DETERMINATION BY SHERIFF KENNETH A ROSS INTO THE CIRCUMSTANCES OF THE DEATHS OF WILLIAN SNEDDON, LEMOND MILROY, DAVID BRODIE McFARLANE, AGNES McCOULL,

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SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT DUMFRIES

DETERMINATION`

by

SHERIFF KENNETH A ROSS

Sheriff of South Strathclyde, Dumfries and Galloway at Dumfries

in

an Inquiry into the circumstances of the deaths of

- **WILLIAM SNEDDON**
- **LEMOND MILROY**
- **DAVID BRODIE McFARLANE**
- **AGNES McCOULL**
- **ARCHIBALD HAINING**

held under

the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

DUMFRIES: 21 January 2004

(1) INTRODUCTION

This Inquiry was held into the circumstances of the deaths of William Sneddon, Lemond Milroy, David Brodie McFarlane, Agnes McCoull and Archibald Haining. These deaths occurred on various dates between 26 July 1999 and 16 March 2001. All except Agnes McCoull died in Dumfries and Galloway Royal Infirmary while receiving treatment there. Mrs McCoull had recently been a patient in the Infirmary but died at home after being discharged. The Inquiry was sought by the Procurator Fiscal in terms of section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 because it appeared to the Lord Advocate to be expedient in the public interest that such an Inquiry be held. In terms of section 1(3)(c) of the 1976 Act the Inquiry related to the five deaths because it appeared to the Lord Advocate that the deaths had occurred in the same or similar circumstances.

The Crown was represented by Mr Martin, the Senior Procurator Fiscal at Dumfries. The only other representation was on behalf of NHS Dumfries and Galloway, the health trust responsible for Dumfries and Galloway Royal Infirmary and for the doctors and nursing and other staff who work there. Mr Ross, Advocate, appeared for them. There was no separate representation on behalf of any of the medical and nursing staff who gave evidence or who were referred to in the evidence. None of the relatives of any of the deceased was represented at the commencement of the Inquiry but, in the course of the evidence about the death of David McFarlane, his daughter Mrs Rona Jess, appeared on her own behalf and questioned the witnesses.

The Inquiry lasted for eight days of evidence between 1 and 10 December 2003. I heard submissions on the evidence on 5 January 2004. Each death was the subject of a separate chapter of evidence about its cause and circumstances. But, having regard to the holding of the Inquiry in terms of section 1(3)(c), the issue of whether the deaths had occurred in the same or similar circumstances was considered as the evidence was heard; and I heard submissions on that matter too.

Firstly I will deal separately with each of the deaths, making the findings about each which section 6 of the 1976 Act obliges me to do, and narrating and discussing the relevant evidence and any other conclusions I reached arising from that death. I will then examine whether the evidence disclosed any similarity between any of the deaths and any conclusions which might arise from that. Finally I will deal with a submission made by counsel for the Trust about the proper scope of the Inquiry, and its purpose, and how similar inquiries might be approached in the future.

(2) DEATH OF WILLIAM SNEDDON

- **Place and time of death**

  William Sneddon died at Dumfries and Galloway Royal Infirmary, Bankend Road, Dumfries on 26 July 1999 at 09.40 hours.

- **Cause of death**

  His death was caused by 1(a) Neutropaenic Sepsis (b) Small Cell Lung Cancer Treatment and 2 Small Cell Lung Cancer.

- **Reasonable precautions whereby the death of William Sneddon might have been avoided**

  None

- **Defects in the system of working which contributed to the death of William Sneddon**

  None

- **Other facts relevant to the circumstances of the death**

  None

- **Recommendations**

None

Note:

- The witnesses who gave evidence were:
  - Mrs Ann Sneddon, the widow of Mr Sneddon
  - Dr Jane Gyson, a Staff Grade Physician at Dumfries and Galloway Royal Infirmary
  - Mrs Michelle Sneddon, a daughter-in-law of Mr Sneddon
  - Kevin Sneddon, a son of Mr Sneddon
  - Ms Alice Paterson, formerly a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - Ms Elspeth Soutar, a Senior Sister at Dumfries and Galloway Royal Infirmary
  - Ms Caroline McDougall, formerly a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - John McClelland, formerly a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - Ms Linda Neill, an Auxiliary Nurse at Dumfries and Galloway Royal Infirmary
  - Mrs Laura Ross, a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - Dr Colin Peters, formerly a Junior House Officer at Dumfries and Galloway Royal Infirmary
  - Dr Paul Rafferty, a Consultant Physician at Dumfries and Galloway Royal Infirmary

    By way of affidavit:

  - Dr Bruce Halliday, a General Practitioner at Greyfriars Medical Centre, Dumfries

    By way of unsworn statement, without objection:

  - Judy Taylor, Senior Nurse in Professional Practice at Vale of Leven Hospital
  - Dr S W Banham, a Consultant Physician at Glasgow Royal Infirmary
- At the conclusion of the evidence of Mrs Sneddon, counsel for NHS Dumfries & Galloway took objection to the line of evidence which he anticipated would be led by the Procurator Fiscal Depute. In doing so he accepted that the taking of such an objection was, in some ways, "extraordinary". He submitted that, from the evidence of Mrs Sneddon, it appeared to be the Crown's intention to suggest that Mr Sneddon's death had been caused or contributed to by the care which he received on the ward in the hospital. This had not been suggested before the Inquiry. No notice had been given of any intention to criticise the medical care Mr Sneddon had received. It was known from his death certificate that the cause of death was small cell lung cancer. It was submitted that could not relate to any issue of lack of water or a dirty bed or to any other domestic concern. Counsel indicated that his clients had obtained a report from Dr Banham to that effect

and that he intended, at a later stage, to lead evidence of that. If the Crown were, in effect, challenging what was said on the death certificate counsel felt entitled to ask what evidence would be led to support that. No intimation had been given of the Crown's intention to do so. There was no medical report lodged to that effect. Unless any lack of care could be said to have caused or contributed to the death evidence about it was inappropriate. There was a well established complaints procedure for such matters. It was not a fit subject for a Fatal Accident Inquiry.

- In reply the Procurator Fiscal Depute indicated that he would be leading evidence from Drs Gyson and Rafferty who would speak to the effect of chemotherapy in causing neutropensis (the reduction of the white cell blood count) and the part which they thought infection had played in Mr Sneddon's death. Each would indicate that reference to such infection as a cause of death should have been made. He would be suggesting that such infection was the cause of death and that the death certificate was wrong. Evidence of the care of Mr Sneddon and his state prior to his death were critical and relevant to establish this.
- In response Counsel expressed surprise that no notice had been given of any intention to challenge the terms of the death certificate. He submitted that there was and would be no considered medical opinion that neutropensis causing infection was the cause of death. An expert opinion would be required and not simply the statement of a single practitioner.
- I repelled the objection. The Procurator Fiscal depute had assured me that he intended to lead evidence which might tend to suggest that the cause of death had been wrongly stated on the death certificate. Whether that was the case, and whether I would require to so find, could not be determined without hearing the evidence. It went to the heart of one of the required determinations in terms section 6(1)(b) of the 1976 Act. It was in the public interest that the matter was explored publicly which is the essential purpose of a Fatal Accident Inquiry. In repelling the objection I indicated that I would certainly entertain any motion which Counsel might make for any adjournment if the Trust felt they might want to investigate any such evidence or lead evidence in rebuttal.
- William Sneddon was 64 when he died. He had suffered from pulmonary fibrosis and occasional angina for several years. His health had caused him to stop work in about 1994. He had difficulty breathing and this inhibited his activities. He was a cigarette smoker. On 9 July 1999 he felt unwell. He was referred to the hospital after a home visit by a GP. Tests there established that Mr Sneddon had small cell lung cancer (carcinoma). There was a very extensive tumour on the lower part of his lung at the anterior lower tracheal wall extending into the right upper lobe and right middle lobe. The trachea (windpipe) was at least 50% occluded. There were signs of superior vena cava obstruction where the tumour presses on the large blood vessels in the upper part of the chest. Small cell carcinoma is the fastest growing lung tumour, doubling in size every 30 days. The average survival rate is three months untreated or a year to eighteen months treated. Because of the occluded windpipe these times would have been less for Mr Sneddon.
- It was decided to treat Mr Sneddon with a course of chemotherapy - four courses at least over twelve weeks. That treatment is not curative but in 90% of cases some shrinkage of the tumour can be expected. He received his first dose of chemotherapy on 16 July and was allowed home on 17 July. After the

diagnosis, but before the discharge, Dr Rafferty, the consultant in charge of Mr Sneddon, spoke to Mrs Sneddon and explained the nature of the tumour. She was very upset by this and the likely rapid progression. Dr Rafferty did not agree with her suggestion that the cause had something to do with Mr Sneddon's former work. Dr Rafferty was of the view that the cause was Mr Sneddon's smoking. That is not a view which found favour with Mrs Sneddon. She also discussed the course of treatment with Dr Gyson. Dr Gyson's intention was to give four to six courses of chemotherapy at intervals of about three weeks although, in evidence, she explained that the intervals might be longer depending on the response of the patient to the drugs. Mrs Sneddon seems to have come away from the conversation with the impression that the treatment would last six months and had the expectation of a remission at the end of it. Dr Gyson could not recall the exact terms of their conversation; nor whether survival times were discussed. It seems that, even if Mrs Sneddon was not told that the treatment would last six months, she reasonably assumed so. This expectation was sadly not realised. That is of importance in assessing Mrs Sneddon's evidence and her reaction to her husband's short stay in hospital.

- Within a few days of Mr Sneddon's return home on 17 July he was agitated and could not settle. A doctor was called on several occasions. Tranquillisers were prescribed. On 23 July he was again very uncomfortable and agitated and he started having diarrhoea. A doctor was called that evening and he was admitted to the Accident and Emergency Department. Mrs Sneddon thought that they arrived there about 8.30 p.m. Mr Sneddon was admitted to Ward 7. He was diagnosed as significantly neutropaenic (a condition resulting from the chemotherapy which causes a lack of neutrophils - a kind of white blood cell which helps to defend the body from infection both external and from organisms already in the body). He was placed in isolation. He was prescribed ciprofloxacin and metronidazole, antibiotics to protect against infection. Over the following days Mr Sneddon's neutrophil count fell. As appropriate he was given diamorphene to relieve his pain. His condition deteriorated badly into 26 July. His diarrhoea continued. He vomited blood. Around 7 a.m. he fell from his bed resulting in diarrhoea on the bed and floor. He was put back to bed and bathed. His family were contacted and arrived about 8.25 a.m. He died with them present at 9.40 a.m.
- An initial issue in relation to Mr Sneddon's death was its cause; or, more precisely, the description of its cause on the death certificate (Small Cell Lung Cancer). He had small cell lung cancer and was going to die. Left untreated the mechanism of death would almost certainly have been choking by the blocking of the windpipe by the growing tumour. Treatment by chemotherapy has the potential to lower the body's resistance to infection inducing neutropaenic sepsis. Mr Sneddon succumbed to that risk. The primary cause of his death was neutropaenic sepsis, secondary to the treatment and the carcinoma. While he would not have died but for the cancer, the terminal event was the infection. That very accurate description was accepted by both Dr Gyson, who signed the death certificate, and by Dr Rafferty. I do not criticise Dr Gyson for the description she noted on the death certificate but the case is an example of the importance of distinguishing and describing as accurately as possible primary and secondary causes of death. In the case of Mr Sneddon it assumed importance, or certainly a potential importance, because of information available about the possible state of cleanliness of the circumstances in which Mr

Sneddon died or those in the period leading up to his death - when he was dying. For these reasons my finding about the cause of death departs from the legend on the death certificate.

- There was no criticism at the Inquiry about the medical care which Mr Sneddon received. There was no evidence on which any such criticism could have been based. Dr Banham, who examined the case notes, concluded that the care "was conducted according to appropriate available guidelines on lung cancer and no additional reasonable precaution was indicated to avoid the unfortunate profound .....episode which resulted in death". I heard nothing which indicated otherwise. It is unfortunate that, after the diagnosis on 23 July, Mrs Sneddon was left with the impression that treatment and survival might have been longer but I accept that it was difficult for either Dr Rafferty or Dr Gyson to be precise and that, if not asked directly, would have restricted themselves to a description of the expected course of treatment which they were starting. I think it is important to make clear that Mr Sneddon's death was not caused by or contributed to by any failure on the part of the medical staff treating him. They did all they could in what was an unfortunately short final illness.
- Nor, after the evidence which I heard at the Inquiry, is there any basis in the suggestion that Mr Sneddon's infection was caused by conditions in Ward 7. It is important to state this clearly and unambiguously because concerns about cleanliness in the ward loomed large during the Inquiry into his death. I will discuss these concerns shortly but, even if, as was said in evidence, there was excrement on his room floor or there were delays in changing his soiled bed or pyjamas, it is not established as probable or even likely that this had any effect on his medical condition or caused or contributed to his death. I accepted the evidence of Dr Gyson and Dr Rafferty that, generally, the most likely source of infection was endogenous - from the bacteria carried in the bowel, the nose, the throat or the skin. Neither excluded an exogenous source but the tenor of their evidence was it was unlikely - "not impossible". The only discussion of how faecal material could transmit infection was in Dr Gyson's evidence. She said that infection could be transmitted by ingesting such material. She thought the risk of contracting an infection from a dirty toilet was "minimal". There was no evidence which contradicted or questioned these views from an experienced medical practitioner. She accepted the importance of clean wards in avoiding the spread of infection but, in the case of Mr Sneddon, she pointed to the likely existence of his infection when he was admitted on 23 July.
- Mr Sneddon was neutropaenic when admitted. That is seen in the medical notes for 23 July when he was examined at 10.30 p.m. by a surgical registrar or house officer and again later by a medical senior house officer. Both noted the neutropaenia. The neutrophil count is recorded. Antibiotics were prescribed. The normal level of the neutrophil count is between 2.5 and 7.5. On admission Mr Sneddon's was 0.7. By the following day (Saturday 24) it had reduced to 0.1. Significantly that is the day before Mrs Sneddon complained about the dirty conditions in her husband's room. Mr Sneddon had the infection when he entered the ward. That is confirmed by the plan for treatment seen in the medical notes following admission, part of which was "isolation"; and Mr Sneddon was placed in a single room. The nursing notes confirm the reason - "For protective isolation due to neutropaenic 0.7". Sister Soutar confirmed that protective isolation was "to try and protect the patient from obtaining infection because they are already very susceptible to infection with the blood count

being lower". So, neither the evidence of conditions in the room (if believed) nor what the doctors said about infection and its likely cause give any support to the proposition that Mr Sneddon's infection was caused or contributed to by conditions in Ward 7.

- That might seem to dispose of the issues where any determination setting out the circumstances of the death is required by section 6 of the 1976 Act. That is certainly the course which Counsel for the Trust, no doubt acting on their instructions, urged on me. For the reasons which I have discussed earlier I did not accept that submission. In the case of Mr Sneddon there was evidence on the basis of which, if believed, it might be possible to make a determination of facts which were relevant to the circumstances of his death. That evidence related to the nursing care given to Mr Sneddon during the days preceding his death including the cleanliness of his conditions in hospital.
- The initial concern spoken to by Mrs Sneddon related to the time spent by Mr Sneddon in the Accident and Emergency Unit on his arrival. His admission had been precipitated by his diarrhoea. That continued while he was in A & E. She told a nurse that her husband needed the toilet. She assumed the nurse knew about the diarrhoea but a bottle was brought. As a result he soiled himself and was distressed. Now, in itself, the incident was distressing and probably unnecessary but of little more than that. It was not suggested to Mrs Sneddon that she was untruthful about it. I heard no evidence to the contrary. Alice Paterson was on duty in A & E. She confirmed that Mr Sneddon had soiled himself in a cubicle when attempting to go to the toilet. She said that there had been no buzzer call for assistance but she could not exclude the possibility that Mrs Sneddon had gone herself to ask. A letter to Mrs Sneddon, dated 13 October 1999, from Gordon Jamieson the Director of Nursing and Quality Assurance was produced in evidence. In this he states "I apologise for the fact that by the time the nurses attended, your husband had attempted to go to the toilet himself and soiled as a result." I accepted Mrs Sneddon was telling the truth about this. I could not ignore that when considering the truthfulness of other parts of her evidence.
- The principal issues which she raised about her husband's care stemmed from two visits she made to him on Sunday 25 July. She first visited in the afternoon with her son Kevin. Two friends were also there. Mr Sneddon said he wanted a drink. There was a small empty water glass in the room. Mrs Sneddon asked a nurse for water and was told there were no jugs available and that a glass had been provided. She visited again in the evening, with her daughter-in-law and a friend John Tallons. (Unfortunately Mr Tallons had died before the Inquiry was held.) Her daughter-in-law had bought a bottle of water and, by then, Mrs Sneddon said, a jug had been provided. Mrs Sneddon spoke to some nurses before she went into the room. Her daughter-in-law and Mr Tallons were already there. When she entered the room her daughter-in-law warned her to watch where she stood. She then saw some human excrement on the floor covered by a piece of toilet tissue. At this point Mr Sneddon asked Mr Tallons to help him to go to the toilet. When the bedclothes were removed Mrs Sneddon saw that the bed was soiled as were Mr Sneddon's pyjamas. She thought that the soiling was not fresh. She became very angry and went to complain to the nurses and ask for the floor and bed to be cleaned. She said that an auxiliary nurse and a staff nurse went to do that. She then went to look for her husband. She met Mr Tallons who told her that the toilet was filthy. He said that the commode was

soiled and that all the bottles were full of liquid. She assumed that was urine. She told an auxiliary nurse about the dirty toilets. When she returned to the room, the floor had been cleaned and the bed changed. Her husband had not been changed. She complained to the sister who told her that her husband had refused a wash earlier in the day. She returned home and, later, phoned to be told that her husband had been given a wash and change. She collected his pyjamas the next day. She said they were "pretty well soiled" at the trousers and part of the leg. The other aspect about cleanliness which concerned her was the presence of a dirty swab under the bed. She had not seen this before Sunday but was told by her son that he had seen it when he visited on Saturday.

- There is support for what Mrs Sneddon says in the evidence of her son and daughter-in-law. Michelle Sneddon said she saw the excrement on the floor when she visited on Sunday. She described it in similar terms to her mother-in-law. She thought the room was hot and smelling of excrement. She also saw one wipe or swab with blood on it beside the bed. She did not see Mr Sneddon's bed. She did not go into the toilet. She confirmed the evidence about the lack of water and a jug. In fact she bought a bottle of water because of that. She visited again in the evening. She saw a dirty bedpan in the toilet. She thought it was in the same place as she had seen a bedpan on her previous visit. She was unable to say if its state was the same then. Kevin Sneddon visited on Saturday and on Monday. On both occasions he saw swabs on the floor. One was under the bed and looked to be same one on both days.
- One odd aspect of Mrs Sneddon's evidence concerned a note which she said that she gave to Dr Rafferty immediately after her husband's death. She had written it after her second visit on Sunday. It mentioned the points which concerned her - lack of water, dirty toilets and dirt on the floor. She found it in the bag containing her husband's clothes when she got home. Dr Rafferty had no recollection of receiving such a note. If he had he would have passed it to the nurses. None of the nursing staff who gave evidence seems to have seen the note. I have no reason to disbelieve Mrs Sneddon about that.
- Some of what Mrs Sneddon says is unquestionably true. I have already referred to the difficulties in the A & E Department. It also seems that she is correct in saying that there was no water jug in her husband's room. That was confirmed by Sister Soutar, who said that they had run out of jugs that morning, and by Staff Nurse Ross who seems to have checked the position by glancing through the room window. Sister Soutar mentioned the complaint about the water in her evidence and in the entry she made in the nursing notes. She also referred to it in a written statement she prepared for Mr Jamieson. Staff Nurse Ross appears to confirm another aspect of Mrs Sneddon's evidence. The initial complaint about the water was made during the afternoon visit. But Mrs Sneddon also said that she went and spoke to nursing staff about the water when she arrived in the evening and before she went to her husband's room. Laura Ross speaks to her first contact with Mrs Sneddon as being about 7 p.m. when she complained about the water. When she looked through the room window she saw the bottle of water which had been purchased by the family earlier in the day.
- Likewise there seems to be no doubt that Mr Sneddon's bed and pyjamas were soiled by the time of the evening visit but not earlier. It is recorded in the notes that he had refused a wash in the morning. At 1.55 p.m. he had an intra-muscular diamorphene injection which, Sister Soutar said, would have been most likely have been administered to the right buttock and involving the

removal of pyjama bottoms by Staff Nurse Todd. No soiling is noted in the nursing notes. Although she did not give evidence, in her written statement to Mr Jamieson, Staff Nurse Todd states that the clothing and bedding were both "clean". Linda Neill said that she and another nursing auxiliary washed Mr Sneddon just after visiting. They put on clean sheets and noticed that his pyjamas were slightly soiled. They changed them. This was the same day on which Mrs Sneddon complained (Sunday 25). Laura Ross said in evidence that she and Staff Nurse Hughes had helped Mr Sneddon onto a commode after visiting time. They noticed that there was slight soiling of the pyjamas and the sheet. They washed Mr Sneddon and changed the bed linen. Staff Nurse Hughes did not give evidence but confirmed, in her written statement to Mr Jamieson, what Laura Ross said. She puts the time, however, at 7.20 p.m. and says that the family were asked to leave the room while the procedure was carried out. They were then re-admitted. That agrees with what Mrs Sneddon said although there is a difference between them as to whether or not the pyjamas were changed and whether the cleaning and change was done by two staff nurses of a staff nurse and an auxiliary. There are puzzling inconsistencies in this evidence. It seems improbable that Mr Sneddon was washed and changed twice by different sets of nurses soon after visiting. The nursing notes record neither. They do record diarrhoea at 9.10 p.m. and there is a note by Caroline McDougall about frequent bed changes because of incontinence. But it is not timed and must relate to the period after 9 p.m. when she came on duty. In any event none of this is inconsistent with Mrs Sneddon having seen soiled pyjamas and bedclothes. Nor is that unexpected given Mr Sneddon's condition. My impression is that she over-reacted in her complaint, affected by the shock of her husband's sudden decline and, perhaps, her earlier annoyance about what happened in A & E and the lack of water earlier. She may also not have taken into account or understood that her husband had refused to be washed earlier. And one cannot leave out of account her own manner which seems to have been aggressive and confrontational. She accepted that she could be hot-headed. Michelle Sneddon also confirmed that her mother-in-law was angry on Sunday evening. While what happened was distressing for Mrs Sneddon in the circumstances I do not find that it indicates a serious lack of nursing care. Mr Jamieson has, of course, recognised that the lack of water jugs was unacceptable and should not have happened. As to the evidence of a dirty toilet and bottles of urine, the principal source of evidence is the hearsay of Mr Tallons. Michelle Sneddon seemed unsure about exactly what she had seen. Mr Tallons did not give evidence. Each of the nursing staff who was asked denied seeing any dirty toilet. I prefer their evidence on this point to that of Mr Tallons. I am inclined to accept that the family may have seen one or more swabs on the floor. They were definite in their recollection.

- The most immediately startling of Mrs Sneddon's concerns relates to the excrement on the floor. None of the nursing staff said that they saw this. None spoke to removing it. Of course, by the time Sister Soutar became aware of the complaint the clearing of the floor would have happened. I was asked to disbelieve Mrs Sneddon and her daughter-in-law. I am not prepared to do that. Her other concerns, about the water and the soiling, were true if, in the case of the soiling, exaggerated. She made her complaint at the time and that was confirmed by Sister Soutar in evidence. What is puzzling is that this complaint was not recorded by Sister Soutar in the nursing notes (the others were); nor is

it to be found in her written statement to Mr Jamieson. That seems very peculiar. While I accept that it is my responsibility alone to assess the credibility of witnesses I note that, in his letter of 3 December 1999 to Mrs Sneddon, Mr Jamieson accepts what she says:- "My reply indicated that I could not find any member of staff who recollected there being faeces on the floor. However it is clear from our conversation and particularly the recollection of your friend that this did take place and I have taken the opportunity again to remind the Ward Sister and all other staff of the absolute importance of maintaining hygiene in all areas where patients are being cared for." So Mr Jamieson appears to have accepted what she said and acted upon it. I do not find that surprising. The inconsistencies in the evidence of the nursing staff to which I have referred make it difficult to reconcile what the staff recall about the evening. I dare say that most are correct when they say they do not recollect seeing excrement on the floor or removing it. I think on balance, however, that someone did. Perhaps they did not give evidence. It is not part of my task to resolve who that might be. But I am satisfied that it was there and that someone must have removed it.

- In relation to Mr Sneddon's death the importance of all this is whether it is relevant to the circumstances of the death. He died in a hospital room. If the condition of that room was likely to cause distress or alarm to him or his relatives or give rise, in a non medical mind, to concerns about cleanliness or infection that, in my opinion, is relevant to the circumstances of his death. But, as this Inquiry into the five deaths showed very clearly, death can be unpleasant and undignified no matter how skilled and caring the doctors and nurses are. Incontinence is unpleasant and undignified. I dare say there will be times when, unavoidably, there is faecal material on hospital floors. In fact there was when Mr Sneddon fell from his bed shortly before his death on Monday morning. The important issue is whether there is an adequate system in place to clean it up quickly. That seems to be the case at Dumfries and Galloway Royal Infirmary. I heard evidence from Dr Bone who, for twenty years, chaired the hospital's Infection Control Committee and from Angela Brown, the Area Domestic Manager for the Trust. Both described the systems in place for cleaning the hospital and monitoring that this was done properly. Random checks on wards are carried out. There are guidelines and protocols in place. Two infection control nurses inspect and observe clinical cleanliness throughout the hospital. I heard evidence of the Performance Audit on Hospital Cleaning carried out by the Auditor General for Scotland in 2002. Dumfries and Galloway Royal Infirmary was in category 1 (very good or acceptable) for both levels of cleanliness in wards and in public areas. There was no evidence that lack of cleanliness was a general problem or that what I had heard about Mr Sneddon's room was other than an isolated and temporary occurrence. The procurator fiscal sought to question part of the methodology of the Auditor General's inspections where advance notice seems to be given. I suppose unannounced checks could have a place in any monitoring or audit regime but the restricted evidence I heard did not begin to provide a basis to examine such issues.
- I was told that this aspect of the Inquiry had attracted considerable media and public interest. Angela Brown alluded to that when she spoke of the effect of that on her staff. I did not doubt her when she said that they take great pride in their work. They live and work in the community. It must be demoralising when they read of allegations of a dirty hospital or hear such allegations repeated or reported by friends and neighbours. The evidence I heard in this Inquiry did not

remotely support any suggestion that standards of cleanliness in Dumfries and Galloway Royal Infirmary are other than as high as in other Scottish hospitals or that there is a general problem of lack of cleanliness in the hospital. So, although I have discussed the evidence fully, that is only to attempt to determine the disputed areas of fact which the Inquiry presented. Accordingly I make no findings on these matters; nor is it necessary for me to make any recommendations. I would add only this. If unavoidable and understandable incidents, such as that which distressed Mrs Sneddon occur, complete frankness and openness, by each and every staff member of the Trust, about what has happened and why, is essential. Otherwise what can be easily and properly resolved by an explanation or apology can develop into the sort of public issue which has a potential to reflect adversely on all.

(3) DEATH OF LEMOND MILROY

- **Place and time of death**

  Lemond Milroy died at Dumfries and Galloway Royal Infirmary on 26 December 2000 at 18.10 hours.

- **Cause of death**

  His death was caused by 1(a) Septicaemia, 1(b) Diarrhoea, 2 Peripheral and Coronary Vascular Disease.

- **Reasonable precautions whereby the death of Lemond Milroy might have been avoided**

  None

- **Defects in the system of working which contributed to the death of Lemond Milroy**

None

- **Other facts relevant to the circumstances of the death**

Some aspects of Mr Milroy's nursing care while in Ward 7 were unsatisfactory and caused distress to him and to his wife. It is probable that these were the result of a shortage on nursing staff on the ward.

- **Recommendations**
- When corresponding with patients or their relatives in relation to concerns expressed about their care in hospital the Trust should be careful to distinguish between medical treatment, nursing care and other concerns.
- The management of the Trust and the senior medical management at Dumfries and Galloway Royal Infirmary should carry out an urgent and thorough review of the practices and procedures at the Infirmary in relation to the need to ensure that the wishes of relatives in relation to a post mortem, particularly following an unexplained death, are ascertained and recorded.

Note:

- The witnesses who gave evidence were:
  - Mrs Margaret Milroy, the widow of Mr Milroy
  - Linda Green, a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - Dr Shona Donaldson, a Staff Grade Physician at Dumfries and Galloway Royal Infirmary
  - Gordon Jamieson, Director of Nursing and Allied Health Professionals at Dumfries and Galloway Royal Infirmary
  - Mr Andrew Walls, a Consultant Surgeon at Dumfries and Galloway Royal Infirmary
  - Dr Paul McClintock, formerly a General Practitioner in practice in Newton Stewart
  - Dr James Lawrence, a Consultant Physician at Dumfries and Galloway Royal Infirmary and Director for Acute Services there
  - Robert Morrison, a Depute Procurator Fiscal at Dumfries
  - Dr James Palmer, formerly a Consultant Anaesthetist at Dumfries and Galloway Royal Infirmary

    By way of affidavit:

  - Dr Alan Jones, a General Practitioner in practice in Newton Stewart
  - Dr Rosemary Manson, formerly a pre-registration House Officer physician at Dumfries and Galloway Royal Infirmary

    By way of unsworn statement, without objection:

  - Judy Taylor
  - Dr I A O'Brien, a Consultant Physician at Wishaw General Hospital
- Lemond Milroy was a 69 year old newsagent from Newton Stewart where he lived with his wife. He seems to have been a hard working man who, generally, had kept good health. He was only very rarely off work. He had been a heavy smoker at one time. (That is spoken to by Dr Jones.) He suffered from circulation problems (peripheral cardiovascular disease) for which he took asprin. On 18 December 2000 he felt unwell and went to bed. He developed diarrhoea. His wife called a doctor on the morning of 19 December. He attended and tablets were prescribed and advice about hydration given. By Sunday night (20 December) Mr Milroy was weaker and the doctor was called again on Monday morning. There was a further visit at 6 p.m. when Dr McClintock attempted to persuade Mr Milroy to go into hospital. He declined. Dr McLintock felt that it was an informed decision and he could not over-ride it. He felt sufficiently concerned, however, to alert his colleague Dr Jones who was coming on call later. That concern was shared by Mrs Milroy who contacted Dr Jones later. He attended at about 10.40 p.m. Mr Milroy was still reluctant to go to hospital but was persuaded by Dr Jones and Mrs Milroy to do so. Dr Jones recorded that Mr Milroy was worse (he says "looked very unwell" in his affidavit), had low blood pressure and a raised pulse and was confused and dehydrated. Mr Milroy, accompanied by his wife, went to the Infirmary by ambulance.
- Mr Milroy arrived at the Infirmary just before midnight. After a short time in Accident and Emergency he was admitted to Ward 7 and placed in a single room for isolation because of his diarrhoea. He was seen by the house officer Dr Manson. She completed what seemed to me, and this was confirmed by her

consultant, Dr Lawrence, a very full admission note. She recorded her impressions as possibly infective diarrhoea or an ischaemic bowel (although she would have expected bloody diarrhoea for the latter). The plan for treatment was to supplement the patient with fluids and to carry out various tests including blood tests and stool cultures. Dr Lawrence saw Mr Milroy at 11.00 a.m. He categorised him as "impressively unwell". He qualified the treatment plan by adding a portable chest x-ray and blood cultures. He added "I'd use antibiotics if consolidation on x-ray, any evidence of pneumonia, or CRP up. I've explained to his wife the severity of the episode and our reliance on iv fluids and O2". It was clear from all the medical evidence that it was not known what was causing Mr Milroy's diarrhoea or other symptoms. Some of the tests were to try and establish if any organism was causing this. Dr Lawrence said that in about 50% of cases no such organism is ever identified. This had significance for the possible administration of antibiotics. Several of the medical witnesses (Drs Lawrence and Donaldson and Mr Walls) spoke to the problem of using these before any organism was identified because their use could blur the picture. It was better not to use them until the source of the problem was known. The position would change, however, if, for example, sepsis were diagnosed. Dr Lawrence provide for that in his plan. The CRP referred to is a sensitive test of inflammation. But his opinion was that, when he saw Mr Milroy, there were no clinical pointers to sepsis. There was no evidence to contradict this. A question arose as to whether Mr Milroy should have been transferred to the medical High Dependency Ward (Ward 8 operated as such at the time). This was apparently commented on in an independent post operative review which followed Mr Milroy's death. Dr Lawrence said that he had considered and rejected this (but he had not noted it). It was clear from the evidence that there was a pressure on the HDU facility and that, clinically, Mr Milroy's condition did not justify a transfer at that time. The principal difference in his care would have been a more intensive observation of him.

- Mr Milroy was transferred to Ward 18 at about 17.00 on 21 December. The principal reason for that seems to have been pressure of beds (particularly single rooms for isolation) in Ward 7 which is an admitting ward from which patients usually move quickly on to other wards. Ward 18 deals primarily with geriatric patients. Mr Milroy was not seen by Dr Lawrence before that transfer. Dr Lawrence, who came across as a caring man, sensitive to his patients' needs, regretted that. He expressed that regret in a spirit of self criticism in a letter he later wrote to Mr Jamieson. I think he was unduly hard on himself. He had been asked about the transfer in general terms and had not linked it with Mr Milroy. He had not noticed Mr Milroy's absence on his later ward round after the transfer. In the circumstances of the busy day he described that was entirely understandable. His principal regrets were that, if he had been asked to assess Mr Milroy, antibiotics might have been started earlier and that the conditions for the commencement of antibiotics could have been made clearer to the nursing staff. After the transfer Mr Milroy was seen by Dr Manson at 05.15 and 07.30 and at 08.30 by the senior house officer Dr Unini. Because of his deteriorating condition the surgical team was asked to review him which they did at 09.40. Antibiotics were prescribed by Dr Donaldson shortly after this. It was decided to discuss transfer to the Intensive Therapy Unit with the consultant. This happened at about 12 noon. It was decided to perform a laparotomy to attempt to discover the source of the sepsis from which he was suffering. He was built

up for the operation in the ITU. The operation was carried out at about 17.30. No evidence of abdominal sepsis was found. Mr Milroy remained in the ITU until his death at 18.10 on 26 December.

- There were few issues which arose about Mr Milroy's medical care. I have already referred to Dr Lawrence's very frank assessment of what he did or did not do. It is not clear to me from the evidence when antibiotics might appropriately have been prescribed between 11.00 on 21 December and the late morning of 22 December; and if they should have been prescribed earlier than they were. The issue is not mentioned in the report by Dr O'Brien, a consultant physician at Wishaw General Hospital, who was asked to review the treatment on the basis of the medical notes. He did not give evidence. Dr Lawrence doubted if their earlier administration would have made any difference. Dr Palmer said that they should be started when there was a diagnosis of sepsis. Mr Walls said it was impossible to tell when sepsis first developed but that Mr Milroy was "extremely ill and probably septicaemic" when he first saw him at the surgical review at about 09.40. In his letter to Mr Jamieson, Dr Lawrence says "Because of the timing of that transfer [to Ward 18] the high CRP (which I had recorded should trigger antibiotic therapy) wasn't acted on." He was referred to this in evidence but the point was not fully explored. I do not seem to have been referred to whether there was a subsequent CRP indication which would have triggered such action. I was unable to determine if there was one documented in the medical notes. So I am left with Dr Lawrence's doubt that earlier antibiotics would have prevented death. That rested on the fact that no organism was ever identified and that the later use of antibiotics failed to arrest either the CRP level or the temperature. Dr Lawrence was an entirely credible witness. In the same context he also said that he doubted if his having seen Mr Milroy before his transfer to Ward 18 would have made any difference. There was no evidence at all that it would. I believed him and so find that there were no reasonable steps whereby Mr Milroy's death might have been avoided.
- Mrs Milroy made various complaints about the quality of the nursing care which her husband received. Some of these were acknowledged by the Trust in a letter dated 18 April 2001 to PASS Direct, the patients' advice agency which corresponded on Mrs Milroy's behalf. Any investigation of Mrs Milroy's complaints was hindered by the length of time it took her to make them - 15 months. From what she said in evidence this was because of her shock after her husband's death; and I can understand that. But it did not make the task of the Trust in answering her complaints any easier. That said, the letter sent by them was ambiguous and really quite unhelpful in identifying what the Trust accepted had gone wrong. For example, it says "I regret to learn that Mrs Milroy feels she and her husband were not treated in an appropriate manner, and that their needs were not met. Clearly this is unacceptable and the issues have been raised with Sister E Soutar, the Senior Sister in Ward 7, and DR J. R. Lawrence, Consultant Physician." On a straightforward reading it is not clear whether it is was the treatment which was unacceptable or whether that Mrs Milroy should feel that way. Certainly no specific failings seem to be identified and admitted in the letter. Later the letter says "I regret that the treatment received by Mr and Mrs Milroy within Ward 7 was less than satisfactory. I apologise for any distress this may have caused. I can assure you that the issues raised have been brought to the attention of the ward staff and I will endeavour to ensure they are

not repeated." The letter contrasts unfavourably with the full, frank and detailed letter by Dr. Lawrence to Mr Jamieson where he identifies and discusses what was said to have gone wrong. I highlight the matter particularly because the ambiguity, particularly in the reference to "treatment" was apparent in the evidence of Mr Jamieson; and whether its use was restricted to medical treatment or used more generally. And, of course, the letter contrasted with the line taken by counsel at the Inquiry where the position of the Trust seemed to be that nothing at all had gone wrong. The Trust should be more precise in the language it uses when responding to the concerns of patients or relatives.

- The principal evidence about the adequacy of the nursing care came from Mrs Milroy. She was not an easy witness to assess. She seemed to have a marked antipathy to the Infirmary. That appeared very clearly in cross examination when she was asked about her husband's apparent unwillingness to go into hospital and whether he had a fear of hospitals. Her reply was "No. He had a fear of that hospital." I noted the emphasis given to the word "that" in my own notes. Generally, she presented as a witness with a very fixed antagonism towards the hospital. Now, she had suffered a great loss there and so this was perhaps, to some extent, understandable. But my clear impression was that it went far beyond what one might expect. There were also difficulties about parts of her recollection which, considering the whole evidence, seemed unlikely to be true. The most marked concerned a conversation about the possible amputation of her husband's foot. She said that this was with Dr Palmer on the morning of Sunday 26 December and that he had a measuring tape when examining the foot. Dr Palmer said that was never raised with him and that he would not be involved in an amputation (that had the ring of truth as he is an anaesthetist). What he says is supported by the absence of any reference to such a procedure in the medical notes. I considered it unlikely that a major operative procedure such as amputation would have been considered without some reference in the notes. In addition, there was nothing in Mr Milroy's condition to suggest it was an appropriate procedure. He was gravely ill (he died eight hours later the same day). Dr Palmer's noted observation of Mr Milroy's feet ("Feet both pale R>>L & mottled & blue. However venous filling still OK") is not suggestive of amputation and confirms what Mr Moorthy, one of the surgeons, had observed shortly before.
- The same applied to Mrs Milroy's evidence that, at about 05.20 on 21 December, she had been told by one of the nurses (who did not give evidence and was not identified) that her husband had dragged his bed to the toilet. I was quite satisfied that this would have been highly improbable. That was the evidence of Linda Green. The beds are braked. Mr Milroy was in a weak condition. He was, however, attached to a monitor on wheels which, Linda Green accepted, could have moved with him if he walked to the toilet. Mrs Milroy was quite resistant to the suggestion this might had happened or that she had might have misheard what the nurse said to her. Her response to that entirely reasonable suggestion was "What warped pleasure could any nurse get in telling me that he had done that, then?" This reply was, in my view, completely inappropriate and disproportionate. I am reluctant to disbelieve, or find unreliable, what a witness says if her evidence stands uncontradicted by that of the other person involved (the nurse) but the surrounding facts, and Mrs Milroy's refusal to countenance any other explanation, leaves me with little choice. I mention these matters in some detail because Mrs Milroy made serious

allegations about the nursing care. Those who take that course must expect that what they say will be the subject of close scrutiny because the reputations of those involved may be affected.

- So far as the suggestion that Mr Milroy had to drag his bed to the toilet is concerned I am satisfied that this did not happen. He may have got out of bed and dragged his monitor to the toilet. But I was also satisfied that there was a call care button system in operation. It is unclear why he did not use that. I am also satisfied that the remark attributed to the nurse was not made.
- Mrs Milroy also complained that no stool sample had been taken from her husband. Perhaps none had been taken at 05.20 (and if Mr Milroy had gone to the toilet and flushed any away that is not surprising) but the nursing notes show that two were taken that day. Judy Taylor, a Senior Professional Practice Nurse from Vale of Leven Hospital, who also reviewed the nursing notes in Mr Milroy's case, comments that not taking a sample until the morning was reasonable if the laboratory was shut at night.
- Mrs Milroy's other complaints were that she was not told about the precautions necessary (gowns and gloves) because her husband was in protective isolation; that her husband was referred to as being "as tough (or fit) as old boots"; that the curtains in his room and other rooms in Ward 7 were generally drawn preventing the nurses from observing the patients; that her husband lacked attention on one occasion when his lips were crusted; that the call bell was not answered; that when her husband was put on a commode (she left the room) and she returned after about 30 minutes he was standing in the middle of the room in a pool of blood; and that when he was transferred to Ward 18 he had no blanket and was wearing his underpants. She said that she had compiled a contemporaneous note of all this (the day after her husband's death) and a copy of it was produced in evidence. It was not suggested that the note was other than contemporaneous. Its value, however, is somewhat reduced by the view which I have taken about the bed incident. Leaving aside the doctors, the only other evidence of what may have happened on Ward 7 over the 17 or so hours during which Mr Milroy was there came from Linda Green, a staff nurse who was on duty that night. She confirmed that it was a very busy ward, and especially so in winter. The night staff seemed to consist of four nurses of varying seniority. This has now been increased. She said that curtains were only drawn when toileting or something intimate was going on. She had no recollection of any conversation about the bed being dragged. She had no idea why advice about gowns and gloves had not been given. So there is little in her evidence to contradict what Mrs Milroy says. The nursing notes are not any more helpful. They contain the admitting entry and then nothing until 09.45. Apart from a note of Dr Lawrence's ward round at about 10.50 they contain only two entries which describe Mr Milroy's incontinence. Judy Taylor has no criticism with the detail, timing etc. of the entries in the notes. She also comments "It is acceptable for the relative to assist in the patient getting back into bed if the nurse is not immediately available. In my experience sometimes a shortage of nursing staff can mean that the patient cannot be attended immediately but for the relative this can be distressing." My impression from all this is that there was a shortage of staff; that Mr Milroy was not attended to as promptly as he should have been; and that this, not unnaturally, upset Mrs Milroy. The most concerning of these matters is the incident on the commode. None of the entries in the nursing notes coincides with when Mrs Milroy said that happened (soon before

the transfer to Ward 18 at about 17.00). She described blood on the floor. If that is correct it seems very strange that it was not recorded. It was the presence of blood in the diarrhoea which triggered the contacting of Dr Manson and the later surgical review. I think it improbable there was blood but probable that there was some delay in the nursing staff completing the toileting. As a result Mrs Milroy witnessed her husband in what was, undoubtedly, an undignified and distressing situation for him. There is no suggestion that any of the matters complained of caused or contributed to Mr Milroy's death. But, despite what Mrs Milroy said, there seems to have been a shortage of staff. Dr Lawrence said the ward had never been staffed to the desired level; the funding was not available. That seems to have been recognised by the Trust because staffing has been increased. I hesitate to describe the apparent shortage of staff as a defect in a system of working but it was clearly not satisfactory and its existence caused unnecessary distress and embarrassment for Mr and Mrs Milroy. It also seems the probable explanation for why Mrs Milroy was not told about the gloves and gown and why she saw her husband's lips crusted and, perhaps, explains the circumstances of his transfer.

- The final matter was whether a post mortem should have been held after Mr Milroy's death. The simple answer is that one should have been held. The death was unexplained. I believed Mrs Milroy when she said that she wanted one. Mr Walls felt it would have been beneficial. Although Dr Lawrence thought not, that was because his experience seemed to be that they rarely revealed anything new. Dr Palmer had one in mind. It was the policy of the unit to hold them in such circumstances; and he telephoned the duty procurator fiscal to discuss it. On the basis of the discussion the fiscal felt that, in the circumstances, he did not require to instruct one but left the question open if the family wanted one. In light of all this it seems puzzling that one was not carried out. Mrs Milroy said that she asked for one just after her husband's death. She said that Dr Palmer told her there was no need and that he had been in touch with the procurator fiscal. Dr Palmer had no recollection of that and no note of it. What his note records is that he "has sought advice from the procurator fiscal that he feels no need for an autopsy (but would like to know the results if the family request one)". This note is not separately timed but implies that the conversation has taken place. Mr Morrison, the procurator fiscal depute, had no real recollection of the call but completed a "Notification of Death" form, recording the time of the call as 18.25. Accordingly any reference to a conversation with the fiscal is unlikely to have taken place immediately after Mr Milroy's death. Nor does it seems likely that Dr Palmer had asked Mrs Milroy before he telephoned the fiscal. So, even if she is mistaken about her having mentioned the post mortem, rather than simply having it in her mind, it is unlikely that the matter was ever raised with her. That should not have happened. I noted that in the case of Mr Haining the request and the family's negative response was recorded clearly in the notes (page 46). I do appreciate that these matters require great sensitivity but, in cases where the cause of death is unexplained, a system should exist to ensure that there is no confusion in an area where retrospective correction is all but impossible.

(4) <u>DEATH OF DAVID BRODIE McFARLANE</u>

- **Place and time of death**

David Brodie McFarlane died at Dumfries and Galloway Royal Infirmary on 17 December 2000 at 02.40 hours.

- **Cause of death**

  His death was caused by Cancer - Liver Metastasis Unknown Primary.

- **Reasonable precautions whereby the death of David Brodie McFarlane might have been avoided**

  None

- **Defects in the system of working which contributed to the death of David Brodie McFarlane**

  None

- **Other facts relevant to the circumstances of the death**
- There was an unexplained delay in changing Mr McFarlane's analgesia to a syringe driver with diamorphene after an ultrasound scan revealed the likely existence of metatstatic lesions on his liver.
- Mr McFarlane was fasted unnecessarily for several days after the ultrasound scan was carried out.
- **Recommendation**

The management of the Trust and the senior medical and nursing management at Dumfries and Galloway Royal Infirmary should carry out an urgent and thorough review of the practices and procedures at the Infirmary in relation to the fasting of patients to ensure that such fasting does not extend beyond what is medically necessary.

Note:

- The witnesses who gave evidence were:
  - Mrs Rona Jess, a daughter of Mr McFarlane
  - Mrs Barbara McFarlane, the former wife of Mr McFarlane
  - John Samuels, a Registered General Nurse at Dumfries and Galloway Royal Infirmary
  - Dr James Boyle, formerly a House Officer at Dumfries and Galloway Royal Infirmary
  - Dr Michael McMahon, a Consultant Physician at Dumfries and Galloway Royal Infirmary
  - Gail Thomson, a Sister at Dumfries and Galloway Royal Infirmary
  - Lisa Sturgeon, a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - Martin Ridding, a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - Mrs Hazel Adamson, a Staff Nurse at Dumfries and Galloway Royal Infirmary
  - Linda Previtt, a specialist Speech and Language Therapist at Dumfries and Galloway Royal Infirmary

    By way of affidavit:

- Dr Guy Beaumont, a General Practitioner in Dumfries
- Dr Stephen Morris, a General Practitioner in Dumfries

By way of unsworn statement, without objection:

- Judy Taylor
- Dr John Gaddie, a Consultant Physician at Borders General Hospital.

- David McFarlane was a 76 year old retired Assistant Director of Social Work. He was divorced from his wife but still kept in touch with her. He lived alone. He had a previous history of heart problems and also suffered from rheumatoid arthritis. He was a relatively heavy smoker until a heart attack in 1993. On 24 October 2000 he was admitted to the Infirmary. He was breathless and coughing up blood (haemoptysis); the latter in quantities described by Dr McMahon as "substantial". He remained in hospital until 18 November. During that time he developed pain in various parts of his body. Various tests were carried out including x-rays and scans. During his stay the medical and nursing staff found Mr McFarlane's behaviour to be inconsistent. Pain and inability to do things had to be contrasted with apparent lack of pain and the ability to walk about. The tests carried out did not reveal the cause of Mr McFarlane's symptoms and he was treated for cardiac failure and respiratory tract infection. Because of Mr McFarlane's behaviour the nursing staff were concerned about his ability to cope at home. They considered whether there should be a psychiatric assessment or social work involvement. Mr McFarlane was disinclined to have either. He returned home on 18 November. His family were immediately concerned about him. He was complaining of pain. He was visited by his GP and other doctors who prescribed pain killers including Trimadol. On 3 December he was re-admitted to the Infirmary because of his previous heart problems, his generally poor condition and his presentation of pain all over.
- Mr McFarlane was accompanied to the Casualty Department by his daughter Mrs Rona Jess. They arrived about 14.00. Mr McFarlane remained in pain. He had not had any pain killers since about 12.00. Mrs Jess drew this to the attention of the staff. She was assured these would be given after an x-ray. Mrs Jess saw him in Ward 7 at about 17.00 and left between 17.30 and 18.00. She was assured that her father would be given something for his pain. That did not happen until 20.00. In the course of the day Mr McFarlane was seen by Dr McMahon. He attributed the pain to fibromyalgia and diagnosed that condition, writing it clearly in the notes.
- Mrs Jess visited her father the following day (Monday 4 December) at about 19.00. He had been transferred to Ward 10 at 17.00. She found him in bed moaning and rocking with pain. His 18.00 analgesia had not been administered before he was transferred. Mrs Jess pointed this out several times before analgesia was administered. She accepted, however that these things can happen on a transfer of ward. The need for analgesia is clear from the nursing notes because at 02.20 on 4 December it is noted "Required further dose of Tramadol 100gm at 02.20 for pain." Mr McFarlane was obviously having some difficulty mobilising because he fell on 5 December while standing at a window, again on 6 December and on 8 December when he cut and bruised his forehead (three stitched were inserted). Mrs Jess spoke to constant complaints of pain during this period. The nursing notes record complaints of pain and also refusal of medication. After the admission on 3 December various tests were carried

out. These included a CT scan of the abdomen. That was requested on 5 December and performed on 8 December. This disclosed the existence of liver lesions. In the nursing notes the result was recorded the same day as "U/S - 4 liver lesions likely to be metastases but hepatic abscesses not excluded". (The x-ray report itself shows a "Report Date" of 11 December which, from the evidence I heard in relation to the death of Agnes McCoull, was the date it was reviewed by the radiologist.) But the medical notes contain a hand-written "Provisional Ultrasound Report" dated 8 December. This was not referred to in evidence. (It presumably formed the basis of the nursing note.) Mr McFarlane continued to complain of pain to Mrs Jess and complaints of pain are recorded in the nursing notes. The medical notes disclose that Mr McFarlane was seen by medical staff three times on 9 December, once during a ward round on 11 December when the liver lesions were noted in the medical notes and, on 12 December, when a CT scan of the liver was requested to determine the nature of the liver lesions. On that occasion Tramadol was discontinued and stronger pain relief by a syringe driver with midazalam and diamorphene was commenced. The CT scan was carried out on 14 December. This confirmed the metastases in the liver. The primary source of the cancer was not identified. The same day Mr McFarlane was transferred to the Alexandra Unit for palliative care which he received until his death on 17 December. Mrs Jess and, I think, other relatives were with him when he died. There was no adverse comment, indeed nothing but praise, for his care during that time.

- The issues which arose in relation to the circumstances of Mr McFarlane's death were, firstly, whether his condition should have been diagnosed at an earlier stage, particularly during his stay in hospital between October and November 2000. The effect of the diagnosis of fibromyalgia was also discussed; both in the context of the symptoms of pain displayed by Mr McFarlane and its effect on the time taken to diagnose the condition which led to his death. Finally his nursing care, both during his earlier admission and, certainly, until the insertion of the syringe driver to relieve pain on 12 December, were the subject of criticism. These criticisms extended to his general care including the approach to his pain; the period between the noting of the liver lesions, and their likely meaning, in the nursing notes and the commencement of the syringe driver anaesthesia (four days later); and whether he was fasted unnecessarily for four days after the U/S scan of his abdomen on 8 December.
- The principal basis of any complaint about a failure to diagnose Mr McFarlane's condition during his earlier stay in hospital in October rested, to a very large extent, on a report by Dr John Gaddie, a consultant physician at Borders General Hospital. He had been instructed by the Trust to review Mr McFarlane's case by reference to the medical records. He did not give evidence. He lists the different x-rays and other tests carried out. The purpose of these was explained in evidence by Dr McMahon, the consultant physician who was responsible for Mr McFarlane's treatment. It is not necessary to review these tests and examinations in detail. All proved negative in respect of the condition which caused Mr McFarlane's death. They did not include an abdominal ultrasound such as was carried out in 1999 during an earlier admission of Mr McFarlane to hospital then. Nor did they include what Dr Gaddie described as "a CT scan of the thorax to determine whether there was any evidence of bronchial carcinoma, primary or secondary." His report stated that such a scan should have been carried out to complete Mr McFarlane's investigations. When discussing Mr

McFarlane's second admission and the discovery of the liver metastases, he goes on to say "The most likely primary site of his hepatic metastases was bronchial carcinoma particularly in a smoker who has smoked until 1993 presenting with haemoptysis." The procurator fiscal submitted that more could have been done during Mr McFarlane's first admission to hospital. The evidential position about all this is less than clear. Both Dr McMahon ("extremely likely") and Dr Boyle ("in hindsight it seems pretty clear") said that Mr McFarlane was suffering from cancer in October. Dr Gaddie's conclusion about the U/S scan of the thorax was not specifically put to Dr McMahon. He was asked whether the sort of tests carried out in December (the ultrasound of the abdomen and then the CT scan) would have found the liver metastases then. He said he thought they would have done. His position was that there was nothing in the earlier admission to justify carrying out these investigations. Dr Boyle, who was involved in Mr McFarlane's treatment in December but does not seem to have been involved in October, was, I thought, quite guarded in his answers in this area. He first of all said that "If it [the ultrasound scan] had been requested soon after his first admission it would have been diagnosed sooner." But, when asked if a CT scan in October would have revealed it, he said "It is impossible to say." Asked about whether it would have been worth carrying out such tests in October he said that it was impossible to say if an abdominal ultrasound and CT scan would have revealed the metastases in October. His exact words were

'I have looked at the notes in detail for the first admission, and I don't know if there were any pointers to suggest that a CT scan should have been done.

Would you agree with the suggestion that by the 24th October Mr. McFarlane should have had a CT scan of the thorax to determine whether there was any evidence of bronchial carcinoma, primary or secondary? - I haven't looked at the notes in detail.'

I think that his first reference to looking at the earlier notes must be a misprint and that he had not looked at them in detail (that was, in fact, confirmed in cross-examination). So Dr Gaddie's conclusion about the CT scan of the thorax was not really discussed by the witnesses who gave evidence; and, of course, there was no opportunity for Dr Gaddie to expand on or explain his conclusion, particularly in the context of the greater explanation of the medical notes and Mr McFarlane's presentation which Dr McMahon was able to give in evidence. This does not make it very easy to form a conclusion about whether it would have been reasonable to carry out either a CT scan of the thorax or the abdominal ultrasound and/or CT scan in October. All I can say is that it is difficult to understand why they were not; particularly as the evidence suggests it is probable that such tests would have revealed the metastases eventually discovered, and confirmed, a few days before Mr McFarlane's death.

- Even if these steps had been taken it cannot be said that they might have prevented Mr McFarlane's death. The matter is found, succinctly put, in Dr Gaddie's report:- "If further investigations had been carried out during his admission in October 2000 and had confirmed a primary site, either in lung or bowel, this would not have influenced his prognosis, the hepatic metastases

being proven six weeks later leading to his death on 17th December 2000." There was no evidence to contradict that conclusion. Nor was there evidence of any defect in any system of working which contributed to the death.

- As to the issue of fibromyalgia the initial question raised was whether it was a correct diagnosis? Dr McMahon was quite confident that it was. He is a general physician with an interest in rheumatology. As such he has a greater than average knowledge of fibromyalgia. He diagnosed it on 3 December soon after Mr McFarlane's admission. He based the diagnosis on his description of the symptoms "Pain 'all over' (all limbs and trunk) Nocturia ap to 12x." He was satisfied that the presentation of pain was genuine. He explained that fibromyalgia produced widespread pain unresponsive to pain killers used for the treatment of more severe pain. It was associated with tenderness and "trigger points". Mr McFarlane showed all 18 of the accepted trigger points. Despite the subsequent discovery of Mr McFarlane's cancer Dr McMahon remained convinced that Mr McFarlane's pain "was fibromyalgia and not due to some other disease process." Fibromyalgia pain differed quite significantly from pain caused by arthritic conditions or widespread tumour pain. In the latter particular areas would be very painful. Mr McFarlane had pain in every part of his body. The fact that Mr McFarlane did not appear to respond to straightforward painkillers pointed towards fibromyalgia. But, on 3 December, Dr McMahon had noted "Looks ill". In general Dr Boyle was much more cautious about this diagnosis ("I had my suspicions that fibromyalgia was not the proper diagnosis.") but, when pressed, deferred to what Dr McMahon had diagnosed. The following passage in his cross examination by counsel for the Trust was illuminative of the difficulty:-

  "But the man had fibromyalgia? - That is what Dr. McMahon diagnosed.

  Fibromyalgia does present in people who have no obvious physical cause? - Yes. How can you possibly decipher this widespread pain diagnosed as fibromyalgia as widespread pain may cause -- that was the symptom on admission, but later on he had cancer, and that would explain widespread pain. If you assume the widespread pain was cancer, he did not have fibromyalgia."

  On 5 December he thought that "something else was going on" and instructed a series of tests . He explained to Mrs Jess that "although we were going to follow Dr McMahon's management we would also consider other things at that time." Dr McMahon agreed with this and pointed to his entry "Looks ill" as indicative of that. He too suggested further tests. But Dr Boyle was of the view that the widespread pain could have been caused by Mr McFarlane's cancer. He accepted, however, that it was a difficult case. Both Dr McMahon and Dr Boyle were credible witnesses. I had no doubt that, in seeking to treat Mr McFarlane, both were acting entirely in his interests. There is nothing in the evidence to suggest conclusively, one way or the other, that fibromyalgia was not an appropriate diagnosis. But, of course with hindsight, there was another much more serious condition.

- Did the early diagnosis of fibromyalgia affect Mr McFarlane's treatment and the investigation of his condition? Certainly not so far as the doctors were concerned. Both accepted that the pain was genuine and analgesia was

prescribed. Dr Boyle seems to have proceeded quickly with a series of investigations which, unsurprisingly, took some time but led to the discovery of Mr McFarlane's cancer. Dr McMahon was supportive of that. There was no evidence that this process should have proceeded differently or more quickly.

- The abdomen ultrasound which disclosed the liver lesions was performed at 15.10 on 8 December. The result was noted in the nursing notes. The first reference in the medical notes is in an untimed entry by Dr Boyle on 11 December. Both the nursing notes and the medical notes for 12 December disclose the decision to commence the syringe driver which started at 11.40. This does seem to have alleviated Mr McFarlane's pain to a considerable extent. That was certainly Mrs Jess's evidence. Why was this step not taken earlier? Dr Boyle was at a loss to explain why the syringe driver was not started earlier. He assumed that the nurses would have told a doctor as well as writing it in the nursing notes. He was honest enough to say that he might have been told on 8 December; he did not know. Although he said that the syringe driver "might" have been started earlier it was clear, observing him giving evidence, that the probability is that this would have happened. The issue was not further explored in evidence. The nurse who made the note was not a witness. So it seems either that no doctor was told of these results or that one was told and no action was taken until Monday. In the light of Dr Boyle's evidence it is difficult to categorise that as other than unsatisfactory. As the purpose of the syringe driver would have been to relieve pain, and as that is what was achieved when it happened, the procurator fiscal is correct in his submission that this palliative care might have been instituted earlier and Mr McFarlane saved some of the pain which affected him over these four days. Although there was no evidence that this caused or contributed to Mr McFarlane's death it was a failure in the hospital's system which should not have happened. It is a fact which is relevant to the circumstances of his death.
- Mr McFarlane was fasted (no food at all) from the night of 7 December until the scan which was carried out on 8 December. Both Mrs Jess and Mrs McFarlane spoke to the apparent continuation of that fasting until 12 December. Both said they saw the word "Fasting" on the board on the wall beside his bed. Both spoke to Mr McFarlane calling out for food - custard and orange juice. Mrs Jess spoke to several nurses who variously told her this was because of constipation, or a blockage or because it was on the instructions of medical staff. Mrs Jess said that in the afternoon of 12 December she spoke to Dr Boyle about this. He seemed surprised and said that there was no reason for it. He spoke to the nursing staff as did Mrs McFarlane just to be sure they knew that he could be given food. In the evening Mrs Jess returned. She was again told by one of the nursing staff that her father was being fasted. She gave him some custard which she had brought in. Much of what Mrs Jess said was supported by Mrs McFarlane, but particularly the sign on the board, Mr McFarlane's calls for food, the conversation with Dr Boyle and her conversation with the nurses when she was assured Mr McFarlane would be fed. Dr Boyle confirmed the conversation and his surprise. He confirmed that there was no medical reason for a fast although he doubted if Mr McFarlane would be inclined to eat much in his condition. He could not remember any sign on the board or his conversation with the nurses or their response. Of the nursing staff who gave evidence Martin Ridding was asked about the fasting. He had no recollection of it. He was surprised at the evidence of Mr McFarlane calling out for food - he could not

recall that, although he remembered him being noisy and agitated. John Samuels was also asked but he was unable to shed any light on the matter. There is no mention of a continuous fast in the nursing notes. Linda Previtt is a speech therapist. She saw Mr McFarlane on 13 December to assess his swallowing. That appears to be as a result of an entry in the medical notes by Dr Boyle. She was unable to say whether or not Mr McFarlane had been fasted. Her notes indicated "No diet for 2/7" which it seems she had taken from the medical note by Dr Boyle. She assessed Mr McFarlane as able to try light puree.

- On this issue I found Mrs Jess and Mrs McFarlane to be credible and compelling witnesses. It was unlikely they were mistaken in their general concern; their expression of that was supported by the evidence of Dr Boyle. I believed them about the board, their conversations with the nursing staff and Mr McFarlane's requests for food. None of this was contradicted by the evidence of the nursing staff. Linda Previtt was speaking to events after any fasting had ceased. Now it is true that Mr McFarlane's condition was deteriorating. I accept Dr Boyle's assessment that he would not really want to eat much. But it is not satisfactory that he was fasted without reason and that the nursing staff in general (no individual was identified) appear to have been deaf to Mrs Jess's requests. Mr McFarlane was dying. For his fasting to have continued unnecessarily is quite unacceptable. Again, although there was no evidence that this caused or contributed to Mr McFarlane's death, it was a failure in the hospital's system which should not have happened. It is a fact which is relevant to the circumstances of his death.
- The issue of a lack of general nursing care is more difficult to assess. The evidence of the nursing staff was that Mr McFarlane was not an easy patient; and this seems to have applied as well to his earlier stay in hospital. Dr McMahon thought that some of his behaviour was inconsistent. So did the nursing staff, both during his stay in October and after 3 December. It seems that he did attempt to walk when, perhaps, he should not have done so. But one effect of the initial diagnosis of fibromyalgia was to encourage mobility. He had three falls but there was no evidence that these occurred because of any particular nursing failing. He was weak. After the third he was provided with cot sides. The nursing notes contain several references to his refusal of medication and his unwillingness to co-operate with the nursing staff. I have no reason to doubt the truth or accuracy of these. I can see why Mrs Jess and Mrs McFarlane felt that the nurses were not paying enough attention to his pain. Perhaps the initial diagnosis informed that perception. But they were looking at the situation as very concerned relatives; and in the light of the mix up about the analgesia on admission and again after the abdominal scan and the distressing matter of the fasting. Mrs Jess, in what was a careful, responsible and helpful examination of the witnesses brought out, particularly from Angela Brown, some issues which might have been better attended to; daily taking of blood pressure and weights; and a lack of documentation about the pressure relieving mattress But she also drew from Dr Boyle the likely side effects of her father's medication and condition, some of which would lead to a risk of falling and to the behaviour noted by the nursing staff. None of the general matters complained of caused or contributed to Mr McFarlane's death. None was a failure in the hospital's system. There is nothing in the report of Judy Taylor to suggest otherwise (although, again, all she did was to review the notes; and she did not give

evidence). Apart from the specific failures which I have dealt with earlier the evidence does not lead to the conclusion that the general nursing care of Mr McFarlane deserves criticism.

(5) <u>DEATH OF AGNES McCOULL</u>

- **Place and time of death**

  Agnes McCoull died at 15 Merse Drive, Kirkcudbright on 10 March 2001. Life was pronounced extinct at 14.22 hours.

- **Cause of death**

  Her death was caused by 1 (a) Shock from Haemoptysis, (b) Erosion of Pulmonary Artery (c) Squamous Cell Carcinoma of Bronchus and (2) Metastatic Carcinoma of Right Adrenal gland.

- **Reasonable precautions whereby the death of Agnes McCoull might have been avoided**

  None

- **Defects in the system of working which contributed to the death of Agnes McCoull**

  None

- **Other facts relevant to the circumstances of the death**

  The radiologist's report on the x-ray taken on Mrs McCoull's admission to the Infirmary was not seen by the treating consultant before her transfer to Kirkcudbright Cottage Hospital and the completion of the discharge letter by the treating consultant.

- **Recommendation**

The management of the Trust and the senior medical management at Dumfries and Galloway Royal Infirmary should carry out an urgent and thorough review of the practices and procedures at the Infirmary in relation to the need to ensure that radiologist's reports are seen by the clinician who has viewed and interpreted any x-ray with particular reference to

- The identification of any person who instructs any action in relation to such reports
- Any need, whether caused by a shortage of medical beds or otherwise, for the discharge of patients before such reports are available

Note:

- The witnesses who gave evidence were:
  - Mrs Evelyn Anderson, a daughter of Mrs McCoull
  - Dr Robert Mack, a General Practitioner in Kirkcudbright

- Dr Christopher Isles, a Consultant Physician at Dumfries and Galloway Royal Infirmary
- Dr Brian Chapman, a Consultant Physician at Edinburgh Royal Infirmary

  By way of affidavit:

- Robby Anderson, a grandson of Mrs McCoull
- Dr Suzanne Christie, a General Practitioner at Dalbeattie
- Dr Jennifer Innes, a General Practitioner at Kirkcudbright
- Dr Lois Sproat, a General Practitioner in Castle Douglas
- Colin Hyslop, an Ambulance Technician with the Ambulance Service at Gatehouse of Fleet
- Dr John Amuesi, a Consultant Pathologist at Dumfries and Galloway Royal Infirmary

  By way of unsworn statement, without objection:

- Dr S W Banham

- Mrs McCoull lived in Kirkcudbright. She was 72 at the time of her death. For several years prior to that she had suffered from arthritis and from episodes of chronic obstructive airways disease. The latter manifested itself from time to time in breathlessness and symptoms of chest infection. From time to time she had been prescribed a nebuliser and steroid tablets. On 24 January 2001 she developed a chest infection and was seen by Dr Christie. One of her symptoms was haemoptysis, that she was coughing up blood; described in the notes as "Coughing white sputum traces of blood). Dr Christie prescribed Augmentine (a broad spectrum antibiotic) and Prednisolone (a steroid to deal with the airways). Dr Jones saw her the next day when it was noted that she felt much better.
- Mrs McCoull was seen again on 30 January by Dr Mack. He felt that she was more unwell again and was showing signs of narrowing airways. He decided to admit her to hospital. She was taken there by ambulance. Dr Mack's referral note raised a question about her underlying pathology, by which he meant that he feared she might have some malignant process - possibly cancer - going on. He emphasised the point by adding "Mrs McCoull is understandably very frightened as her husband died of laryngeal cancer."
- The admission to hospital is recorded as 21.30 hours on 30 January. She was admitted by a house officer who seems to have instructed an x-ray because one was taken on 30 January. She was seen the following day, 31 January, by the consultant Dr Isles. He examined her, and the x-ray, and diagnosed an exacerbation of chronic obstructive airways disease. He recommended treatment by Prednisolone, nebulised bronchodilator, low dose oxygen and physiotherapy. He felt she was well enough to go to the cottage hospital at Kirkcudbright, nearer her home. Dr Isles dictated and completed a discharge letter to Dr Mack on 1 February. That included the observation "Chest x-ray showed no active lung disease." Mrs McCoull was discharged on 1 February to Kirkcudbright Cottage Hospital.
- The x-ray taken was reviewed by Dr Jones, the consultant radiologist, on 31 January. In his report he observed "Some ill defined shadowing has been projected over the right hilum, and it would be worth having a right lateral view for more information. No evidence of any active disease seen elsewhere in the

lung fields." That report was never seen by Dr Isles. It was filed on the authority of someone whose initials are illegible. If Dr Isles had seen the report he would have instructed a further x-ray. It is possible that such an x-ray would have allowed the detection of the tumour which had developed in Mrs McCoull's lung and which led to her death.

- Following her return to Kirkcudbright hospital Mrs McCoull went home after eleven days. She did not seem to be getting any better. On 8 March her daughter, Mrs Anderson, called Dr Innes who attended. She prescribed another inhaler. On Saturday 10 March Mrs McCoull's daughter visited her. She was intending to go and shop for her mother but, before she could go, Mrs McCoull started to cough. There was a trickle of blood from her mouth and then considerably more. Mrs McCoull died in her daughter's arms. An ambulance was called, and a doctor, but Mrs McCoull was dead on their arrival. The death was very distressing for her daughter; and for her grandson who was also in the house.
- I am satisfied that there were no reasonable precautions by way of diagnosis or medical treatment which could have avoided Mrs McCoull's death. The evidence of Dr Chapman was that Dr Isles' assessment, in the absence of Dr Jones' report, was reasonable. That is confirmed by Dr Banham's report. The haemoptysis and the minor shadowing on the x-ray were agreed by all to be compatible with an acute exacerbation of chronic obstructive airways disease. Dr Chapman would have favoured a follow up four weeks after discharge to see if the haemoptysis had settled and for a further x-ray. But Dr Jones seemed to doubt that a further x-ray would have shown significant change for about three months. Even if the tumour had been detected when Dr Isles examined Mrs McCoull during her stay in hospital at the end of January it was Dr Isles' view, supported by Dr Chapman and Dr Banham, that treatment would not have prevented death. The immediate cause of death was the massive internal bleeding (haemoptysis) which resulted from the growth of the tumour into the pulmonary artery. Even if it had been possible to reduce the tumour or slow its growth the same haemoptysis might well have occurred. Again there was really no difference about that in the views of Drs Isles, Chapman and Banham. The cancer was well advanced. It had spread to other organs. Death would have resulted from another complication within a few weeks.
- There was, of course, a defect in the hospital's system of working. That was accepted by Dr Isles. He should have seen the report from Dr Jones. He did not. It was filed before he did so. The author of the unidentified initials which sanctioned the filing failed to appreciate the need to draw the attention of Dr Isles to the report. Both Dr Jones and Dr Chapman confirmed that should not have happened. (Dr Banham, who was instructed by the Trust, does not seem to have considered that point, although he must have seen Dr Jones' report in the medical records.) If Dr Isles had seen the report he would have ordered a further x-ray with a right lateral view. There is no guarantee that would have altered his diagnosis but the weight of the evidence makes it probable that it might have done. Dr Chapman explained the difficulties in interpreting lateral x-rays but he mentioned the possibility of looking at earlier x-rays for comparison. So did Dr Jones. But any earlier diagnosis would not have prevented the death and so the defect in the hospital's system of working did not contribute to it. It might, however, have allowed the possibility of radiotherapy or palliative treatment, either to slow the growth of the tumour or bring relief from pain. Or it

might have allowed access to intensive palliative care from the Alexandra Unit (a terminal care unit at Dumfries and Galloway Royal Infirmary) or at home from McMillan Nurses. Mrs McCoull could have had the opportunity to prepare herself for death and her family would have had the opportunity to support her as she approached death. Of course some of these options might not have been taken up but the possibility would have existed. The failure to ensure that Dr Isles saw Dr Jones' report removed that possibility entirely.

- One reason why the report was not drawn to Dr Isles' attention was Mrs McCoull's speedy discharge to Kirkcudbright. Now that had its advantages. Beds in medical wards were at a premium and, in light of Dr Isles' diagnosis, he felt that she could be better cared for at Kirkcudbright than going into another ward such as a surgical ward; and it was closer to her home. But if she had remained at Dumfries longer it is at least possible that Dr Isles would have seen the report before her discharge and been able to refer to it in his discharge letter. Dr Isles said in evidence that there should be more beds in medical wards. I did not hear other evidence about whether that was desirable or any evidence about whether it was possible. So I make no findings about that. What I will say, however, is this. If the number of beds compels the discharge of patients before all the information to assess properly their condition is to hand, that is an aspect of the hospital's system of working which requires attention and examination as much as the need for the assessing doctor to see such information; or a proper system to ensure that such information is not filed in error or prematurely.
- The Procurator Fiscal submitted that that I should make recommendations as to how the identified failure in the system of working could be remedied. He suggested some. The position of the Trust appeared to be that because the system failure did not cause the death or contribute to it I should make no findings; and in any event many of the suggested solutions (e.g. each report to be signed as seen by a consultant) were too difficult and demanding. Although Dr Isles had clearly given careful thought to the matter it was puzzling to me that there did not seem to have been any formal step taken by the Trust to look at the issue. They should do so now if only to avoid the embarrassment of having the failure repeated; but principally for the benefit of their patients. What detailed steps they take should be informed by what is practical and take into account the beds issue to which I referred.
- It would be wrong to leave discussion of Mrs McCoull's death without referring to the dignified and personal words of apology for what had happened given by Dr Isles at the conclusion of his evidence. They were a model of how such matters should be expressed. The Trust would do well to ponder them.

(6) <u>DEATH OF ARCHIBALD HAINING</u>

- **Place and time of death**

  Archibald Haining died at Dumfries and Galloway Infirmary on 16 March 2001 at 09.10 hours.

- **Cause of death**

His death was caused by 1(a) Post-Operative Bronchopneumonia, 1(b) Perforated Duodenal Ulcer, (2) Severe Aortic Stenosis, Congestive Cardiac Failure.

- **Reasonable precautions whereby the death of Archibald Haining might have been avoided**
  None

- **Defects in the system of working which contributed to the death of Archibald Haining**

  None

- **Other facts relevant to the circumstances of the death**
- Pressure on the Intensive Care Unit resulting from a staff shortage caused the closure of the High Dependency Unit while Mr Haining was a patient there. As a result he was transferred to one of the wards. He was re-admitted to the Intensive Care Unit the next day.
- While in that ward there was a lack of nursing attention to Mr Haining between about 12 noon and 14.00 during which his condition deteriorated.
- **Recommendation**

The management of the Trust and the senior medical management at Dumfries and Galloway Royal Infirmary should carry out an urgent and thorough review of the practices and procedures at the Infirmary in relation to the provision of staff in the High Dependency Units at the Infirmary to avoid their closure in circumstances where, but for any shortage of staff, patients would have remained there.

Note:

- The witnesses who gave evidence were:
  - Mrs Moira Gray, a daughter of Mr Haining.
  - Dr Alison Smith, a General Practitioner in castle Douglas
  - Dr Bangaraswamy Sriharsha, formerly a Senior House Officer at Dumfries and Galloway Royal Infirmary
  - Dr David Ball, a Consultant Anaesthetist at Dumfries and Galloway Royal Infirmary
  - Mr Charles Auld, a Consultant Surgeon at Dumfries and Galloway Royal Infirmary
  - Dr Dewi Williams, a Consultant Anaesthetist at Dumfries and Galloway Royal Infirmary
  - Louise McMicken, a Senior Sister at Dumfries and Galloway Royal Infirmary

    By way of affidavit:

  - Mrs Lynne Jardine, a daughter of Mr Haining
  - Dr Lois Sproat
  - Dr Peter Scott, a General Practitioner in Castle Douglas

    By way of unsworn statement, without objection:

    - Judy Taylor
    - Professor P J O'Dwyer of The University of Glasgow
- At the time of his death Mr Haining was an 81 year old man with a previous history of heart problems. In 1988 he was diagnosed with high blood pressure and tested regularly. In May 2000 he was referred to the cardiology department at the Infirmary. Tests showed arterial fibrillation and aortic stenosis. Treatment was by the prescription of various drugs including digoxin, atenolol and capozide. Mr Haining recovered and, according to his family, lived a fairly normal life for a man of his age. He also had arthritic pains in his joints. For some years before 2001 he had been prescribed and was taking diclofenac (voltarol) to help this. His voltarol was stopped on 10 January 2001 when he was prescribed warfarin. Voltarol should not be used with warfarin except for short courses. Voltarol can also cause, over the long term, stomach ulcers. On Monday 12 February 2001 Mr Haining saw Dr Peter Scott at the surgery in Castle Douglas complaining of a sore foot. A short course of Voltarol was prescribed "to be reviewed on Friday". On Friday 16 February Mr Haining reported an improvement in his foot. The voltarol was stopped. He was again seen at home by Dr Sproat on 19 February. He seems to have been short of breath but must have mentioned his foot and, the fact that the voltarol had not in fact helped, because she prescribed co-proxamol for it. In a sense this preliminary history is not strictly relevant to Mr Haining's admission to hospital and his subsequent death. But a question was raised at the Inquiry about the combination of voltarol and warfarin. There was nothing in the evidence which I heard which suggested that this caused or contributed to his death. Dr Scott was aware of the potential problem. He limited the re-prescription after warfarin had commenced. There must, however, have been some confusion about when it stopped because, when Mr Haining was admitted to hospital, diclofenac (voltarol) was listed as one of the drugs he was taking and appears in the admission notes.
- On 20 February Dr Alison Smith attended at Mr Haining's home at 21.21 hours. He was complaining of abdominal pain which she noted as "fairly sudden onset of epigastric pain through to back assoc with nausea". She examined him and noted that he had a tender epigastrum with guarding and that bowel sounds were not heard. She suspected a perforation of a pre-existing ulcer. She recommended his admission to hospital and he agreed. She completed an admission form for the hospital. This either went with Mr Haining in the ambulance or was faxed to the hospital by Dr Smith. It was in the following terms "This gentleman has increasing upper abdominal pain, which has become constant ® back tonight. Tongue coated, nauseated, guarding over epigastrum, P100 distressed and sweaty. BP140/70. He has been off his food & lost some wt recently. Under Ix by GP for lots of vague symptoms most recently gout". She lists his drugs and adds "I wonder if he has a small perforation of an existing peptic ulcer". I believed Dr Smith that she had sent or faxed this form to the hospital. A copy of it was to be found in Mr Haining's GP notes. It was not with the hospital notes. Whether it was ever seen by the admitting doctors is unknown. The matter assumed some importance at the Inquiry because Dr Smith's impression of a perforated ulcer, while not discounted as a possibility by the Senior House officer Dr Sriharsha or the consultant Mr Auld, did not form their definitive diagnosis of Mr Haining's condition. That has to be seen in the light of the fact that when, 24 hours later, Mr Haining underwent a laparotomy to

determine the cause of his symptoms, which had certainly deteriorated, it was found that he had a perforated ulcer which was repaired during that operation.

- Mr Haining must have arrived at the hospital some time before midnight. The medical notes disclose no time for his initial examinations by the House Officer or by Dr Sriharsha. Both, however, are dated 20 February. The House Officer noted a history which included "back pain since Saturday" and "recent weight loss ¯ appetite - (under GP Ix)". I mention this because it seems to me that, from its terms, he or she most likely saw Dr Smith's note as well as taking a history from Mr Haining. The examination by the house officer records no guarding, no rebound and bowel sounds being present. The impression recorded by the House Officer was " ? perf DU" - the possibility of a perforated duodenal ulcer. The notes of Dr Sriharsha's examination record that he found Mr Haining looking ill. He had mild tenderness on the right side of the upper abdomen. There was no guarding or rigidity. Bowel sounds were present. He instructed blood tests and an x-ray. The blood tests, in particular the white cell count, were normal. The x-ray disclosed no gas under the diaphragm. His differential diagnosis was 1) Acid peptic disease 2) Intra-abdominal malignancy 3) Hepatolmegaly (an enlarged liver). Dr Sriharsha discussed the case with Mr Auld. It was agreed to treat Mr Haining conservatively (that is without operative intervention). The treatment included intravenous fluids and an intravenous drug to promote ulcer healing in case Mr Haining's condition was the result of an exacerbation of an old duodenal ulcer. Mr Auld said in evidence that this was a possibility because he was on non-steroidal inflammatory drugs which can cause ulceration (the Diclifenac (voltarol) to which I have already referred). His urine output was monitored because his kidney function was slightly abnormal. It seems to have been agreed that, because of the enlarged liver, a scan or gastrograffin study (I heard no evidence about what that was) might be carried out later in the morning.
- Mr Auld saw Mr Haining on the morning of 21 February. It is noted that he was improved. Because of the previous heart condition (and the signs of heart failure which had been confirmed on the x-ray and clinical examination in hospital) a medical review was requested to determine if Mr Haining had suffered a heart attack.
- At 18.00 on 21 February there was a change in Mr Haining's condition. Mr Auld examined him. He noted tenderness and guarding across the abdomen, increasing pulse rate), reduced urinary output, possible fluid in the lungs, increasing CRP (an inflammatory marker used to monitor patients' progress) and deteriorating renal function. His diagnosis was of an acute abdomen with signs of heart and kidney failure which might be secondary. He noted that the septic focus was in the abdomen and that a laparotomy was required. Unfortunately Mr Auld's explanation, in evidence, about why Mr Haining had deteriorated was less than clear. That is not intended as a criticism of him. He was asked about it and started to refer to two possibilities. One was that Mr Haining "did in fact have, as was suggested, an acute exacerbation of an ulcer on admission, and in the afternoon he perforated that ulcer and became very unwell. It is well known that some ulcers do seal spontaneously, and that may have happened". He then went on to stress that in Mr Haining's case, particularly with his cardiac problems, surgery would have been inappropriate. He was then asked if it was possible that there was a perforation on admission. He replied "Well I have referred to that in that second statement." Asked about

the healing he explained the mechanism (by the omentum - the fatty layer inside the abdomen). He then said "But I would emphasise that I think that is unlikely on the basis of the laboratory tests and the x-ray investigations that were carried out on admission". He favoured the view that the perforation had occurred in hospital on 21 February but it was impossible to be certain. It is not clear from all this what the second of his possibilities was. But he seems to rule out the existence of the perforation on admission.

- The laparotomy was performed and, as I have already briefly noted, this disclosed the existence of "marked peritonitis and a 1cm perforated ulcer at the 1st and 2nd part of the duodenum with chronic duodenal ulcer". That was repaired. Mr Haining was admitted to the Intensive Therapy Unit where he remained until 27 February when he was discharged to the surgical High Dependency Unit. It is not really necessary for me to dwell to any great extent on the evidence which I heard about the operation itself. There was no criticism at all about that. But something has to be said about Mr Haining's general fitness for an operation. Mr Haining was over 80. He had signs of heart and renal failure. Dr David Ball, the consultant anaesthetist in charge of Mr Haining during the operation, (whose evidence about the procedures which he carried out was a model of clarity and careful explanation) assessed him as Grade ASA4 for operative purposes. That meant he had a serious disease sufficient to cause a continual risk to life at all times. Dr Ball explained that this was because of the acute abdomen, a severe condition in itself, which had also affected his physiology, particularly seen in the renal failure and the arterial fibrillation and also the warfarin which thins the blood. Although Dr Ball made the formal assessment that was also Mr Auld's view. The significance of this for Mr Haining was twofold. He required the operation. He would have died otherwise. But the operation involved considerable risks. Mr Auld, who has written internationally on the subject, had found that in a sample group of ASA4 patients morbidity (adverse problems) after surgery was 100% and mortality (death) was 75%. Before the operation Mr Haining required to be prepared for it - "optimised" as Dr Ball put it. He describe that process in detail. Surgery was, of course, possible and Mr Haining survived the operation. I think it reasonable to infer that surgery would have been possible, at no more risk, shortly after his admission on 20 February but before his noted deterioration in the afternoon of 21 February.
- The questions which were raised, both by Mr Haining's family and by the Procurator Fiscal, were whether the perforated ulcer repaired in the operation should have been diagnosed on admission on 20 February, whether that would have led to an earlier operation and, of course, in the context of the Inquiry, whether both or either would have been a reasonable precaution whereby Mr Haining's death might have been avoided. In one sense it does not matter if the perforated ulcer existed when he arrived at the hospital or, as seemed possible, it had sealed before he got there. The true issue is whether Mr Haining's condition and symptoms from his admission until his deterioration in the afternoon of 21 February should reasonably have led to a diagnosis which required earlier surgery; whether surgery with a view to repairing a suspected perforated ulcer or, as happened, to investigate surgically unexplained acute peritoneal symptoms. Although he did not give evidence in person I had the benefit of the report from Professor O'Dwyer. He had reviewed the medical notes. His conclusion was that "there was no indication to operate on Mr Haining

following his admission on 20.02.01 or on the following morning when reviewed by his Consultant"; and "that the correct decision was taken on the evening of 21.02.01, when it was clear that the patient had peritonitis and was septic, to undertake a laparotomy following adequate resuscitation". On the basis of the evidence I heard I agree with that. Both Mr Auld and Dr Sriharsha spoke to the absence of signs in keeping with a perforated ulcer or the generalised peritonitis which is usually indicative of it. There was the absence of guarding or rebound. That was noted by both doctors who saw Mr Haining on admission. The only other reference to it in the notes seems to be in the course of the medical review which Mr Auld said was conducted on the morning of 21 February. (He may be mistaken about that because the notes about it come between two other notes timed 13.40 and 18.00.) "Guarding" appears in the description of the abdominal examination. Dr Sriharsha explained guarding as an involuntary tensing of the muscles by the patient when touched at the site of pain. Rebound tenderness was rigidity because the underlying peritoneum was inflamed. Both are to some extent subjective. Mr Auld said that tenderness and guarding may not suggest that there is peritonitis as such but, if localised, merely an underlying inflammatory condition which does not require surgery. There was also the presence of the bowel sounds. Dr Smith explained that the absence of bowel sounds suggested some sort of acute event in the abdomen such as a perforated viscus or an appendicitis. The bowel effectively shuts down. Bowel sounds were noted by both the admitting doctors; and by whoever examined Mr Haining at 13.40 ("BS++"). Most significantly, according to both Mr Auld and Dr Sriharsha, the x-ray revealed no gas under the diaphragm. Nor were the blood tests indicative of a perforated ulcer. Mr Auld said that while, in itself, it was not an index of a perforated ulcer he would expect a raised temperature and pulse rate. These were not present. In 90% of cases there would be the presence of generalised peritonitis associated with gas under the diaphragm. Both Mr Auld and Dr Sriharsha were giving opinions on their own diagnoses. In the context of an Inquiry such as this it is not unreasonable nor disrespectful to approach these cautiously and critically. But both were convincing in themselves and supported by Professor O'Dwyer. The only evidence which suggested they were mistaken not to recognise a perforated ulcer earlier was that of Dr Smith. I have absolutely no criticism of her. She formed a view on the basis of her observations. The procurator fiscal sought to make something of the fact that her initial impression was, in fact, correct. But she accepted in evidence that she was not a surgeon. Counsel for the Trust referred to her language "I wonder" as indicating that her view was tentative. I did not draw that conclusion. It seemed to me to be more a reflection of medical courtesy. The notes are peppered with professional politeness such as "thanks" to the referring doctor being noted. Dr Smith's phrase was no more than that when referring Mr Haining to the expertise of the hospital doctors. What these hospital doctors observed differed from her impression on examination. They did not exclude her diagnosis as a possibility. They gave the fluids and ulcer healing treatment I have referred to They concluded, however, that such a possibility did not justify surgery. In that decision they had regard to the risk of such surgery to a man of Mr Haining's age and medical condition. I am satisfied that Mr Haining could have been operated on when he was admitted. There was no direct evidence of that but, as I have discussed above, it is a reasonable inference from the other evidence of his condition when admitted and prior to the operation which took place. But I

am also satisfied that it was entirely reasonable for Mr Auld not to operate until he did. There is nothing to suggest that it was other than the correct medical decision arrived at after a careful and professional review of the information available. He cannot be faulted in any way for what he did.

- One minor footnote to this chapter concerns Dr Smith's admission form. I think, despite its absence from the medical notes, that it was received and seen, certainly by the admitting house officer. While I appreciate that, quite properly, the patient is separately assessed at hospital it is only sensible that all information about the patient at any relevant stage is available to those doing that assessment. Although something was made of the absence of bowel sounds recorded at her examination of Mr Haining that was not in fact mentioned in her admission form. But if it had been it might or might not have been of relevance to those examining him later. The procurator fiscal identified the lack of the admission form in the medical records as "a serious system failure". Looking at the evidence in the round I think that overstates the matter. But I think it is important that all such documents are in the notes. I restrict myself to that observation.
- One question which, oddly, was not answered at the Inquiry was whether an earlier operation might have avoided Mr Haining's death. That seemed to be the expectation, certainly the hope, of his family. It is clear there was no guarantee that the operation which was carried out would save his life. I have already noted the evidence about the risks. That was explained to the family by Dr Ball who noted "I've explained he has a high risk of death despite all our efforts. They understand." The only time the issue was raised was in a question to Mr Auld. The passage is in the following terms:-

  "Are you able to say whether things might have been different if in fact the assessment, or the operation, had been carried out 24 hours before on his initial admission to hospital? - There was absolutely no indication to carry out an operation on admission. In my view that would have amounted to medical negligence. We had no evidence that that patient had peritonitis, or evidence of perforation at that stage. And I think that none of the clinical blood tests, X-rays, none of the hallmarks of perforation were there at that time."

  There is, so far as I can see, no other evidence on the matter. The question was not repeated. And, of course, Mr Auld's answer, no doubt unintentionally, avoided the question and is of no help. I am not prepared to speculate on this central question in the absence of evidence; particularly in this difficult area of elderly and high risk patients. In one sense Mr Haining survived the operation because he did not die for a further seven days. Without it, on the evidence of Dr Hall and Mr Auld, he would very probably have died sooner. So the operation could be said to have avoided that sooner death but not to have avoided his death during the treatment and care which were a necessary consequence of the operation. In relation to severely ill or high risk patients, or those suffering acutely from a terminal disease, very difficult potential questions exist in discussing whether death might reasonably have been avoided. The evidence in the present Inquiry was very far from providing an adequate basis for any informed discussion about that. What can be said, however, is that there was no reasonable precaution which might have avoided Mr Haining's death.

- It is not necessary to review the evidence about Mr Haining's care in the Intensive Therapy Unit between 22 and 27 February. His family had no criticisms and described it as excellent. That was also the evidence which I heard. The working of the Unit (which has now been re-named the Intensive Care Unit), and the associated High Dependency Unit, was explained by Dr Williams. The ITU is run by the anaesthetists who decide which patients to admit. The HDU is run by the surgeons who make the admission decisions, though frequently after consultation with the anaesthetists. The ITU has capacity for four ventilated or intensive care patients. It has a very high ratio of nursing staff to patients. It is possible to cope with five such patients in an emergency but that involves drawing extra nursing staff from the HDU. In these circumstances one HDU patient can also be managed, depending on how many nurses are on shift. Other HDU patients are moved onto one of the surgical wards. That does not happen without a review of whether the patient is fit to be on the ward. If not then the additional ITU patient would be moved to another ITU, such as Carlisle. Dr William's evidence was that this happened "occasionally - not very often." So far as I can see the only evidence about the number of HDU beds came from Mr Auld who explained that, although a committee had recommended six high dependency beds for the hospital there was only resource for four. The precise difference between the two units was not ever fully explained but the extent of the greater support provided by the ITU was referred to by Mr Auld - respiratory support by ventilation, support for the heart with very potent drugs and support for the kidneys, even by dialysis.
- On 26 February Mr Haining was transferred to the HDU. There was no evidence about the circumstances of that transfer save that it was after the usual medical and nursing discussion. It was not suggested that it was other than appropriate. When the HDU nurses were drawn up to the ITU on 27 February, Mr Haining was transferred to Ward 6. (The actual transfer seems to have been in the very early morning of 28 February, according to Sister McMiken.) Again Dr Williams said that this would be after discussion with the medical and nursing staff. He could not recall the specifics of the discussion but he said that it could be deduced from the transfer to the ward that he was fit for that transfer. Mr Auld's evidence added nothing to that although he was clear that the transfer from HDU had not altered Mr Haining's outcome. Of course, about 36 hours after the transfer to the Ward, Mr Haining's condition deteriorated to the extent that he was re-admitted to the ITU in circumstances which I shall describe. But, in relation to the transfer from HDU, what is of more significance is the evidence about his state thereafter. He was seen on the ward by a medical Senior House Officer at 18.00 on 28 February and by Dr Kingsmore at 1 a.m. on 1 March. The nursing notes for the morning of 1 March record that he was "much brighter" and "breathing much better". He was able to stand whilst washed. He was able to sit in a chair. So there is no evidence to contradict what Dr Williams said. He was an impressive witness who came across as a caring and competent doctor. I have no reason whatsoever to doubt his evidence that, even although Mr Haining might have remained in the HDU longer, he was fit to be transferred to the ward.
- At about 11.30 on 1 March Sister McMiken was asked to see Mr Haining because his condition had deteriorated. He was moved back into his bed. He was seen by Dr Kingsmore, the surgical registrar. He noted "Sudden deterioration, unresponsive, peripherally shut down and cyanosed, and

respiratory." His impression was "probably pulmonary embolus or myocardial infection". It appears from the medical notes that he was also seen by the medical senior house officer who noted "complaining of sudden onset of shortness of breath, unresponsiveness. No chest pain. No vomiting". He recorded his impression as "?? Pulmonary embolism" and "?? myocardial infarct". It was decided to telephone Mr Haining's family. His daughter Mrs Gray arrived shortly after 12 noon and his daughter Mrs Jardine at about 1 p.m. They observed that their father was having difficulty breathing. He was pulling at his oxygen mask. Although Mrs Jardine was comforted by the fact that her father was sitting up in bed (he looked better than the phone call suggested he might be), he seemed to get worse. His head slumped to the side and saliva came from his mouth. She mentioned this to a nurse who put a tissue under his chin and said there was nothing to worry about. Mrs Gray and Mrs Jardine were not both in the room together continuously from 12 until 2 but one or other was. At about 1.50 p.m. Mrs Gray was in the ward corridor. She met Dr Williams who recognised her from her father's previous stay in the ITU. He asked why she was there. When told that her father's condition had deteriorated he entered his room. He immediately asked Mrs Jardine to leave the room. He found Mr Haining to be deeply unconscious with quite laboured breathing. Because of the poor condition a decision was made to resuscitate him. He intubated him. He was taken to the ITU immediately. Dr William's impression of what had happened is in the notes. He had suffered a peri-arrest - he was about to have a respiratory or cardiac arrest; his condition was so poor that arrest was imminent. In evidence he said that the reason for the deterioration was that he was too weak to cough up secretions in his chest. He had really developed a pneumonia which he was not strong enough to clear. Dr Williams was not called to see Mr Haining by the nursing staff. His attendance was entirely as a result of the chance meeting with Mrs Gray. He told me that, from the inability to create secretions ("what I consider went wrong"), it would have taken a little bit of time to become unconscious and for the carbon dioxide level to rise - at least 10 to 20 minutes for the level which he had found. I will quote, in full, the passage of evidence where, in cross-examination by counsel for the Trust, Dr Williams dealt with the effect or otherwise of his being called earlier to see Mr Haining:-

"Just finally, in retrospect do you consider that there is anything more that you would have done for Mr. Haining at the time? - I think -- we have reflected on this many times, as you can imagine -- and I think the main issue was regarding, you know, the earlier recognition of patients who are critically unwell on the wards, although in this particular case he did have quite a lot of medical care beforehand, and quite senior impressions at that time. But I don't think that would have altered the eventual outcome, but it may have been nice if we had been called earlier with an intensive care consultant so that we could have looked at him when he was starting to deteriorate rather than when he was, as we describe, peri-arrest, or almost at cardiac arrest.

And by "earlier", you mean presumably 10 or 20 minutes earlier? - Yes, in that sort of area really -- but that may have made things a little bit easier.

BY THE COURT: Which date is it you are talking about? - On the 1st of March.

On the 1st of March? - Yes, when he deteriorated rapidly at half past 11 and then he rallied somewhat.

Yes? - And at that point there was perhaps an opportunity to liaise with the Intensive Care staff about whether he should have returned back to Intensive Care. And to be frank, there would have been a difficult decision for us to make to bring Mr. Haining back to Intensive Care then, because we knew the prognosis was poor. At the time I was left in no choice but to bring him to Intensive Care, because of the suddenness of the event, and I needed more information, and we acted to give him the benefit of the doubt and bring him back to Intensive Care.

BY MR. ROSS CONTINUED: So I think you have described in effect the decision being made for you by Mr. Haining's condition, in effect; is that correct? - Yes, we needed more time to pass to get more information and to collect opinions about ongoing life support.

But do I understand you correctly when you say even if you had had the information 20 minutes earlier when Mr. Haining was still relatively healthy, or fit to speak to you, it would have been a difficult decision whether to take him away from Ward 6 or not? - I would have had to have spoken to the relatives and Mr. Auld and, you know, carefully considered whether further intensive care admission was in his best interests given what we knew was a very poor prognosis.

Right. So in fact even if you had had this consideration 20 minutes earlier, he may have gone off Ward 6, he may not have, depending on what the discussions agreed upon? - Yes, but if those full and frank discussions had not happened then we would always act on the benefit of the doubt for the patient.

Yes? - So we can have fuller information."

- The evidence suggests that during this time (between 12 and 2) three nurses entered the room. One "popped in to look" when Mrs Gray was there. She said her father's oxygen mask was off but it was not replaced. Sister McMiken and a doctor came in when Mrs Jardine was there and asked what her father's weight was. (Sister McMiken could not remember this.) And then there was the nurse who placed the tissue under Mr Haining's chin. Nothing is recorded in the nursing notes. When asked about this the tone of Sister McMiken's evidence was defensive. She referred to the separate blood pressure recordings. These were not easy to follow because times had been omitted. The last timed recording is 10.a.m. There are three other recordings which are not timed. The first also includes the result of a test for a blood sugar check. The second records the figure "2" in the row below that intended for the times. Sister McMiken accepted that this made no sense. I am unable to infer from this that there was any blood pressure or blood sugar check between 12 noon and when Mr Haining left the ward, following Dr Williams' intervention, at 1.50 p.m. I had no reason to regard Mrs Gray or Mrs Jardine as other than truthful witnesses and I accept their evidence about what they say the nurses did while they were there between 12 and 2. They did not see blood pressure readings being taken

or anything to indicate that a blood sugar check had been carried out. It was not suggested to Mrs Gray that the position was otherwise. From this I conclude that the only nursing intervention after Mrs Gray's arrival just after 12 until Dr William's intervention at 1. 50 was as they described.

- On the subject of Mr Haining's nursing care I heard Mr Auld's evidence. Generally he thought it had been excellent and said he would be happy to be a patient in the ward. But he was not asked about the details of the care between 12 and 1.50. I also had the benefit of a report from Judy Taylor, a Senior Nurse Professional Practice at Vale of Leven Hospital. She comments that the care was adequately documented, the various charts completed appropriately and the nursing records are of a good standard. But, because her view depended solely on a review of the records, and she did not hear the evidence about the surrounding circumstances, she does not make, indeed cannot make, any comment about the actual care. The only other comment on the nursing care is to be found in a letter dated 19 November 2001 to Mrs Gray from Dr Lawrence, then the Medical Director of the Infirmary. This was lodged by the Trust as a production. Dr Lawrence writes "Appreciating the vulnerability of patients who have to be transferred unacceptably early the sequence which occurred after you were called (following a deterioration in your father's condition) on the morning of 1st March undoubtedly reflects an unacceptable level of care and support. We think it is very difficult to fault the individual staff members who each saw only a brief snapshot of the situation. They initially thought they were dealing with a pulmonary embolus for which appropriate assessments were performed and treatment commenced. The very major defects were that more frequent observations were not called for by the attending medical staff and that worrying recorded observations were not highlighted by the nursing staff who made them." Unfortunately, although he had given evidence earlier in the Inquiry, primarily into the death of Lemond Milroy, he was not asked about this letter.
- Mr Haining's nursing care over the period 12 noon until 1.50 p.m. has to be set against the circumstances of why he was in Ward 6. The HDU had been closed. Dr Williams preferred not to use that word but accepted that in ordinary English that is what had happened. Mr Auld called what had happened a closure. It is likely that if there had been no staff shortage in ITU Mr Haining would have remained in the HDU with the closer observation there available. Given the evidence about his condition during the period, and that of Dr Williams, it is probable that his deterioration would have been noted earlier in the HDU. Why did that not happen on the ward? It is difficult to avoid the conclusion that he was not being monitored with an eye to his condition as someone who might well have been in the HDU. The absence of entries in the nursing notes suggests that. The family's description of what they saw confirms it. The evidence of Dr Williams suggests it. Although he mentions a time of 10 to 20 minutes the deterioration before that had been sufficient to have the family called. So I agree with the conclusion which Dr Lawrence reached that during this important period the nursing care and attention was less than it should have been. Better care might have led to the earlier alerting of the medical staff, in particular the ITU staff to the deterioration which Dr Williams described.
- But even if Mr Haining had remained in HDU, and that had allowed an earlier detection of the deterioration, it is not possible to say that his death might have been avoided. On the evidence I heard I think that is most unlikely. Both before

and after his operation Mr Haining was very ill. I have referred to Dr Ball's discussion with his family before the operation and his note of that. On 1 March the medical notes disclose a discussion with the family - "Current situation explained. Guarded prognosis and timescale". When referred to this Dr Williams said that it meant that the prognosis was pretty poor. On 14 March Dr Williams again notes the prognosis as "very poor. I do not think we will get Archie home let alone off the ventilator." After a discussion with the family it was agreed that there would be no resuscitation in the event of a cardiac arrest, no escalation of therapy or support and no re-commencement of ventilation if he had been weaned off it. On 15 March he was transferred to Ward 3. The medical notes are marked "Not for re-admission to ITU." And, of course, Mr Haining died at 9.10 a.m. on 16 March. Now while these notes relate primarily to the period after the re-admission to ITU on 1 March they have to be read in the context of the passage from Dr Williams' evidence which I quoted earlier. It was the suddenness of finding Mr Haining in the peri-arrest state which precipitated the return to ITU. The stay there did not avoid death. I think it is probable, and perhaps likely, that the sort of discussion to which Dr Williams refers, if it had happened earlier, would have resulted in a decision not to re-admit to the ITU. That, in my view, is the guarded tenor of his evidence. There was no evidence that this would have been an unreasonable decision. It is, in effect, the decision which was taken on 14 March. I believed Mr Auld and Dr Williams when they said that they thought the removal to the ward had not affected the ultimate outcome.

- So I do not find that there were any reasonable precautions which would have avoided Mr Haining's death. Nor, notwithstanding the criticisms which I make about aspects of his nursing care, was there any defect in any system of working which contributed to his death. These criticisms apart I agree entirely with Professor O'Dwyer's conclusion in not identifying "any area of concern in the management of this high risk patient who died despite the efforts of dedicated medical and nursing staff."
- I will add something about the staffing levels in the HDU. Mr Auld indicated that the correct nursing ratios had not been applied. My impression was that he was referring to a continuing situation. He said that clinicians had corresponded (presumably with the hospital management) about this on several occasions. I heard no evidence about these ratios. But I did hear evidence that the unit was closed because of the withdrawal of staff to the ITU. As a matter of logic that is more likely to happen if there are fewer staff in the HDU. Because of the concern expressed publicly by a senior Consultant this an area which the Trust should review.
- As a post script, in relation to all the deaths, I will say something about medical records. The independent medical reports instructed by the Trust, and the report on the nursing notes by Judy Taylor, were generally full of praise for the standards in these notes. As a "lay" reader of them I agree with that. But there were two general points which I noticed. To the unfamiliar eye it was not always clear from a minority of the signatures or initials who had completed the entries. (In the case of Mrs McCoull this meant that it will never be known who was responsible for filing the radiologist's report unseen by Dr Isles.) Not all the entries were timed. That certainly caused me some difficulty, and not a little time, in preparing this Determination. Such notes are not only for the eyes of medical professionals. Patients and relatives have a legitimate interest in them.

It should always be clear from the face of the notes when events happened and who is responsible.

(7) SAME OR SIMILAR CIRCUMSTANCES RELATING TO THE DEATHS

- The procurator fiscal submitted that, although there was nothing in the evidence to link the deaths or their causes and there was no systems failure which contributed to any of them, there were common "threads" which ran through the evidence. He pointed to the failure to diagnose the condition of Mrs McCoull, Mr Milroy, Mr McFarlane and Mr Haining at a time when it might have been possible to make a difference, if not to the outcome then to the patient's comfort in the time before death. I have examined each of these matters in detail. What is suggested may apply to Mrs McCoull and Mr McFarlane but there is no suggestion that there is any link beyond the fact that it does apply to both. He also mentioned a failure to appreciate just how ill each patient was. In essence this is simply another way of saying the same thing. There were failures in the nursing management of some of the deceased but I did not find in the evidence any link between their care which suggested a common cause for such failings; save, perhaps, medical and nursing staff under some pressure of resources but that is a matter which is beyond the scope of this Inquiry.

(8) TRUST SUBMISSION ABOUT THE SCOPE AND PURPOSE OF THE INQUIRY

The Submission

- At the conclusion of his submissions in relation to each of the deaths, counsel for the trust made a detailed submission in more general terms. It was clear that this was made on the specific instructions of the Trust. He said that his intention was not to criticise the present proceedings but to provide a framework for the future. He prefaced his submission by indicating that it raised an issue which the Trust identified as of crucial importance; that of public trust in Dumfries and Galloway Royal Infirmary. Dumfries and Galloway had an ageing population. The Infirmary was the only hospital available to a large part of the population. The mere holding of a Fatal Accident Inquiry could damage the trust of the public. There was, he said, a perception among those associated with the Trust and others that public trust may have been permanently damaged because the Inquiry had been held. He accepted that it was right and proper that such an Inquiry should be held if there were matters which gave rise to genuine cause for public concern; even if, after investigation, such concerns proved to be without foundation and the public were thereby reassured. There was, however, a balance to be struck between two public interests; that any systemic failures are brought to the attention of the public and seen to be dealt with; and that public trust about the care people receive in hospital, particularly the ill and the vulnerable who may have no choice as to where they are treated, should not be undermined. If there was no justified cause for concern, by which he meant no objective evidence to support any failure, the public should not be given that perception by the holding of an Inquiry.
- Counsel invited me to consider two matters. The first was the holding of the five Inquiries together. That in itself, he submitted, raised a suspicion, prior to any evidence being heard, that there really was a serious institutional failure. He accepted that the procurator fiscal had emphasised that there was no

connection between the deaths and no common factor. But perceptions were different. News reporting inevitably affected that. Once proceedings started they were out of the control of any of the parties. Although administratively less convenient, nothing would have been lost by holding five separate inquiries if that was appropriate. Counsel sought that I lay down guidelines for the future in this area.

- The second matter related to the holding of what he referred to as " a medical FAI without supporting medical information which raises a prima facie case of fault". In only one of the five deaths (Mrs McCoull) had the Crown produced a medical report. Several issues were said to arise from that. Firstly, the purpose of a Fatal Accident Inquiry was to enlighten (he referred me to some remarks to that effect in a Determination by Sheriff Kearney quoted in *Carmichael*: Sudden deaths and Fatal Accident Inquiries (2nd Edn.) at para 11.06. If there was no "expert view" this could not be achieved. In the present case it was the Trust which had provided such enlightenment in the reports which they had instructed. Secondly, a Fatal Accident Inquiry should not be held in the absence of "genuine public concern". While an Inquiry might sometimes be justified without medical opinion where there was a repeated or serious problem with a hospital, the existence of a single complaint, or even a series of unrelated complaints, did not indicate a genuine public concern; rather one or more private concerns. An independent medical report would act as a filter for grievances without merit and against individuals who simply wished to cause mischief or find a soapbox. Thirdly a Fatal Accident Inquiry must be fully informed. A medical witness might venture an opinion without notice and be used as "an ad hoc expert witness". Counsel gave as an example the evidence about the cause of death in the case of Mr Sneddon to which he took objection. (I have dealt with this at greater length in that part of the Determination). Fourthly, fair notice of the central issues must be given otherwise the Inquiry might not be properly informed about these and interested parties might not have an opportunity to explore them fully. He referred again to his objection in relation to Mr Sneddon's death.
- Pausing to deal with the question of fair notice, this can be a difficulty in a procedure which is essentially summary in character. The procurator fiscal assured me that the Crown would always take steps to respond to the inquiries of those who had an interest in the Inquiry and provide information about what the Crown expected witnesses to say. In the present Inquiry, of course, the Trust also had substantial prior knowledge of the areas of concern from the previous correspondence with the families of the deceased.
- Counsel invited me to make two recommendations. First that it was inappropriate to hold a Fatal Accident Inquiry, involving questions of medical causation and fault, without a supporting expert opinion and, second, to give effect to that, that the existing Crown Office guidelines "Death and the Procurator Fiscal", should be amended to add, in paragraph 3(4) that it would normally be appropriate to ask the treating doctor to report on any death and, in paragraph 3(6) that only in exceptional circumstances will it be appropriate to hold an Fatal Accident Inquiry where the independent medical opinion does not link a death to an act or omission. The effect of these would be, he submitted, that the holding of a fatal accident Inquiry would be unjustified if any hypothetical cause of death which the procurator fiscal wished to put forward was not independently supported. At least the possibility of the suggested cause should be independently supported. That would leave the discretion of the procurator

fiscal intact and leave the court free to accept or reject the suggested cause of death.

- Counsel submitted that, in the present Inquiry, if the Trust had not gone to the trouble and expense of being represented medical issues may have been at risk of being decided purely by lawyers or lay witnesses' suppositions. Examples of that were the proposition that Mr Sneddon's neutropaenia might have been caused by a dirty ward; that Mr Milroy should have had antibiotics administered directly on admission to hospital; or that Mr Haining should have been operated on 24 hours earlier. These unfounded concerns could have been alleviated, and explained to the families, if an independent report had been obtained earlier. He submitted that following such explanations it would not really have been possible to identify a legitimate public concern. The examination of "ancillary matters" was to usurp the domestic complaints procedure, up to and including the Ombudsman provided for by statute. It was an abuse for a complainer to seek to use a Fatal Accident Inquiry for a complaint which was truly a matter of administration. A fatality was not enough. There must be something which can, even loosely, be described as an accident or incident leading to death. The suggested changes would give the procurator fiscal grounds to refuse to apply for an Inquiry on medical matters if there was no independent medical support for causation. The concern of relatives was not enough. The guidelines should make it clear that it was unlikely to be in the public interest to hold an Inquiry unless a report had been obtained which indicates that some real question of public interest arises.

My Decision

- Inquiries such as the present are held in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. The Act has to be seen against the background of the general right and duty of the procurator fiscal "to inquire into any death which is brought to his notice if he thinks it necessary to do so" (*Carmichael* para 1.07). There are many deaths which form the subject of inquiry by the procurator fiscal where no Fatal Accident Inquiry is held. That is the proper context for consideration of "Death and the Procurator Fiscal", the guidelines to which counsel referred. There is no mention in the guidelines to Fatal Accident Inquiries or to the 1976 Act. That is hardly surprising. They are not guidelines as to the exercise of the discretion of the Lord Advocate to which I shall shortly refer. They concern the general duty of the procurator fiscal to which I have already referred; and they offer guidance as to how that duty will be carried out, both generally and in relation to particular classes of death. Paragraph 3 deals with "Deaths under Medical Care/Medical Mishap". It lays down procedures to be adopted where such deaths are intimated. Paragraph 3(4) provides that "the Procurator Fiscal will consider whether it is appropriate to request the doctor in charge of the case, and where appropriate other doctors who have been involved in the treatment or investigation of the patient, to provide a full written report detailing the circumstances leading up to and surrounding the circumstances of the death." Paragraph 3(5) allows the Procurator Fiscal, on receipt of such a report to take no further action. If he deems further action necessary he will obtain a report from a forensic pathologist or an independent consultant or practitioner in the speciality concerned. Paragraph 3(6) provides that "The Procurator Fiscal will ask the

forensic pathologist and/or the independent specialist adviser to provide a report considering objectively the standards of medical care, the treatment given and the availability and adequacy of the emergency steps taken. Where appropriate, any deficiencies in the standards should be brought to the attention of the Procurator Fiscal." For completeness, paragraph 3(7) directs the attention of the pathologist/specialist to particular points. So there is, in my opinion, no place in the Guidelines for the amendments which counsel proposed. Asking the treating doctor to report "normally" would create an unnecessary burden in a very large number of cases. The decision to apply for the holding of an FAI is not governed by the Guidelines. I can see the good sense of obtaining reports from the relevant doctors but that can be done in a variety of ways and, depending on the information available to the procurator fiscal, at different times. I was told that, in the present inquiries, it was done by asking the police to take statements. That may be entirely appropriate. And if the concern about the death arises some time after it may be better. So I decline to make the recommendations about the Guidelines sought by counsel. They are inappropriate for inclusion in the Guidelines, likely to impose unnecessary work and I am not convinced that they would add anything to what the procurator fiscal actually does in investigating deaths reported to him.

- The proposition that a Fatal Accident Inquiry is not an open ended public inquiry is well established and oft repeated but does not, in itself, define the nature of a Fatal Accident Inquiry. The purpose of the 1976 Act is set out in its long title which reads: "An Act to make provision for Scotland for the holding of public inquiries in respect of fatal accidents, deaths of persons in legal custody, sudden, suspicious and unexplained deaths and deaths occurring in circumstances giving rise to serious public concern". So it is immediately obvious that the scope of the Act goes beyond the accidental and sudden deaths referred to in the short title and includes suspicious and unexplained deaths and "deaths occurring in circumstances giving rise to serious public concern".
- Section 1 provides for the procurator fiscal to investigate deaths and apply to the sheriff for a holding of an Inquiry under the Act. Section 1(1)(a) provides that, for some deaths (those resulting from an accident in the course of employment or of persons in legal custody), an Inquiry must be held except in very limited circumstances. The application for the present Inquiry was made in terms of section 1(1)(b). This states that where:- "it appears to the Lord Advocate to be expedient in the public interest in the case of a death to which this paragraph applies that an Inquiry under this Act should be held into the circumstances of the death on the ground that it was sudden, suspicious or unexplained or has occurred in circumstances such as to give rise to serious public concern" application for an Inquiry "shall be made". Two points should be noted. Firstly, the decision to apply for the Inquiry is that of the Lord Advocate acting in the public interest. It is at his discretion. The procurator fiscal acts for him in investigating the death and, invariably, conducting the Inquiry but it is the decision of the Lord Advocate whether to make the application to the court. In the present Inquiry the procurator fiscal confirmed to me that the Inquiry was instructed after reference to the Lord Advocate. Secondly, the death need not be sudden, suspicious or unexplained. It may have occurred in "circumstances such as to give rise to serious public concern". That, in itself, triggers the operation of the Lord Advocate's discretion.

- Section 1(3) provides that the application "may, if it appears that more deaths than one have occurred as a result of the same accident or in the same or similar circumstances, relate to both or all such deaths." Again, the discretion here is that of the Lord Advocate because the sheriff has no power to refuse to order an Inquiry if an application is made to him (Section 3; *Carmichael* para 3.18).
- Section 6(1) is also informative of the purpose of a Fatal Accident Inquiry. It details the circumstances of the death which, if established to the sheriff's satisfaction, he shall set out in his determination. These include the time and place of the death - s. 6(1)(a), its cause - s. 6(1)(b), any reasonable precautions whereby the death might have been avoided - s. 6(1)(c), any defects in any system of working which contributed to the death - s. 6(1)(d) and, in s. 6(1)(e), "any other facts which are relevant to the circumstances of the death". Significantly, section 6(1)(e) is not limited to the "cause" of the death or even to "the circumstances of the cause of the death". In *Carmichael* the matter is expressed as follows:- "The wording of this paragraph, though it gives the sheriff wide scope, none the less provides that the facts which the sheriff finds established under this head must be relevant to the circumstances of the death. This does not mean that they must be, so to speak, tied up with the cause of the death. It means, it is submitted, the circumstances of the death as they may affect the public interest. There is a distinction between findings under s. 6(1)(c) and s. 6(1)(d) where there is required to be a causal connection and s. 6(1)(e) where no such connection is required." I agree with that analysis.
- It seems to me that counsel's submission which, at its heart, really was that if there was no factual material which pointed to a causal connection between the death and some act or omission by some person or some other legal entity there should be no Inquiry, is misconceived. It does not accord with the wording of section 1(1)(b) which is the basis for the Lord Advocate instructing the making of an application for an Inquiry. Nor does it find support in the description of the matters about which the sheriff may make a finding seen in section 6(1)(e). Different Fatal Accident Inquiries will tend to focus on different parts of section 6(1). In some what caused the death may be the central issue. In others the cause of death will be plain and the emphasis will be on what might have prevented it or if any system failure contributed to it. But, to my eye, there is nothing in the legislation to prevent the focus being the circumstances in which a death has occurred. Indeed the prospect of such inquiry is specifically provided for in section 1(1)(b) as a separate category of death where the Lord Advocate's discretion may be exercised. The procurator fiscal submitted, correctly in my view, that the place where a death occurred was a circumstance of the death; and the same must apply to the conditions or surroundings of the death. I do not think that can be limited to the moment of death, particularly when death is not a sudden and unexpected event but the end of an illness where, at least in the latter stages, its inevitability cannot be doubted and treatment or care is its inevitable precursor. There are places where death tends to occur frequently. Hospitals are an obvious example. So too, today, with the ageing population to which counsel referred, are nursing homes. Given the terms of the legislation which I have described it would be an extraordinary proposition if no Inquiry in terms of the 1976 Act were possible into the circumstances of a death or deaths in such establishments where it appeared, on information available to the Lord Advocate, that distress or discomfort to the dying had occurred or where there

were suggestions of ill treatment; whether or not that caused or contributed to the death. These would, in my view, clearly be circumstances in which the death had occurred and so circumstances of the death.

- Even if I am in error as to the proper scope of an Inquiry under the 1976 Act, it would, in my view, be quite improper for me to seek to influence or inform the exercise of the Lord Advocate's discretion to apply for the holding of an Inquiry. *Carmichael* refers, at para 9.03, to a judgement of Sheriff J Irvine Smith in an action to interdict the procurator fiscal from holding an Inquiry into the death of Gary William Sloan. Sheriff Irvine Smith held that the discretion of the Lord Advocate in terms of section 1(1)(b) of the 1976 Act was not open to challenge. There are, of course, other well established remedies for challenging the exercise of ministerial discretion. The Act has, quite rightly it seems to me, made the Lord Advocate the guardian of the public interest in these matters and the arbiter of what gives rise to serious public concern. That is the proper filter for grievances without merit and not the "expert reports" to which counsel referred. In making these decisions the Lord Advocate operates in a quasi-judicial capacity as a Law Officer. That is recognised in the Scotland Act 1998 (cf. Sections 48 and 52). But he is also one of the Scottish Ministers. He has a wide discretion the independence of which is protected by his position as a Law Officer but the exercise of which is informed by virtue of his position as part of the Scottish Executive. He may decide that the circumstances of a death should be inquired into publicly, precisely so that public confidence is maintained; or so that ill-founded misconceptions are publicly examined and refuted.
- I also reject counsel's submission that the holding of a Fatal Accident Inquiry usurps any internal complaints procedure or even the statutory ombudsman to whom he referred. They are quite different in nature from an independent judicial Inquiry held in public with rights of representation for interested parties and the right to cross examine witnesses. Indeed, although there was no suggestion of it in the case of the present deaths, the operation of such internal procedures may, in itself, be a circumstance of the death. In the present Inquiry there was, in the evidence of the families of the deceased, a flavour that private, internal administrative inquiries do not necessarily always command public trust. The Lord Advocate may quite properly judge it to be in the public interest that, where death has occurred, something more is required if public confidence is to be maintained. I fail to see how that could be an unreasonable exercise of his discretion even if, at the end of the day, nothing adverse about the circumstances of the death, or those in which it occurred, was established.
- Counsel's submission about the jointly held Inquiry is not something I can make recommendations about. It is not a fact which is relevant to the circumstances of any of the deaths. I doubt whether, in terms of section 6, it could properly form part of my Determination. Furthermore, as I point out above, I have no discretion about whether an Inquiry is held or whether several deaths should be inquired into together. So I would be seeking to determine, in the abstract, a matter which the Act gives me no power to determine in the case of any particular application put before me.
- In the present Inquiry there were, in my opinion, matters of serious public concern which justified the holding of an Inquiry. In the case of Mr Sneddon there was an inaccuracy in the stated cause of death and the procurator fiscal had information which was suggestive of unsatisfactory circumstances in the hospital room of a dying man. Mr Milroy's death was unexplained. The lack of a

post mortem required explanation. The circumstances of Mr McFarlane's diagnosis and his conditions in hospital had given rise to concern by his relatives. Mrs McCoull's case indicated a system failure which, although it did not cause or contribute to her death, was a concerning circumstance of it. In Mr Haining's case the procurator fiscal had information which was suggestive of a possible failure to diagnose at an earlier stage and a failure to observe the patient when his condition deteriorated. All those who died were being or had been treated in the same hospital. Some of the information available to the procurator fiscal was suggestive of poor nursing standards in several of the cases. The issue of the appropriateness of transfers between wards arose in more than one case. I do not think it is reasonable to seek to criticise the Crown for drawing all that together in the public interest. If all I heard had been true, or if certain of the families' concerns had been made out, that would have given rise to very grave public concern. As it was a public examination of the evidence, and the more serious concerns, in a public and independent Inquiry established some failures but established even more clearly that many of the most serious concerns were without foundation. That can only be beneficial and, to achieve that is, in my respectful view, a perfectly proper exercise of the Lord Advocate's discretion.

CONCLUSION

- This Inquiry appeared to generate considerable media and public interest. Unfortunately media coverage, perhaps because of constraints of space or time, rarely gives a complete picture of all that is said at an Inquiry of this length. For these reasons I have tried to set out the larger picture in greater detail. It is important to emphasise that none of the evidence established, or even suggested, that any of the deaths was caused by any act or omission of the medical or nursing staff at Dumfries and Galloway Royal Infirmary. Nor were there any reasonable precautions whereby any of the deaths might have been avoided. The evidence identified defects in some systems of working and deficiencies in some of the nursing care which was given. But this must be placed in context. One of the nursing witnesses referred to the thousands of patients who had passed through her ward since the events described in the evidence. While what happened in the cases I have described was, in some instances unacceptable and upsetting, it does not justify any lack of trust in the doctors, nurses and other medical and auxiliary staff who work at Dumfries and Galloway Royal Infirmary. Indeed, many of the witnesses were impressive examples of their professions and it was clear that they took a caring and responsible attitude to their work and to the patients under their charge. It was also clear, however, that they worked under considerable pressure of resources.

Sheriff of South Strathclyde Dumfries and Galloway