

Sheriffdom of Tayside, Central and Fife at Dunfermline

DETERMINATION

of

**Sheriff Ian D Dunbar, Sheriff of Tayside, Central and Fife at
Dunfermline**

in terms of

**The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act
1976**

into the death of

Mrs Christina Watson Dougall

who died on 15 July 2009

within Queen Margaret Hospital, Dunfermline.

This Inquiry was conducted for the Crown by Ms L Ward, Procurator Fiscal Depute.

Fife Health Board was represented by Mr Kinroy Q.C.

Doctors McKenzie, Pound and Chapman were represented by Mr Jessiman, Solicitor.

Staff Nurse MacAulay was represented by Mr Finnieston, Solicitor.

Staff Nurse Hammon was represented by Ms Watt, Solicitor.

Dunfermline.

April 2011.

The Sheriff having resumed consideration of the Inquiry, in terms of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976 makes the following findings.

1. In terms of Section 6 (1) (a) that Christina Watson or Dougall, born 28 December 1924 died on 15 July 2009 at 15.30 hours within Queen Margaret Hospital, Whitefield Road, Dunfermline, Fife.
2. In terms of Section 6 (1) (b) Christina Watson or Dougall died as a result of
 - (a) Acute myocardial infarction.
 - (b) Left coronary artery thrombosis.
 - (c) Atherosclerotic coronary artery disease.

There was no accident resulting in her death.

3. In terms of Section 6 (1) (c) there were no reasonable precautions whereby the death might have been avoided.
4. In terms of Section 6 (1) (d) there were no defects in any system of working which contributed to the death.

This Inquiry commenced on 10 January 2011 and heard evidence for seven days until 30 March 2011 when we heard from the final witness and the parties made submissions. In the course of this Note I will refer to Queen Margaret Hospital, Dunfermline as “QMH.” I am grateful to the agents for their presentation of the evidence which stuck very closely to the purpose laid out in the Act although that restriction may well have resulted in the family of Mrs Dougall feeling slightly frustrated that they have not had all the answers they may wish. I will comment further on this shortly. The witnesses who gave evidence in the order in which they were called were:-

1. Shona Dougall, a daughter of the deceased.
2. Margaret Nekrews, Health Care Support Worker, Ward 5, QMH.
3. Kelly Glencross, Auxiliary Nurse, Ward 5, QMH.
4. Gillian Wallace, Auxiliary Nurse, Ward 5, QMH.
5. Fiona Swan, Auxiliary Nurse, Ward 5, QMH.
6. Mary Carberry, Health Care Support Worker, Whitefield Day Hospital.
7. Helen Hunter, Auxiliary Nurse, Ward 5, QMH.
8. Michael Labonte, Senior Charge Nurse, Ward 5, QMH.
9. Andrew Murray, Clinical Nurse Manager, NHS Fife at QMH.
10. Elaine Hammon, Charge Nurse, Ward 5, QMH.
11. William MacAulay, Charge Nurse, Ward 5, QMH.
12. Dr John McKenzie, Consultant Geriatrician, QMH.
13. Dr Andrew Coull, Consultant in Medicine for the Elderly at Edinburgh Royal Infirmary.
14. Professor Derrick Pounder, Professor of Forensic Medicine, the University of Dundee.

1. In stating what I am about to state about the purpose of this Inquiry, I stress that I am in no way unsympathetic to the family of Mrs Dougall nor do I mean to sound insensitive to them at this time. Mrs Dougall's death was, to them at the time, unexpected. From the evidence of her daughter, Shona Dougall, the family had a number of unanswered questions about her stay in hospital, her treatment there and the circumstances of her death. She had been admitted to hospital due to pain in her back which may have been associated with a previous fall. Initially she was looking well, talking to her family and not in too much pain. While in hospital she had a fall and, possibly, a second fall as a result of which she fractured her femur. The family had questions about this but there was limited evidence before the court about which comment could be made. She was moved to another ward and was not too happy about it. She did not want to be there and her mood varied. She had an operation on her femur and Ms Dougall said that the family got conflicting reports on her progress. Some nurses said that she was difficult and disruptive while others said that she was no problem to them. She was eventually put into a side room and the family was told it was because she was disruptive. Mrs Dougall did not like being there and did not like the door being closed. Ms Dougall said that her buzzer was out of reach and when she asked it was apparently because she was using it too much. Mrs Dougall needed help with personal matters such as toileting, washing and dressing.
2. The family were also concerned about the circumstances of the fall on 11 July 2009 and the aftermath of that fall. They did not believe that they ever got an answer as to why the door to the side room was closed and it is clear from the evidence that is not something we know even yet. After Mrs Dougall died and the preliminary death certificate was issued the family said they knew nothing of any heart attack although they were aware of

previous medical treatment for heart problems. The family had a meeting with Mr Labonte and Mr Murray but still did not feel that they had any clear answers.

3. So it is clear why the family might wish to see the facts aired in a forum such as this Inquiry but I rather suspect that having sat through all the evidence they will feel a sense of frustration that they still do not have the answers they wish and I regret that I am not in a position to ease that frustration. Having heard all the evidence I looked at the purposes of a Fatal Accident Inquiry in terms of the Act and my initial reaction was to wonder what was intended to be achieved and then what actually has been achieved. This was a lady of 84 who was prone to falls. This much was noted and, indeed, she had more than one fall while in hospital. That suggests that risk assessment in general and falls risk assessment in particular could have been an issue. There was no evidence about it. Mrs Dougall was described as disruptive and that was, apparently, the reason she was moved to a side room. She was recovering from a fractured femur and her mobility was limited. She needed assistance with all aspects of personal care. The question of observation of someone with such limited mobility and with such needs was something which might have been considered but again there was no evidence about this. Questions were put to witnesses about doors to side rooms being opened or closed and what any policy might have been. It is fair to say that there were different understandings of what might have been said to have been the “policy” but no expert or even managerial evidence about this. There was clear confusion in the eyes of some witnesses about who was in charge of the ward. The status of Staff Nurse Hammon (who was a grade higher than Staff Nurse MacAulay) when she was not working a core shift and was working a bank shift seemed to be the cause of confusion at least to some staff. While she herself was clear about her status on 11 July she was nevertheless undertaking tasks that were normally done by the

charge nurse such as preparing rotas. Did the confusion have any effect on what was happening on the ward the day of the fall? What is the “official” position about staff working at a lower level when they are working on the bank and not on the core staff? What would be the view of an independent expert in nursing practice? Once again no evidence was led about these matters. There was conflicting evidence about the part played by qualified nurses in washing, dressing or toileting or otherwise taking part in the personal care of patients. That could have been relevant insofar as there was evidence that while Mrs Dougall was shouting from the side room (possibly that she needed to go to the toilet) the two senior qualified nurses on the ward were at the nursing station a matter of feet away. I raise these matters because there was some evidence about them but, in the end of the day, there was no evidence of any direct connection to Mrs Dougall’s death and, therefore, it is not appropriate to criticise or comment in detail. The issues may, however, be of importance to Fife Health Board in their consideration of ongoing issues arising from the whole circumstances of the days from 11 to 15 July 2009.

4. So, bearing in mind the purposes of a Fatal Accident Inquiry, we appear to be left to deal with the unfortunate death of Mrs Dougall, an elderly and somewhat frail lady with a pre-existing heart condition. According to some of the medical evidence her heart condition was such that she could have had a heart attack at any time. She had a fall four days before her death as a result of which she sustained a fractured humerus. Did that fall contribute to her fatal heart attack? Could the fall have been prevented? Was there any fault in any system which contributed to her death? In the absence of independent or expert evidence it is difficult to comment beyond these areas. Given all that one may wonder why the Crown decided to go to the trouble and expense of a Fatal Accident Inquiry. It became clear as the evidence came out that the reason for that was likely to have been the terms of the post mortem report produced by Dr Risso

and the attachment of a contributory factor to the death of the fractured left humerus. Indeed the relevant evidence focussed on whether or not there was any causal connection between the fall Mrs Dougall sustained on 11 July and her death on 15 July. Unfortunately, for a variety of reasons, the Inquiry did not hear from Dr Risso who was unable to come from Italy. That meant there was no direct evidence of the post mortem report and no evidence about why or how he reached his conclusions. Fortunately there was evidence from Dr Coull and Professor Pounder which was of considerable assistance in considering the cause of death.

5. While there is no causal connection between the fall and the death, I feel it is important to lay out the evidence as given if only to serve as a reminder to all about what happened or what was done or not done. There has been a full Inquiry conducted by Fife Health Board and there have been disciplinary proceedings. I do not regard it as necessary or appropriate, standing the evidence heard and the purposes of a Fatal Accident Inquiry to make any recommendations with regard to further inquiry or discipline. I was, however, pleased to hear the fulsome apology made by Mr Kinroy on behalf of Fife Health Board and also his concession that points made in the evidence would be considered in relation to appropriate practices and procedures.
6. As far as the witnesses were concerned, for the most part they were doing their best to remember what they could about the circumstances surrounding the fall and the consequences of it. However in respect of one area of evidence I regret that someone may not have been telling the whole truth. I refer to the closed door to the side room immediately before the fall. We had a witness say she saw Mr MacAulay leave the room and close the door. Another said Mr MacAulay came out of the room and she immediately heard the door close. Mr MacAulay was adamant he did not close the door. On balance of probabilities he did but given his denial we

will never know for sure if he did or why that was done. As I said, there have been disciplinary proceedings and in the absence of any causal connection between the closing of the door and Mrs Dougall's death I leave that matter there.

7. Ward 5 at QMH was in July 2009 and is today a medical assessment ward for the elderly (patients over 65). It comprises 4 bays containing 6 beds each and 6 side rooms each containing 1 bed. The side rooms were often used for patients who had infections but we heard evidence that Mrs Dougall had been put into side room 2 as she had been disruptive to other patients while on the ward. It is a busy ward and was in July 2009, full. The day shift worked from 7am until 3pm but there were nurses who worked from 7 am until 7.30pm. During the day the complement of staff on the ward was 4 trained nurses and 4 auxiliaries (or Health Care Support Workers), on the back shift 3 trained and 3 auxiliaries and on the night shift 2 trained and 2 auxiliaries. In addition, if there were requirements for observation additional auxiliary staff were made available to comply with observation policy.
8. The patients were elderly, ill and, in many cases, demanding. There were frequent calls from them and the patients' buzzers were used regularly. As I understand it, if a patient pressed a buzzer which was by the bed, that buzzer kept going on and off until a member of staff attended and deactivated it. More than one witness described ward 5 as "a busy shift" and indeed one bank nurse said that there were many nurses on the bank who would not do work on ward 5 as it was so busy, demanding or stressful.
9. The hospital has what it describes as core staff which I understand to be the permanent employees who work regular shifts. The trained nurses fall into categories of seniority and those which concern this Inquiry seem to be the levels of staff nurse – band 5, staff nurse – band 6 (or junior charge

nurse), senior charge nurse – band 7 and clinical nurse manager – band 8. The untrained staff also came into bands and I understand auxiliaries to be band 2 and Health Care Support Workers to be band 3. These latter individuals were untrained nurses who had received training in certain tasks which were once routinely carried out by nurses such as taking observations or bloods.

10. The nurse bank seems to be a group of nurses, trained or untrained, who can be called upon when required to fill needs in any area of the hospital's need. Some of the bank nurses were also members of the core staff and did shifts as a bank nurse in addition to their contracted work. If that happened they might be doing work at a lower grade or band than that which they had on the core staff. For example, Elaine Hammon is a band 6 charge nurse who, in her normal duties, was a charge nurse on ward 5. However, on 11 July 2009 she was doing a shift as a bank nurse and the grade of the nurse on that shift was band 5. The nurse in charge of the ward on 11 July during the early shift was William MacAulay who is also a band 5 nurse. There is no doubt whatsoever that this caused confusion in the minds of some staff. They were accustomed to seeing Nurse Hammon as the charge nurse. She was wearing the uniform of the charge nurse albeit she had a badge signifying her status that day and that status was also made clear at the shift handover. Indeed from her own evidence she spent part of the day undertaking tasks that the charge nurse would normally do such as dealing with rotas on future shifts. While technically she may not have been in charge of the ward at the relevant time I am in no doubt that to all intents and purposes she was regarded as the charge nurse by some of the staff. After the fall she took it upon herself to instigate the internal investigation, a decision that would normally be taken by the nurse in charge of the ward. Once again I make this comment against the background that from the evidence there is nothing to connect any issue about her status to Mrs Dougall's death.

11. When the day shift comes on duty at around 7am the first task is the handover by the night shift. This will normally be done by the 2 qualified nurse from the night shift and will be given to all those coming on duty at that time, qualified or unqualified. The handover involves the night staff telling the day staff what matters of significance have occurred overnight and updating the day shift on the condition of each patient.
12. The charge nurse for the day shift will have prepared a duty rota and written this on the white board at the nurses' station. This board will also tell who is the charge nurse and will contain phone numbers for such people as the on-call medical team. The incoming shift will check the board to see what their individual duties are to be. Generally a qualified nurse and an auxiliary or health care support worker will be allocated to each bay and this may include one or more of the side rooms. If observations are required an auxiliary may be allocated to a bay to conduct such observations. He or she would not be permitted to leave the area unless someone took over the observation duties. On 11 July 2009 we heard evidence that there were 2 auxiliaries doing observation duties in ward 5 including one, Gillian Wallace, who was allocated to bay 2. The nurse responsible for bay 2 and side room 2 was William MacAulay assisted by health care support worker Margaret Nekrews. In the course of the morning Mrs Nekrews had other duties including taking bloods from various patients.
13. From the evidence generally and also the Notes (Crown Production 8) it is clear that Mrs Dougall had been a cause of concern throughout the night of 10/11 July. There are references to her shouting, banging a cup or glass and generally causing considerable disturbance. From the evidence of some of the witnesses this behaviour was not out of the ordinary for her. It is clear that she did not like being in the side room and may well

have felt lonely and detached from the rest of the ward. She was, to all intents and purposes, immobile. She had sustained a fall in March as a result of which she had fractured her femur. If she walked at all she needed the use of a zimmer. She was generally helped to the toilet and that could require 2 members of staff. She needed daily help to wash and dress. When that was done she was usually put into a seat beside her bed.

14. It is appropriate to comment on two issues but once again I have to stress that there is no connection between them and Mrs Dougall's death. I make the comments to assist Fife Health Board in looking at issues which have arisen in the course of evidence and which might merit some attention. The first relates to the nature of the tasks carried out by staff at different levels. On the one hand some of the auxiliary nurses thought that qualified staff would not carry out such tasks as personal care, toileting etc. On the other hand qualified nurses suggested that everyone pitched in and did what was required. I do not think there is evidence of any culture of demarcation and the only possible relevance of this evidence in this Inquiry is where there is a suggestion that two nurses, Elaine Hammon and William MacAulay sat at the nurses' station while Mrs Dougall was calling out that she needed to go to the toilet in the minutes immediately before she was found on the floor. These nurses agreed that they were at the station but they were undertaking various tasks and, in any event, different people including Mr MacAulay had been in the room. If, as was said by some witnesses, Mrs Dougall was calling for help to go to the toilet and she was calling out a lot, then regardless of whether or not Mr MacAulay had been in the room, she felt she needed help. I find it slightly puzzling that two senior nurses should sit close to the source of these calls and, apparently, ignore them. One of them had been in the room and had done nothing to get help for the toilet if that is indeed what she wanted. The other said that when Mr MacAulay came out of the room she

heard the door close behind him. Mrs Dougall's calls for help were noticed but not acted upon. The auxiliaries who gave evidence were all busy. Mrs Nekrews having finished taking bloods, left her equipment and samples at the nursing station and took it upon herself to go to see what she could do to help. Sadly by then it was too late and Mrs Dougall had fallen. I mention this simply so that Fife Health Board might consider looking at whether or not there is any issue about "who does what" when it comes to answering calls for personal services.

15. The second issue relates to the doors and curtains of the side rooms and whether they should normally be open or closed. The door is glazed for most of the top half and there is a curtain on a rail over that part of the door. To the side of the door is a window which also has a curtain on a rail along its full length. There was not complete agreement in the evidence as to when doors are open or closed or curtains drawn closed or open. However it appears that the general policy would be for the door to be open and the curtains drawn open. That enables staff to see the patient inside the room. The door might be closed if the patient had an infection. For the avoidance of any doubt there is no suggestion that Mrs Dougall had an infection. The door may also be closed and the curtains pulled closed if the patient was being seen by a doctor or if there were personal care needs being attended to such as washing or dressing or using the toilet. While there was a WC in the side room, I understand that Mrs Dougall quite often used a commode when she needed to use the toilet. Outwith these times the doors and curtains would normally be open. This could have been an issue in the Inquiry since there was evidence that immediately before Mrs Dougall was found on the floor in her room the door to side room 2 had been closed and the curtains pulled closed. Had they not been it is possible that someone might have seen what happened before Mrs Dougall was on the ground. Whether or not anything could have been done to prevent her getting to the ground is a matter of

speculation. However the practice relating to doors and curtains does bear some attention and education of staff.

16. Mrs Dougall was in hospital from March 2009. She had a fall and fractured her femur. She was described as frail and had a number of pre-existing conditions. She had both knees replaced. She had a hip replacement and work done on her other hip which seems to have been a partial replacement. She had atrial fibrillation. She had other problems relating to her heart. From the post mortem report she had previously had a heart attack. She was mentally alert and communicative. She knew her own mind but could be impatient. The hospital notes contain a number of references to her being noisy and disruptive. She would use her buzzer frequently, shout and bang a cup or glass to attract the attention of staff. She was described as demanding but seemed to be liked by most of the staff. Other patients complained about the noise she made particularly at night and some were even threatening to self-discharge. A decision was taken to move her into a side room which decision she did not like. Dr Mackenzie was on leave when that happened but agreed with the decision when he returned. She continued to be noisy when in the side room.

17. There was evidence that during the handover on 11 July 2009 she was persistently buzzing or shouting. A number of members of staff answered her calls during the handover. She seemed to want to be got up and dressed and was told that would happen after the handover. The notes for the night of 10/11 July disclose that she had been noisy and disruptive throughout the night and had not had much sleep. She was got out of bed, washed and dressed and put into a chair beside the bed. The door to the side room was open and she could be seen through the door. A number of witnesses saw her over the course of the morning sitting in her chair. As the morning went on she began to shout. While some witnesses could not hear what she was shouting others heard that she was wishing to go to

the toilet. Gillian Wallace was on observations in bay 2 and looked over to see Mrs Dougall. At that point the door to the side room was open. She could not leave the bay as she was on observations but said that she went to the door of the bay and looked over to the nurses' station where she saw Elaine Hammon and William MacAulay. She seemed concerned that no one was responding to Mrs Dougall.

18. There was evidence that more than one person had gone to the room and asked Mrs Dougall what she was wanting. Mr MacAulay said that he went in and he was probably the last person in the room before Mrs Dougall was found on the floor. After he had been in the room the door was closed and the curtains drawn shut. He was adamant that he did not close the door or draw the curtains. Elaine Hammon said she heard the door closed and then saw Mr MacAulay appear but she did not actually see him shut the door. Kelly Glencross said that she did see Mr MacAulay switch the buzzer off at the wall and close the door on his way out of the room saying something like the patient was a pain and always buzzed. This was strenuously denied by Mr MacAulay. Gillian Wallace was busy in bay 2 and at one point she turned and saw that the door and curtains at side room 2 were closed. She assumed this was because someone was taking Mrs Dougall to the toilet and paid no more attention.

19. In my view it is impossible to say with certainty who closed the door of side room 2. It is also possible that the window curtains were drawn shut. People did not really notice the window curtains as Mrs Dougall could be seen quite clearly through the open door. Once the door and curtains were closed it was a perfectly reasonable presumption to make that Mrs Dougall was receiving personal care and was therefore entitled to privacy. There was, however, evidence from Margaret Nekrews that after the door was closed Mrs Dougall was still shouting for help. When she finished what she was doing she took her bloods to the nurses' station and asked

Elaine Hammon to help with the paperwork while she attended to Mrs Dougall. In the way she gave evidence she seemed a little perturbed that neither Elaine Hammon nor William MacAulay had moved from the nurses' station (which was right beside side room 2) to assist Mrs Dougall who appeared to need assistance.

20. Mrs Nekrews went to the door of the side room and could not open it. It seemed jammed from the inside. She pushed and managed to get it open a few inches to enable her to look in. She found that the bed had moved and was blocking the door and that Mrs Dougall was on the floor partly under the bed. She shouted for help and squeezed her way into the room. Mrs Nekrews is very slightly built and there was barely enough room for her to squeeze in. Once there she found that there was urine and faeces on the floor and she proceeded to clean that up. She called for a slide sheet and once that was available slid Mrs Dougall out from under the bed. She was able to move the bed away from the door which allowed others to access the room. At around the same time an emergency buzzer was sounding in another part of the ward and Elaine Hammon went to attend to that incident leaving auxiliaries to deal with Mrs Dougall. They got her initially to a seat and then on to her bed within the side room.

21. Mr MacAulay was questioned about being absent from the ward while all this was going on. Indeed it was suggested that he knew something was amiss and that Mrs Dougall was on the floor yet continued to leave the ward. He had been checking for some drugs and realised that over the weekend a patient would need certain prescribed drugs and there was insufficient to fulfil the need. He talked to Elaine Hammon about this and it being Saturday the pharmacy closed at 12 noon. There was a difference of evidence regarding what was said but the upshot was that Mr MacAulay decided that he would take the prescription to the pharmacy himself which is what he did. This took him to the other side of the hospital and he was

off the ward for about 15 to 20 minutes. According to some witnesses he had not left the ward when it was discovered that Mrs Dougall was on the floor. His position was that he was out of the ward and was not aware of her fall until he returned. Mrs Nekrews had taken observations on Mrs Dougall and she and the other auxiliaries seem to have done all that could be expected of them. It is not clear what more the presence of Mr MacAulay would have added. The only comment I would make about this particular chapter of the evidence is that it was, perhaps, not the most efficient use of nursing time for the nurse in charge of the ward to run an errand to the pharmacy when there were a number of auxiliary nurses on the ward at the time.

22. When he returned to the ward and ascertained what had happened Staff Nurse MacAulay went in to see Mrs Dougall who was sitting in a chair. He had been told that she may have hurt both her left arm and left leg. He tried to confirm this and asked if she was in pain but got no reply. He arranged that she be placed on the bed for better examination and realised that there was no trained nurse in the room. When he asked where everyone was he was told there had been another fall and that Staff Nurse Hammon had gone there. He went and found three trained nurses at that fall. He was told that a doctor had been called but was busy. He then called the junior doctor on call and said there had been two falls and she said she would come as soon as possible. He then went back to the side room and found Mrs Dougall quiet and lying still on top of the bedcovers. He completed his examination, ascertained that observations had been done and went to get an Incident Report Form (Health Board production 4-1). The doctor came and examined Mrs Dougall. She got little response and thought there was probably no injury but ordered a precautionary x-ray. Mrs Dougall was given pain killers and taken to x-ray. The doctor later said that the arm was fractured. Mr MacAulay completed the Incident Form and put it into the charge nurse's office for investigation

and signature. Staff Nurse Hammon had said that because the door had been closed she would ask for an investigation. There was some conversation during the afternoon about an investigation which would need to find out who closed the door. Mr. MacAulay maintained it was not he and he did not know who it was.

23. Mrs Dougall's health then deteriorated. She was seen to be very quiet over the next two days. Her family was shocked at the suddenness of the deterioration and they were critical of some of the care received at this time and the information they were given. Staff Nurse Hammon was on duty on the Sunday but had little to do with Mrs Dougall and could not recall if she had any conversation with her. There did not seem to be too much amiss when her vital signs were taken on 12 July although by 13 July there were signs that she may have had some sort of coronary incident.

24. Dr McKenzie had been on leave and returned to duty on Monday 13 July. He gave evidence about her general medical condition. She was a frail lady with a history of falls and fractures, she had had atrial fibrillation a condition not typically serious but which could increase stroke risk. She had a history of osteoporosis and previous fractures of the hip and hip and knee replacements. An ECG 4 years before had disclosed aortic calcification. With her various problems she was at risk of death at any time. She was, however, described as strong willed but at times became frustrated especially when having bed rest. She was at times confused and she was very frail. Dr McKenzie had not been involved in the decision to move Mrs Dougall to a side room but, having read the notes and other measures having been attempted it was not unreasonable to move her.

25. When he returned to the ward he was told of the circumstances of the fall and the injuries. The fracture was just below the ball of the shoulder and

the collar and cuff applied was the usual and ideal treatment. He noted that Mrs Dougall was less well than when he had left to go on leave. She could communicate but was quite sleepy, confused, less coherent and frail. Her condition continued to deteriorate on 14 and 15 July and she died at 15.30 on 15 July 2007. When asked to comment on the cause of death as certified following a post mortem examination he said that 1 (a) was a heart attack; 1 (b) he was not sure but believed it related to the wall of the artery opening and 1 (c) was coronary artery disease or furring of the arteries which would develop over years. Where the form referred to other significant conditions contributing to the death there was put "fractured left humerus". Dr McKenzie could not describe a direct link between the fall and the death. It was, however, reasonable to say that a fractured humerus could be a contributory factor in an older, frail lady when looking at causes 1 (a) and (b).

26. Dr Andrew Coull had been asked by the Crown to review the medical notes, the post mortem report and certain witness statements and had produced a report (Crown production 5). On page 7 at paragraph 5.6 he states *"Mrs Dougall's autopsy showed she had widespread severe atherosclerosis of major blood vessels to the heart and brain. She was at risk of a heart attack and stroke at any time. She was at significant risk of this after her initial fall, fractured femur and operative repair. I do not believe the fall and fracture of humerus significantly added to her risk of a heart attack."* She had widespread furring of the arteries. He was asked if pain or stress in an elderly person could cause sudden death. He said there was an association between emotional stress and coronary thrombosis i.e. where a clot occurs on top of a plaque which has ruptured and is created by furring of the arteries. That clot causes the heart attack by blocking the blood vessel. The autopsy does not say that Mrs Dougall had a coronary thrombosis.

27. Turning to the causes of death he described 1 (a) as a heart attack; 1 (b) there was a break in a blood vessel wall and blood had tracked into the space. This creates pressure within the artery and therefore blocks the artery; 1 (c) was furring of the arteries which can reduce the flow of blood and increase the chances of the furred arteries becoming ruptured. Furring also makes the vessel wall weaker therefore more susceptible to dissection. The result of both these processes is a heart attack. Turning to the fracture of the humerus he said there was an association between psychological stress including pain and an acute myocardial infarction which could be the cause of sudden death. The fracture here would have been painful for Mrs Dougall. Pain increases heart rate. It is a stress response. There are hormone changes often described as a "fight or flight response". Pain can affect blood pressure. It is difficult to tease out the whole cause of an event like a heart attack,

28. He felt it was impossible to say if the fall on 11 July caused the heart attack which led to her death on 15 July. Following the fall the Notes say that on 12 July she was looking well. On 13 July she was less well and had an irregular heart rhythm which was quite fast. Her kidney function was impaired. Her ECG had changed and it was likely that at that point she had a heart attack. He still found it difficult to associate the fall with the death. There was a risk of heart attack at any time. He could not dissociate the fall from the death either as the notes say that she was well then she deteriorated.

29. Professor Derrick Pounder is Professor of Forensic Medicine at the University of Dundee. From his CV and by reputation he is a leading authority in forensic medicine. Dr Risso had worked for him as a trainee for about 18 months after he obtained his Italian qualification in forensic medicine. Professor Pounder had obtained the taped notes of the autopsy and had them typed. He also obtained the histology slides. The full post

mortem report (FHB 5/1) would be the unrevised first draft and Dr Risso has not had the opportunity to revise it. He also produced a report (FHB 5/2).

30. Where he refers to the heart being enlarged that was because of hypertension and there was therefore a higher risk factor of heart attack. The greater the mass of the heart the greater the blood flow is needed. The fact that the mitral valve was calcified would be a factor for a heart attack but not the sort of heart attack suffered by Mrs Dougall. The hardening and narrowing of the coronary arteries would be the main risk factor in heart attacks. In this case the degree of narrowing could have led to a heart attack at any time. He was sceptical about the finding relating to the left anterior descending coronary artery. There may have been a thrombosis instead. A coronary dissection is uncommon and involves bleeding into the layers of the wall of the artery so the wall pushes into the lumen causing restricted flow of blood. Dissection usually occurs in younger people. Thrombosis occurs typically in the older age group and is when a fatty deposit in the wall of the artery ruptures. A blood clot forms in the lumen and this partially obstructs the flow of blood. Dissection and thrombosis do look similar and can only be seen properly under a microscope. The histology slides of the heart show sub-endocardial left ventricular fibrosis and fresh patchy infarction without an inflammatory infiltrate. The fresh infarction is sub-endocardial and not transmural. Fibrosis is scarring which indicates that Mrs Dougall had had a heart attack in the past even if she maybe did not know about it. It would have been months or years previously. The fresh patchy infarction shows a fresh heart attack. There is no inflammation which means it was very recent, typically 12 to 24 hours before. Therefore there was a heart attack 12 to 24 hours before she died. Sub-endocardial means the inner surface of the wall is damaged. That can arise where there is an imbalance between the muscle demand for bloodflow and actual bloodflow. So, if

there was a thrombosis in the coronary artery which did not completely block or an atherosclerosis then strain is put on the heart. It would have needed a fair increase in work rate of Mrs Dougall's heart to cause her death. Here we have something in the lumen and therefore a coronary infarction. Death was the result of a heart attack caused by a narrowed lumen.

31. He was then asked about the contribution of the fall and fracture on 11 July to death on 15 July. Hypotension can be excluded as that occurs immediately after a fall. There is no pulmonary embolism present. Where there is a fracture this can spill fat into the blood stream and from there to the lungs and this can cause death. There is none present. Pneumonia can complicate all conditions in elderly patients but it is not linked to a fracture as such. There is a potential theoretical linkage between the fracture and the death but it is improbable. There is no evidence that the fracture caused death.
32. When taken to the death certificate (Crown production 2) he accepted cause of death 1 (a) acute myocardial infarction. He suggested 1 (b) should be left coronary artery thrombosis. He accepted 1 (c) atherosclerotic coronary artery disease. Mrs Dougall had been at risk of sudden death for many years and he was not surprised that she died suddenly. I asked him if the fracture could have contributed to the heart attack and he said it could be theoretically linked but it was not possible to weigh one way or the other. It was fair to record it and leave the issue open but he might also have recorded the fractured femur. The linkage would be inflammation which could precipitate a heart attack.
33. In her submission Ms Ward suggested that I should make a formal finding in respect of Section 6 (1) (a). In respect of 6 (1) (b) I should accept wholly or in part Dr Risso's findings as disclosed on the death certificate. I should

consider if finding 1(b) should be changed as a result of Professor Pounder's evidence. She argued that the reference to the fracture of the humerus should remain. Professor Pounder said that it was fair to record it and I should possibly add the fracture of the femur as well. There was no evidence of a direct causal link between the fall and the death and it was not appropriate therefore to seek any further findings. She acknowledged the clear distress to the family by both the circumstances surrounding the fall and her subsequent death. Fife Health Board initiated an inquiry and disciplinary action was taken. They have sought to address issues and improve working practices.

34. Mr Kinroy opened by suggesting that there was no jurisdiction to address anything that happened on 11 July if there was no causal connection with the death. He accepted the care of Mrs Dougall was not adequate but it had no connection with her death. Fife Health Board could accept things went wrong and he offered a full, formal apology to the family. (I indicated that I did not believe there was a causal connection established from the evidence between the fracture and the death but I might find it appropriate to summarise the evidence in the course of my determination and that would include the events of 11 July). There was no proof the fracture caused death. The question is whether there is any connection between them. The facts pertaining to the accident on 11 July are not relevant to the circumstances of the death. He stressed that the Crown had avoided unnecessary examination of irrelevant factors. He could understand why there had been a Fatal Accident Inquiry based on Dr Risso's post mortem report but the matter raised there had now been aired. For the purposes of these proceedings he suggested that section 6 (1) (a) should be more or less per the death certificate except that there should be a reference to "thrombosis" in part 1(b); part 2 should be excluded. There should be no other findings.

35. He finally made a full public apology on behalf of Fife Health Board to the family of Mrs Dougall.
36. Mr Jessiman adopted Mr Kinroy's submission and suggested findings in terms of section 6 (1) (a) and (b) only and the exclusion of part 2 in line with the evidence of Dr Coull and Professor Pounder who said the connection between fracture and death was "theoretical and improbable".
37. Mr Finnieston adopted the same line. He expressed on behalf of his client concern and regret about what happened but there had been an Inquiry and steps had been taken.
38. Ms Watt adopted the same line regarding the approach to be taken, formal findings and lack of direct causal link.
39. What I have stated above with regard to the evidence is stated to show the whole picture surrounding the circumstances of Mrs Dougall within ward 5 from the morning of 11 July 2009 until her death on 15 July. It is important to summarise the evidence if only to demonstrate how I came to the conclusion that there was no causal link between the fracture sustained in the fall on 11 July (or indeed the fracture of the femur sustained in the earlier fall) and Mrs Dougall's death on 15 July as a result of a heart attack. The majority of the witnesses were witnesses to fact and I have summarised their factual evidence. Some of them expressed opinions but they must be taken for what they are, their own personal opinions. The expert evidence related to the cause of death and the connection between the fall/fracture and death. It is not appropriate to make comment on matters such as nursing practice, risk assessment or observation when there has been little evidence of them and in any event they have little relevance when dealing with the cause of death.

40. It is important to remember both the purpose of a Fatal Accident Inquiry and what such an Inquiry does not do. The purpose of an inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is for the Sheriff to make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:-

- a) Where and when the death and any accident causing the death took place
- b) The cause or causes of death and any accident resulting in the death
- c) The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided
- d) The defect, if any, in any system of working which contributed to the death or any accident resulting in the death
- e) Any other facts which are relevant to the circumstances of the death

41. The court proceeds upon the evidence and information placed before it, and the Sheriff's powers generally do not go beyond the making of a determination in relation to the circumstances established to his satisfaction from the evidence following investigation by the procurator fiscal, and other relevant parties. It is not truly an inquiry, and it is not the appropriate forum for determining negligence, or civil liability and thus such Inquiries should not enter into a discussion of negligence. This is in contrast to the position which existed under the previous legislation. Accordingly, in the context of this Inquiry, it is not the function of the court to look for evidence of fault in the care, management or supervision of the late Mrs Dougall.

42. That Mrs Dougall died as a result of a heart attack is beyond doubt. Her family was aware that there was some previous history of heart trouble but nevertheless were surprised at the suddenness of her death. Unfortunately, it is only upon death and subsequent post mortem examination that the full extent of someone's heart problem may come to light. From all the medical evidence before the Inquiry, Mrs Dougall's history and the condition of her heart meant that she could have sustained a heart attack at any time and such an attack could have been fatal. After hearing all the evidence there were only two issues left to consider whether the cause of death on the certificate was correctly expressed and whether the fall sustained by Mrs Dougall on 11 July 2009 either caused or contributed to her heart attack as was suggested by the insertion in the death certificate of a reference to the fracture. The death certificate was issued following a post mortem examination by Dr Risso. Unfortunately we did not have the benefit of his evidence. He now lives and works in Italy and there appeared to be a series of problems arising when he was to attend. Illness intervened and I understand that it became difficult to get him to commit to a date. The decision was taken to proceed without him, a decision that was quite understandable in the circumstances. It meant, however, that no one was able to question him on why he concluded that the fractured arm should be considered as a secondary cause of death. It also meant that we had no direct evidence of the post mortem or the report.

43. Fortunately we did have evidence from Dr Coull and Professor Pounder. Two issues arose from that evidence and from their consideration of the productions available to them. One was whether the cause of death 1(b) was accurate. The other was whether or not the fracture caused or contributed to the heart attack. In the latter point there was also evidence from Dr McKenzie. Professor Pounder explained the difference between a coronary dissection and a coronary thrombosis. The fact that a dissection

is relatively uncommon and tends to occur in younger people is relevant. Thrombosis is more common and is certainly more common in older people. We did not hear from Dr Risso who was the only person to see the heart at post mortem. I have to be guided by Professor Pounder's expertise and agree that thrombosis was the appropriate diagnosis in cause of death 1(b). Dr Coull was not asked specifically about this distinction and commented on the fact that thrombosis was not mentioned in the death certificate. However the appearance of dissection and thrombosis is similar. He described the effect of bleeding in the heart wall. His speciality is medicine for the elderly. Professor Pounder is very experienced in the field of forensic medicine. From his report and his examination of the histology slides he concluded that there was an incomplete obstruction of the lumen of the artery. That may give rise to sub-endocardial myocardial infarction of a type present in the histology slides. This was a recent event which he suggested had occurred less than 24 hours prior to death. Scarring in the heart muscle suggested many months or years before there had been one or more similar events.

44. He goes on to say *"The cause of death, namely a myocardial infarction, has occurred as a natural evolution of the pre-existing disease process of coronary atherosclerosis (hardening and narrowing of the blood vessels supplying the muscles of the heart). There is no direct relationship between the fracture of the humerus and the heart attack."* Dr McKenzie could not describe a direct link between the fall and Mrs Dougall's death but did say it was reasonable to record that the fractured humerus was a contributory factor in an older frail lady. Dr Coull felt it was impossible to say if the fall caused the heart attack. From the Notes he was able to say that on 12 July Mrs Dougall looked well but by 13 July she was less well, had an irregular heart rhythm, impaired kidney function and a changed ECG. At the end of his evidence he said it was difficult to associate the fall and the death. There was a risk of heart attack at any time. However he

could not dissociate it either as the Notes said she was well then deteriorated.

45. Professor Pounder does say that severe physical stressors (such as a significant fracture) would increase the risk of a heart attack of the kind seen in Mrs Dougall. However, she was at such serious risk of a heart attack at any time that it is not possible to conclude from the autopsy findings alone that the fracture of the humerus was a significant factor in the death. The Notes showed that a doctor had said to Mrs Dougall's daughter that the fracture of the arm had tipped the balance and put a strain on the heart. On the other hand Dr Coull concluded in his report that *"I do not believe that the fall and fracture of the humerus added to her risk of heart attack."* Professor Pounder considered that whether or not the fall and fracture made a significant contribution to the death is a matter of clinical judgement based upon the clinical record. The autopsy findings do no more than leave open the possibility without permitting a conclusion.
46. We did not hear from the doctor who had the conversation and therefore cannot fully put the entry in the Notes into context. We did hear that, generally, if a fall or fracture which will cause stress was to trigger some sort of coronary event then that was likely to have happened fairly soon after the fall or fracture. There is clear evidence that Mrs Dougall looked well on 12 July. We had the evidence of Professor Pounder that the damage to the heart indicated that the heart attack had happened between 12 and 24 hours before death. We had the opinions of Professor Pounder and Dr Coull that there is not likely to be any connection between the fracture and the heart attack. I accept the evidence from Professor Pounder that it was reasonable to include the fractured humerus as a secondary cause of death. However, in the context of Section 6 of the Act, there was no accident which **caused** death. Accordingly in the context of

the findings of this Inquiry, there is no need to refer to the fall/fracture as either a cause or contributory factor in Mrs Dougall's death.

47. As I said at the outset Mrs Dougall's family will probably feel frustrated that this Inquiry has not given them the answers they may be seeking concerning the care and treatment of Mrs Dougall. I hope they can understand that unless care and treatment had a direct part to play in the death it is not relevant to the purposes of an Inquiry under the 1976 Act. Had there been a causal connection between the fall/fracture and the death then issues of nursing practice, observation, risk assessment and the like would have been a relevant consideration for this Inquiry. However, there is none. Where there is reference made to these areas it is because witnesses gave evidence pertinent to these areas and they may be relevant to Fife Health Board's own inquiries and reviews of practices. While it may be little consolation to the family, the Health Board's public acknowledgement of the shortcomings in the care and treatment of Mrs Dougall was to be welcomed. They do seem to have taken the matter seriously, conducted an internal inquiry and instigated disciplinary proceedings. There was an assurance that matters raised in this Inquiry would be looked at in their ongoing reviews of services.

48. I would conclude by extending my own sympathy to the family of Mrs Dougall in their sad loss. They attended the whole Inquiry and listened to evidence which must have been upsetting to hear with great decorum.

