OUTER HOUSE, COURT OF SESSION

[2019] CSOH 42

A848/15

OPINION OF LORD CLARK

In the cause

(FIRST) FRANCIS HUGHES; (SECOND) JACQUELINE HUGHES; (THIRD) GARY HUGHES; (FOURTH) NATALIE HUGHES; (FIFTH) BRIAN HUGHES; and (SIXTH) FRANCIS HUGHES JNR

Pursuers

against

TURNING POINT SCOTLAND

Defender

Pursuers: Sutherland QC, Nicholson; Drummond Miller LLP
Defender: Dunlop QC, Manson; Brodies LLP

17 May 2019

Introduction

[1] Turning Point Scotland, the defender in this action, is a charity which operated a facility known as "Link Up" at 112 Commerce Street, Glasgow. Link Up provided a service for people who were homeless or sleeping rough and experiencing a crisis, including as a result of addiction to alcohol. On 1 July 2013 at approximately 12.40 pm Francis Hughes, a 34 year old man with a history of alcoholism, attended at Link Up. He was accompanied by

his alcohol support worker. Mr Hughes wished to use the Link Up service, which offered accommodation and also assistance in withdrawal from alcohol. He had used the service on previous occasions. The initial assessment of Mr Hughes on 1 July 2013 was carried out by Stephen McCourtney, a project worker with the defender. Following the initial assessment, Mr Hughes was admitted to a bedroom in the Crisis Residential Unit ("CRU") within the building at approximately 3.30pm. At around 6.30pm, he was found motionless on the bed and soon afterwards was pronounced dead.

[2] In this action, the father, two sisters, two brothers and son of Mr Hughes seek damages from the defender in terms of the Damages (Scotland) Act 2011 on the grounds that the defender, and separately Mr McCourtney (for whose actings the defender is vicariously liable) failed to exercise reasonable care in their dealings with and treatment of Mr Hughes. These failures are averred to have caused his death. The case called for a proof before answer on the parties' whole averments. In the event that the defender was found liable in damages, quantum was agreed in respect of all of the pursuers, with the exception of Natalie Hughes.

Background

[3] Mr Hughes had suffered from chronic alcoholism for many years prior to his death. He had a history of suffering from alcohol-related seizures. Service users seeking access to Link Up must avoid alcohol consumption if they are to be permitted to use the service and Mr Hughes was aware that Link Up was an alcohol-free facility. He was assaulted in early June 2013 and admitted to Glasgow Royal Infirmary ("GRI"), suffering from a head injury but then discharged on 18 June 2013. On 27 June 2013 Mr Hughes' alcohol support worker,

Marion Kydd, was advised in a telephone conversation with the defender that it could offer Mr Hughes an appointment on 1 July 2013 at 12.30 pm for the purposes of assessing whether he could be admitted to the CRU. At approximately 12.40 pm on 1 July 2013 Mr Hughes attended at Link Up with Ms Kydd.

[4] Mr Hughes had consumed cider earlier that day, although the time when he did so was not known. Between about 12.40 pm and 1.15 pm Stephen McCourtney carried out the assessment of Mr Hughes in the "One Stop" area of the defender's premises. Once the assessment was completed and a decision to admit Mr Hughes was made, Mr McCourtney undertook a Clinical Institute Withdrawal Assessment ("CIWA") for alcohol. This records responses by the person being assessed and observations by the assessor on ten separate points, and results in a score being given on what is called the CIWA scale. Mr Hughes was scored at 24 on the CIWA scale on the basis of the responses he gave to questions put to him and the observations that Mr McCourtney made. Mr McCourtney did not take the blood pressure or pulse rate of Mr Hughes; this was not something done by the defender as part of the assessment process. The CIWA score was understood by Mr McCourtney to indicate that Mr Hughes required alcohol detoxification ("detox") by use of medication such as diazepam, or its equivalent librium.

[5] The defender had arrangements with two doctors, Dr Poole and Dr Gilhooly, both general practitioners, who acted as on-call Voluntary Medical Officers ("VMOs") for the defender. From the inception of Link Up, the VMOs had assisted the defender with certain medical services. Link Up did not hold medication on site, other than the medication which had been prescribed by one or other of the VMOs for use by specific individuals currently

using the defender's service. The defender's "alcohol detox care plan" at the material time provided that the staff should consult with a VMO regarding detox medication.

[6] After having carried out the CIWA score, Mr McCourtney telephoned Dr Poole at 1.15 pm. The contemporaneous notes record that the call was made "to request detox" for Mr Hughes. Dr Poole was not available to answer the call. Mr McCourtney left a message, to the effect that a prescription for detox medication was sought. At 2.30 pm the breath alcohol level of Mr Hughes was tested by using an alcometer. The reading was 0.15 and this confirmed the presence of alcohol. At 3.30 pm the alcometer test was repeated and the result was zero. Mr Hughes advised Mr McCourtney that he was tired and wished to "get his head down". At around 3.30 pm Mr Hughes was admitted to the CRU and shown to a bedroom which had been allocated for his use. Mr McCourtney made two further calls to Dr Poole for the same purpose as the earlier call, one at around 3.00 pm and the other at around 4.15 pm. Again, messages were left. Dr Poole was not available. The CIWA scoring exercise was not repeated. No alcohol detox medication was available for use by Mr Hughes.

[7] Billie McNeill, a work colleague of Mr McCourtney, had observed Mr Hughes going into his bedroom at 3.30 pm. She checked on him at 4.30 pm and noted that he was asleep. At around 5.30 pm she checked on him again. He was in the same position as before and looked as if he was sleeping. Dr Poole called back at around 5.30 pm to say that a prescription had been faxed to a chemist shop near to Central Station in Glasgow. At some point thereafter Mr McCourtney left the defender's premises with a colleague to collect it. Billie McNeill checked on Mr Hughes again at 6.30 pm. He was lying on the bed in the same position as previously. He was still wearing his jacket and had not moved. She became

concerned. She could not wake him. A 999 call was made and a colleague performed CPR on Mr Hughes. Paramedics arrived and Mr Hughes was pronounced dead.

[8] A post-mortem was carried out by Dr Marjorie Turner and a colleague. There was no evidence at post-mortem of any injury to the brain or surrounding tissue sufficient to cause death. Following upon the post-mortem, the cause of death was certified by Dr Turner as "suspected seizure related to alcohol withdrawal".

The issues

[9] In very broad terms, the pursuers' position was as follows. The defender owed a common law duty of care to not assess or admit a person such as Mr Hughes to use its Link Up service. If that was incorrect, then there was a duty to provide a safe system for the admission and treatment of him. Separately, Mr McCourtney also owed a duty of care to Mr Hughes. These duties had been breached, firstly by the defender not having prepared and followed an appropriate protocol or system for dealing with persons such as Mr Hughes, for whose care it had assumed responsibility, and secondly by Mr McCourtney having failed to obtain medication and having failed to call an ambulance, having regard to the CIWA score and the lack of immediate access to medication. The pursuers further contended that had these duties not been breached in this manner, the death of Mr Hughes (however caused) would have been prevented. This was so because if not admitted to the CRU he would have gone on to consume alcohol and thereby avoided withdrawal, or he would have gone to and been treated in an NHS facility or other unit. A seizure was submitted to be the probable cause of death, for a number of reasons based upon the expert

evidence, including that Mr Hughes had a history of alcohol withdrawal seizures. There had been no contributory negligence on the part of Mr Hughes.

[10] The defender contended that it had acted in the capacity of rescuer and therefore that the scope of any duty of care was restricted to ensuring that no additional harm was done to Mr Hughes. If that was not accepted, the defender had not in event breached any duty of care owed by it, nor had Mr McCourtney. In any event, the pursuers' case failed on legal and factual causation. In particular, the pursuers had failed to establish that even if the steps they claim ought to have been taken by the defender or Mr McCourtney had been taken, the death of Mr Hughes would have been prevented. It was further contended that, on the expert evidence, the probable cause of death of Mr Hughes was not an alcohol withdrawal seizure. If that was not accepted, it was not possible to reach a concluded view as to the probable cause of death. If there was liability, there had been significant contributory negligence on the part of Mr Hughes.

[11] The issues in the case are therefore as follows:

(i) what is the nature and scope of the duty of care owed by the defender, and Mr McCourtney, to Mr Hughes?

(ii) did the defender, or Mr McCourtney, breach their duties of care?

(iii) if so, did a breach of duty cause, as a matter of fact and law, the death of Mr Hughes?

(iv) was there any contributory negligence on the part of Mr Hughes?

(v) if the defender is liable in damages, what sum is due to Natalie Hughes?

The evidence

Factual evidence

[12] Evidence was given over a seven day period. The testimony of the factual witnesses was given partly in the form of witness statements or affidavits. For certain factual witnesses the evidence was agreed. Each of the several expert witnesses produced an expert report and gave evidence. The oral evidence of one of the experts who gave evidence on behalf of the pursuer, Professor Jonathan Chick, was taken at a Commission. I have considered in full all of the witness statements and affidavits, the expert reports and the report of the Commission, as well as the oral evidence of the witnesses. I have also considered the productions referred to in evidence, including the articles in the medical and scientific journals and the evidence about those articles given by the experts. In view of the volume of the evidence, and the need to keep this Opinion within reasonable bounds, it would be inappropriate to seek to set out the evidence in detail. What follows is therefore a brief account of the evidence on key relevant matters, with particular emphasis on those parts of the evidence founded upon by the parties.

[13] Jacqueline Hughes is the older sister of Mr Hughes and had a close and loving relationship with him. The assessment form filled in by Mr McCourtney at Turning Point had indicated that Mr Hughes had been rough sleeping, but that was not true. While he didn't have a fixed abode, he always had somewhere to go. In the weeks leading up to his death, he had spent some nights at her house and he had also stayed with their father. Family members lived in the same street and Mr Hughes frequently stayed with them. If he was not in withdrawal from alcohol he would be drinking. He was scared of seizures. Alcohol would stop him having a seizure. He had been to Turning Point before. Medication

was needed because he was scared of seizures or having a fit. Mr Hughes would not have lain down in bed unless he was medicated. She had seen him in the past having hallucinations and shaking in the course of seizures. He did not bite his tongue. If he had known that he would not be getting medication from Turning Point, he would have walked out and had a drink.

[14] Natalie Hughes was the other sister of Mr Hughes. She described the close relationship among family members. He was dearly loved. She was upset by the effects of alcohol on his life and wanted him to get better. She had been devastated by his death. If Turning Point had not taken him in, the family would have given him support. He understood he needed medication if withdrawing from alcohol and if he had been told by Turning Point he was getting no medication he would have left to get another drink. She rejected the possibility of Mr Hughes having been rough sleeping since 18 June 2013; there was "always a door".

[15] Stephen McCourtney had been a project worker at Turning Point for some 12 years prior to the day in question, having previously been a support worker. He had worked in the Link Up service for some nine years. Link Up was a facility for homeless people in crisis. There were 12 beds in the CRU. It provided a facility for librium detox. The main criterion for admission to Link Up was that the person was homeless. Housing benefit was the means by which Link Up was funded. Nurses had worked at Turning Point in the past but that was some years prior to the date of the admission of Mr Hughes. The VMOs came in on Mondays to Fridays, but not at weekends. There was no set time for them to visit. They dealt with the medical needs of the service users. When a person needed a librium detox a VMO would not necessarily attend to assess the person but might simply issue a prescription. To obtain a

prescription, a telephone call was made to a VMO. If one of the VMOs was not available the other could be called. The VMO would fax the prescription to a local chemist. If urgent detox was needed the emergency services could be contacted. Mr McCourtney had completed the defender's "Primary assessment form" in respect of Mr Hughes in the One Stop area after Mr Hughes had arrived at around 12.40 pm on 1 July 2013. Once completed this assessment tool allowed a decision to be made about admission and that matter would be discussed with other team members. That had occurred with Mr Hughes. Mr McCourtney knew Mr Hughes well as he had been in Turning Point a couple of times before and had been in the long stay unit. Mr Hughes had told Mr McCourtney, as noted in the Primary assessment form, that he had been rough sleeping for some two weeks. He had been assaulted on or around 4 June 2013 and had been discharged from hospital on 18 June 2013. There was nothing in the presentation of Mr Hughes to give Mr McCourtney any concerns. The defender's "New patient" form had also been filled in for Mr Hughes and this indicated that he needed a librium detox. Mr Hughes required as part of the defender's policy to stay in the One Stop area until his breath alcohol reading reached zero. A full risk assessment is done after admission to the CRU. An "Alcohol detox care plan" form was completed. Mr McCourtney was aware that abrupt withdrawal from alcohol could be dangerous. He also accepted that *delirium tremens* ("DTs") can be quite damaging. The aim for Mr Hughes was a safe and comfortable alcohol detox.

[16] Mr McCourtney accepted that there could be a risk if a person admitted to the CRU went to sleep. A sudden reduction in alcohol can result in severe alcohol withdrawal. The CIWA score was helpful in that respect. It was correct that the CIWA scoring should be repeated every 1 to 2 hours and that it can give a rough indication as to whether withdrawal

is getting better or not. A CIWA score of 24 was important but not everyone develops the same symptoms. Mr Hughes needed medication. Mr McCourtney was aware of the previous history of seizures. Mr Hughes had been placed on hourly observation. Staff had not been told that a person with a higher risk of developing seizures or in acute alcohol withdrawal should be referred to hospital. The first message left for Dr Poole at about 1.15 pm was that detox was needed for a resident and requested Dr Poole to call back. Mr McCourtney could not recall whether he had told Mr Hughes that he had called the doctor. The protocol at Turning Point was to get hold of the doctor who was on call unless there were major reasons why the worker thought the person should get emergency attention. Nothing gave Mr McCourtney any concern that Mr Hughes needed emergency treatment. When it was put to him that there was no problem in phoning the hospital, he replied that in his experience people did not always get admitted to hospital. He had in the past phoned for hospital admissions for a person in severe withdrawal. Further calls had been made to Dr Poole at around 3.00 pm and 4.15 pm and messages left. Other staff in Turning Point were aware that Mr McCourtney had been trying to contact Dr Poole. Dr Poole called back at 5.30 pm and said that a prescription had been faxed to the chemist. Mr McCourtney and a colleague went to collect the prescription. If Mr Hughes was in alcohol withdrawal it was the beginning of the process and was not severe. When it was put to him that he had failed in providing care, he accepted "with hindsight" that was possibly correct. He accepted that he should possibly have done more. He also accepted, "with hindsight", that as the doctor had not called him back he should have tried to get the other doctor and get Mr Hughes to hospital. However, other senior members of staff saw Mr Hughes and didn't think that he needed medical attention.

[17] In cross-examination, Mr McCourtney adopted his affidavit. Link Up was not a hospital but was a crisis centre with a particular focus on homelessness. It was not a specialist alcohol detox facility such as Castle Craig and had no nurses or doctors. The charity was fulfilling what was perceived to be a gap for homeless people in the Glasgow area. Reliance was placed on the VMOs. It was not unusual to have difficulties in seeking to contact a VMO. No-one had previously died at the centre. He did not think at the time that Mr Hughes was at any risk. He had experience of seeing people in severe withdrawal and Mr Hughes was not in severe withdrawal at that point in time. That was why no ambulance was called. The basis of the CIWA assessment was what the client had said. No-one else expressed any concern about Mr Hughes. Putting hindsight to one side, there was no reason to think that medical attention was needed. In re-examination he stated that he had worked with people in severe withdrawal who needed emergency help and Mr Hughes did not. He accepted that the point to be addressed for a person such as Mr Hughes was to get medication to stop severe withdrawal.

[18] Dr Marjorie Turner is the head of Forensic Pathology at the University of Glasgow. She has extensive experience as a forensic pathologist and has conducted a very large number of post-mortems involving many different causes of death. She had signed the death certificate for Mr Hughes which stated that the cause of death was "suspected seizure related to alcohol withdrawal". At the post-mortem, she had been the lead pathologist and a colleague had provided pathological corroboration. In her view, the fact that she had performed the post-mortem allowed her to give the best evidence of the cause of death. There was no evidence of any significant heart problems or cardiac conditions that could have caused death. While cardiac arrhythmia could not be excluded as the cause of death,

there was nothing found in the post-mortem which indicated a predisposition to it. Mr Hughes did have a fatty liver and metabolic abnormalities of a fatty liver can cause cardiac arrhythmia, but there was a lack of any other evidence pointing towards cardiac arrhythmia. The more likely explanation was a seizure. Where death had been caused by a seizure it was not uncommon to find nothing in the form of positive evidence of seizure at the point of death. Signs such as foaming at the mouth, aspiration of food, the tongue having been bitten, urination or defecation, the bladder being empty or bruising of muscle areas at the side of the neck, were not present in the case of Mr Hughes. But in any event these signs may or may not be present when a seizure has occurred. She was taken through various articles in medical publications. In relation to Dr BouHaidar's conclusions, she did not accept that it was equally possible that the cause was something other than a seizure. In effect, there were three possible causes. The first was a fatty liver causing ketosis but there was no sign of ketosis, so this was unlikely to be the cause. Taking into account that Mr Hughes had a history of alcohol withdrawal seizures that was the more likely cause, but cardiac arrhythmia could not be excluded. A seizure could be unwitnessed.

[19] In cross-examination she accepted that there was simply nothing in the evidence of the results of the post-mortem which pointed to either a seizure or cardiac arrhythmia. Prior to obtaining the results of the neuropathic examination, the cause of death had been viewed as unascertained. If she did not have the background history of Mr Hughes having had seizures, she would not have certified death in those terms. Cardiac arrhythmia can leave traces. If there was no history of seizures she would have put the death down to sudden unexpected death from alcohol misuse (known as "SUDAM"). It would be relevant to

understand the nature of the prior seizures. Her view on the cause of death had been a diagnosis of exclusion.

[20] Dr Thomas Gilhooly has worked as a GP in Glasgow for some 29 years and was a VMO with Turning Point. He was not involved in setting up the Turning Point service in Glasgow. Link Up had always offered alcohol detox but it was not set up to offer a safe haven. He had been involved in discussing what detox regime should be used at Link Up (that is, which drugs and which doses) and the decision was made to use chlordiazepoxide (librium). A scale of dosage was devised. If one of the VMOs could not be contacted by one of the staff at Turning Point, a call could be made to the other VMO. However, on 1 July 2013, he was on holiday abroad. He had not devised a protocol for staff as to which service users could be safely admitted; that would have been a matter for Turning Point. If the CIWA score was over 10, medicine was required to support the detox. The CIWA score of 24 for Mr Hughes showed that he was in the early stages of withdrawal. If a person is very agitated and has a marked tremor, he has to be treated quickly. A CIWA score of 24 was not enough to admit the person to hospital. The CIWA score was subject to what could be described as operator bias or interpretation. The person being scored might exaggerate symptoms. The vast majority of people in acute withdrawal would be agitated and unable to sleep. A service user having a prior known history of seizures was very common: 50% of those who present had this; it was not a "red flag". Detox was not hugely difficult and the vast majority of users could be detoxed in the service unit. It was not appropriate to compare Link Up with an acute hospital service. Link Up was developed on the model used by voluntary or charitable organisations throughout the UK and this had proved to be an essential service to this vulnerable group of patients. Unlike NHS hospital based services,

permanent medical or nursing staff could not be employed. To insist on such cover would lead to the closure of these vital services and put an increased strain on the NHS.

[21] Billie McNeill, who described her job as a practitioner, had worked at Link Up since 2009. She performed similar work to that of Mr McCourtney. She saw Mr Hughes come in and saw him with Mr McCourtney but her first involvement with him was when he went through to the CRU at 3.30 pm. At that point she saw, from a distance, Mr Hughes go into the bedroom with Mr McCourtney and recorded on the observation chart that he was awake. She went to check on Mr Hughes at 4.30 pm because she wondered if he wanted something to eat. He was lying on the bed facing the wall, on his left hand side. When he did not respond she left the room, because she thought he was sleeping. She went back into his bedroom again at 5.30 pm. She did the same thing as before: she knocked the door and went in shouting his name. He was lying in the same position. She made the entries at 3.30 pm, 4.30 pm and 5.30 pm in the observation chart, writing "bedroom asleep" for the last two visits. On each visit, he had not moved or changed position on the bed. The bed covers were not wrinkled at all. When it was getting to about 6.30 pm she had to check him again. She went in and tried to rouse him but could not do so. She went out to get help. There was no one downstairs so she ran upstairs to the long stay unit to tell the supervisor. There was a 999 call and the supervisor performed CPR on Mr Hughes. During her time working at Turning Point she had seen five other service users having seizures.

[22] Helen McFadden was the Service Co-ordinator at Link Up. Before admission to the CRU the breath alcohol level of the person had to be zero. Link Up provided an alcohol detox facility for homeless people. If a person showed signs of withdrawal, a VMO would

be consulted. If there was a seizure, a 999 call would be made. She was aware that on the day in question Stephen McCourtney had made several calls to a VMO.

[23] Christine Buntrock was the Operations Manager with Turning Point until her retirement in 2017. She is a qualified nurse. There were two similar services to Turning Point in Glasgow. These services did not have nurses and doctors on site. She had not worked in these services and did not know whether they had exclusion criteria for admission. Even with a CIWA score at 30 she might not give medication if the person looked alright. At Turning Point, medication would be withheld until the breath alcohol was zero no matter what CIWA score was reached. She attended Turning Point in the evening of 1 July 2013 after Mr Hughes died, in order to support the staff. She did not see Mr Hughes but said she was told he that he had been sleeping on his front. She demonstrated a position with his face to the side, on the pillow, and agreed that it was not "face down". Alcoholics can be detoxed in the community by the NHS. There is a detox facility in a few hospitals but otherwise "hospitals tend not to want to deal with this service group. They are more likely to send them to the Link Up facility". People in the Turning Point service group wait in Accident and Emergency ("A & E") for so long that they then just leave. Each detox is different. Turning Point started to monitor blood pressure and pulse from January 2016.

[24] Wendy Spencer has worked with Turning Point since 2001, initially as Senior Operations Manager and then as Director of Operations. She is a registered psychiatric nurse and is responsible for the Turning Point operations across Scotland. Turning Point is an organisation split into Turning Point England and Turning Point Scotland but they are two "unique and separate" organisations. Link Up was a service set up in 1998 and funded

by Glasgow Health and Social Care Partnership. It was a crisis service. The service did and could change to meet requirements of safety. If things required to be introduced to make the service safer that could and would be done. Persons such as Mr Hughes were entitled to a safe system of detox. Link Up was not a medical facility but was very much on the social care model. It was set up to support the most marginalised and vulnerable people in society. It filled a gap in the provision of services. Refusing to deal with people like Mr Hughes would have a significant effect on persons in his position.

[25] Marion Kydd is a Social Care Worker in the field of addiction services, working for Glasgow City Council. Her evidence, in her witness statement, was agreed. She was the Social Care Worker for Mr Hughes from August 2010. Mr Hughes had attended the Homeless Casework Team, run by the Council, but often lived with his father. He had been in a number of units which deal with withdrawal from alcohol, including Eriskay House at Stobhill Hospital in Glasgow, Castle Craig Hospital in Peebleshire and in Link Up. He had also been detoxed while in hospital. She had phoned for an appointment at Link Up for an assessment of Mr Hughes in relation to a possible admission to the unit. She was not aware that he had a history of seizures. She was aware that Link Up offered an alcohol detox, but did not know the details of what that might involve. She had taken others to hospital in the past. She could not remember anything remarkable about how Mr Hughes appeared on 1 July 2013 and she had not recorded that Mr Hughes was unwell. She left the defender's premises once it was decided that Mr Hughes should be admitted.

[26] Dr Carsten Grimm is a general practitioner who holds a number of appointments on groups, councils and societies, including in relation to alcohol and addiction. His witness statement was agreed as being his evidence in chief and he was not called to give further

evidence at the proof. He had been a Voluntary Medical Officer at Turning Point in Smithfield, Manchester for over two years. He explained how that unit operated. Nurses were employed and were on duty "24/7". There was an admission clinic run by VMOs. The nurses would supervise the initial assessment of service users. If a nurse was concerned about a person and could not get a VMO the nurse would transfer the person to hospital. The Smithfield facility was very protocol-driven. Medication was always pre-arranged and available by the time of admission. He explained what he would have done if he had been called as a VMO in relation to Mr Hughes.

[27] Dr Norman Poole is a GP and was one of the two VMOs working for the defender. He provided an affidavit but due to illness he was unable to attend court to give his evidence.

Expert evidence for the pursuers

[28] Dr Stephen Hearns is a Consultant in Emergency Medicine and a Lead Consultant in Emergency Medical Retrieval Service, employed by NHS Greater Glasgow and Clyde. The CIWA score was a tool which had been validated prior to introduction, indicating that it is a reliable tool. A presentation of a person with intoxication is a wholly different presentation from that of withdrawal from alcohol. Reference was made to ambulance response times and the distance between Turning Point and GRI. In relation to the prior admissions of Mr Hughes to GRI, he explained that a person in withdrawal attending A & E can receive diazepam if necessary prior to being assessed by a doctor. When a person arrived in A & E he would be triaged by a triage nurse and observations would be done. A triage nurse could obtain medication for a patient from a doctor if it was thought necessary and give it to

the patient before the medical review. People in A & E normally would also be placed on monitors to record their heart rate which would set off an alarm if there was cardiac arrhythmia. Medication such as benzodiazepines and pabrinex would be given to persons in withdrawal in A & E. It was important that persons such as Mr Hughes be given pabrinex, a vitamin which corrects electrolyte imbalances. The CIWA score or the alternative assessment tool used in GRI, the Glasgow Modified Alcohol Withdrawal Scale ("GMAWS"), would be done in A & E and it is likely that had he attended GRI on 1 July 2013 Mr Hughes' CIWA score in excess of 24 would reflect a GMAWS score of 8. Medication would be titrated to the needs of the particular patient. A person should not die in hospital from having a seizure. Past behaviour on withdrawal was a good predictor for what would happen in a later withdrawal. Mr Hughes was in severe or acute withdrawal on 1 July 2013, based on his CIWA score of 24. He was at particular risk due to his history of alcohol withdrawal seizures and he required treatment in a medical facility. Reference was made to the National Institute for Health and Clinical Excellence ("NICE") guidance of 2 June 2010 and the Scottish Intercollegiate Guidelines Network ("SIGN") guideline 74 from September 2003. The practices at GRI and Castle Craig, as shown in the notes for each, were consistent with a reasonable body of opinion. He accepted that there were variations in practice. The danger zone for those in alcohol withdrawal began at around 6 hours after the last drink. The most common form of seizure found in an alcohol withdrawal context was a "tonic-clonic" seizure.

[29] Dr Barry Vallance is a Consultant Physician and Interventional Cardiologist, now retired. He has managed patients in alcohol withdrawal on an acute receiving ward. Had the CIWA score (a validated and reliable tool) been repeated at a time when the breath

alcohol of Mr Hughes was zero, the score is likely to have been higher than 24. The risk period was at first admission. Under reference to the GRI records, the ECG results within the clinical notes were normal. There was nothing in the clinical notes in a number of prior admissions to indicate that any doctor or nurse suggested that Mr Hughes was suffering from any arrhythmia and there was no note of him complaining of palpitations or chest pain. The risk of the condition Wernicke-Korsakoff encephalopathy is the reason that pabrinex is given to persons in alcohol withdrawal. Mr Hughes could go into withdrawal when he still had alcohol in his blood. Had Mr Hughes attended hospital and gone into acute receiving he would not have died there. Dr Vallance's experience was that diazepam could be given to a person in alcohol withdrawal in A & E. The person would be assessed in A & E and would receive treatment there until such time as he was assessed by the acute receiving physician. Medication would then be titrated to the needs of the particular patient and the CIWA score. He supported the view that past behaviour on withdrawal was a good predictor for what would happen in a later withdrawal.

[30] The description given by the sister of Mr Hughes about an earlier seizure was consistent with a tonic-clonic seizure. A head injury can increase the risk of seizure. Not all seizures require the person to thrash about. It was incorrect to suggest that alcohol withdrawal seizures most commonly occur between 24-48 hours after stopping drinking. There was an association between heavy alcoholic drinking and sudden cardiac death. However, heart rates come under control quite quickly when librium is given, perhaps within half an hour. Hospitals had facilities to deal with a seizure should it occur and would also be able to deal with an arrhythmia. In his view the cause of death was a withdrawal seizure. Mr McCourtney should have called an ambulance. Dr Vallance gave

succinct explanations of what could be taken from the various articles in the medical literature which were produced in the case.

[31] In cross-examination, he accepted that the imposition of the pleaded duties would mean, in the future, that the defender would be precluded from much of what it sets out to do, and has done in the past. But this was justified because "one death is too many". He also accepted that what had happened at Castle Craig and GRI, when Mr Hughes had been admitted to these places, showed that there were varying approaches taken when it came to patient scoring and drug administration. While these other approaches would not reflect his own practice, it was reasonable to accept these practices as representing the views and practices of a reasonable body of medical opinion. The most common form of seizure found in an alcohol withdrawal context was a tonic-clonic seizure, which normally involved movement. Librium would in his opinion have fought off the fatal effect of arrhythmia.

[32] Dr Jim Craig is a Consultant Psychiatrist. He had been a consultant in general adult psychiatry in Midlothian from 1980 to 2005 and a consultant in alcohol and addictions at Castle Craig hospital, a private hospital specialising in the treatment of addiction. Each of these posts had involved him in assessing, admitting and managing patients withdrawing from alcohol. Dr Craig was involved in the treatment of Mr Hughes at Castle Craig. The risk period was at first admission. A distinction should be made between the intoxicated person and the person in withdrawal. Mr Hughes could go into withdrawal when he still had alcohol in his blood. The fact that the person had sustained a head injury was important. In Castle Craig, patients are not allowed to sleep when they are admitted. Castle Craig often had referrals from places like Turning Point with more difficult cases. He explained the system that is thought to be safe in Castle Craig. Alcoholics have a positive

drive to drink which is both physical and psychological. He confirmed that Mr Hughes had been diagnosed with an alcohol withdrawal problem in terms of DSM-IV.

[33] Professor Jonathan Chick is a Visiting Professor at the School of Health and Social Care at Edinburgh Napier University and is the Medical Director and Consultant Psychiatrist at Castle Craig hospital. He has very extensive experience in dealing with individuals with alcohol problems. He had chaired the group which was responsible for producing the SIGN Guidance. He was involved with research internationally and he also trains GPs, psychiatrists and other doctors in management of alcohol problems. He has advised the World Health Organisation and the Scottish Health Department. He is trained not only in psychiatry but also in general medicine. He was familiar with organisations such as Turning Point and the services they render.

[34] The CIWA assessment was used universally. It enabled a prediction to be made of what serious medical complications, such as seizures or hallucinations or palpitations, could develop. It was a reliable method of scoring although there could be variations in how people would be rated. The dose of medication to be given is directly related to the CIWA score. Someone with a high CIWA score required to have the CIWA score re-taken more frequently. If the CIWA score was 10 but the person had a lot of alcohol in their body the CIWA score might increase and the CIWA score should be repeated as the blood alcohol level falls. Above a score of 10 medication is given. Medication is titrated up to a point when the CIWA score is below 10. It was important to see that the score is coming down, not going up. The medication requires to be given before a person becomes seriously unwell. He was of the view that if a CIWA score had been taken in respect of Mr Hughes at 2.30 pm, it would have been higher than 24.

[35] The first 24 hours is the important period and the time of the biggest risk when a person is withdrawing from alcohol. Seizures and other physical disturbances occur in the first 24 hours. Someone like Mr Hughes was at high risk of serious withdrawal symptoms. Withdrawal is more severe if the cessation of drinking is abrupt. It is the relative fall in the level of alcohol that is important. Heavy drinkers such as Mr Hughes experience withdrawal as the level falls and will start to withdraw even if there is alcohol in the body. Those who treat people with alcohol problems know they need to start acting to treat the withdrawal symptoms even though there is alcohol still in the body. Mr Hughes' CIWA score on its own was on the "cusp of being life-threatening" and one would want to know if it was coming down. The NHS does take patients that organisations such as Turning Point feel they can't safely accept.

[36] People who have had a seizure in the past are much more likely to have another one the next time they go through alcohol withdrawal. It was well established that there is an increasing pattern for the symptoms to recur the next time. DTs account for the highest mortality and result in fatality in 15-20% of patients, so early detection and prompt initiation of treatment is important to prevent onset. A prior history of withdrawal seizures was one of a number of factors in the clinical history that would be "an alarm bell" independent of the CIWA score. A recent head injury would be a "red flag" as it could increase the risk of seizure. A number of different types of seizure can cause death in withdrawal. He agreed that the dramatic tonic-clonic type of seizure is the commonest type but not the only type. It is recognised that persons who withdraw from alcohol can have temporal lobe seizures or partial seizures and no tongue-biting or incontinence. Seizures can occur before the blood alcohol reaches zero because there has been a relative fall in the level. With a tonic-clonic

type of seizure, it was common to have tongue biting and for the bladder to empty but this was not the position in all cases. He accepted that if Mr Hughes was always lying on the bed in the same position this was a pointer away from a tonic-clonic seizure. It is rare for an alcoholic withdawal seizure to end in death but it could not be said that this type of death does not occur. It is rare to die from a seizure in hospital, when properly managed. There are some types of seizure where you would not see much movement.

[37] Professor Chick agreed that cardiac arrhythmia can occur when a person is in withdrawal. He stated that he had not seen in the records any evidence of that in the pulse charts. He explained the mechanism of arrhythmia. It was a very common experience in people going into withdrawal. The administration of diazepam has no cardio-protective effect in itself but it has an indirect effect by reducing the hyperadreneric and neurotransmitter disturbance of alcohol withdrawal, which is a very potent cause of arrhythmia. Thus, librium would have an effect on cardiac hyperactivity. He did accept the association between heavy alcoholic drinking and sudden cardiac death. It was recognised that alcoholic patients die from cardiac causes with no abnormal findings at post-mortem. There was a growing awareness of SUDAM, in which there was no obvious cause of death.

[38] It was not safe to put someone like Mr Hughes in a room and allow him to go to bed after being admitted without medication. A reasonably competent facility would not allow Mr Hughes to sleep and he would be wakened for observations. The units Professor Chick worked in would follow that practice. A VMO should be consulted in relation to someone like Mr Hughes immediately. The failure to have immediate access to a doctor for such a person was not safe. People with high CIWA scores need access to medication urgently. If medication was not available and alcohol withdrawal diagnosed the person should be taken

to hospital. However, it was reasonable to admit Mr Hughes to Link Up in the expectation that medication would be available. Turning Point should have a protocol for people who should be seen by a doctor. That would be to determine whether, with the facilities they had on site, they could take the person safely. Turning Point had not performed observations of pulse and respiratory rate. If there had been observations and Mr Hughes was suffering a cardiac arrhythmia these would have picked up that he was running a rapid pulse with irregular beats.

[39] When Mr McCourtney did not get the VMO at 1.15 pm another doctor should have been phoned or the patient taken to hospital. Mr McCourtney had to immediately look for medication for Mr Hughes. The decision to wait a few hours for the doctor to attend was open to criticism. Professor Chick accepted that it was not valid to equate Turning Point to a hospital. He had never run such a facility as Turning Point but stated that he had advised facilities similar to Turning Point. He felt he could provide the court with valuable expert evidence on managing alcoholics in withdrawal and causes of death. He had advised about the protocol of a place in Aberdeen and also on the protocol in a place in Inverness similar to Turning Point. Places like Turning Point fill a need and homelessness is a dreadful problem, but the service users must be managed safely. A safe system would require a protocol that there are certain individuals who cannot be managed in the unit.

[40] Professor Chick had read the paperwork and articles produced and these did not cause him to change his view on the cause of death. He remained convinced that it was most likely a seizure, but a cardiac event could explain it. Had Mr Hughes received diazepam within an hour of arrival it is likely that a seizure or even death by cardiac arrhythmia would have been prevented. Professor Chick agreed that the defender was a charity which is trying to help

people, and which is reliant on others for medical assessment. He accepted that there were variations in practice and that in the assessment of what was done on the day in question at Turning Point, reasonable people might reasonably differ.

Expert evidence for the defender

[41] Dr William Morrison is a Consultant in Accident and Emergency Medicine with NHS Tayside and has been in that position for some 24 years. He gave opinion evidence, on behalf of the defender, on the level of care provided by Turning Point and also on the cause of death of Mr Hughes. While a number of published documents made recommendations regarding detoxification and withdrawal from chronic alcohol abuse, where an individual presented in acute withdrawal there was, perhaps regrettably, a discrepancy between recommendations, published standards and practice. It was possible to be critical of some aspects of the assessment and care provided by staff at Turning Point, but he was not of the opinion that the actions or omissions made by the defenders were ones that no other Primary Medical Care Facility acting with ordinary skill would have adopted had they been acting with ordinary care in the circumstances. In his opinion, the criteria for negligence were not fulfilled. The risk of seizures and DTs required to be assessed separately and in conjunction with the CIWA score. Alcohol withdrawal is an extremely unpleasant process for people. The highest risk period was not in the immediate couple of hours after a person stopped drinking. As the CIWA score was greater than 10 that was an indication that Mr Hughes was in more severe withdrawal. A presentation with intoxication is a wholly different presentation from presenting in withdrawal. Prior seizures indicated a good chance of seizures recurring. A head injury under a month prior to death had relevance in

assessing risk. Dr Morrison would not send someone with the risk factors Mr Hughes had to Turning Point. GRI does admit homeless people to hospital for withdrawal. Mr Hughes was admitted on each occasion he presented in withdrawal. He attended and waited for triage on a number of occasions. Dr Gilhooly was wrong to state that detox treatment would not be commenced in A & E. If alcoholics could not get medication they knew that the way to deal with the withdrawal was to get alcohol. Dr Morrison has mainly worked in Tayside and has never worked in a Glasgow hospital but there would be a number of similarities in practice between the two cities. When a person arrived in A & E they would be assessed by a triage nurse; there were guidelines on how quickly a person should be reviewed.

Dr Hearns stated that a triage nurse could obtain medication for a patient from a doctor if it was thought necessary and give it to the patient before the medical review. Dr Morrison agreed that this could happen, as the records indicated. He had managed some patients in A & E in a small facility he had worked at but accepted it was not for any lengthy period. Hospital medication would be titrated to the needs of the particular patient and the CIWA score. It was important that persons such as Mr Hughes have pabrinex. Dr Morrison in his last report accepted an instruction to attempt to compare Turning Point with a primary care facility. He accepted that he had severe reservations about this instruction but he proceeded to do so. He had read the GRI notes. It could not be said that no reasonably competent person would have done what was done by Mr McCourtney and Turning Point here. The delay for diazepam was however unacceptable. But an almost instantaneous administration of medication upon an immediate medical assessment was not realistic. The defender's conduct did not amount to a significant deviation from what trained medical professionals would have done even if the delay in obtaining diazepam might not be regarded as

acceptable. On the balance of probability, the cause of death was arrhythmia. In relation to the past history of seizures, it was not known precisely what these seizures were from a medical perspective. The most common form of seizure found in an alcohol withdrawal context was a tonic-clonic seizure which involved spasms and movements. While it was quite true to say that the absence of certain manifestations of seizure did not automatically exclude seizure, the absence of these tended to support the conclusion that SUDAM presumed to be due to cardiac arrhythmia was the most likely cause of death, based on the full clinical picture, both pathological and historical. It would be unsafe to conclude that the administration of diazepam or similar would have prevented Mr Hughes dying from arrhythmia.

[42] Dr Ralph BouHaidar is a Consultant Forensic Pathologist working for Lothian NHS Trust and the University of Edinburgh, with some nine years' experience in that post. It was in his view possible on the evidence to state the cause of death, on the balance of probabilities, as having been a suspected alcohol withdrawal seizure. However, the evidence suggested that Mr Hughes was not showing signs of withdrawal. It could equally be arguably possible that the deceased might have succumbed to other causes of death which relate to chronic alcohol intake. In light of the absence of a witnessed seizure around the time of death, and the absence of findings at the post-mortem which might support a seizure having occurred (such as foaming of the mouth and in the airways, the possibility of aspiration of food, lung congestion and oedema, a bitten tongue, evidence of urination, an empty bladder and potentially defecation, and haemorrhage at the clavicular junction of the sternocleidomastoid muscles) and the absence of an identifiable acute or traumatic cause of death, it would arguably be best to state the cause of death as complications of chronic and

excessive alcohol intake. This would encompass such other possibilities as cardiac arrhythmia.

[43] Dr Miles Behan is a Consultant Cardiologist at Edinburgh Royal Infirmary. There was no evidence of arrhythmia in the GRI notes either on recording of pulse or on analysis of the notes. There are three sets of ECG results for Mr Hughes within the clinical notes and these were normal, with no evidence of any arrhythmia. There can be signs or symptoms of arrhythmia but these are not always present. Atrial fibrillation is a very common form of cardiac arrhythmia affecting a large amount of the population but it was not relevant to this case. If Mr Hughes died of a fatal arrhythmia, it was not likely to have been a result of atrial fibrillation. There was no post-mortem evidence of the kind of activity commonly seen when there has been a seizure and Mr Hughes had been found in the same position as he had been noted to be in when asleep earlier. While it was impossible to know for certain what was the cause of death on the balance of probabilities it was SUDAM, presumed to be due to cardiac arrhythmia, for all of the reasons given in his report.

Submissions

[44] I have had full regard to the written and oral submissions made on behalf of the pursuers and the defender. It would not be appropriate to seek to set out the submissions of the parties in detail (in part because, in the case of the pursuers, the written submissions were extremely lengthy) and I shall therefore briefly summarise the key points made.

The pursuers' submissions

Existence of a duty of care

[45] At common law the defender owed a duty of care to Mr Hughes. This was not a novel situation. There was an established duty not to act in such a way as to cause foreseeable injury. The defender was aware that the service would be used by persons such as Mr Hughes and that the defender would be caring for some of the most vulnerable members of society. It was reasonably foreseeable that some of those who attended for alcohol withdrawal would have a history of significant abuse of alcohol and would have medical issues and problems both related and unrelated to withdrawal from alcohol that would put them at risk of injury or death. Accordingly, the defender knew or ought to have known that where a person presented to them with a prior history of seizures and DTs when withdrawing from alcohol, such a person could not be safely managed in the unit with the facilities they had. There should have been a clear protocol on who could be admitted to the CRU. With reference to the SIGN and NICE guidance, Mr Hughes was not someone who could be safely managed by Turning Point with the facilities they had. The pursuers' primary position was therefore that someone like Mr Hughes should not have been invited to attend Turning Point for assessment.

[46] If that was incorrect then as soon as Mr Hughes attended Turning Point seeking admission for detox and had been accepted into their system and entered into a relationship with Turning Point, it was recognised in law that a duty of care was assumed. The defender had set up a specific facility with the intention of providing services for persons like Mr Hughes to withdraw from alcohol. In doing so the defender had a duty to set up a safe

system for persons whom it could reasonably be anticipated would be admitted to the unit for detox.

[47] In setting up a safe system for withdrawal from alcohol the defender had the following duties: to instruct staff in the management of users by means of an alcohol detoxification protocol which should have included an instruction on the use of the CIWA score and how to manage persons with a CIWA score in excess of 10; to instruct staff that if they were unable to obtain immediate medication for persons with a CIWA score in excess of 10 such persons required to be sent or taken to hospital for care; to instruct staff that if the defender was only able to offer a service that had social care workers patients who were in withdrawal with a CIWA score in excess of 10 should not be admitted; to provide immediate access to suitably trained medical staff and monitoring by nursing staff or other staff fully trained in the management of patients in withdrawal; and to provide immediate access to medication. There was a duty to risk-assess which people they could take safely into their service, given the facilities they had available at any given time. If the defender was unable to offer a safe system for withdrawal to persons such as Mr Hughes who had a CIWA score in excess of 24 and a previous history of withdrawal seizures and DTs, they had a duty to instruct staff specifically that there should be a hospital referral. The failure to have immediate access to a doctor for someone like Mr Hughes was not safe.

[48] As part of the agreement entered into with Mr Hughes the defender offered Mr Hughes "A Safe Comfortable Alcohol Detox Intervention." In doing so the defender entered into a contract with him that his detox would not only be supported but would be "safe". In the circumstances, the defender assumed responsibility for Mr Hughes and his safety on their premises as he underwent withdrawal. This was not the situation of a

rescuer. In fact, Mr Hughes was provided with misleading information, because the service as just stated could not be provided. The defender was under a duty to provide this to him in the manner the defender stated within its own paperwork. The defender had a duty to have a system where the medication was immediately available. Mr Hughes reasonably believed in accepting and signing for a detox at Turning Point that he would be given a safe detoxification. Mr Hughes would also be required to pay a weekly sum of £492.62 for living in the accommodation from his Housing Benefit and a further contribution per week, for the service being provided. Dr Gilhooly had said that the imposition of the precautions suggested by the pursuer as safe would have an effect on the service and result in the closure of the service. This had no relevance to the issue of a common law duty of care imposed on Turning Point when it accepted Mr Hughes into Link Up. In any event Wendy Spencer stated that if things required to be introduced to make the service safe that could and would be done. No member of senior management at Turning Point provided evidence along the lines of Dr Gilhooly. There have been changes in practice at Turning Point since 2013 and whilst these changes do not amount to an admission of liability they may be useful in assessing what could have been done.

[49] The defender was also vicariously liable for the acts and omissions of Mr McCourtney in the course of his employment with the defender. The case of fault against Mr McCourtney was based on his failure to get immediate medication for Mr Hughes, his failure to appreciate the risks and the need to get Mr Hughes immediately to hospital by ambulance.

Mr McCourtney was not a qualified nurse nor was he a doctor. He was employed by the defender as a project worker. His role was not a complex one as he understood it and it was his duty to obtain medication for Mr Hughes, given the CIWA score. The standard to be

applied to his conduct was that of the average competent well-informed person in his role performing his function. Mr McCourtney was not a medical practitioner and his status was not covered by the professional practice test found in *Hunter* v *Hanley* 1955 SC 200, 1955 SLT 213. Reference was made to *French* v *Strathclyde Fireboard* 2013 SLT 247.

Breach of duty

[50] The defender was clearly in breach of its duty of care. It did not have a protocol advising members of its staff which people could be safely admitted to the service for withdrawal from alcohol. It failed to comply with the offer of a safe and comfortable detox. Professor Chick provided clear and uncontradicted evidence that the defender did not have a safe system for the management of the persons it had elected to take into Link Up. He was clear in his evidence that he was not applying the standard of the hospital but applying a standard of a unit trying to offer the service that Turning Point offered in July 2013. He was well aware of how such facilities work. Dr Grimm's statement explained what is thought to be safe procedure in Turning Point in England. Turning Point in Scotland was set up on a model based on Turning Point in England. Dr Craig had provided the court with evidence of the system that is thought to be safe in Castle Craig. Dr Vallance and Dr Hearns had provided expert evidence on how persons are treated within hospital when they are withdrawing from alcohol.

[51] The weight of all the expert evidence was that Mr Hughes was in severe withdrawal at the time the CIWA score was done. The court should accept the evidence of Professor Chick that the system was not safe unless there was immediate access to medication. Dr Hearns, Dr Morrison and Dr Vallance gave evidence about the importance of persons

such as Mr Hughes having pabrinex. Mr Hughes could not receive this care at Turning Point and that evidence was relevant in an assessment of whether he was ever a suitable candidate for admission to Turning Point. The NICE and SIGN guidance, as spoken to by the experts, support the proposition that Turning Point failed in their duty of care in not having a policy of advising staff about those individuals who could not be safely admitted to the unit.

[52] The defender did not provide suitable expert evidence from which the court could infer that the system it had was a safe system. Reference was made to *Kennedy* v *Cordia (Services) LLP* 2016 SC (UKSC) 59 and *AW* v *Greater Glasgow Health Board* [2017] CSIH 58. The court should reject the evidence of Dr Morrison on the issue of a safe system. His report was a contrived attempt to lead expert evidence to support that the defender had a safe system which even Dr Morrison recognised had significant limitations. He was not an expert in alcohol withdrawal like Professor Chick and he had no experience of units such as Turning Point.

[53] In relation to the case against Mr McCourtney, Professor Chick was clear in his evidence that a competent person in the position of Mr McCourtney would have sent Mr Hughes to hospital when he could not get the VMO. Also, Mr Hughes should not have been allowed to sleep. When he had been assessed and his history recorded, Mr McCourtney should have sent Mr Hughes to hospital by ambulance. Dr Vallance also took that view. In any event by 1.15 pm Mr McCourtney was aware that the CIWA score was 24 and that medication was required. He was aware that Mr Hughes had previously suffered seizures when withdrawing from alcohol and that he had previously suffered from DTs. He was aware that Mr Hughes had suffered a recent head injury. In that situation, he knew or ought

to have known that there were significant risks to Mr Hughes if he failed to obtain medication for him. The only excuse given by him for waiting was that he did not think Mr Hughes looked that bad, despite the CIWA score of 24. Mr McCourtney could not know when he would be able to get a doctor for Mr Hughes and he failed in his duty in not calling an ambulance when he was unable to get Dr Poole at 1.15 pm. It also appeared from the evidence that Mr McCourtney did not advise Mr Hughes that he was having any issues obtaining medication for him. Reference was made to *Darnley* v *Croydon Health Services NHS Trust* [2018] UKSC 50: a misrepresentation could also amount to fault. Had Mr Hughes known that there was a problem getting medication his sister thought he would have done something about it and left. It was put to Mr McCourtney that he had failed in his duties and he had accepted that he had failed. While he did so "with hindsight", he appeared to accept that even without hindsight he had failed.

Causation

[54] If Mr Hughes had not been admitted to Turning Point, he would either have simply continued drinking as he normally did or, if he did not and went into withdrawal, he would have gone to A & E at GRI for help. While it was not possible to specify an exact time when Mr Hughes died, he was last seen alive at 3.30 pm. Had Mr Hughes been referred to hospital, on the balance of probabilities he would not have died either from a seizure or from cardiac arrhythmia. On the evidence, it was anticipated that Mr Hughes would have been at hospital at least before 2.00 pm and would on the balance of probabilities have started to receive medication to control his detoxification. In all of his previous admissions to hospital he had not suffered a seizure or cardiac arrhythmia. Dr Behan stood alone in being

concerned that Mr Hughes would not have survived. Mr Hughes was admitted to hospital on a number of occasions when he presented to A & E at GRI in alcohol withdrawal. The GRI notes confirm that he was reviewed and was given medication in A & E. He received fluids and pabrinex and he had his observations done. He was admitted to the acute receiving ward and he received diazepam and other medication titrated to his needs. On each occasion, when he was admitted in withdrawal he was successfully withdrawn from alcohol. In the numerous attendances in withdrawal when his pulse was taken there was no evidence of any abnormality in the form of an arrhythmia. There was no evidence in the clinical notes of him having a seizure when he was managed in hospital.

[55] The GMAWS protocol does not, as was suggested on behalf of the defender, support holding off treatment until 8 hours after the last drink. Senior Counsel for the defender had inappropriately suggested to Dr Vallance that what was being said in the GMAWS scoring form referred to everyone and not only to those who were intoxicated. The evidence was that persons who have withdrawal seizures are likely to have them in later withdrawal. The past history of withdrawal seizures and recent withdrawal seizures provided powerful support for the contention that the death of Mr Hughes, on the balance of probabilities, was caused by a withdrawal seizure. There was evidence of him having three witnessed seizures around four months prior to his death when he was in withdrawal.

[56] When considering the issue of cause of death, it was important to note that the pursuers' position is that Mr Hughes should never have been in Turning Point in the first place and he should have withdrawn from alcohol in hospital as he did previously, or in one of the units such as Castle Craig where he had also previously withdrawn from alcohol. In any event, Dr Turner's conclusion on the cause of death was corroborated by another

pathologist at the post-mortem. Dr BouHaidar, in his report, narrated a history which was clearly inaccurate. Dr BouHaidar did not suggest a cause of death as SUDAM despite the fact that Dr Turner was inappropriately criticised for not doing so. The evidence of Billie McNeill about the apparent lack of movement of Mr Hughes when on the bed should not be accepted. Dr Turner in her post-mortem report recorded that Mr Hughes was found face down, which was what Christine Buntrock had been told. The fact that Mr Hughes had withdrawal seizures proximate to his death was an extremely important piece of evidence for the court in assessment of the issue of cause of death.

Contributory Negligence

[57] Applying the recognised principles, Mr Hughes was not contributorily negligent in going to Turning Point for help, or in continuing to drink, against a background where he had a recognised psychiatric condition that caused him to drink. He had a diagnosis in terms of DSM-IV. Turning Point was an organization whose very existence was for the purpose of supporting people with alcohol and drug dependence and the staff would be well aware of the significant psychological and physical effects of an addiction. The onus was on the defender to prove that the fault of Mr Hughes contributed to the harm sustained. The court has to have regard to both blameworthiness and causal potency: *Corr* v *IBC Vehicles Limited* [2008] UKHL 13, [2008] UKHL 1; *Stapley* v *Gypsum Mines Limited* [1953] AC 663. A patient who has suffered harm as a consequence of medical negligence is not contributorily negligent merely because of lifestyle choices such as smoking or drinking, where that has led them to seek medical treatment: Thomson, *Delictual Liability* 5th ed., 6.12-6.13. There had been a misrepresentation by the defender of the facility it could provide. Reference was made to

St George v *The Home Office* [2008] EWCA 1068; *Darnley* v *Croydon Health Services NHS Trust* [2018] UKSC 50; and *Bowes* v *Highland Council* [2018] CSIH 38.

Other points

[58] The defender's submission that it was in the same position as a "voluntary rescuer" was misconceived on the facts of this case and the applicable law. Reference was made to *East Suffolk Rivers Catchment Board* v *Kent [1941] AC 74* and *AJ Allan (Blairnyle) Limited* v *Strathclyde Fire Board*. These cases concerned public service liability. The relationship between Turning Point and Mr Hughes was one of close proximity. It was reasonably foreseeable that if it did not provide him with a safe and comfortable detox, he would suffer harm. Turning Point assumed responsibility to assist him in his alcohol withdrawal. He relied upon them to do so. Reference was also made to *Aitken* v *The Scottish Ambulance Service* 2011 SLT 822 and *Kent* v *Griffiths* [2001] QB 36. This was not a rescue: Turning Point arranged for Mr Hughes to attend their facility in advance with a view to providing services to him if he was assessed as requiring them. Dr Morrison had wrongly applied the *Hunter* v *Hanley* test and his report should be entirely disregarded. The court should have regard to the accuracy of the propositions put to the witnesses. For example, the GRI notes and clinical notes were on occasion put by the defender inaccurately and out of context in an attempt to undermine the view of the expert witnesses.

Submissions for the defender

[59] In overview, the defender's position was as follows: firstly, that the duty incumbent on a person in the position of the defender was not such as to allow the claim to succeed;

secondly, in any event, the pursuers had not established that the defender's conduct amounted to a breach of the narrow range of duties averred; thirdly, the pursuers had not established, on the balance of probabilities, legal or factual causation; fourthly, even if there was to be an award of damages, it should be substantially modified to take account of the significant degree of contributory negligence.

[60] The witnesses to fact were all credible and reliable. Dr Turner had arrived at a conclusion on the cause of death in a very different context and without the full background picture or analysis having been presented to her. Dr BouHaidar approached matters much more objectively. Of the other medical experts, Dr Vallance stuck out as a witness guilty of dogmatic assertion. The court should place more weight on the evidence of the defender's skilled witnesses when it came to controversial areas of difference. Those experts took care in properly researching their positions and seeking to draw from the literature in testing the same. The pursuers' experts mainly sought simply to rely on their own views rather than seeking to support those from peer-reviewed academic works.

Existence of a duty of care

[61] The defender was a rescuer and its duty of care should be assessed in that context. It owed a duty to Mr Hughes, but the scope of that duty was restricted to the exercise of reasonable care not to inflict fresh injury upon him. That the defender was a rescuer was amply vouched by the evidence and moreover by the pursuers' contention that the defender should not have accepted Mr Hughes at all. From that contention it was clear that (a) there was no duty to accept Mr Hughes; and (b) had the defender simply closed its door to Mr Hughes there would have been no breach of duty. That narrative was redolent of the

position of the rescuer. Reference was made to *East Suffolk Rivers Catchment Board* v *Kent* [1941] AC 74, *Capital & Counties Plc* v *Hampshire County Council* [1997] QB 1004, *OLL Ltd* v *Secretary of State for Transport* [1997] 3 All ER 897, and *Antonucci* v *Ayrshire & Arran Health Board* [2001] ScotCS 35.

[62] Certainly, by attempting a rescue (and embarking upon affirmative action as opposed to doing nothing) a rescuer may be said to have assumed some sort of responsibility. But this was only responsibility not to make matters worse, or not to inflict fresh injury. That was the approach of the Court of Appeal of Ontario in *The Ogopogo* [1970] 1 Lloyd's Rep. 257, cited with approval in *Antonucci* v *Ayrshire & Arran Health Board* and in *AJ Allan (Blairnyle) Limited* v *Strathclyde Fire Board* 2016 SC 304.

[63] In the present case, it was plain that the defender engaged with rough sleepers and the homeless with a view to rescuing such people from the predicaments in which they found themselves. The defender was under no legal obligation to do so, and was able (as the pursuers' case recognised) to decide who it may help and who it will not. The defender (through Mr McCourtney) attempted to help Mr Hughes by providing him with a place to rest and in seeking to obtain medication for him after Mr Hughes had decided to abstain. The defender could not be criticised for this. The intervention inflicted no fresh injury. The pursuers argue that Mr McCourtney ought to have turned Mr Hughes away or ensured that he was admitted to hospital by way of ambulance or some other means. The rescuer was not required by law to do any of these things. They would only be relevant if the rescuer had a duty to take reasonable care to be successful in the rescue. No such duty existed. Nothing the defender did or omitted to do inflicted a fresh injury upon Mr Hughes.

[64] The pursuers' reliance on *Darnley* v *Croydon Health Services NHS Trust* [2018] WLR 1153 was misconceived. Also, in *Kent* v *Griffiths* [2001] QB 36 the Court of Appeal distinguished the ambulance service from the other emergency services, because it is part of the NHS. Applying the "fair, just and reasonable" test, there were clear policy grounds warning against the imposition of a further duty on the defender. The duties alleged by the pursuers would preclude the defender and others like it from fulfilling an extremely valuable function to an extremely vulnerable strata of society. Reference was made to *Tomlinson* v *Congleton Borough Council* [2004] 1 AC 46. The law operated in a real world, which carries risks and dangers requiring to be balanced against the value of the activities which give rise to those risks and dangers. The pursuers' case proceeded on an erroneous foundation in equiparating the defender with medical institutions or professional rehabilitation facilities and must therefore fail.

Breach of duty

[65] The next problem that the pursuers faced was the absence of an appropriate comparator. Self-evidently, it would be inappropriate and indeed unfair to judge the defender as if it was a hospital or specialist medical unit when it was no such thing. Reference was made to *Muir* v *Stewart* 1938 SC 590. There being no expert evidence from the same area of practice, the pursuers could not succeed. Nor was there evidence from any practitioner or alcohol worker as a direct comparator to Mr McCourtney.

[66] Furthermore, it was settled law that in such a case the court will generally not prefer one body of opinion over another. Reference was made to *Honisz* v *Lothian Health Board* 2008

SC 235. In the present case, there were variations in practice and differing views of what a reasonably competent person would have done.

[67] In any event, nothing the defender or Mr McCourtney did or omitted to do could properly be characterised as negligent. Reference was made to *Eckersley* v *Binnie* [1955-1995] PNLR 348. A reasonable body of medical opinion and practice would not necessarily have mandated the immediate dispensation of diazepam to Mr Hughes. Reference was also made to the GMAWS protocol operated by GRI and to how the Castle Craig facility had dealt with Mr Hughes. Furthermore, if the court accepted that the views of Dr Morrison represented a reasonable body of medical opinion, there was a perfectly respectable view that Mr Hughes was not at material risk of the effects of alcohol withdrawal in the limited period after his admission to Link Up. On the evidence of Mr McCourtney, the situation did not call for an emergency response in the order of phoning Dr Gilhooly or an ambulance. There was nothing to put Mr McCourtney on notice that there was any imminent danger.

[68] In addition, the pursuers also criticised the defender itself for failure to have certain protocols put in place. These criticisms also fell to be rejected. Applying the principles in *Haseldine* v *CA Daw and Son Limited and Others* [1941] 2 KB 343 and *McManus* v *City Link Development Company Limited* [2015] CSOH 178, the processes at Turning Point could not be described as negligent.

Causation

[69] The burden rested with the pursuers to establish a causal connection between the breach and the injury complained of: *McWilliams* v *WM Arrol & Co* 1962 SC (HL). On the facts, the pursuers had not proved this fundamental requirement. The evidence simply did not

allow the court to decide that the cause of death was seizure. The expert views tendered in this regard by the pursuers were nothing more that *ipse dixit,* and as such fell to be rejected: *Pratt* v *The Scottish Ministers* 2013 SLT 590; *Kennedy* v *Cordia* 2016 SC (UKSC) 59. There was no evidence pointing towards the most common form of seizure found in an alcohol withdrawal context, a tonic-clonic seizure. The unchallenged evidence of Mr McCourtney that the deceased was tired and wanted to "get his head down" was a significant factor pointing away from the likelihood that Mr Hughes was in acute alcohol withdrawal or heading into an imminent seizure before he was found dead. On the balance of probabilities, the evidence supported the conclusion that Mr Hughes died of cardiac arrhythmia. The suggestion that librium would have fought off the fatal effect of arrhythmia was also offered as an *ipse dixit* assertion and not grounded in any medical literature. It was therefore worthless: *Kennedy* v *Cordia* 2016 SC (UKSC) 59.

[70] Even if the court arrived at the view that SUDAM presumed to be due to cardiac arrhythmia was not a more likely cause of death than seizure, the court still had two reasonable competing explanations disclosed by the evidence before it. It should therefore follow the line of analysis in *The Popi M* [1985] 1 WLR 948, approved of by the Inner House in *Caledonia North Sea* v *London Bridge Engineering Ltd* 2000 SLT 1123. The pursuers had failed to prove their case irrespective of whichever cause of death the court found proved.

Contributory negligence

[71] Mr Hughes died because of his alarming consumption, over a period of many years, of excessive alcohol. In addressing contributory negligence, the court must assess the causative potency and blameworthiness of the deceased's conduct: *Jackson* v *Murray* [2015]

UKSC 5. Both were substantial here. In a similar vein to the approach of the courts in relation to the question of smoking, it was fair and just that a substantial reduction of any award of damages ought to be made albeit at a higher level (see *Badger* v *Ministry of Defence* [2006] 3 All ER 173; *Blackmore* v *Department for Communities & Local Government* [2018] QB 471). The most potent causative factor in Mr Hughes' death was the effect of alcoholism. The defender did nothing whatsoever to bring about that state of affairs. The case of *St George* v *The Home Office* relied upon by the pursuers was in fact of no assistance. It would be appropriate to assess contributory negligence here as being in the order of 90%.

Quantum

[72] Only one pursuer (Natalie Hughes) required the court to adjudicate on *quantum*. Given that the pursuers' evidence clearly disclosed that Mr Hughes' closest sibling relationship was with Jacqueline, it would be unreasonable to award Natalie Hughes any more than her sister. As such, the appropriate award, should one be made, was £12,500 inclusive of interest to 30 October 2018, in line with her siblings.

Decision and reasons

The evidence

[73] During the course of the proof a number of objections were made by each of the parties. Several of these were dealt with at the proof. However, some of the objections resulted in evidence being allowed subject to competency and relevancy. Those objections were not maintained in submissions and I make no further rulings on them.

Factual witnesses

[74] For the reasons submitted by the pursuers, I have attached no real weight to the signed affidavit of Dr Poole, largely because it was not the subject of cross-examination. I accept that the factual witnesses who gave evidence or whose evidence was agreed did their best to tell the truth. Stephen McCourtney came across as entirely candid and balanced in his evidence. I was left in no doubt from his manner, his experience and his obviously high level of empathy that he was a valuable worker in a facility which offered care and support to vulnerable people. His honesty was such that he was prepared to accept, albeit with the benefit of hindsight, that he had perhaps failed. However, these were really expressions of regret. Viewed overall, he was not in his evidence admitting any breach of duty. In any event, on an objective consideration of the whole of the evidence, for the reasons explained below, I conclude that he did not in any way fail in his duties. I accept his evidence in its entirety. This includes his evidence to the effect that in his dealings with Mr Hughes on 1 July 2013 there were no indications that Mr Hughes required emergency support or was in acute or severe withdrawal. It also includes his evidence about Mr Hughes being tired and wishing to "get his head down". Mr McCourtney recorded that point in the contemporaneous notes made during the admission procedure for Mr Hughes. It was not at any time put to Mr McCourtney that this was untrue or that the notes had somehow been fabricated. The pursuers' criticism of Mr McCourtney in relation to whether he or Mr Hughes used the expression "get his head down" is of no substance, the key point being that Mr Hughes did indeed wish to lie down, in contradiction of how he would have been expected to present had he been in severe withdrawal. I also accept Mr McCourtney's evidence that the decision to offer Mr Hughes a place in Link Up was discussed with his

other experienced colleagues and that no-one raised any concerns. Mr McCourtney's conduct falls to be assessed in the context of these circumstances. Mr McCourtney bears no responsibility whatsoever for the death of Mr Hughes.

[75] Dr Gilhooly had significant experience in dealing with service users at Turning Point. However, I reject the defender's contentions that the Turning Point arrangements were put in place on the basis of expert medical advice from Dr Poole and Dr Gilhooly and were the subject of continuing oversight by them. That position does not accord with the evidence of Dr Gilhooly. While some of his evidence (including about CIWA scores) differed from the evidence of the experts and cannot, on balance, be relied upon, there are two material points made by him which I do accept. Firstly, he observed that service users seeking admission sometimes exaggerate their symptoms. The evidence of the two sisters of Mr Hughes implied either that Mr McCourtney had wrongly noted Mr Hughes as having said he was homeless and rough sleeping or, if Mr Hughes did indeed say these things, that they weren't true. If Mr Hughes was not telling the truth on that matter, which was plainly an essential element for his potential admission, doubts may arise as to the credibility or reliability of the responses given by Mr Hughes when the CIWA assessment was being made. On the evidence I have accepted, Mr Hughes was tired and wished to have a sleep and was not showing any signs of acute or severe withdrawal, which all of the expert witnesses said they would expect to have seen, given the CIWA score. I do not make any finding to the effect that the responses of Mr Hughes were not credible or reliable, but I do place significant force on the circumstances as they appeared to Stephen McCourtney, his balanced and experienced assessment of matters, and the evidence of the expert witnesses about expected manifestations of acute or severe alcohol withdrawal which were simply not

present and indeed were contradicted by the factual evidence. Dr Gilhooly's observation, as an experienced practitioner on the front-line, is a possible explanation of the discrepancies between the presentation of Mr Hughes as witnessed by Mr McCourtney and the expected presentation of a person in severe or acute withdrawal. Secondly, Dr Gilhooly observed that Link Up filled a gap in the provision of services for persons such as Mr Hughes and that the imposition of duties which might cause the services to cease would be to the detriment of homeless people in Glasgow. While I accept that there was no evidence about the financial resources available to the defender, I do have regard to the fact that the provision of such services to homeless persons in crisis is extremely valuable to those vulnerable members of the community.

[76] In relation to the evidence of Billie McNeill about checking on Mr Hughes and the position in which he was seen by her to be lying on the bed, I have no reason whatsoever to doubt the veracity of that account. I reject the pursuers' contention that her evidence is somehow contradicted by that of Christine Buntrock about what she was told, there being no material difference in the descriptions they gave.

[77] The pursuers also say that on the evidence Turning Point was not helping rough sleepers and they were not providing Mr Hughes with a place to rest: "They were in fact running a service which they charged homeless people for through their housing benefit to provide them with a safe and comfortable detox". I regard this assertion as plainly unfounded. There was no basis in the evidence for concluding that the housing benefit was in effect some form of consideration for an express undertaking to provide a safe and comfortable detox. Moreover, for the reasons I give below, there was no such express undertaking.

Expert witnesses

[78] The expert witnesses led on behalf of the pursuers at the proof (Dr Hearns, Dr Vallance, Dr Craig) and in the commission held prior to the proof (Professor Chrick) gave impressive evidence and were able to explain their reasoning in a very articulate, structured and clear manner. However, their evidence suffered from three fundamental problems. Firstly, they were each distinguished medical professionals speaking to the high standards of care, based on their experience, provided in the NHS facilities (and in the case of Professor Chick and Dr Craig, Castle Craig) where they had been or still were working. While impressive and convincing in that context, their evidence was of limited relevance or value to the circumstances of the present case, which simply does not involve such a facility. Secondly, I firmly conclude from the evidence of each of them that they were speaking to modes of care and treatment at a best practice level, rather than the ordinary standard in the real world. This was borne out by their evidence on the records of GRI and Castle Craig about practices there which differed from what they had spoken to as being appropriate and by, for example, the concession by Dr Vallance that it was reasonable to accept these different approaches as representing the views and practices of a reasonable body of medical opinion. Thirdly, while none of them in my view breached the principles for the giving of expert evidence, they did not display the same balanced, authoritative and reality-driven approach shown in the evidence of the defender's expert Dr William Morrison.

[79] Turning to the evidence of Dr Morrison, he was extremely impressive in relation to his reasoning and opinions. Even more compelling was the transparently honest manner of his testimony. I was in no doubt that his evidence was being given purely to assist the court. When, as occurred on several occasions, he accepted points put to him which might well be

seen as supporting the pursuers' case, he did so with absolutely no hesitation or reluctance. Equally compelling was the clear theme in his evidence that while there are high standards and best practices which NHS facilities and others seek to achieve, the practical reality is rather different. I have no hesitation in accepting his evidence in its entirety and where it differs from the expert evidence led on behalf of the pursuers I prefer it. Dr BouHaidar, who as I have noted dealt with the issue of the cause of death, impressed as someone who was really just explaining that there were no sufficiently clear pointers in either direction as to the cause of death and therefore that a more general cause (complications of alcohol withdrawal) should have been identified. Dr Behan's evidence was given in a well-informed and straightforward manner and provided support for the proposition that cardiac arrhythmia was the more likely cause of death. He was not swayed in his views by the points put in the detailed cross examination by senior counsel for the pursuers, including in relation to atrial fibrillation. I do not regard the pursuers' criticisms of the defender's experts as well-founded. I incline to the view that Dr Turner was a witness to fact: she carried out the post-mortem and spoke to the cause of death she had certified, but it would make no difference to my conclusions if I regarded her as an expert witness.

Issue 1: did the defender owe to Mr Hughes the duty of care founded upon by the pursuers?

Relevant legal principles

[80] As Lord Reed put it in *Robinson* v *Chief Constable of West Yorkshire Police* [2018] UKSC 4, the long established principles of the law of negligence "have been eroded in recent times by uncertainty and confusion" (para [3]). Lord Reed then explained how some of this

had come about, set out the proper interpretation of the decision in *Caparo Industries Plc* v *Dickman* [1990] 2 AC 605 and clarified several other key issues.

[81] For the purposes of the present case I draw the following principles from *Robinson*. There is no single test to be applied in all cases to determine whether a duty of care exists. The proper approach is to consider whether the situation facing the court is one in which it has been clearly established that a duty of care is or is not owed. It is normally only in the novel type of case, where established principles do not provide an answer, that the courts need to go beyond those principles in order to decide whether a duty of care should be recognised. In those situations, the law should develop incrementally and by analogy with established authority. The drawing of an analogy depends on identifying the legally significant features of the situations with which the earlier authorities were concerned. The judgment of whether a duty of care exists in a novel situation involves consideration of what is fair, just and reasonable. The court should weigh up the reasons for and against imposing liability, in order to decide whether the existence of a duty of care would be just and reasonable. Policy considerations have a role to play in such circumstances. In the absence of special circumstances, the common law does not normally impose liability for omissions, or more particularly for a failure to prevent harm resulting from the conduct of third parties or the pursuer himself. One of the special circumstances in which liability for omissions can apply is where there has been an assumption of responsibility for the individual's safety, upon which the individual has relied.

[82] The distinction between acts and omissions is not always easy to draw. There will be conduct which can be described as either an act or an omission, the classic example probably being that given by Lord Hoffman in *Stovin* v *Wise* [1996] AC 923 that a failure to apply the

brakes when driving, resulting in a collision, can also be viewed as driving into the other vehicle. Failures to do things may occur in the context of the performance of some positive actions and it seems therefore correct to say that "where the conduct that is alleged involves a composite of acts and omissions that cannot sensibly be disentangled, it is treated as an instance of positive action" *Charlesworth and Percy on Negligence*, 14th ed, 2-56). Where however, there is a pure omission the general principle is that there is no liability: the law does not impose a duty to provide a person with benefits, such as the prevention of harm caused by that person or by others.

[83] Assumption of responsibility is a free-standing basis for the existence of a duty of care. Some aspects of the meaning of assumption of responsibility and the application of that concept have not yet been fully settled. However, a number of principles, relevant for present purposes, can be drawn from the authorities. The seminal decision in this area is of course *Hedley Byrne & Co Ltd* v *Heller & Partners Ltd* [1964] AC 465 (HL). The key aspects of the concept of assumption of responsibility as articulated in that case, for present purposes, can be found in certain *dicta* of Lord Devlin (at 529-530) which have regularly been quoted in subsequent decisions on the matter. In the further development of the concept additional points about its application also relevant for present purposes have been settled, largely in the speech of Lord Goff of Chieveley in *Henderson* v *Merrett Syndicates Ltd* [1995] 2 AC 145, at 180-181. Given the central relevance of the concept of assumption of responsibility in the present case, I shall set out the principles I draw from these authorities and where appropriate make reference to later cases.

[84] The concept involves a responsibility that is voluntarily accepted or undertaken, either generally (where a general relationship such as that of solicitor and client or banker and customer is created) or specifically in relation to a particular transaction or matter. Responsibility can attach to a particular act only if the doing of that act implies a voluntary undertaking to assume responsibility. When there is a relationship equivalent to contract, there is a duty of care: the paradigm situation is where there is a relationship having all the *indicia* of contract save consideration (*Customs and Excise Commissioners* v *Barclay's Bank plc* [2006] UKHL 28, [2007] AC 181, *per* Lord Bingham, para [4]). Situations in which there has been a voluntary assumption of responsibility to prevent harm may fall into the category of being akin to contract (*Robinson* v *Chief Constable of West Yorkshire Police*, *per* Lord Reed, paragraph [69]). An assumption of responsibility requires a proximate relationship between the parties (see eg *Caparo Industries Plc* v *Dickman*; *Playboy Club London Ltd* v *Banca Nazionale del Lavoro SpA* [2018] UKSC 43; [2018] 1 WLR 4041). Where what is relied on is a particular relationship created *ad hoc*, it will be necessary to examine the facts to see whether there is an express or implied undertaking of responsibility. The concept of a "special skill" referred to in the speech of Lord Morris in *Hedley Byrne* must be understood broadly, certainly broadly enough to include special knowledge. The principle of assumption of responsibility extends beyond the provision of information and advice to include the performance of other services (see eg *Customs and Excise Commissioners v Barclays Bank Plc*; *Lejonvarn* v *Burgess* [2017] EWCA Civ 254; [2017] BLR 277). Especially in a context concerned with a liability which may arise under a contract or in a situation equivalent to contract, it must be expected that an objective test will be applied when asking the question whether, in a particular case, responsibility should be held to have been assumed (*Caparo Industries Plc* v *Dickman* [1990],

at 637). Once the case is identified as falling within the *Hedley Byrne* principle, there should be no need to embark upon any further enquiry as to whether it is fair, just and reasonable to impose liability for economic loss. An assumption of responsibility by, for example, a professional man may give rise to liability in respect of negligent omissions as much as negligent acts of commission (see eg *Midland Bank Trust Co Ltd* v *Hett, Stubbs and Kemp* [1979] Ch 384, 416F-G). The scope of the matters in respect of which responsibility is assumed is determined by what is said or done between the parties:

> "… if a person assumes responsibility to another *in respect of certain services*, there is no reason why he should not be liable in damages for that other, in respect of economic loss which flows from the negligent performance *of those services*." (*Henderson* v *Merrett Syndicates Ltd* [1995] 2 AC 145, *per* Lord Goff at 181, emphasis added.)

> "The touchstone of liability is not the state of mind of the defendant. An objective test means that the primary focus must be on things said or done by the defendant or on his behalf in dealings with the plaintiff. Obviously, the impact of what a defendant says or does must be judged in the light of the relevant contextual scene. Subject to this qualification the primary focus must be on exchanges (in which term I include statements and conduct) which cross the line between the defendant and the plaintiff." (*Williams* v *Natural Life Health Foods Ltd* [1998] 1WLR 830, *per* Lord Steyn at 835).

While it has been suggested that assumption of responsibility may potentially arise independently of reliance (see *Charlesworth & Percy, on Negligence*, 14th ed, para 2-86) there is strong authority that it is essential for the representee reasonably to have relied on the representation and for the representor reasonably to have foreseen that he would do so (*Steel v NRAM Ltd* [2018] UKSC 13; [2018] 1 WLR 1190 (SC); *Playboy Club London Ltd* v *Banca Nazionale del Lavoro SpA*).

[85] Where the individual is in a vulnerable or dependent position, that may be a relevant factor in considering whether there has been reliance, as well as whether, and in respect of

what, responsibility has been assumed (*Charlesworth & Percy on Negligence*, 14th ed, paras 2-86 and 2-102). An assumption of responsibility may be for the welfare of the individual, for example where the relationship is one of control (such as in a hospital) or it may be more specific, such as to carry out a particular activity or task.

Application of these principles

The nature and scope of the duty of care

[86] Each of the parties is saying that there are established legal principles which support their conflicting submissions as to the existence and scope of a duty of care in the present case. It is however notable that at least in part the pursuers base their so-called system case on assumption of responsibility. For the reasons which I come to discuss below, I am firmly of the view that in the circumstances of the relationship between Mr Hughes and the defender the duty of care issue is best dealt with by applying the principles on assumption of responsibility. It would be wholly artificial not to view as critical to the duty question the exchanges that crossed the line between the parties (using Lord Steyn's words) and instead to deal with the duty question on a general basis. Those exchanges were akin to a contract and set up the nature and scope of the assumption of responsibility and hence of the duty of care. I therefore reject the pursuers' contentions as to the existence of a duty of care by the defender based on other grounds and I also reject the defender's contention that any duty of care owed by it falls to be dealt with on the basis that it was simply a rescuer.

[87] However, in deference to the submissions advanced on points other than assumption of responsibility, I make the following observations. The difference between the two approaches is clear: the pursuers' position would cover positive acts and omissions by the

defender which did not avert the potential danger to Mr Hughes created by his own withdrawal from alcohol. The defender's contention that it is a rescuer would result in the duty being restricted to one of not causing fresh danger or harm (in accordance with the pure omissions principle, as authoritatively explained by Lord Drummond Young in *AJ Allan (Blairnyle) Limited* v *Strathclyde Fire Board*, at paragraphs [60]-[75]).

The defender's position

[88] The defender argued that the pursuers' contention that Mr Hughes should never have been assessed at or admitted to Turning Point is consistent with there being no duty on the defender to intervene or become involved (as was the position in the rescuer cases). However, the pursuers do not contend that there was no duty on the part of the defender to intervene; rather, the pursuers' position is that there was a positive duty on the defender not to intervene, or at least not to continue its involvement after the assessment of Mr Hughes. I therefore reject the defender's submission that the pursuers' position provides support for the defender's contention that it is a rescuer.

[89] While the defender may be correct that if one is a rescuer then the assumption of responsibility arising from the intervention is only in respect of avoiding additional harm, that proposition can fall away where there is a different basis for assumption of responsibility, founded upon what has been said and done between the parties. As I have noted above, the primary reason for rejecting the defender's contentions about being a rescuer is that there was in this case an assumption of responsibility on that basis.

The pursuers' position

[90] Turning to the pursuers' position, there are two sets of arguments as to duties of care: the first is the system case against the defender as an organisation; the second is the case based upon vicarious liability for what are said to be the negligent acts or omissions of Mr McCourtney.

[91] In relation to the system case, the pursuers' position involves two separate points. Firstly, as it was put in the pursuers' written submissions, the pursuers' "primary position" was that "someone like Mr Hughes should not have been invited to attend Turning Point for assessment". In their supplementary written submissions, the pursuers contended that when Ms Kydd phoned Turning Point for an appointment for Mr Hughes, if the defender had an appropriate protocol in place the defender would have "checked his criteria and when he was noted to have had a complex previous alcohol withdrawal, DTs and also alcohol withdrawal seizures they would have required to advise her that they could not assess Mr Hughes for a place". In relation to the SIGN guidance the pursuers submitted that it clearly set out situations where inpatient detoxification would be advised and that the list "… includes people like Mr Hughes who have had complicated withdrawal, history of epilepsy or fits and risk of suicide."

[92] If that is incorrect, then secondly the defender contended that Mr Hughes attended Turning Point seeking admission for detox, had been accepted into their system and entered into a relationship with Turning Point, with the result that a duty of care was assumed. The defender had set up a specific facility with the intention of providing facilities for persons like Mr Hughes to withdraw from alcohol. In doing so the defender had a duty to set up a safe system for persons whom it could reasonably be anticipated would be admitted to the

unit for detox. I have noted above the particular points which the pursuers contend should have formed part of the system. It appears that this argument is based on a broad assumption of responsibility, but it may also be founded on a general duty to provide a safe system.

The system case: general observations

[93] I will return below to the question of assumption of responsibility, but the broader system case is not in my view supported by any established legal principles. I do not consider that in the present case one can simply approach matters on the basis of the principles expressed in *Donoghue* v *Stevenson* 1932 SC (HL) 31, as the pursuers submitted. The defender is a charity, which ran a crisis unit for homeless persons, and which on any view was performing a service of the utmost importance for vulnerable people in that position. It did not have the staffing or equipment of a medical or NHS facility, including nurses and doctors and immediate access to medication. Indeed, no legal basis was presented as to how the defender could hold a stock of medication without it having been prescribed for the individual service users. Consideration of the steps to be taken as a matter of law by an entity such as the defender in the present circumstances makes this a novel type of case, where established principles (apart from assumption of responsibility) do not provide an answer. In relation to the drawing of an analogy, no submissions were made by the pursuers which sought to identify the legally significant features of situations with which earlier authorities were concerned and which might support the proposition that there were analogous situations already dealt with by the law. To the extent that the expert evidence for the pursuers founded upon procedures in NHS hospitals and similar facilities,

there are clear differences in the legally significant features in such situations. Such a facility will have funding, equipment and resources, including medication, as well as trained and specialist staff at various levels. Doctors are seen as holding themselves out as possessing special skill. Nurses are judged by the standard of a reasonably competent nurse exercising proper care and skill. A range of other staff members are available for particular matters.

[94] The judgment of whether a duty of care exists in a novel situation also involves consideration of what is fair, just and reasonable. No properly developed submission was made to the effect that it would be fair, just and reasonable to impose the broader "system" duty upon which the pursuers appear to rely. Weighing in the balance the total detriment to the public interest from holding such a class of person as the defender liable in negligence as against the total loss to all would-be pursuers if they are not to have a cause of action in respect of the loss they have individually suffered, I conclude that it would not be fair, just or reasonable to impose the general duty to have a safe system contended for by the pursuers. In reaching that view, I have regard to the fact that the defender is a homelessness charity, which sought to assist with alcohol detox, but it only had limited staff and other resources and relied upon the VMOs. Moreover, having regard to policy matters, there was no evidence of any substance led on behalf of the pursuers which supported the proposition that the defender could continue to provide its crucially important services if it were to be subjected to such a duty; indeed, there was some evidence to the contrary.

Assumption of responsibility

[95] The other basis for the system case is said to be assumption of responsibility for the care and welfare of Mr Hughes and in particular for the provision of a safe and comfortable

alcohol detox. As I discuss below, there are certain factors which point to the relationship between Mr Hughes and Turning Point as being akin to a contract. The whole point of the application of the concept of assumption of responsibility to a situation akin to a contract must be that the scope of the responsibility assumed is defined by the agreed, promised, or represented position. It is necessary to identify the specific or general matters for which the defender assumed responsibility. It is evident that the Link Up service was explained to Mr Hughes and indeed he signed a document to that effect. He also signed an "Admission Agreement (Part 1)" where he indicated that he understood and gave consent *inter alia* "To be given medication by Project Staff as prescribed by VMO". The defender's documentation specifically refers to this as a contract: the Link Up 1 Stop Admissions Checklist states "Admission Agreement Part 1 Contract Explained & Signed" and that is recorded as having been done on 1 July 2013.

[96] The defender's document "Alcohol Detox Care Plan" noted Mr Hughes' history of DTs and seizures and stated "Aim: A Safe and Comfortable Alcohol Detox Intervention". Importantly, it then indicated precisely what the defender would do. It stated that he would be observed "for signs of physical and psychological withdrawals" and the CIWA score would be recorded. It also stated "Staff will consult with VMO regarding detox medication (Chlordiazepoxide)" and "Assessment by VMO will be ongoing and provided on site". A further document, the "Care Plan", stated that the objectives were to provide *inter alia* "a comfortable safe detox if required". It then set out the "Planned action". It also stated: "Placed on hourly obs. for 48 hours. Complete Full Risk Assessment following this". This document was also signed by Mr Hughes.

[97] Having regard to this documentation, it is clear that the defender undertook and assumed responsibility for consulting with a VMO regarding alcohol detox medication and giving any medication to Mr Hughes as prescribed by the VMO. While a specified aim and objective was to provide a safe and comfortable alcohol detox intervention, it is quite incorrect to suggest that the defender undertook or assumed responsibility to do so. The difference between, on the one hand, an aim or objective and, on the other, a promised or represented outcome is patently obvious. By way of example, the Care Plan also lists as an objective "Provide physical care/stabilise mental health". If the defender was, as the pursuers contend, as a matter of law expressly undertaking or guaranteeing to achieve its objectives including to provide a safe and comfortable alcohol detox and to stabilise the mental health of its highly vulnerable and marginalised service users, many of whom were in crisis, it would be taking on tasks which were extremely difficult if not impossible for it to achieve.

[98] All of this supports the finding that the defender did not assume responsibility for the welfare of Mr Hughes as a generality. It did not have control over Mr Hughes in the same manner as a hospital. The defender simply did not have medical and nursing staff of various ranks and roles, and medication, to be taken as having held itself out to provide a safe and comfortable detox. There is no basis in the evidence for concluding that Mr Hughes was either advised that the defender had such resources or could reasonably have understood or believed that they had them.

[99] Thus, the defender assumed responsibility to provide its services to Mr Hughes, including the provision of a bed, to request medication from a VMO and, if it was prescribed, to administer it to Mr Hughes. Mr Hughes was, on the material available, fully

aware of the nature and scope of the services which were to be provided. He recorded his agreement by signing certain documents. I infer that he relied upon the defender, but can only have done so to the extent of the responsibility assumed by it. I reject the pursuers' position that the defender contracted with Mr Hughes to provide a safe and comfortable detox. I also reject the defender's contention that the only matter for which the defender assumed responsibility was not to cause further harm to Mr Hughes.

Vicarious liability for the acts and omissions of Mr McCourtney

[100] In relation to the case against Mr McCourtney, I accept that he owed a duty to exercise reasonable care in his dealings with Mr Hughes. However, the scope of that duty is delineated by the extent to which responsibility was assumed by the defender and the whole context in which the defender and Mr McCourtney operated. The case against Mr McCourtney is better analysed with reference to the standard of care he was required to provide and whether the pursuers have demonstrated a breach of duty on his part. I deal with those matters below.

Issue 2: was the defender in breach of the duty of care?

[101] Having regard to the limits upon the matters for which the defender assumed responsibility, I conclude that there was no breach of duty of the kind contended for by the pursuers. The defender carried out what it had undertaken to do and did so with reasonable care, as discussed below. Responsibility was not assumed in respect of any of the so-called system points relied upon by the pursuers. These points were primarily based

upon the pursuers' position that the assumption of responsibility was to provide a safe and comfortable alcohol detox. I have rejected that contention, for the reasons given above.

[102] If I am wrong about that, and there was indeed a duty or an assumption of responsibility to provide a safe and comfortable alcohol detox, then I would nonetheless have concluded that there was no breach of duty, for the following reasons. I accept the defender's submission that where the court is not dealing with something commonly experienced in ordinary life (such as driving), appropriate skilled evidence is necessary to allow the court to decide on questions of standard of care: *Muir* v *Stewart* 1938 SC 590. The skilled evidence requires to be about the conduct or practice of persons of skill and experience in carrying on the same class of business or activity. That evidence is required in order to determine the standard of the reasonably competent supplier of services of the kind offered by the defender. In the present case, there was no expert evidence from the same area of practice, that is to say the provision by an entity such as the defender of services for homeless persons in crisis, including assistance with alcohol detox. It is correct that Professor Chick and Dr Craig had experience of organisations offering alcohol detox, but they were simply not addressing the circumstances and context in which a body such as the defender operated. They gave evidence as senior and experienced medical practitioners. Dr Grimm explained what takes place at Turning Point in England, but there was no real basis in the evidence for concluding that this organisation, operating in a different jurisdiction and under a different regulatory regime, was a direct comparator. Indeed, on the evidence of Wendy Spencer, which I accept, they were unique and separate organisations. No witness made any reference to the specific terms of an actual protocol or detailed system operated by an entity which provided similar services to those of the

defender. No documents of that kind were produced. For the reasons I have already given, it would be entirely inappropriate and indeed unfair to judge the defender as if it was a hospital or specialist medical unit. In relation to the case against Mr McCourtney, there was simply no evidence from any practitioner or support worker who carried on similar activities. I therefore conclude that there was no evidence of an appropriate comparator either in relation to the wider grounds of the pursuers' case (the system case and the more general approach to assumption of responsibility) or in relation to the case against Mr McCourtney. On that ground alone, the pursuers' case on breach of duty must fail.

[103] Separately, even if the duties contended for by the pursuers were owed, I would not have found the defender or Mr McCourtney to have breached the standards of care required of them. I agree entirely with the view expressed by Lord Hodge in *ICL Tech Ltd* v *Johnston Oils Ltd* 2001 SLT 667 and by Lord Drummond Young in *French* v *Strathclyde Fireboard* 2013 SLT 247 as to how Scots law approaches the question of the standard of care of persons professing a special skill. The decision in *Hunter* v *Hanley* allows different schools of thought and practice to develop within professions. Technical or intellectual choices may be made which differ and to find one choice as being negligent, even where supported by a reasonable body of opinion, may discourage advances within the particular profession. Thus *Hunter* v *Hanley* established the test, in respect of a doctor, *inter alia* that the course adopted has to be one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. That approach was endorsed by the House of Lords in *Maynard* v *West Midlands Regional Heath Authority* [1984] 1 WLR 634, [1985] 1 All ER 635. In the widely accepted judgment *in Bolam* v *Friern Hospital Management Committee* [1957] 1 WLR 582, McNair J considered that he was expressing the same test in a different way when

he said (at 587) that a doctor "is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art". This test applies to circumstances (such as allegations of medical negligence) "where there is room for genuine differences of view on the propriety of one course of action as against another": *Phelps* v *London Hillingdon Borough Council* [2001] 2 AC 619, *per* Lord Clyde at 672. That principle is now of course subject to the qualification made by the House of Lords in *Bolitho* v *City and Hackney Health Authority* [1988] AC 232, [1997] 3 WLR 1151, [1997] 4 All ER 771 that a body of opinion might be rejected by the court if it does not withstand logical analysis. Lord Hodge set out the relevant principles succinctly in *Honisz* v *Lothian Health Board* 2008 SC 235.

[104] I accept the pursuers' submission that these cases have no application in the present context and that, given the circumstances in which they operated, the defender and Mr McCourtney should not be judged on the *Hunter* v *Hanley* test. But that simply means that the pursuers' case does not fail only because there was evidence that the defender and Mr McCourtney acted in accordance with a practice accepted as proper by a responsible body of persons skilled in that particular art. Thus, it is not of itself enough to reject the pursuers' case that Professor Chick, Dr Vallance and Dr Hearns each gave evidence accepting that there were variations in practice in relation to facilities offering alcohol detox and the first two of these experts also agreed that in the assessment of what was done by the defender reasonable people might reasonably differ. Nor is it enough to trump the pursuers' case that, to the extent that one can rely upon the GRI and Castle Craig records, the experts accepted that these also demonstrate no uniform approach as to when someone should be scored and when diazepam should be administered.

[105] But where the *Hunter* v *Hanley* test does not apply, the court can of course still take into account this evidence and can also prefer one body of expert opinion over another. For the reasons I have given above, I accept the views expressed by Dr Morrison (albeit that he was addressing the position in a primary care facility, involving persons with greater levels of skill than Mr McCourtney). I am satisfied that nothing the defender or Mr McCourtney did or omitted to do can properly be characterised as negligent. The evidence of Mr McCourtney as to how Mr Hughes appeared to him contradicts the suggestion that Mr Hughes was in severe withdrawal, and a number of experienced colleagues of Mr McCourtney were aware of the situation and did not suggest any steps such as phoning an ambulance. The allegations against him and the defender must be viewed in that context. As Dr Morrison put it in his report:

> "The scaling that accompanies the CIWA would indicate that Mr Hughes was in severe withdrawal. However, this would appear to be at variance with the subjective view and opinion of the attending carer that he had "no concerns about the deceased's presentation". This score would, in my opinion, also appear to be at variance with the documented fact that Mr Hughes was tired and simply wanted to go to his room and get some sleep".

I also note that the SIGN guidance states that those assessing and monitoring patients in alcohol withdrawal should consider using a tool such as the CIWA scale "as an adjunct to clinical judgment". Dr Morrison endorsed that approach. While Mr McCourtney was not making a clinical judgment in the ordinary sense, he was an experienced project worker dealing with persons in alcohol withdrawal and he used the CIWA scale as an adjunct.

[106] Taking the first part of the system case, having regard to the whole factual context the decision to assess and then admit Mr Hughes was reasonable in all of the circumstances. Indeed, Professor Chick appeared in part of his evidence to accept that to be so. In relation

to the absence of immediate access to medication or the alleged failure to obtain it timeously, as I have noted above, a reasonable body of medical opinion and practice would not necessarily have proceeded to the immediate dispensation of diazepam to Mr Hughes. In relation to the failures to phone an ambulance and have Mr Hughes admitted to hospital regard must be had to the points quoted above from Dr Morrison's report. A blanket requirement to have a protocol or instructions to take these steps is overly strict in the circumstances of the present case. I also accept that there was no evidence of any prior difficulty suffered by the defender's service users until the death of Mr Hughes and hence nothing to suggest that the defender knew or ought to have known of such a potential problem. As for the case against Mr McCourtney, it is clear that he correctly recognised that there was a need for medication based upon the CIWA score and he sought to obtain it. On his evidence, if at any stage he had become concerned as to the condition of Mr Hughes he would have phoned an ambulance, as he had done for others on other occasions. He was clear that there was no basis for any such concern. I have also accepted Dr Morrison's view that on the evidence Mr Hughes was not at material risk of the effects of alcohol withdrawal in the limited period after his admission to Link Up. Given that on Mr McCourtney's evidence there was no concern (on the part of any of the staff) about Mr Hughes' presentation and that he wanted to sleep and was not agitated (factors upon which the experts agreed were pointers away from severe withdrawal), it was not unreasonable for Mr McCourtney to phone Dr Poole to seek to obtain medication and continue to try to contact him when there was no reply. Mr McCourtney was entitled to reasonably expect that the VMO would respond to his call within a reasonable period. He considered, again based upon reasonable grounds, Mr Hughes to be safe. The circumstances as presented to

Mr McCourtney and the others in the defender's unit did not merit an emergency response such as phoning an ambulance.

[107] For these reasons, I conclude that even if the broader duty of care founded upon by the pursuers was held to exist, it would not have been breached. Nor was there any breach of duty on the part of Mr McCourtney. The defender and its staff reacted reasonably in all the circumstances and took reasonable care in responding to Mr Hughes' presentation.

Issue 3: causation

[108] The burden rests with the pursuers to prove on the balance of probabilities that, if any breach of duty which the court finds to have occurred had been avoided, Mr Hughes would not have died: *McWilliams* v *Wm Arrol & Co* 1962 SC (HL). The pursuers' position is that Mr Hughes died from the effects of an alcohol withdrawal seizure. Another potential cause was identified in the evidence: SUDAM, presumed to be due to cardiac arrhythmia. Each party relied upon the absence of any positive pathological evidence from the post-mortem findings which supported the cause of death postulated by the other party. Each party also relied upon the absence of any circumstantial or indicative features which it was said would be likely to have been present had the cause of death been as the other party contended. Thus, the pursuers pointed to the absence of anything in the medical notes from earlier admissions to hospital, including ECG results, which indicated any cardiac-related health issue on the part of Mr Hughes. The defender pointed to the absence of features such as foaming of the mouth, aspiration of food, a bitten tongue, evidence of urination, an empty bladder and defecation, at least some of which were said commonly to be present when a seizure occurred. I have set out earlier the expert evidence on this issue. I conclude from

that evidence that on the balance of probabilities the cause of death was cardiac arrhythmia (relying in particular on the evidence of Dr Behan and Dr Morrison).

[109] My reasons for reaching this view are as follows. The fact that Mr Hughes had previously suffered seizures is of limited assistance given that the evidence on the medical nature of these earlier seizures was not clear. That said, the expert evidence was that the most common form of seizure found in an alcohol withdrawal context was a tonic-clonic seizure, involving jerking movements. The evidence of what Jacqueline Hughes witnessed when an earlier seizure occurred fits with the description of that type of seizure. On that description, one would expect there to have been evidence of movement, or disturbance to the bed clothes, noticed when Mr Hughes was seen at different points in time on the bed. I have accepted the evidence of Billie McNeill on what she witnessed, including the absence of any movement or change in the position of Mr Hughes and the bed covers not being wrinkled at all. As the pursuers' experts accepted, this points away from a tonic-clonic seizure having occurred.

[110] While some of the medical literature was not of particular assistance, parts of it did support the conclusion that sudden arrhythmic cardiac death can occur in chronic misusers of alcohol and in that case the only findings at post-mortem would commonly be fatty liver and negative or low blood alcohol. Mr Hughes was found at the post-mortem to have a fatty liver. The broad view expressed in the key articles was that there is increasing support for the position that SUDAM, presumed to be due to cardiac arrhythmia, may be the most appropriate way to express the cause of death where it is otherwise unexplained or unsupported by evidence pointing in a particular direction. I accept the opinion evidence of

the defender's experts in reliance upon the medical literature. However, that evidence was also based on the full factual and clinical picture both pathological and historical. Death by a seizure during withdrawal from alcohol was described in one of the articles as very rare, as Dr Vallance accepted. The factual evidence effectively rules out a tonic-clonic seizure having occurred. This makes death by seizure an even more remote possibility. I conclude, primarily on the evidence of the defender's experts, that the absence of at least some of the commonly occurring pointers towards seizure creates further doubt about a seizure being the cause of death. I therefore accept the opinions advanced by Dr Morrison, Dr BouHaidar and Dr Behan and find that, on the balance of probabilities, the evidence supports the conclusion that Mr Hughes died of SUDAM, presumed to be due to cardiac arrhythmia. I would add that Professor Chick accepted that the vast majority of seizures experienced in alcohol withdrawal are not fatal and that, under reference to the medical literature, it is rare for an alcoholic withdrawal seizure to end in death. He also accepted that it was difficult to imagine how Mr Hughes could have had a seizure in such a way as to result in his death without evidence of him having experienced a fit.

[111] The experts broadly agreed that if diazepam had been administered it would have had an impact in lessening the adrenaline in the system of Mr Hughes and that would have some benefit in relation to cardiac issues. However, the preponderance of the expert evidence was to the effect that diazepam is not administered to prevent cardiac arrhythmia. It would be unsafe to conclude that the administration of diazepam (or librium) would have prevented Mr Hughes dying from cardiac arrhythmia. In particular, I accept the evidence of Dr Behan that, on the balance of probabilities, administration of diazepam would not have prevented death by that cause. Accordingly, those aspects of the pursuers' case which

found upon a duty to obtain and administer diazepam cannot, even if there was such a duty, succeed in establishing that death by SUDAM presumed to be due to cardiac arrhythmia would have been avoided. Had that duty been complied with, there would have been no breach of duty but Mr Hughes would not have been saved and would still have died. Any breach of that duty was not therefore the cause of death.

[112] If I had not been persuaded that the cause of death was, on the balance of probabilities SUDAM presumed to be due to cardiac arrhythmia, I would then have concluded (as Dr BouHaidar indicated) that there was no real basis to prefer either of the two competing explanations disclosed by the evidence.

[113] In any event, the pursuers' case on causation fails at an even more fundamental level. The pursuers require to establish that but for the alleged negligence the outcome would have been different and Mr Hughes would not have died: *McWilliams supra.* In terms of the time of death, on the evidence it could have occurred at any time between just after 3.30 pm and 6.30 pm. The question is whether or not death by a seizure or cardiac arrhythmia would have been avoided if the defender had obtempered the duties which the pursuers say were incumbent upon it. Dealing firstly with the duty said to arise in the system case to refuse to allow Mr Hughes to attend for assessment, precisely when he would have been told that he was not to attend for assessment and what he would then have done on that day were not established. As to what he would have done had he not been admitted to the defender's CRU on 1 July 2013, there is only a vague and rather speculative basis for saying that he would have immediately resumed drinking or decided to seek admission to another form of alcohol detox unit or NHS facility.

[114] On the broader system case or the case based on the wider assumption of responsibility, and the case against Mr McCourtney, Mr Hughes should have been sent to hospital. However, it cannot be reasonably inferred from the evidence that on the balance of probabilities Mr Hughes would have been received into hospital and administered with diazepam to prevent death by seizure, or tested and monitored in a manner which would have prevented death by cardiac arrhythmia, before the time of death (whenever that occurred). There are too many unknowns, having regard to Mr Hughes' presentation as stated by Mr McCourtney, including when he would have been reviewed in A & E, when he would have been assessed (using GMAWS or CIWA), when he would have been tested and monitored for any cardiac issues, and whether and if so when he would have been given diazepam. On the last point, while there was support for the view, based on the records, that Mr Hughes had on some earlier occasions been administered diazepam in A & E, there were other occasions when that had not occurred and there was expert evidence about the differences in approach. Moreover, there was some evidence that GRI would, on the express terms of its own GMAWS protocol, have waited before scoring Mr Hughes for 8 hours from his last drink. The pursuers did not establish in evidence that the terms of the GMAWS protocol meant something else. The evidence did not disclose when the last drink as taken. I am therefore unable to conclude that if the defender had complied with its alleged duties in respect of not admitting Mr Hughes or phoning an ambulance and seeking to get him to hospital, he would have been treated with appropriate medication prior to the time of his death. The same applies to testing and monitoring which would have discovered and allowed prevention of cardiac arrhythmia.

Issue 4: contributory negligence

[115] If, against the views I have expressed, there was a breach of duty by the defender which caused the death of Mr Hughes, the issue of contributory negligence falls to be considered. The key questions to be addressed in relation to contributory negligence are the causative potency and blameworthiness of Mr Hughes' conduct: *Jackson* v *Murray* [2015] UKSC 5; *Corr* v *IBC Vehicles Limited* [2008] UKHL 13, [2008] UKHL 1; *Stapley* v *Gypsum Mines Limited* [1953] AC 663. It was absolutely clear on the evidence that Mr Hughes knew his alcohol consumption to be harmful. He had been admitted to hospital as a result of his alcohol misuse on numerous previous occasions. The evidence of his two sisters supported the view that he was aware of the problems his alcoholism was causing. The fact that any breach of duty by the defender was a cause of his death does not mean that his own conduct was not also a cause of his death. The consequence of Mr Hughes putting himself in danger was the very thing that the pursuers say the defender should have prevented. His condition as a result of his alcohol consumption was closely connected in time and place, and indeed intermixed with, the allegedly negligent conduct of the defender. Mr Hughes contributed to his own death by putting himself in significant danger and a potent causative factor was the effect of his alcoholism. The case of *St George* v *The Home Office* relied upon by the pursuers is not relevant. In that case, the causative potency of the plaintiff's addiction to drink and drugs was very limited and it was the defendant's decision to place him in a dangerous position that truly caused the harm suffered. Accordingly, if there had been a breach of duty by the defender or a breach of duty by Mr McCourtney for which the defender is responsible, I would have found Mr Hughes to have been contributorily negligent and reduced any award of damages by 60%.

Issue 5: quantum

[116] If there had been any liability in damages, I would have quantified the loss suffered by Natalie Hughes in the same amount as that of her sister Jacqueline Hughes, namely £12,500 inclusive of interest.

Conclusion

[117] For the reasons given, I conclude that the defender is not liable for the tragic death of Francis Hughes. Accordingly, I shall sustain the third and fourth pleas-in-law for the defender and grant decree of absolvitor.