressure on the head wound.

[17] Dr Rae's evidence was that the call back also came through on the loud speaker function of the same mobile phone. This meant that Mr O'Neill could hear Ms Noden and she could hear him. Dr Rae's recollection was that before she was asked to relay any information to Ms Noden about his condition, Ms Noden said there would be a 2-3 hour delay before an ambulance could be sent. Her impression was that Ms Noden was seeking to discourage them from insisting on an ambulance being sent. Dr Rae queried the length of the waiting time and asked if that was usual where an individual had a head injury and had been drinking. She was told by Ms Noden that it was due to the covid emergency. Once Brian O'Neill heard Ms Noden saying that there would be a 2-3 hour wait for an ambulance, he said he would not be going to hospital. Dr Rae said that the mention of the lengthy delay was the "pivotal thing that changed everything". Mr O'Neill had been happy to wait for an ambulance up to the point that the delay of 2-3 hours was mentioned. Dr Rae's evidence was that Ms Noden either heard Mr O'Neill saying he would not go to hospital, or heard

Dr Rae repeating what he had said. At that point, Ms Noden said she would not be sending an ambulance out.

[18] Dr Rae's evidence was that she felt that Mr O'Neill needed to attend hospital for further assessment including a likely CT scan to rule out the risk of internal bleeding. She conveyed her continuing concerns to Ms Noden but to no avail. Once it was clear to Dr Rae that an ambulance was not going to be sent, she made a comment to the effect that at least the bleeding had stopped. She was clear that this comment was made subsequent to the decision not to send the ambulance and was said as a form of reassurance to herself. Dr Rae then asked Ms Noden what she was supposed to do and there was discussion about the possibility of taking a taxi to the hospital. Mr O'Neill was not willing to take a taxi despite Dr Rae's entreaties that he needed to go to hospital.

[19] Dr Rae was adamant that she did not give any undertaking to Ms Noden that she would stay with Mr O'Neill and monitor the situation. She did not agree that she had told Ms Noden that she would deal with Mr O'Neill's condition herself. She accepted that she was probably provided with "safety netting" advice from Ms Noden at the end of the call. Dr Rae said that Ms Noden knew that Mr O'Neill was not going to hospital and appeared happy with that course of action. Dr Rae remained unhappy with that decision.

[20] At the end of the call, it was clear to Dr Rae that no ambulance would be sent and Brian O'Neill was not willing to attend hospital by any other mode of transport. Dr Rae and others stayed with him for about an hour. They helped him get changed into new clothes and sat with him for a period of time. The bleeding had not started up again by the time they left his hut.

*Ms Elaine Noden*

[21] A written statement was provided and spoken to by Ms Noden. This was undated but Ms Noden believed that it had been completed in January or February 2022. In addition, she had provided answers to a series of written questions submitted to her by the pursuers' legal team.

[22] At the relevant time, Ms Noden was a trainee advanced paramedic practitioner. She worked from a base in Aberdeen connecting into the Scottish Ambulance Service Computer. A co-ordinator based in Edinburgh would allocate calls which had been coded by the initial call handler as requiring further assessment or advice from an advanced paramedic. Advanced paramedics do not operate from a script. They exercise clinical judgment based on their training and experience. To aid their clinical judgment, they use the Joint Royal College Ambulance Lainson Committee (JRCALC) guidelines.

[23] Ms Noden had some recollection of the call but largely relied upon her note. That note was in the following terms

> "Tel triage – Brian O''Neill 59 yomGroup [sic] of friends all been drinking. Brian fell and cut head, initially bleeding quite heavily but has now settled. Dr Ray is with pt (psychiatrist) and when I explained likely delay of 2 hrs and whether taxi would be an option she has reassessed wound and thinks they will manage to deal with it themselves. They will call back if there are any further issues. Pt had previous CVA but there is no back or neck pain, no new deficit, is alert and orientated. No further SAS assistance is required at this time"

[24] Ms Noden's recollection was that the call was not on loudspeaker and that she spoke only with Dr Rae. She did not hear Mr O'Neill speak during the call. She did not speak to Mr O'Neill as she did not feel that necessary as Dr Rae was medically qualified and was relaying the information. She also wished to avoid a mobile phone being passed around during the covid pandemic. She was made aware that Mr O'Neill was intoxicated but did not ask how much he had consumed. She said that she received an assessment of the

patient's condition from Dr Rae before there was any discussion about ambulance availability. Her evidence in chief was that Mr O'Neill needed to go to hospital due to the combination of the alcohol intake and head injury.

[25] She told Dr Rae that there would be a 2-3 hour waiting time for an ambulance. She made that estimate based on other calls which had been triaged but did not have access to details of ambulance availability. Once this likely wait was explained, Dr Rae expressed surprise to her and then went on to discuss other means of transport as an option. Her evidence was that she had no recollection of any argument or disagreement with Dr Rae, or Dr Rae insisting on an ambulance being sent. Her evidence was that Dr Rae took responsibility and said that they could manage without further assistance. When the call ended, she was not expecting the patient to attend hospital by taxi.

[26] Her oral evidence that the call ended on the basis that Mr O'Neill was not going to hospital as Dr Rae would be looking after him at Carbeth, differed to her written answers which included the following:

> "Q92. Do you accept that having made a clinical decision to transfer him to hospital this should have been done?
>
> A92. Yes but I believe Dr Rae was going to facilitate that.
> ……
> Q105. You state that Dr Rae did not request an ambulance Do you adhere to that?
> A105. She did want an ambulance, but she didn't become argumentative or insistent when I had gone through the assessment and we then discussed the options for any alternative transportation as I believed we both agreed the patient needed to be reviewed in hospital.
> …..
> Q117. Why do you say the Mr O'Neill was not transferred to hospital?
> A117. Because I believed that Dr Rae was arranging transport for the patient.
> ….
> Q119. Why did you not follow your own clinical decision/judgement on this since both red flags remained even if the bleeding had stopped?
>
> A119. I did because I believed that transport was being arranged.

> Q120. Do you accept no matter what was said about dealing with it you could have dispatched an ambulance as in your clinical judgement an ambulance was needed?
>
> A120. No – An ambulance wasn't dispatched because another means of transport was being arranged. If there had been no other transport I would have arranged an ambulance. It would be for colleagues who dispatch to allocate the dispatch of ambulance.
>
> Q121. You say that Dr Rae made the decision that he should not go to hospital. Did you agree with that decision?
>
> A121. I understood that we both agreed that he needed to go to hospital."

[27] Ms Noden signed off the question & answer document with a declaration that the statement was true to the best of her knowledge and belief. Ms Noden was asked why her oral evidence differed from her evidence in the Q & A. It was put to her that it was only when the stop code was recently brought to her attention that she realised that her evidence from the Q & A could not stand. If it had been left with Dr Rae that the patient would travel to hospital by taxi, a different stop code would be used. Ms Noden agreed that her answers in the Q & A document with regard to Dr Rae arranging a taxi were wrong. She had been mistaken how the call had been closed.

[28] As she had not spoken to Mr O'Neill, and had not heard him speaking during the call, she was not aware that he was refusing to attend hospital. She said that had she been aware that he was refusing to attend hospital she would have tried to persuade him to go. Ms Noden accepted that she did not establish what type of medication had been prescribed to Mr O'Neill in relation to his stroke and that she ought to have done this. Her evidence was that she simply assumed he was on anti-platelet medication for the previous stroke without confirming that.

***Mr Michael Jackson***

[29] Michael Jackson is a consultant paramedic employed by North West Ambulance Service NHS Trust. He qualified as a paramedic in 1987 and has been a consultant since 2012. There are approximately 15 consultant paramedics in the UK. His role involves supervision, training and leadership functions and he maintains a clinical practice with weekly shifts working with advanced paramedics. Mr Jackson prepared a report on this case in July 2024.

[30] Mr Jackson explained that the JRCALC guidance contained a "conveyance decision tool" for head injury cases which categorised "red criteria" cases which required immediate transport to hospital. The relevant part of the guidance states:

> Immediately transport to hospital if any one of the following is found:
>
> - Any loss of consciousness as a result of the injury
> - …..
> - Amnesia for events before or after the injury
> - ….
> - Current anticoagulant therapy such as warfarin (see further detail below)
> - Current drug or alcohol intoxication
> - …..
> - No one is able to observe the injured person at home
> - ….
>
> ….Patients undergoing anti-platelet therapy do not automatically require assessment in hospital. Have a lower threshold for conveyance of patients on dual anti-platelets and refer to local procedures. Common anti-platelets include:
>
> ….Clopodogrel

[31] Mr Jackson explained that if a patient was on anti-coagulant medication then transfer to hospital was mandated but if the patient was on anti-platelet medication alone then that was a factor in deciding whether to transfer to hospital. His opinion was that Ms Noden

required to refer Mr O'Neill to hospital in terms of the guidelines as he had sustained a head injury; was intoxicated; and it was not established that someone would be supervising him overnight. The fact that the external bleeding may have stopped made no difference. The risk of internal bleeding was the more significant concern which needed to be checked out.

[32] Mr Jackson described the call back by the advanced paramedic as being designed to probe and explore the patient's symptoms in greater detail. The patient should be spoken to in order to explore both the patient's symptoms and their capacity. The paramedic should record their findings and decision. Ms Noden's note was not in the usual format and it was very brief. She made no record of any assessment of loss of consciousness. There was no note that he was on anti-platelet medication.

[33] Mr Jackson's evidence was that if a patient was assessed as meeting the red criteria which mandated transfer to hospital but was refusing to do so, that refusal should be recorded. In that situation, the paramedic should try to persuade the patient to attend hospital by explaining the risks of not being medically assessed at hospital. This was a common part of the paramedic's job and they were often very skilled at persuading patients to attend hospital. In some situations, family and friends can be used to help persuade the patient.

[34] In Mr Jackson's opinion, there was a failure on the part of Ms Noden to properly assess Mr O'Neill as well as a failure to transport him to hospital on the 27 June.

Mr Jackson's evidence was that the advanced paramedic retained responsibility even where a medically qualified bystander was with the patient. A medically qualified bystander could not override what the advanced paramedic determined was the appropriate course of action. He disagreed with Professor Deakin that Ms Noden was entitled to accept any assurance given by Dr Rae.

***Dr Stephen Hearns***

[35] Dr Hearns is a consultant in Emergency & Retrieval Medicine with NHS Greater Glasgow & Clyde. He has 20 years' experience in working with, training and assessing paramedics, advanced paramedics and paramedic practitioners. He prepared an expert report dated 15 May 2024 which he adopted as part of his evidence.

[36] Dr Hearns was critical of the note made by Ms Noden following the second 999 call. He considered that the note was brief and omitted critical pieces of information. It failed to include any reference to important matters such as loss of consciousness or whether an assessment was made on amnesia. Nor did the note describe the size or location of the wound or the nature of the bleeding. The note ought to have identified the medication that Mr O'Neill was taking. If a patient was on an anti-coagulant medication, it would be vital to conduct a CT scan. Mr O'Neill was on an anti-platelet medication which presented a lower risk than anti-coagulant medication but, nevertheless, it increased the risk of uncontrolled bleeds and was likely to have been a contributory factor in his death.

[37] Dr Hearns considered that it was vitally important for a paramedic to speak directly to the patient if at all possible. That would allow a better assessment of the level of intoxication and the patient's recollection of events. In assessing a possible brain injury, you would want to assess retrograde and antegrade amnesia.

[38] He considered that the head injury and intoxication necessitated assessment at hospital. The fact that the external bleeding had stopped did not alter the need for an assessment as internal bleeding or bruising inside the skull remained a possibility.

[39] The person triaging the patient was responsible for that decision. A medically qualified person at the scene may be able to provide important information to the person

conducting the remote triage but it would depend on the background knowledge, skills and experience of the person at the scene.

[40] Dr Hearns' report explained the care which would have been provided by an ambulance unit and then within a hospital setting if Mr O'Neill had been transferred to hospital. Mr O'Neill died from blood loss from a 1cm diameter scalp wound. The risk of further bleeding from that wound would have been removed by the application of sutures or staples. If necessary a blood transfusion could have been carried out if there had been significant loss of blood. In Dr Hearns' opinion, Mr O'Neill would have survived if he had been treated in hospital with relatively basic wound care.

[41] If a person refused to go to hospital, good practice would be to assess their capacity to decide. If they have capacity, you would explain the risks and try to persuade them to attend hospital.

[42] Dr Hearns had seen an ambulance service dispatch audit for that evening which identified that an ambulance was available and could have attend to Mr O'Neill within 17 minutes of the call.

***Professor Charles Deakin***

[43] Professor Deakin is a consultant in anaesthesia and intensive care and a medical director of the South Central Ambulance Service NHS Trust. He is a member of the Joint Royal Colleges Ambulance Liaison Committee and has contributed towards the JRCALC guidelines since 2006. Professor Deakin's report was dated 26 October 2022. As he acknowledged in evidence, it was prepared on the assumption that the facts were as stated in Ms Noden's initial statement. He did not have access to Dr Rae's statement at the time of the preparation of his report although he had seen the defender's SAERdocument which

included a degree of input from Dr Rae. He had also listened to the oral testimony of both Dr Rae and Ms Noden.

[44] Professor Deakin explained that intoxication, in the context of the JRCALC guidelines, was somewhat subjective. The guidelines were seeking to identify people with a degree of intoxication which might be masking symptoms from a head injury. A person who had been drinking but who was assessed as alert and orientated would be viewed as being at low risk of having sustained a head injury. Intoxication in the guideline was looking at an individual whose functioning in terms of thought or speech was clearly impaired such that their ability to communicate was poor. Ms Noden had information which indicated that Mr O'Neill's level of intoxication was not clinically significant. He had been described by Dr Rae as alert and orientated. He passed mini-mental tests and was also able to tell Dr Rae that he had a pre-existing right sided weakness when she carried out a basic neurological assessment. Professor Deakin did not think that the evidence indicated that Mr O'Neill's level of intoxication mandated transfer to hospital in terms of the guideline. He thought that Ms Noden had mis-interpreted the guideline in this regard.

[45] Professor Deakin's opinion was that a doctor at the scene took primacy over a paramedic assessing the patient remotely. It was reasonable for the paramedic to rely on the accuracy of the information passed to them by an on scene doctor. He considered that it was inconceivable that a paramedic operating remotely would seek to overturn the decision taken by the on scene doctor. Ms Noden was entitled to accept any assurance given by Dr Rae that she could manage Mr O'Neill's wound on her own. If Dr Rae said that no ambulance was required, Ms Noden did not fall below the standard of reasonable care by accepting that statement. Conversely, if Dr Rae asked for an ambulance to be sent, Professor Deakin would expect that to be actioned. If Ms Noden had been speaking to a lay

member of the public then he would agree that it would be appropriate to speak directly to the patient at some point but, in the particular circumstances of this case, there were advantages having Dr Rae acting as the conduit.

[46] Professor Deakin considered that the core aspects of Ms Noden's notes were satisfactory, albeit brief. However, she should have confirmed the medication which Mr O'Neill was on. In response to a question from the court, Professor Deakin described Ms Noden as taking a "big risk" by simply assuming that he was on anti-platelet medication as opposed to anti-coagulant medication. It would have been helpful to also record the findings in relation to any loss of consciousness but, in this case, the details provided via Dr Rae were reassuring and suggested no loss of consciousness.

**Pursuers' submissions**

[47] The pursuers lodged a detailed written submission and I do not propose to repeat the detail of the submission. On the factual evidence, I was asked to find that Dr Rae was a credible and reliable witness. In particular, to find that she did not stand down the ambulance or indicate that she could look after the patient. I should also find, on the basis of Ms Noden's evidence to the court and the guidelines, that the combination of a head injury and intoxication required Brian O'Neill's transfer to hospital for assessment. I should not accept Ms Noden's evidence where it differed from Dr Rae's evidence. The written submissions at paras 56-61 set out an analysis of how it was said Ms Noden's account had evolved over time.

[48] Depending on the view which the court took of the factual evidence, the expert evidence might not affect the court's decision. If the expert evidence was relevant, I was asked to note that Mr Michael Jackson was the only practising paramedic. His evidence was

that Mr O'Neill was intoxicated with a head injury, and that Ms Noden failed in her duty to send an ambulance to convey him to hospital for assessment. Dr Hearn's evidence was relevant in relation to the care which he would have been likely to receive at hospital and his high chances of survival. Both experts were critical of Ms Noden's assessment. Ms Noden required to apply her independent judgment and if her view was that the patient needed hospital assessment, her duty was to dispatch an ambulance to achieve that. In relation to the evidence of Professor Deakin, it was submitted that his role as a medical director of an ambulance service was not akin to a paramedic. He was not an appropriate expert in this case and, at times, had strayed beyond the role of an expert witness. Professor Deakin had added a gloss to the word "intoxication" found in the red criteria of the JRCALC guideline which should not be accepted.

[49] It was submitted that causation was established from the evidence that Mr O'Neill was content to go to hospital until the 2-3 hour delay was mentioned. The 2-3 hour time delay was wrong as was now accepted in the SAER document and by the experts for both parties. The court should find that Mr O'Neill would have gone to hospital if Ms Noden had not provided erroneous information. In any event, there was evidence from Mr Jackson and Dr Hearns that paramedics are commonly tasked to persuade patients to attend hospital and such persuasion is often successful.

**Defender's submissions**

[50] The defender submitted that the dispute was a narrow one which could be encapsulated in two sequential questions, namely (1) did Dr Rae tell Ms Noden that she could manage Mr O'Neill's wound and he did not require an ambulance, and (2), if so, was Ms Noden entitled to accept that assurance from Dr Rae. There was no dispute that a duty

of care was owed by the defender to Mr O'Neill and that the standard of care expected of Ms Noden was determined by an application of *Hunter* v *Hanley* 1955 SC 200 and *Honisz* v *Lothian Health Board* 2008 SC 235. On this second question, the defender was not seeking to suggest that Dr Rae's actions amounted to a breach of any duty of care which she might have assumed to Mr O'Neill. Rather, the defender's position was that Ms Noden had fulfilled her duty of care when she received an assurance from a medically qualified person that she was able to cope with Mr O'Neill's injury.

[51] Dr Rae's evidence should not be accepted as credible and reliable on certain aspects. It was submitted that there was an inconsistency in her account which was exposed by reference to an admission made in the pursuers' pleadings. The admission in the pursuers' pleadings at p12D-E was to the effect that Ms Noden had advised Dr Rae that an ambulance would be dispatched albeit with a delay, which was said to conflict with Dr Rae's evidence in chief that Ms Noden had not offered to send an ambulance. It was submitted that her evidence of being dismayed by an ambulance not being sent was inconsistent with the fact that she subsequently left Mr O'Neill unsupervised in his hut and did not make further attempts to obtain an ambulance by re-dialling 999. It was also submitted that there were significant differences between Dr Rae's testimony and her account contained in the SAER document. Finally, it was suggested that Dr Rae may have unwittingly overstated certain issues, such as whether she was concerned about internal bleeding during the second 999 call, as she saw her role as advocating for Mr O'Neill's family. Conversely, it was submitted that Ms Noden's evidence was internally and externally consistent. The court should accept Ms Noden's evidence and, in particular, should find that Dr Rae told her that she could manage Mr O'Neill's injury without ambulance assistance.

[52] On the second question posed at the outset of the defender's submission, the court should accept Professor Deakin's explanation that a paramedic carrying out a remote triage was entitled to rely on the assessment made by a medically qualified bystander including a conclusion that further assistance from the ambulance service was not required. There was little separating the various experts as the pursuers' experts also accepted that the paramedic in such a situation must have regard to the information passed to them by the medically qualified bystander. It was said to be illogical for the pursuers' experts to accept that Ms Noden could have regard to Dr Rae's assessment of Mr O'Neill's condition but that she was not entitled to accept Dr Rae's assurance (if such an assurance was given) that she could manage without ambulance assistance. Professor Deakin was a suitably skilled witness who provided input into the JRCALC guidelines. His evidence should be accepted. Even if the court was not willing to positively accept Professor Deakin's conclusion on this point, his opinion demonstrated that there was a respectable body of professional thought which supported Ms Noden's course of action.

[53] The court should not be satisfied that causation had been proved. The evidence indicated that Brian O'Neill had set his mind against attending hospital that evening. The court should find that Mr O'Neill would not have accepted assistance via an ambulance and he would not have attended hospital.

**Discussion**

[54] There are important differences between the evidence of Dr Rae and Ms Noden in relation to the second 999 Call. I am satisfied that Dr Rae's recollection of the call is significantly more complete and accurate than Ms Noden's. There are a number of reasons for that conclusion. In the first place, Dr Rae was recollecting traumatic events which she

witnessed first hand. She knew early on the 28th June 2020 that Mr O'Neill had died and she gave a police statement that morning. The significance of what was discussed in the second 999 call would have been clear to her less than 10 hours later. By way of contrast, Ms Noden was trying to recollect the detail from one 999 call from a busy shift during the early stages of the covid pandemic. She was not advised of Mr O'Neill's death until August/September 2020. I accept that she has some recollection of the call insofar as it would have been unusual to be speaking to a psychiatrist during a 999 call, but it is inherently less likely that she can recall the specific detail of the call where a number of months elapsed before she was asked to reflect on that night.

[55] In the second place, Dr Rae gave her evidence in a straightforward manner and, despite the defender's criticisms which I shall return to in paragraph [58] below, there were no significant inconsistencies brought out between her testimony and anything she had said previously. Ms Noden's evidence to the court did differ significantly from her evidence in the question & answers document. So, while her evidence in court was that Dr Rae gave an assurance that she was able to cope with Mr O'Neill without hospital assessment, the import of her various answers to the written questions was that she and Dr Rae agreed that Mr O'Neill needed hospital assessment and Dr Rae would action this via a taxi. I do not accept that Ms Noden simply got muddled about the taxi discussions when she produced this Q & A document. Her evidence in court and her evidence in the Q & A document purport to recall fundamentally different outcomes for where Mr O'Neill was to be treated. It is concerning that Ms Noden provided a misleading version of events on such a critical issue in a document which was submitted to the court with a statement of truth declaration. At the very least, it suggests a lack of clarity in her own recollection about the discussions which took place that evening.

[56] In the third place, Ms Noden accepted that she did not identify the specific medication which Mr O'Neill was on. Her evidence was that she simply assumed he was on anti-platelet medication. Professor Deakin agreed that she was taking a big risk in not clarifying his medication. It was also accepted by the expert witnesses that her note of the call was brief and did not follow one of the standard formats which paramedics are taught to use. Ms Noden could not recall if she asked whether Mr O'Neill lost consciousness although she believed she would have asked that standard question. All of this suggests to me that Ms Noden was not as thorough in the conduct or recording of her triage assessment as she should have been. I infer from that that Ms Noden's attention to the detail of what was discussed in the second 999 call was sub-optimal which further causes me to doubt her recollection of events.

[57] Overall, while I felt that Ms Noden was trying to do her best to recall matters accurately, it seemed to me that she was trying to rationalise her original decision which, with the benefit of hindsight, she now appreciated was inconsistent with the JRCALC guideline.

[58] I was not persuaded by any of the specific criticisms made by the defender of Dr Rae's evidence. I shall deal with these criticisms briefly. My note of Dr Rae's evidence in chief is that in response to the question "Did they offer an ambulance to come to get Brian?" her answer was "No, well vaguely, by saying they could but it would be 3 hours". In cross-examination, she was taken to the admission in the closed record and it was put to her that at the outset of the call Ms Noden must have been intending to send an ambulance. My note of her response was "Yes initially Elaine was sending an ambulance but as soon as she said 3 hours it changed. You could say she was willing to send one but also could say she wasn't". I do not detect any change of her position as she moved from examination in chief

into cross-examination as suggested by the defender. Rather, her position was consistent that the possibility of sending an ambulance was notionally on the table but, in Dr Rae's opinion, it felt that Ms Noden was doing her best to take it back off the table. The attempt to suggest an inconsistency between the pleadings and Dr Rae's evidence rather falls flat when it is remembered that these are not pleadings put forward on behalf of Dr Rae. She has no control over the pursuers' pleadings. Indeed, in this case, the written statement from Dr Rae was not provided by her directly to the pursuers' legal advisers but was prepared and submitted by solicitors employed by her medicaldefence society very shortly before the proof before answer. In such circumstances, seeking to equate an admission on record with a prior statement made by her is not appropriate. In relation to the observation that she cannot have been that concerned about the need for Mr O'Neill to be assessed in hospital as she did not seek to re-dial 999 later that evening, I consider that Dr Rae adequately answered that point in her evidence. When this was put to her in cross-examination, her response was "What was I meant to do? If I called back with the same information, they won't change the decision". The submission that her evidence was inconsistent with her account narrated in the SAER document does not convince me. It was put to her in cross-examination that the SAER document did not record her expressing concerns about the internal bleeding or her being dismayed by the decision not to send the ambulance. Her response was "No it doesn't say that but the person who wrote that knows my views and that is how they summarised it. I didn't produce this document". She accepted that she provided information for this document but qualified that by saying "I didn't write it. It misses things". The individual who spoke to Dr Rae for the purposes of the SAER was not led as a witness by the defender. The strength of a criticism that a witness made a prior inconsistent statement (or more properly here, failed to make a prior consistent statement)

depends, to a large extent, on the circumstances in which the prior statement was made. The SAER was not produced by Dr Rae although she said she had read it at some point. If the defender considers that Dr Rae gave a fundamentally different account of the second 999 call to the author of the SAER, it would have been far better to hear from the individual who spoke to Dr Rae to set up exactly what Dr Rae is alleged to have told him. Finally, in relation to the suggestion that Dr Rae may have overstated some parts of her evidence as she had assumed an advocacy role for the family, I simply do not accept that criticism of the witness. That was not the impression I gained from the manner in which she gave her testimony. Dr Rae did say at one point that she felt the "need to advocate for Brian's family" but she clarified in re-examination that she was using the word "advocate" in the sense that her fellowship training emphasised the role of a doctor was to advocate for patients and families.

[59] Having determined that Dr Rae's evidence is to be preferred to Ms Noden in relation to the second 999 call that has the following consequences. I find that Mr O'Neill was intoxicated and that his presentation when Dr Rae assessed him reflected the fact that he was under the influence of alcohol. He was co-operative but his speech, both in manner and content, was adversely affected by alcohol. I find that the call was relayed through the speaker facility on the mobile phone so that Mr O'Neill could hear Ms Noden and she was potentially able to hear any responses from him. There is no doubt that the first 999 call was dealt with in that manner and it seems inherently likely that the second 999 call would likewise. I find that early on in this short call, Ms Noden did mention a delay of around 2-3 hours for an ambulance to attend. This information was volunteered by Ms Noden before Dr Rae had advised Ms Noden of her assessment of Mr O'Neill. The order of Ms Noden's own note of the call supports that conclusion. The 2-3 hour delay was an estimate which

Ms Noden made on the basis of information on her computer screen but she did not have access to dispatch information for ambulances. Her estimate was, in fact, very inaccurate. Dr Rae did question the extent of the delay and emphasised that she considered Mr O'Neill needed to be assessed at hospital but, by this time, Ms Noden was aware of Mr O'Neill's reluctance to wait for an ambulance and made clear that she would not be sending an ambulance. There was a discussion about taking Mr O'Neill by a taxi but he was also unwilling, by this time, to consider that. Ms Noden did not carry out an assessment of Mr O'Neill. She did not identify the medication he was on. She did not seek further details regarding important matters such as periods of amnesia. Crucially, at no time did she advise Dr Rae that he presented the level of risk which necessitated hospital assessment in accordance with the guidelines which she operated to. If that was truly her conclusion at the time, as she told the Court, she did not articulate that to Dr Rae or Mr O'Neill. Nor, after becoming aware that Mr O'Neill was refusing to be transported to hospital, did she try to persuade Mr O'Neill directly, or through Dr Rae, that he should re-consider that refusal since it was in his best interests to be medically assessed in a hospital setting.

[60] In their submissions, parties were at one that, if I accepted Dr Rae's evidence in preference to Ms Noden's, the inevitable consequence was that Mr O'Neill should have been transported to hospital that evening if he was willing to go. As Professor Deakin afforded primacy for decision making to the doctor at the scene, he considered that an ambulance should have been sent if Dr Rae was saying that one was needed. However, there is one aspect of Professor Deakin's evidence which I need to say a little more on. Professor Deakin expressed doubts as to whether Mr O'Neill's level of intoxication was such to trigger the red criteria under the JRCALC guidelines. To that extent, he disagreed with Ms Noden's own evidence. Mr Jackson and Dr Hearns disagreed with Professor Deakin on this issue.

Without disputing for one moment that levels of intoxication can vary enormously and that the risk of masking of a head injury increases as the level of intoxication increases, I favour Mr Jackson and Dr Hearns approach to the interpretation of "intoxication" in this part of the guideline. Intoxication within the guideline is not qualified either by the word "significant" (which Professor Deakin does at para 8.17 of his report), nor is the paramedic expressly directed to assess whether the intoxication reaches a particular level by reference to the patient's specific communication deficits as Professor Deakin considered appropriate. I consider that intoxication in the guideline means whether the patient is affected by the consumption of alcohol or drugs in how they act. That approach accords with the wording of the guideline but also the context in which the guideline falls to be operated. This is part of a direction tool to guide the paramedic quickly and efficiently towards a decision whether to recommend hospital assessment. It is not diagnostic but rather part of a filter which aims for a relatively consistent application by paramedics. Thus, the various factors for consideration in terms of the red criteria are framed, in the main, in a manner which requires no, or fairly limited, qualitative assessment of the particular factor. As both Mr Jackson and Dr Hearns said in their evidence, when it comes to assessing intoxication in the context of a head injury, it is better for the paramedic to err on the side of caution since the consequences of missing a significant head injury may be serious.

[61] I conclude that Ms Noden failed in a number of duties incumbent upon her. She failed to carry out a comprehensive triage assessment of Mr O'Neill. She failed to advise Dr Rae or Mr O'Neill that his presentation raised red flags which indicated that a hospital assessment was required that evening. She failed to send an ambulance despite knowing that alternative transport to hospital had not been arranged. Nor did she make any attempt to persuade Mr O'Neill of the need to attend hospital once she became aware that he was

reluctant to attend. For the avoidance of doubt, I do not find that Ms Noden breached any duty of care when she mentioned the possible time delay in an ambulance being sent. It was not a wise thing to say at the outset of the call and it was certainly inaccurate but I did not hear any expert evidence to the effect that an advanced paramedic practitioner should avoid all discussion of potential delays.

[62] The defender made a submission that causation had not been established. This was on the basis that there was no evidence that Mr O'Neill would have attended hospital even if Ms Noden had actioned an ambulance. I reject this argument and consider that the pursuers have proved the causal link between the failures of the defender's employee and the death of Mr O'Neill. I accept Dr Rae's evidence that Mr O'Neill was a co-operative patient who was happy for a 999 call to be placed. He could hear that Dr Rae was asking for an ambulance to be sent as she considered he needed a medical assessment beyond that which she could carry out. It was only when the erroneous 2-3 hour delay was first mentioned that his attitude shifted. But I consider that it is also highly likely that his change in attitude was also influenced by hearing Ms Noden who gave the impression that she was satisfied that he could remain where he was. If Ms Noden had explained to him that he needed an assessment to stitch/suture the external injury; check for a potential brain injury; and exclude the risk of internal bleeding in the light of his anti-platelet medication, then I consider it more than likely he would have followed that advice. Such advice from Ms Noden would have been consistent with Dr Rae's advice. If faced with the same advice from both women, I think it very likely he would have followed that advice and would have agreed to be transported to hospital either by ambulance or taxi. The evidence from both Dr Hearns' and Professor Deakin's reviews of dispatch information was that an ambulance, if actioned at the end of the second 999 call, could have been at Carbeth within a relatively

short period of time. Based on the unchallenged evidence of Dr Hearns, if Mr O'Neill had been assessed at hospital, basic wound repairs would have resulted in the head laceration being sutured or stitched and he would not have suffered the loss of blood which led to his death.

[63] The pursuers' case was based on Dr Rae's recollection of the second 999 call being accepted. There was no alternative case based on Ms Noden's version of that call. The interesting issue of whether, on Ms Noden's evidence of the second 999 call, she had discharged her duty of care by accepting the assurances of a medically qualified bystander only arose as part of the defence to this case. It is unnecessary for me to resolve that issue and I do not propose to say much about it other than some very general remarks. The defender's submission was that the issue of whether a paramedic discharged their duty of care where they relied upon assurances from a medically qualified bystander was distinct from the question of whether the medically qualified bystander owed a duty of care. As such, it was not necessary for the defender to seek to convene Dr Rae into these proceedings. However, on reflection, it seems to me to be very difficult to answer the second question posed at the outset of the defender's submission without some consideration of the circumstances in which a medically qualified bystander assumes a duty of care to the member of the public and the scope of any such duty assumed. I was not addressed on this in any level of detail. It also seems to me that the interplay between duties owed by trained personnel carrying out a remote triage and any duty owed by a medically qualified bystander, raises interesting issues of informed consent on the part of the patient. If there are different views as to the appropriate course of action, is it correct that one individual defers to the other individual in terms of some established hierarchy without the patient being informed of the merits and risks of the different courses of action? None of this was

analysed in the present case. I would also observe that, ultimately, I found the evidence of Professor Deakin and Mr Jackson on this matter of who took primacy to be of limited value. Neither gave evidence of an established practice within triaging systems in 2020 as to how such differences of view fell to be resolved. Both gave their own views of what they thought ought to happen but such evidence does not assist the court to any real extent. Ms Noden herself said that she had received no training by June 2020 on how to deal with the situation of triaging a patient who is being attended by a medically qualified bystander. For these reasons, I do not consider that the evidence led, or the legal submissions made, were sufficient to make it worthwhile expressing even an *obiter* view on the interplay between the duties of care owed by a paramedic and the assistance offered by a medically qualified bystander.

**Disposal**

[64] I shall sustain the first and second pleas in law for the pursuers, repel all of the pleas-in-law for the defenders, and shall grant decrees in the following terms:

(a) decree for £13,212 to the first pursuer as executor in terms of conclusion 1.

(b) decree for £277,875.73 to the first pursuer in terms of conclusion 2.

(c) decree for £52,452 to the second pursuer in terms of conclusion 3.

(d) decree for £20,981 to the third pursuer in terms of conclusion 4.

(e) decree of £20,981 to the fourth pursuer in terms of conclusion 5.

(f) decree of £52,452 to the fifth pursuer in terms of conclusion 6.

(g) decree of £20,981 to the sixth pursuer in terms of conclusion 7

(h) decree of £52,452 to the seventh pursuer in terms of conclusion 8

(i) decree of £11,656 to the eighth pursuer in terms of conclusion 9.

As per the motion in the pursuers' written submissions, I will award interest on these sums at the judicial rate of interest from the date of this decision until payment. I shall leave it for parties to inform the clerk of court as to the disposal of any outstanding issues of expenses in this case for inclusion in a final interlocutor. In the event that parties are unable to agree on the issue of expenses, the matter will be put out by order.

**Coda**

[65] I wish to add a final observation. In this case, the defender did not formally seek to apportion blame to Dr Rae for the death of Brian O'Neill but they did seek to elide their own responsibility by claiming that Dr Rae had voluntarily assumed responsibility for Brian O'Neill's care that evening. One possible implication of the defender's approach was that Dr Rae made a judgment call which overrode Ms Noden's own view and that this led to Mr O'Neill's death. It was apparent to me from watching Dr Rae give her evidence, that she was conscious of this implied criticism and felt scapegoated by it. Regardless of that, Dr Rae made herself available as a witness despite moving from this jurisdiction and she appeared to answer all questions to the best of her ability. In my opinion, Dr Rae should be commended for everything she sought to do that evening and the next morning for Brian O'Neill. She did not hesitate to go to his aid when she heard that he had been injured. Her judgment that he ought to be assessed at a hospital has, sadly, proved to be only too correct. I hope it is clear from this Opinion that I do not accept as accurate any suggestion made by the defenders that Dr Rae gave an undertaking or failed to follow through on any undertaking made that evening.