SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNDEE

[2022] FAI 2

DUN-B7-20

DETERMINATION

By

SHERIFF JILLIAN MARTIN-BROWN

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC. (SCOTLAND) ACT 2016

into the death of

LEYLAN FORTE

Dundee, 15 December 2021

The sheriff, having considered the information presented at an inquiry on 29 and 30 November and 1 December 2021; the written submissions received on 2 December 2021; and the oral submissions made on 3 December 2021, under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, finds and determines that:

Findings

Section 26(2)(a)

Leylan Forte died on 27 April 2015 at 12:28 in an ambulance parked outside the deceased's home in Montrose.

Section 26(2)(b)

His death was not the result of an accident.

Section 26(2)(c)

The cause of Leylan Forte's death was acute dehydration and electrolyte disturbance secondary to viral gastoenteritis (norovirus), with the possible contributory factor of cerebral palsy.

Section 26(2)(d)

His death was not the result of an accident.

Section 26(1)(e)

There were no precautions which could reasonably have been taken whereby his death might realistically have been avoided.

Section 26(2)(f)

There were no defects in any sytem of working which contributed to his death.

Section 26(2)(g)

1. The arrangement of a telephone assessment with NHS Tayside Out of Hours service within one hour or a home visit before 8am when the GP practice reopened was a precaution which could reasonably have been taken by NHS 24.

2. The use of the Key Information Summary of the Emergency Care Summary by the deceased's GP practice to note his his low BMI and parental vulnerabilities might have avoided Leylan Forte's death.

Recommendations

Section 26(4)(a)

There are no recommendations as to the taking of reasonable precautions which might realistically prevent other deaths in similar circumstances.

Section 26(4)(b)

There are no recommendations as to the making of improvements to any system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(c)

There are no recommendations as to the introduction of a system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(d)

GP practices making greater use of Key Information Summaries on Emergency Care Summaries where appropriate to improve information sharing between GP practices and NHS 24 might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] This was a discretionary inquiry held under section 4(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act").

[2] Preliminary hearings were held on 7 November and 13 December 2019; 13 January and 23 July 2020; and 16 March, 15 June and 25 October 2021. The inquiry was held on 29 and 30 November 2021 and 1 December 2021. Outline written submissions were received on 2 December 2021. Oral submissions were made on 3 December 2021. Oral evidence of the witnesses and submissions were given by way of WebEx and the preliminary hearings took place by teleconference and WebEx due to COVID-19 restrictions.

[3] Mr Sadiq, procurator fiscal depute, represented the Crown. Miss Watts, Advocate, represented NHS 24. Mr Fraser, Solicitor, represented the deceased's father. Ms Toner, Advocate, represented Nurse Donald Corbett. Miss Docherty, Solicitor, represented Dr Monica Ireland.

[4] The following witnesses gave evidence to the inquiry:

1. Donald Corbett, Nurse Practitioner, NHS 24.
2. Dr Monica Ireland, retired General Practitioner (practising in 2015).
3. Dr Norman Wallace, retired General Practitioner (Crown expert).
4. Dr Chris Kidson, Consultant Clinical Specialist in Cardiac and General Paediatric Intensive Care (Crown expert).
5. Nurse Sally-Anne Pygall (Crown expert).
6. Dr Guy Krauth, General Practitioner (Dr Ireland's expert).
7. Nurse Janice Houston, Associate Director of Operations and Nursing, NHS 24.

[5] A joint minute of agreement was entered into by the parties. Affidavits and police statements were used for evidence-in-chief.

Background facts and circumstances

[6] The facts outlined within this section of the determination were agreed between the parties and were contained in the joint minute.

[7] Leylan Forte ("the deceased") resided in Montrose with his mother and his father. The deceased was born eight weeks prematurely on 26 November 2010. There was a known history of maternal gestational drug abuse. An MRI scan performed neonatally diagnosed brain injury (periventricular leukomalacia).

[8] The deceased was treated for neonatal abstinence syndrome (withdrawal) as a result of his mother's drug use during pregnancy. The deceased was discharged from hospital on 20 December 2010. Over the course of his early years the extent of the deceased's physical and cognitive disability began to emerge. Amongst other problems,

the deceased was partially sighted. He suffered from cerebral palsy and global developmental delay.

[9] As a result of his many serious and complex health problems, the deceased required input from multiple different specialities including paediatrics, physiotherapy, opthomology, speech and language therapy and dieticians. In the year before his death and throughout his life prior to that, the deceased was frequently not taken to important medical appointments.

[10] Concern by the reviewing professionals regarding the deceased's poor growth and lack of food intake resulted in a referal to a dietician. He was assessed on 12 July 2011 and prescribed Infatrini milk supplement in place of baby formula. Dieticians continued to provide advice and support and on 15 October 2012 the supplement was changed to Paediasure Plus milk supplement. The deceased gained 1kg of weight between 18 February 2014 and 17 February 2015. The deceased was seen regularly at his home by his health visitor and dietician. They last met with the deceased on 7 April 2015.

[11] The deceased's weight problems were significant and long-standing. In October 2014 he was noted to have a BMI of 12.9 (healthy range 20-25) and a weight well below the 0.4th centile for his age. The deceased was dangerously underweight and required specialist input from dieticians and paediatrics. The deceased's difficulties were known to multiple medical, social work and charitable agencies.

[12] On or around 10:00 on 25 April 2015, the deceased became unwell, initially vomiting. On 26 April 2015 following further episodes of sickness, his mother contacted NHS 24 for advice and reassurance. Said call was received and answered by NHS 24 at 00:10 on 26 April 2015. At the conclusion of the call a report was generated by NHS 24 and sent electronically to NHS Tayside. The report contained demographic information, triage information including the call reason, the clinical summary, any notes (including any note made by the call handler) and any decision support tool which was used during the call. It also included any actions, e.g. a request for an out of hours appointment and the timeframe within which that had been requested by NHS 24. The report was received by Annat Bank surgery by 07:00 on 27 April 2015 from NHS Tayside Out of Hours Service.

[13] The deceased's condition deteriorated further and episodes of diarrhoea began. Shortly thereafter the deceased's mother began to vomit. On 27 April 2015 the deceased's father contacted NHS 24 to raise concerns for his partner and the deceased. At 06:11 Daniel Paterson, a call handler employed by NHS 24, spoke with the deceased's father. For confidentiality reasons he asked to speak to the deceased's mother and he then captured details of their conversation before transferring her to Donald Corbett, a nurse practitioner employed by NHS 24.

[14] The past medical history and emergency care summary were visible to Donald Corbett when speaking to the deceased's parents. The only data entered in the past medical history section was in the drugs section which listed Paediasure Plus. The

call concluded at 06:49. At the conclusion of the call the deceased's father was told to contact his GP surgery when it opened that morning. Another report was produced containing the information previously listed and was received by Annat Bank surgery by 07:00 on 27 April 2015 from NHS Tayside Out of Hours service.

[15] On Monday 27 April 2015, Dr Monica Ireland, General Practitioner at Annat Bank surgery, Montrose was acting as the duty doctor. Part of her duties was to respond to requests for home visits and review facts and information from Tayside Out of Hours service. Dr Ireland had sight of the information contained within the summaries relating to the calls to NHS 24 on 26 and 27 April 2015. At 09:00 on 27 April 2015, Dr Ireland telephoned the deceased's father in respect of his request for a house call. Dr Ireland made a subsequent record that she was advised during that call that the deceased had poor fluid intake. She confirmed she would call at the house later that morning. Dr Ireland recorded in her significant event analysis that she was advised during the call that the deceased's fluid intake was poor but he was managing sips of fluid and passing urine.

[16] Between 09:00 and 11:00 the deceased's condition deteriorated. The deceased's father contacted Annat Bank surgery at approximately 11:00 seeking urgent assistance. He spoke with a receptionist at the practice who telephoned through to Dr Ireland's room to pass the message to her. Dr Ireland left the surgery immediately and made her way to the deceased's home, arriving at approximately 11:10. On arrival Dr Ireland observed that the deceased was seriously ill and advised his parents to call an

emergency ambulance. At the same time, Dr Ireland was carrying out observations and arranging for a GP colleague from Annat Bank surgery to attend urgently with oxygen. A 999 ambulance was requested at 11:16 and arrived at 11:32 whilst Dr Ireland was speaking with ambulance control centre, having checked 999 to check on the progress of the ambulance.

[17] The deceased died on 27 April 2015 at 12:28 in an ambulance parked outside the deceased's home in Montrose. Dr Amanda Murphy, Consultant Paediatric and Perinatal Pathologist, noted the cause of death as acute dehydration and electrolyte disturbance secondary to viral gastoenteritis (norovirus), with the possible contributory factor of cerebral palsy.

[18] A significant event analysis carried out by Annat Bank practice within one month after the deceased's death (dated 27 May 2015) noted that it may have been helpful to highlight poor nutrition so that this was information was available to NHS 24.

[19] An adverse event investigation carried out by NHS 24 within three months after the deceased's death (dated 22 July 2015) concluded that the information available from the first call and the clinical symptoms and additional conditions described during the second call could have alerted Nurse Donald Corbett to the fact that the deceased was at greater risk of dehydration.

[20] A significant clinical event analysis review carried out by NHS Tayside within 18 months of the deceased's death (dated 20 September 2016) found that internal processes had worked in accordance with expectation and there was no necessity to modify those.

However, NHS 24 acknowledged that had additional information been available from partner agencies as a standard, consideration may have been given to the deceased being seen by the out of hours service in a face to face context. The GP practice reflected that the emergency care summary held within the practice might not reflect the correct level of vulnerability of individual patients should they become ill. Work was therefore ongoing within the practice to ensure that a fully informative emergency care summary was available for more vulnerable patients.

[21] In a letter dated 21 May 2018, NHS 24 replied to a request from the Crown Office and Procurator Fiscal Service ("COPFS") Scottish Fatalities Investgation Unit around three years after the deceased's death (dated 19 April 2018) seeking further information about the circumstances of the deceased's death. NHS 24 highlighted, *inter alia*, that Professor George Crooks, the then NHS Medical Director, had written to the PF Depute for Tayside within six months of the deceased's death (dated 21 September 2015) concluding that during the call on 27 April 2015, consideration should have been given for the deceased to receive a face to face assessment during the out of hours period (before the GP surgery opened).

[22] In a letter dated 22 June 2018, NHS 24 replied to a request from COPFS Scottish Fatalities Investigation Unit more than three years after the deceased's death (dated 4 June 2015) indicating that COPFS Scottish Fatalities Investigation Unit were considering whether a FAI should be convened relating to the care provided by NHS 24 to the deceased. NHS 24 indicated in their reply that they agreed with the Crown expert (Dr

Wallace) that in retrospect, the deceased required an urgent assessment in the out of hours period. They also indicated that they agreed with Dr Wallace's conclusion that a Key Information Summary would have likely prompted earlier admission to hospital, consistent with the presenting clinical history and processes around out of hours care.

Scope of Inquiry

[23] In light of the detailed joint minute, the scope of the inquiry was restricted to: (i) whether the second practitioner nurse (Nurse Donald Corbett) at NHS 24 responded adequately to the contact made by the deceased's parents; (ii) whether the GP (Dr Ireland) responded adequately to the contacts made by the deceased's parents; and (iii) the adequacy of the information provided to NHS 24 by the deceased's GP practice contained within his Emergency Care Summary.

(i) Whether the second practitioner nurse at NHS 24 responded adequately to the contact made by the deceased's parents

[24] Nurse Corbett qualified as an enrolled nurse in December 1981. He had considerable experience in a number of different areas before moving to NHS 24 in January 2007. He had worked for NHS 24 for over 14 years and had been a nurse practitioner for all that time.

[25] Nurse Corbett explained that the first call allocated was for the deceased's mother. Based on the information from the call handler, the deceased's mother had

stated she was the most unwell and the call came through as "serious and urgent". The deceased's mother had abdominal pain radiating to her back. The back pain was not new but was an ongoing problem. Nurse Corbett triaged her symptoms first, before moving on to assess the deceased.

[26] The information that Nurse Corbett had before him was the call reason, symptoms, names, age, date of birth and the information from the previous call on 26 April 2015. There was not a Key Information Summary ("KIS") for the deceased in his Emergency Care Summary ("ECS"). If there had been, Nurse Corbett would have looked at it. The KIS would contain any relevant past history of which the deceased's GP felt that other healthcare professionals needed to be aware. In many cases it would list the past medical history or special notes about the patient's physical or mental health that might be relevant when assessing someone outwith normal working hours.

[27] Nurse Corbett did not know that the deceased was premature with neonatal abstinence syndrome. He did not know about his limited weight gain. The deceased would be at high risk if he had diarrhoea and vomiting and was not getting better.

[28] Nurse Corbett thought that the deceased's mother needed to see a doctor to give her something to ease her pain and discomfort as she could not tolerate fluid or medication. He recommended that she needed to see a doctor within a four hour period. He advised her to contact the GP surgery when it opened at 08:00.

[29] The deceased's mother was not satisfied with Nurse Corbett's recommendation and became more upset. Nurse Corbett asked to speak to the deceased's father, who

was not feeling unwell or upset. Nurse Corbett believed speaking to the deceased's father would allow him to assess the deceased better.

[30] The deceased's father told Nurse Corbett that the deceased was lifeless, whereas his mother had said he had been rolling about in his cot for about for two days. Nurse Corbett needed to know what was happening there and then. If the deceased was in fact lifeless then that made it a life threatening situation. However, Nurse Corbett established that the deceased was rousable. He established that he was sitting up and watching TV. Nurse Corbett was told that the deceased had diarrhoea and may have autism. Nurse Corbett asked the deceased's father if the deceased had any other health issues and was told he did not. Nurse Corbett was aware the deceased was on Paediasure as this information was on the Emergency Care Summary.

[31] Nurse Corbett was reassured when the deceased's father checked on the deceased and informed him that he was sitting up and watching TV. He therefore did not consider that an ambulance was required. The deceased vomiting every time he took a drink was a red flag but Nurse Corbett did not consider that the deceased needed emergency treatment at that time.

[32] Having considered all that he was told and the other information that he had, Nurse Corbett decided that the appropriate time frame for the deceased to be seen was within four hours and advised the deceased's father to contact the GP surgery at 08:00 when it opened. The out of hours service was due to end in just over one hour at 08:00. If the call had been earlier in the night with the same symptoms, then Nurse Corbett

would have requested for both mother and child to be seen within a four hour period. If a nurse considered that a patient was too unwell to wait four hours then the nurse could request for a doctor to attend the patient within one hour. Nurse Corbett's decision at the time of the call was that it was safe to wait for the parents to contact the GP surgery when it opened at 08:00 so that the deceased was seen within a four hour period.

[33] Had Nurse Corbett been aware and alerted to other issues, namely: the deceased being born premature, his neonatal abstinence syndrome and additional risk factors, then Nurse Corbett would have phoned the ambulance service to request an ambulance within one hour to take the deceased to Ninewells Hospital Accident & Emergency department.

[34] During cross-examination by the procurator fiscal, Nurse Corbett accepted that from listening to the call after the event, it would have been better for him to explore in more detail how the deceased was at the time of the call; to have asked more questions about the deceased's eyes; to have picked up on the comment that the deceased had not slept for 48 hours; and to have explored further issues around vomiting and what had happened over the past two days. He accepted that perhaps he had made an assumption that the out of hours service would not be able to see the deceased within one hour and that it was probably wrong of him to make that assumption. He accepted that he could have given more detail at the end of the call about what he meant about calling back if the child became more unwell, such as vomiting again, becoming less rousable or any sort of deterioration. Nurse Corbett accepted that on reflection and with

the benefit of hindsight, consideration could have been given to a face to face assessment before the GP surgery opened at 8am.

[35] Nurse Corbett wholeheartedly agreed that a KIS in the ECS would have made him aware of greater risk to the deceased and with that information he would probably have arranged for an ambulance to attend within one hour.

[36] In cross-examination by Mr Fraser on behalf of the deceased's family, Nurse Corbett accepted that in hindsight, he acknowledged that some symptoms about the deceased's illness could have been probed further, such as his colour; whether he was hot or cold; what the vomiting was like; what was coming up; and how much was being given to the deceased to drink. Had he done so, he accepted that there was a chance that may have resulted in a different outcome.

[37] In cross-examination by Miss Docherty on behalf of Dr Ireland, Nurse Corbett accepted that his advice was for the deceased's father to contact the GP surgery at around 08:00 so that the deceased could be seen by a GP. Nurse Corbett could not guarantee that the deceased would be seen by a GP within a four hour period.

Expert opinion – adequacy of response

[38] Nurse Sally-Anne Pygall qualified as a nurse in 1985. Her specialist field was telephone triage and consultations in primary care and out of hours services. She conducted quality assurance work on behalf of out of hours services, including auditing

and reporting on the quality and safety of nurse and doctor telephone triage interactions.

[39] In her report dated December 2020, Nurse Sally-Anne Pygall concluded that Nurse Corbett did not meet the standards of ordinary care. He did not adequately explore the presenting complaint as stated by the deceased's parents and failed to ask a significant number of questions in relation to potential dehydration, which would be an increased risk given the prolonged nature of the vomiting; the uncertainty of fluid input and output; combined with the onset of diarrhoea; and the deceased's medical history. This placed the deceased at greater risk than at the time of the first call. Nurse Corbett also failed to offer adequate safety netting to ensure the deceased's parents were aware of what signs or symptoms to observe for, and what would indicate further assessment was required.

Expert opinion - causation

[40] In his report dated 21 February 2020, Dr Christopher Kidson, Consultant Clinical Specialist in Cardiac and General Paediatric Intensive Care, indicated that he was not of the opinion that the apparent delay between the second NHS 24 call at 06:11 on 27 April 2015 and the face to face consultation with the GP at 11:10 - 11:20 on 27 April 2015 *caused* the death of the deceased. The deceased died as a result of vomiting and diarrhoea caused by an infectious gastro-intestinal illness (norovirus) that led to a combination of

hypovolaemic shock and electrolyte disturbance which without rapid correction led to irreversible cardiac arrest.

[41] However, it was his opinion that had the deceased been transferred immediately to hospital for definitive treatment, he would not have died. Moderate to severe dehydration was very likely to respond to the urgent administration of intra-venous fluids and with dilligent titration of fluid and electrolyte replacement, according to biochemical response, Dr Kidson would expect a patient to make a full recovery.

Submissions

[42] The procurator fiscal submitted that Nurse Corbett had made a judgment. Referral to out of hours within one hour could not be described as a reasonable precaution that might have prevented the death but perhaps a remote possibility. If he had known that the deceased was premature with neonatal abstinence syndrome and had limited weight gain, then he would have been more at risk with diarrhoea and vomiting which was not settling. If Nurse Corbett had known this then the outcome he arrived at would have been different.

[43] The procurator fiscal submitted that Nurse Corbett did accept some of the criticism made by the experts and accepted that he could have probed more but also stated if the deceased was at greater risk, he would have sent him to hospital. He was given the impression that the deceased did not require hospital because the deceased's father told him that the deceased was awake, sitting up and watching TV.

[44] Miss Toner on behalf of Nurse Corbett accepted that Nurse Corbett had made an error, with the benefit of hindsight, resulting from a decision in what was recognised to be very difficult circumstances. However a finding in relation to a reasonable precaution ought not to be made in this regard. Firstly, it was a question of clinical judgment of a professional. Secondly, there were issues with causation.

[45] Ms Toner submitted that Nurse Corbett had explained that if he had made an out of hours referral, then that would become a triage decision for the out of hours GP within the local health board, which in this case was NHS Tayside. That would be a decision for the clinical judgment of the out of hours GP who took that call. It was not the case that Nurse Corbett could guarantee that the deceased would be seen within one hour. No evidence had been led about what an out of hours GP would have done in the circumstances. However, the approach by Dr Ireland was instructive. When the deceased was assessed by his own GP, Dr Ireland made a decision that a one hour assessment was not required and that emergency treatment was not required. There had been no criticism of Dr Ireland's approach. As the deceased's GP she had the benefit of other information about the deceased contained within his GP records, which Nurse Corbett did not have. That placed his clinical judgment in context. Dr Ireland had a fuller picture and yet also concluded also that it was safe for the deceased to wait.

Findings and recommendations

[46] Nurse Corbett was candid that with the benefit of hindsight, he ought to have made a referral to the out of hours service within one hour. That was also the opinion of independent Crown expert Nurse Sally-Anne Pygall and Nurse Janice Houston from NHS 24. The arrangement of a telephone assessment with NHS Tayside Out of Hours service within one hour or a home visit before 8am when the GP practice reopened was therefore a precaution which could reasonably have been taken by NHS 24.

[47] However, *arranging a referral* within a one hour time frame would not necessarily have resulted in the deceased *being seen* by a medical professional within that time frame. Whilst it is impossible to know for certain what would have happened, the best evidence as to what was likely to have happened comes from the actions of Dr Ireland. She triaged the deceased by speaking to his father over the telephone at around 09:00. On the basis of the information that she had from NHS 24 and her conversation with the deceased's father, she assessed that it was not an emergency presentation and that the deceased required to be seen later that day. That approach was not criticised by Dr Wallace, the independent Crown expert, nor Dr Krauth, the independent GP expert for Dr Ireland.

[48] Therefore, while the response of Nurse Corbett is *relevant* to the deceased's death and lessons can be learned from his thoughtful and very candid reflections upon his response with the benefit of hindsight, I do not consider that the arrangement of a telephone assessment with NHS Tayside Out of Hours service within one hour or a

home visit before 8am when the GP practice reopened *might realistically have avoided* the deceased's death.

(ii) Whether the GP responded adequately to the contacts made by the deceased's parents

[49] Dr Monica Ireland had been a GP for 35 years before she retired in March 2020. She was the duty doctor at the practice on the morning of Monday 27 April 2015. The role of the duty doctor was to review any NHS 24 call notes received that morning, as well as notes of any calls to the practice reception that morning requesting returning calls or home visits. The duty doctor would return calls to patients to assess whether the patient needed to be seen, in what time frame and to make the appropriate arrangements. In April 2015 the practice had started running a morning drop-in clinic between 08:30 and 10:30. Patients could drop in during that clinic and would be seen by the first available GP. The duty doctor would assist with this clinic unless there were more urgent telephone calls or home visits to be made.

[50] Dr Ireland would have arrived at the practice at 08:00 and reviewed the NHS 24 call notes before 09:00, in addition to seeing perhaps a couple of patients at the start of the 08:30 drop-in clinic. During that time frame, she received a note from the administrative staff to say that the deceased's father had called the practice asking to arrange a home visit for his son. A note of his call to the practice was made at 08:22, which indicated "sickness and diarrhoea. Dad said not able to come in to surgery".

There was also a corresponding note in relation to the deceased's mother who had similar symptoms.

[51] Dr Ireland called the deceased's father at around 09:00. He was quite capable of communicating with her about his son. He never had any difficulty communicating clearly with her when he attended appointments with the deceased's mother. During that conversation, the deceased's father told Dr Ireland that his son had vomited and had diarrhoea. In those circumstances, it was Dr Ireland's usual practice to explore the parent's concerns about the child's illness. She would ask about fluid intake and urine output; ask how the parent felt the child was; give advice about what to do in the meantime; and then agree a course of action. In this case, she recalled that she was told that the deceased was passing urine and that he was able to keep some liquid down. She asked the deceased's father to continue that and advised that she would come to visit the deceased after the morning surgery. She had a very clear impression that the deceased's father was pleased with that plan and he did not question it, nor raise any concerns.

[52] Dr Ireland was aware that the deceased's parents had called NHS 24 twice over the weekend. It did raise her initial level of concern that there had been two forms of contact with out of hours services and meant that she wanted to examine the deceased that day. Having spoken to the deceased's father she was reassured that the deceased was passing urine and was able to keep some liquid down. In addition, the information provided in the NHS 24 call summaries were not indicative of a patient who required an

urgent examination. With all of that in mind, she considered that an appropriate plan was to examine the deceased following the morning surgery. Expressions that had been used to describe the deceased to the out of hours service at 06:10, such as "looks terrible", "absolutely lifeless", "lethargic", "pale" and "gaunt" were not used during her call with the deceased's father.

[53] At around 11:00 Dr Ireland received a call from the practice receptionist to tell her that the deceased's father had called the practice again as he was concerned that his son had deteriorated. She decided to go and see the deceased straight away. She knew it would only take five minutes to drive from the practice to the family's home. She arrived at the deceased's home at approximately 11:10. She considered it would be a better use of time for her simply to go straight to examine the deceased in person rather than to spend time calling the deceased's father back to ask for a description of the deceased's condition. She did not conisder ordering an emergency ambulance before she left. She did not think there was any cause to do so. She was anticipating that she was going to see a child who was unwell with a sickness bug and who had become more unwell but certainly not that she was attending an emergency situation. It would be very rare to order an emergency ambulance for a patient over the telephone unless they were perhaps having a seizure or cardiac arrest.

[54] As soon as Dr Ireland saw the deceased she realised how unwell he was. She immediately asked his parents to call for an emergency ambulance. She also called a GP colleague at the practice to attend urgently with oxygen and a defibriliator. Dr Ireland

recognised that on occasions it can take some time for an ambulance to arrive in Montrose. The deceased's observations were very concerning, particularly his oxygen saturation of 64%, which was very low. She wanted to get him on oxygen as quickly as possible. GPs do not carry emergency equipment with them to house calls as a matter of course because they are not an emergency service and they do not usually anticipate requiring this equipment. In this instance, Dr Ireland thought that perhaps one of her colleagues in the practice could arrive quicker than the ambulance or at least be an additional pair of hands. In the end, the ambulance arrived just after her GP colleague had arrived and accordingly the oxygen was not necessary. While carrying out observations and attending to the deceased, she called 999 to ask for an update on when the ambulance was going to arrive. It arrived while she was on the call.

[55] When the ambulance paramedics arrived, they quickly made the decision to transfer the deceased to the ambulance which was just outside the flat. After talking to the deceased's parents for a few minutes, she left the flat to go to the ambulance. One of the paramedics was on his way to inform her that the deceased had had a cardiac arrest and cardiopulmonary resuscitation ("CPR") was in progress. It was agreed that somebody should act as a liaison with the parents and keep them up to date with what was happening and Dr Ireland took on this role. She recalled going back and forth between the ambulance and the deceased's parents to let them know exactly what was going on. It was a very difficult period. It was apparent that the deceased was in a very

poor state of health but it was agreed to keep his CPR ongoing until the emergency consultant arrived from Ninewells Hhospital.

[56] An A&E consultant from Ninewells Hospital arrived at some point during the resuscitation efforts. Shortly after the A&E consultant arrived it was agreed by the doctors and paramedics to stop resuscitation. CPR had been unsuccesful and after 50 minutes it was unlikely that continuing would be of any benefit.

Expert opinion – adequacy of response

[57] Dr Guy Krauth was a GP with over 20 years of full-time experience. In addition, he worked regular clinical sessions in Lothian Unscheduled Care Service (LUCS). LUCS was the out of hours primary care provider for NHS Lothian. That work consisted of the acute management of a wide range of medical problems through face to face consultations at a primary care emergency centre or on home visits as well as telephone triage.

[58] Dr Krauth was of the view that any decision to attend to the deceased immediately would have to be weighed and judged against competing requests for other home visits, urgent telephone advice calls and a need to assess patients face to face at the surgery. At that time and based upon the notes available to him, he was of the opinion that Dr Ireland's decision to visit the deceased within the next few hours was reasonable and that many other GPs acting in a similar capacity might have made the same decision.

[59] Similarly, no criticism was made of Dr Ireland's response by the Crown's expert Dr Wallace.

Submissions

[60] No findings in terms of section 26(2)(e), (f) or (g) were sought by any party in relation to Dr Ireland's response.

Findings and recommendations

[61] In the absence of any criticism from either GP expert, nor from any other witnesses, I have made no findings or recommendations in relation to Dr Ireland's response.

(iii) The adequacy of the information provided to NHS 24 by the deceased's GP practice contained within his Emergency Care Summary

[62] Nurse Janice Houston, Associate Director of Operations and Nursing at NHS 24 had held that role for 15 years. She explained that it was important to emphasise the limited nature of the information which was available to NHS 24. There was no single entity of NHS Scotland. NHS services are provided by a variety of different health boards of which NHS 24 is only one. They keep their own records of clinical contacts with patients so they will be able to see on their system the notes of the previous calls a patient has made to their service. They do not have access to the records kept by other

services. They do not have access to the records kept by a patient's GP practice which will record all of their attendances and any correspondence sent by or to their GP. They do not have access to the records of their local health board which will contain all of the records of any attendances at hospital and any correspondence sent to or from hospital doctors involved in their care. They do not have access to any records of the Scottish Ambulance Service. When a patient has a complex medical history their medical records can often run to thousands of pages. It would be impracticable for their nurses to review these records and discern the relevant information from them for the purposes of making a quick assessment in the out of hours period even if they had access to those records.

[63] As a result of this lack of information, NHS 24 are entirely dependent on a patient's GP practice providing them with a summary of the information which they will need to have about a patient in order to provide them with safe care in the out of hours period. The ECS holds details of a patient's medication and allergies. The ECS is populated from the GP system and retrieved by NHS 24 from a third party store. If there is special information relating to a patient such as a particular medical condition from which a patient suffers; particular problems or concerns that they should be aware of; or any particular plan that is in place for care, then the GP can add a special note. For instance, if a patient is known to be terminally ill and wants to be palliated at home, then they could arrange a prompt home visit to help with prescribing medication for symptom control but would not arrange an ambulance transfer to hospital unless the

patient wanted them to do so. Special notes are uploaded by NHS 24 on a daily basis. The GP fills in a form and sends it to the out of hours service of the territorial board, from where it is uploaded by NHS 24.

[64] It was Nurse Houston's understanding that GP partnerships were allowed to render a separate charge to their health board for the production of this information for each of their registered patients to reflect the fact that it was acknowledged to be critically important that they were able to take the time to prepare a careful summary to enable them to provide safe out of hours care.

[65] There was no special note for the deceased. The deceased was exactly the sort of patient for whom she would have expected that a special note should be provided. For a child with this background, which included: significant prematurity after maternal drug use during pregnancy; difficulties consuming solid food leading to significant doubt about the adequacy of his nourishment; a history of social work involvement and being placed in foster care; issues with drug abuse by both parents; together with persistent problems in gaining and maintaining a healthy weight; and a prolonged and extensive history of not being taken to important follow-up medical appointments, she would have expected a special note to alert NHS 24 to the need to arrange for the deceased to be seen if help was sought in the out of hours period. If NHS 24 knew his feeding regime, for example, this would have informed the likelihood of his dehydrating quickly. Given the background there was an obvious risk that it might be very difficult

for his parents to accurately assess and respond to the deceased's medical needs, although they were no doubt doing their best to care for him.

[66] Dr Ireland gave evidence that in 2015, there were about 4,500 patients registered at her practice. Of those, about 101 had a KIS. Of those, three were children. Back in 2015, a KIS was mainly used for people who were clinically vulnerable. The type of people that the practice mainly prioritised were receiving palliative care; suffering from dementia; in care homes; frequent attenders to out of hours; or had frequent hospital admissions.

Expert opinion – use of KIS

[67] In his report of 26 April 2018, Dr Norman Wallace indicated that this case illustrated a lack of communication between primary care services and NHS 24. The deceased was a vulnerable individual and it was unwise and unsafe to rely entirely on his parents being a satisfactory conduit of information. He was of the opinion that the deceased's ECS should have been expanded to include a KIS.

[68] However, Dr Wallace also accepted that back in 2015, such an approach would have been a counsel of perfection. He accepted that in 2015, a KIS was typically and primarily used for terminal care instructions and its use was only recently widened. If anything was to be learned from the deceased's death then he was of the view that it must be that a KIS was a very useful tool available to GP practices and was perhaps underused.

[69] Dr Krauth, independent GP expert for Dr Ireland, explained that an ECS was a very basic data set generated from the GP computer system containing demographic details, allergies, medication and was automatically generated for any patient in Scotland. Patients could choose to opt out. KIS was a relatively new innovation in 2013 and included much more of the past medical history pulled through from the GP notes. From 2013/2014 onwards, KIS was really an evolving process. There was a drive initially to include anticipatory care planning within KIS and areas that GPs were asked to share with the out of hours service included things such as age; frailty; and the risk of repeated hospital admissions.

[70] Dr Krauth's practice was slightly larger than Dr Ireland's at 6,300. Only two children had a KIS in 2015. A very informal survey of some neighbouring practices indicated that it was infrequent for a child to have a KIS in 2015. Dr Krauth suspected that it was part of a culture at that time. In around 2013 - 2016 it was being built on year by year. A big issue was that GPs were not able to turn on KIS without explicit consent. That had changed as a result of the COVID-19 pandemic, which had impacted positively on the interaction between GPs and the out of hours services.

Submissions

[71] Mr Fraser on behalf of the family submitted that the deceased was let down by "the system". The KIS system was not fully operational at the time of the deceased's

death. However, if anyone was a candidate for inclusion for KIS then then deceased was.

[72] The procurator fiscal submitted that anticipatory care plans and any relevant medical history should be fully recorded on KIS. It is clear that KIS was operational in 2015. It was an integral component for NHS 24 and primary care providers. Good record keeping on KIS should enable continuity of care and enhance communication between different health care professionals.

[73] Miss Watts on behalf of NHS 24 submitted that no convincing reason was provided to explain why the deceased did not have a KIS beyond a vague assertion that it simply was not generally done at that time. Reference to contemporary KIS guidance made it clear that there was no basis for any suggestion that in 2015 KIS was used principally for adult patients. The guidance which had been produced, which Dr Krauth acknowledged was in circulation at the time, specifically and repeatedly stressed the appropriateness of creating a KIS for children with vulnerability or complex medical problems. Any suggestion that the deceased was not vulnerable or did not suffer from complex medical problems would be wholly lacking in credibility. Dr Ireland's only substantive explanation for the absence of KIS was that the practice would not have known of his difficulties because he was not frequently brought to the surgery. That position became unsustainable when she was taken to a small selection of the multiple letters sent to the practice highlighting the many problems the deceased was experiencing.

[74] It was the unchallenged evidence of Nurse Houston that it was more and not less important to have a KIS for a child than for an adult because their vulnerability can considerably exceed that of an adult. The vague assertion that it was not generally not done at that time was contrary to the unchallenged evidence of Nurse Houston, who was far better placed to comment given her broader knowledge which was not confined to one small geographical area. It was the clear and unchallenged evidence of Nurse Houston that GP practices across Scotland were making much broader use of the KIS system, in particular for paediatric patients, than Dr Krauth and Dr Ireland had suggested. Mrs Houston was the only witness who was able to give evidence beyond limited local knowledge and her position on this matter should be accepted.

[75] It was the unchallenged evidence of Nurse Corbett that if there had been a KIS highlighting the important features of the deceased's medical history, then he would have sent him to Accident and Emergency in an ambulance which he would have sought within a one hour time period. There was no basis to conclude that the provision of a KIS would not have made a difference to the assessment that Nurse Corbett made. Taking into account the totality of the evidence led during the inquiry, NHS 24 submitted that the provision of a KIS by the deceased's GP practice and a face to face assessment by the out of hours service following a second call to NHS 24 were two reasonable precautions which might have been taken.

[76] Miss Docherty on behalf of Dr Ireland submitted that this case had to be placed in the context of standard practice back in 2015 some 6 ½ years ago about the way in

which a KIS was used. Dr Ireland and Dr Krauth had both indicated that it was not standard practice at the time for a GP practice to create a KIS for children such as the deceased. It was unusual to create a KIS for children at all. Dr Krauth indicated that the focus was on anticipatory care plans focusing on medical issues exclusively affecting adults at higher risk of repeated hospital admissions. Dr Ireland said that a KIS was created almost exclusively for adults such as dementia patients and those requiring palliative care. It was unusual to create a KIS for any child. Even if the practice had opted to produce a KIS for the deceased in 2015, what was likely to have been put on it was that Leylan had cerebral palsy. To have included information about his low BMI was not standard practice. Dr Ireland must be judged against the reasonable expectation of an ordinary competent general practitioner at the relevant time. It could not reasonably be concluded that Dr Ireland and Dr Krauth as well as the training practices that Dr Krauth told the court about in NHS Lothian were outliers.

[77] Having a KIS for a child such as the deceased including a special note of his low BMI would perhaps be an appropriate recommendation for the future but not an appropriate criticism of the past.

[78] Ms Toner on behalf of Nurse Corbett submitted that in 2015 to have created a KIS for the deceased would have been both reasonable and expected according to the evidence of Nurse Houston. Nurse Corbett's evidence had been that if he had that extra information on a KIS, then he would have arranged for an emergency ambulance. Dr Kidson's opinion was that if the deceased been transferred immediately to hospital for

definitive treatment, he would not have died. A KIS was therefore a reasonable precaution which might have avoided the deceased's death.

Findings and recommendations

[79] All witnesses were agreed that it would have been very helpful to have included information about the deceased's low BMI and parental vulnerabilities in the KIS. In light of Nurse Corbett's evidence that if he knew this additional information, then he would have arranged for an emergency ambulance, combined with Dr Kidson's opinion that if the deceased been transferred immediately to hospital for definitive treatment, he would likely have made a full recovery, I am of the view that the use of the Key Information Summary of the Emergency Care Summary by the deceased's GP practice to note his his low BMI and parental vulnerabilities might have avoided the deceased's death.

[80] As to whether use of the KIS in that way would have been a reasonable precaution for the deceased's GP practice to have taken, I accept the evidence of Nurse Houston that the deceased was exactly the sort of patient for whom she would have *expected* a special note to have been provided on the KIS, based on her own experience of the use of KIS from her perspective as Associate Director of Operations and Nursing at NHS 24 for the past 15 years. However, that evidence is of limited assistance to the question of what a GP *ought to have done* in 2015. In answering that question, I require to have regard to the evidence of the two independent expert GPs (Dr Wallace and

Dr Krauth), as well as the treating GP (Dr Ireland). Despite guidance indicating that it was possible to create a KIS for any patient, the evidence of *all three* general practitioners who gave evidence to the inquiry was that this was a counsel of perfection rather than standard practice back in 2015. I therefore do not find that this was a *reasonable* precaution which could have been taken.

[81] I am pleased to hear that greater use is being made of the KIS after the COVID-19 pandemic. However, in light of the lessons learned from this inquiry, I think it would be useful to recommend that GP practices should make greater use of Key Information Summaries on Emergency Care Summaries where appropriate to improve information sharing between GP practices and NHS 24. In doing so, I acknowledge that Dr Kidson in his report made reference to the risk of too much information becoming overwhelming. However, the brief details identified by Dr Ireland and Nurse Corbett in hindsight as being useful are the sorts of things that may help to prevent deaths in other similar situations in the future.

Conclusion

[82] I was pleased that the manner in which this inquiry was conducted was inquisitorial rather than adversarial. That provided the opportuity to scrutinise the decisions of medical professionals with the benefit of hindsight. All witnesses gave serious consideration to what lessons could be learned and reflected in depth upon their own actions.

[83] I would like to thank the witnesses for their time, co-operation and candour with this inquiry. I am also very grateful to all the solicitors and counsel involved for their assistance in focussing the scope of the inquiry, conducting the inquiry via WebEx and for their detailed submissions. Finally, I wish to express my sincere condolences to Leylan's family, which were echoed in the submissions made by all parties.

Delays

[84] However, it falls to be highlighted that the conclusions of this FAI are essentially the same as those reached by the GP practice and NHS 24 following their own investigations completed within one month and three months of the deceased's death respectively, namely that it may have been helpful for the GP practice to highlight poor nutrition to NHS 24 and that the information available to the second Nurse Practitioner should have alerted him to the fact that the deceased was at greater risk of dehydration. If the purpose of this discretionary FAI was to draw wider attention to those lessons learned and avoid future deaths, then it ought to have taken place much sooner after the deceased's death. Otherwise, it is difficult to understand how the public interest is served by an inquiry taking place six years after the deceased's death covering the same issues.

[85] Some four years passed before notice that an inquiry was to be held was given by the procurator fiscal in September 2019. Despite the passage of time, it was apparent at the first preliminary hearing in November 2019 that the Crown were not properly

prepared. They had still not obtained the deceased's full GP records. In addition, I required to highlight to the procurator fiscal that commentary by experts outwith their areas of expertise would not assist the inquiry. Despite several preliminary hearings, the Crown failed to comply with various court deadlines in relation to agreement of evidence and lodging of affidavits and productions.

[86] The Cullen Review in 2009 made a number of recommendations, which led to the establishment of the Scottish Fatalities Investigation Unit. The 2016 Act made provision for preliminary hearings and agreement of evidence in FAIs. Despite those developments, it is extremely disappointing that in this inquiry there have been protracted investigations and unexplained delays.