2012 FAI 8

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

Determination

by

Sheriff Andrew Christie Normand, Sheriff of Glasgow and Strathkelvin

in the Fatal Accident Inquiry into the death of

Catherine Hattie

Glasgow, 30 January 2012

The Sheriff, having heard evidence and having resumed consideration of the cause, determines that

1. In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:
   Catherine Hattie, born 7 September 1926, formerly residing at 154 Hillhead Road, Kirkintilloch died in Ward 5 of Stobhill Hospital, Glasgow at about 2.40 am on 3 March 2006; an accident resulting in the death of Catherine Hattie occurred between 9.30pm and 10pm on 2 March 2006 in the toilet in Ward 5 of Stobhill Hospital, Glasgow, when Catherine Hattie had an accidental fall.

2. In terms of section 6(1)(b) of the Act:
   The Cause of Catherine Hattie's death was:
   primary cause
   1a Chest and abdominal injuries,
   due to
   b Fall,
   due to
   c Post-operative hemi-colectomy,
   due to
   d Carcinoma of sigmoid colon.
   The cause of the accident resulting in the death is not determined.

3. In terms of section 6(1)(c) of the Act:
   There is no determination about reasonable precautions whereby the death might have been avoided.
   The reasonable precautions whereby the accident resulting in the death might have been avoided were that Nursing Auxiliary Clark should have remained in a position in the toilet to continue to observe Catherine Hattie, in sufficiently close proximity to Catherine Hattie to be able if necessary to render her assistance and prevent her from falling or catch her if she did, or Nursing Auxiliary Clark

should have returned Catherine Hattie to a sitting position while she briefly turned away from her and left her side.

4. In terms of section 6(1)(d) of the Act:
   There is no determination about defects in any system of working which contributed to the death or any accident resulting in the death.

5. In terms of section 6(1)(e):
   Other facts which are relevant to the circumstances of the death are: intravenous fluids should have been administered to Catherine Hattie soon after her accidental fall**.**

(Signed) Andrew C Normand

NOTE

Contents:

Representation at the Inquiry:

For the Crown: Mr. Ian Wallace, Senior Procurator Fiscal Depute
For the family of Mrs Catherine Hattie: Ms Deborah Shepherd and Mr. Stephen Shepherd (grand-daughter and son-in law)
For Dr. Gary Wong and and Dr. Aileen Helps: Ms Laura Donald, Solicitor Advocate and Mr James Stewart, Solicitor
For Greater Glasgow Health Board (GGHB): Mr. Douglas Ross, Advocate

1. The participation of family members in the proceedings was supported by the Crown and not opposed by the other parties. The cross examination of witnesses and leading of evidence was largely undertaken by Ms Deborah Shepherd. In my view the family representatives effectively represented the family interest in the Inquiry. They are to be commended on the amount of work they undertook in preparation for and during the Inquiry. I am grateful to all parties for their courteous conduct of the proceedings.

2. It was clear that Mrs Hattie's death had a profound effect on her family. The love, respect and loyalty of the family was demonstrated by the attendance of family members at every day of the court hearings. The family members conducted themselves throughout with composure, patience, and dignity and I pay tribute to

them in that regard. I expressed the condolences of the court to Mrs Hattie's family at the end of the Inquiry.

Legal Framework

3. This was an Inquiry held under section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, on the ground, stated in the Application of the Procurator Fiscal, that "it appears to the Lord Advocate to be expedient in the public interest that an inquiry under the said Act should be held into the circumstances of said death". Section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides for the holding of an inquiry under the Act where "it appears to the Lord Advocate to be expedient in the public interest…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."

4. The purpose of an Inquiry held in terms of the Fatal Accident 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 resulting in the death took place;
> (b) The cause or causes of such death and any accident resulting in the death;
> (c) The reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided;
> (d) the defects, if any, in the 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
> (all in terms of Section 6(1) of the Act)

5. The Court proceeds on the basis of evidence placed before it and although described as an Inquiry, the Sheriff's powers generally do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the Procurator Fiscal and any other party if so advised. That determination is limited to the matters defined in Section 6(1) of the Act.

6. This Inquiry is not the proper forum for determination of civil liability or of negligence and any findings in any such inquiry should avoid connotations of negligence (See *Black -v- Scott 1990 SLT 612* and *Dekker 2000 SCLR 1087*).

7. In the *Report of Findings of the Review of Fatal Accident Inquiries*, which was published in November 2009, Lord Cullen considered the role of the Sheriff. With particular reference to the making of recommendations by the Sheriff he expressed the following views:-

> "3.28 …it is, in my view, unsatisfactory that there is uncertainty as to the power of the sheriff to make recommendation arising out of his or her findings, or as to the potential scope for such recommendations. I am in no doubt that the sheriff should be able to make recommendations directly related to the circumstances

of the individual death. At the same time I consider that there is considerable force in the arguments against the sheriff making recommendations of general application.

3.29 It would be inappropriate, in my view, for an FAI to be treated as if it were a public enquiry taking a nationwide approach and calling for far greater resources. For a sheriff to over-reach what could be supported from his evidence would detract from the respect which his or her recommendations deserve."

8. In framing this determination I have in mind the statutory restrictions on the Inquiry and the powers to make recommendations.

9. I note and adopt Sheriff Kearney's observations in his determination in relation to the death of James McAlpine, issued on 17 January 1986, and referred to at paragraph 8-99 of the 3rd edition of *Sudden Deaths and Fatal Accident Inquiries* by Ian Carmichael. Sheriff Kearney observed:-

> "In deciding whether to make any determination (under section 6(1)(d)) as to the defects if any in any system of working which contributed to the death or any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof and rules of evidence (apart from the consideration that evidence did not require to be corroborated) is that applicable in civil business (1976 Act section 4(7)) and accordingly the standard of proof is that of the balance of probabilities."
>
> "In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one."

Sheriff Kearney went on to say:-

> "The phrase 'might have been avoided' is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than 'would, on the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."

10. As I have noted above, this was an Inquiry held under section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, on the ground, stated in the Application of the Procurator Fiscal, that "it appears to the Lord Advocate to be expedient in the public interest that an inquiry under the said Act should be held into the circumstances of said death". The decision to apply for the holding of a Fatal Accident Inquiry ("FAI") on the above ground was a matter entirely for the Lord Advocate.

11. I was made aware that in this case the decision to hold an Inquiry under section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 was made against a background of concerns, dissatisfaction and complaints on the part of

Mrs Hattie's family about the circumstances of Mrs Hattie's death and the way the circumstances were investigated and the concerns and complaints of the family were dealt with by the hospital authorities. The application for an FAI apparently followed exchanges between Mrs Hattie's family and the hospital authorities over a period of years. I believe the family's concerns and criticisms were a factor that influenced the decision of the Lord Advocate that it appeared to be expedient in the public interest that an FAI should be held into the circumstances of Mrs Hattie's death.

12. However, while some of the family's concerns and criticisms related to the actual circumstances of Mrs Hattie's death it was evident that others related to communications and inquiries after the death. I made clear at an early stage of this Inquiry that I did not consider the remit of this Inquiry to cover detailed investigation of the hospital authorities' dealings with the family of Mrs Hattie in the period following the death, and in particular that I did not consider it appropriate for the FAI to investigate and review the inquiries carried out by the hospital authorities. The subject matter of the FAI was the circumstances of Mrs Hattie's death. This Inquiry has allowed the family of Mrs Catherine Hattie to air their concerns and criticisms about various aspects of the performance of the hospital and its staff in relation to the circumstances of Mrs Hattie's death and in preparing my determination I have had regard to any relevant concerns and any evidence relating to them.

The Proceedings

13. I heard evidence from 25 to 29 October 2010, 30 November to 1 December 2010, 22 to 25 February 2011, 3 to 5 May 2011, 26 and 29 August 2011 from the witnesses noted below.

14. Parties' submissions were provided in written form and the hearing on submissions was on 11 November 2011, when brief supplementary written submissions were lodged by Mr Ross for Greater Glasgow Health Board. The written submissions are attached to my Determination as an Annex. (In view of their length they have been edited, but only as regards format.) The Procurator Fiscal's Submissions helpfully include a summary of the evidence I heard in the course of the inquiry – which has been accepted by those representing Dr Wong and Dr Helps and GGHB as a fair and accurate summary of the main evidence bearing upon the issues of significance before the Inquiry. That is generally my view also and I proceed upon that basis. I should also say that I have given all the parties' submissions careful consideration, even where there is no specific reference or comment in the relevant part of my determination.

Witnesses

15. The witnesses are listed in the order in which they gave evidence.
Witnesses led by the Procurator Fiscal:

Stephen Shepherd
Clare Shepherd
Mary Shepherd
Mr David Chong

Mr. Sarhang Hussein
Dr. Gary Wong
Dr. Aileen Helps
Lia Clark
Martin Hattie
Lorraine Reid
Catherine McDaid
Julie Bridgewater
Shona Manson
Dr. Allan Cameron
Dr. John Clark
Lesley McGill
David Mains
Fiona Smyth
Mary McGinley
Dr. William Primrose
Anne Wilson

Witnesses led by the family:

Jane Grant
Ellice (Alice) Pender
Pat Burns
Mr George Welch
Edward Hattie
Irene Hattie

The Quality of the Evidence and the Credibility and Reliability of the Witnesses

16. This Inquiry started four and a half years after Mrs Catherine Hattie's death, and as noted above the Inquiry took over a year to complete. I heard evidence from witnesses over a period of 10 months.

17. I accept the submission that, inevitably, recollections of witnesses to the Inquiry were affected by this passage of time. I have kept in mind the difficulties faced by the witnesses in giving evidence in relation to events which happened such a long time ago, particularly under sometimes very detailed questioning. Some of the witnesses to the Inquiry stated that they had no direct recollection of events, others had much better recall of the events.

18. The delay in proceeding with this Inquiry meant that there was inevitably substantial reliance on the medical records for evidence, including evidence about timings, and some important witnesses relied almost entirely on the records in giving their evidence.

19. Questions were raised during the Inquiry about the reliability, accuracy, and completeness of the records. While it was conceded on behalf of the Hospital Board that certain aspects of record-keeping were not satisfactory and certain records were incomplete it is not clear that the task of the Inquiry was seriously hindered by any such deficiencies. I accept the submissions on behalf of the Board about the limitations in the use of medical records in reconstructing events, where a witness's

ability to recollect all relevant circumstances has been affected by the passage of time. Reference to the records may assist such a witness's recollection, but there may still be gaps, which will not be filled by the records because records, quite properly, do not contain a full transcript or account of all interactions between staff and patients or among staff.

20. I also accept explanations given by certain of the witnesses about aspects of the record-keeping that might have appeared to be unsatisfactory in terms of the noting of a contemporaneous record. It was, in my view, understandable and acceptable that substantial entries in the notes by two important medical witnesses, Mr Hussein and Dr Helps were made retrospectively in circumstances where they were treating a critically ill patient. However, the apparently retrospective completion of other records was criticised by the independent, expert witness Dr Primrose, who stated that it was not good practice to construct such records after the event, without at least noting that they were completed in retrospect.

21. Reference was also made in these proceedings to statements previously made or given by some of the witnesses, in part to refresh the witness's memory, but also to test the credibility and reliability of their evidence to the inquiry. Such statements had been obtained in connection with the hospital authorities' enquiries.

22. In general it appeared to me that the witnesses who gave evidence to the Inquiry were attempting to do so the best of their ability, having regard to the passage of time and the consequent difficulty of recollection. Some witnesses were more impressive in that regard others. The submissions for the family submit that the evidence of Mr Hussein, who relied to a significant extent on the medical records, is not credible or reliable. There is not, in my view, evidence to allow such a general conclusion, but I shall comment as appropriate below on any aspects of this witness's evidence where I have doubts about reliability. The family submission also contains a submission that the evidence of Dr Wong is not reliable. I am not prepared to disregard Dr Wong's evidence as unreliable, but he was a witness who depended even more heavily on the medical records and I take that into account in assessing the reliability of his evidence on any particular points of relevance. Particular issues were raised about the credibility or reliability of the key nursing witnesses, Nursing Auxiliary Lia Clark and Staff Nurse Catherine McDaid. I shall deal with those issues in relevant subsequent sections of this determination.

Summary of Evidence

23. I have referred above to the summary of the evidence which is included in the Procurator Fiscal's Submissions. I am grateful for that contribution and in setting out here an outline of the evidence I shall draw on the relevant section of the Procurator Fiscal's Submissions as I think appropriate, dealing with the circumstances in chronological order. I would add that there was lodged by the parties a Joint Minute of Agreement, agreeing a limited number of matters, to which reference will be made where relevant. Analysis and further details of evidence will be set out under the relevant determination headings, as appropriate.

- Mrs Catherine Hattie

24. The lady with whose death this Inquiry was concerned was a 79 year old married lady, who was described by her son-in-law, the witness Stephen Shepherd, as a matriarchal figure of a large and loving family. She was a lively and active participant in all family activities. She was held in great affection and respect by her family. This was commented on by a number of the hospital witnesses, as well as family witnesses. She was described as being straightforward, ethical and very independent. Mrs Hattie had experienced various medical problems and had endured a difficult time in hospital prior to her death, but from the evidence I heard it was clear she had a stoical nature, a strong will, and a fighting spirit.

- Evidence concerning treatment/care prior to the night of 2 March 2006.

25. There was evidence that Mrs Catherine Hattie was admitted to Stobhill Hospital as an emergency on 31 December 2005 and subsequently on 9 January 2006 she was operated on by the witness Mr David Chong, a Consultant Surgeon, who was a colo-rectal specialist. A laporotomy and anterior resection operation was carried out, to deal with a large bowel obstruction, which was found to be caused by a tumour.

26. Mrs Hattie was in the High Dependency Unit (HDU) at the hospital after the operation, but had to be transferred to the Intensive Care Unit on 20 January 2006 following deterioration in her condition. When her condition improved she was returned to the HDU on 4 February. Mrs Hattie was then admitted to Ward 5, a general surgical ward, on 7 February 2006.

27. As mentioned above, a considerable amount of the evidence about the care and treatment of Mrs Hattie came from the medical records, which were spoken to by the medical, nursing, and physiotherapy witnesses. Much of this evidence came from notes contained in sheets which were kept with Mrs Hattie's patient file in the ward. These were referred to in various terms, including “communication sheets”, which is the description adopted by the PF in his submission. Doctors, nurses and, physiotherapists had access to these notes and made entries in them, which were updated a number of times each day.

28. Another document - a Care Plan (Crown Production [CP] 3 pgs1775/6) - recorded the assessment made of Mrs Hattie by nursing staff on her admission to Ward 5. This was a general assessment of all aspects of her medical condition, including her mobility which was of particular interest to this inquiry. This assessment was recorded on a Moving and Handling Care Plan (CP3 pgs1693/4), Fall Prevention Care Plan (pg1695), and Fall Risk Assessment Chart (p1696). These documents were all referred to in the course of the Inquiry. The Procurator Fiscal refers to these collectively in his submission as the "Care Plan documents".

29. Mrs Hattie was recorded as having very limited mobility at the time of admission to the ward and requiring significant assistance for any kind of movement. There was an instruction that she should not walk without this first being instructed by a physiotherapist. There was evidence that throughout her time in Ward 5 Mrs Hattie received treatment from physiotherapy staff. Their aim was to help her increase her mobility, ultimately to as near as possible to her previous level of independence, so

that she could return home.

30. Julie Bridgewater, the senior physiotherapist leading the team who treated Mrs Hattie, gave evidence about the progress in her mobility. Ms Bridgewater recalled that her team spent a lot of time with Mrs Hattie. She could become anxious and physiotherapists spent significant time with her, speaking to her in order to address any concerns she had which might impact on the progress of her mobility. Progress was not always easy and there was not a smooth, continuous improvement in Mrs Hattie's mobility. There was some evidence of two or more falls, one of which occurred on 13 February (CP3 pg1597) and another possibly on 15 February. The witness Mrs Mary Shepherd (Mrs Hattie's daughter) gave evidence of being told about another fall, which she said she was told required an x-ray to be taken. However, there was no relevant record in the medical records and it was agreed in a Joint Minute that the doctor who Mrs Shepherd believed had told her about this had no recollection of being told that Mrs Hattie fell (apart from the fall on 2 March) and that he did not recall telling any member of Mrs Hattie's family that she fell.

31. There was evidence that in the days leading up to 27 February 2006 there seemed to be an improvement in Mrs Hattie's mobility. On that date, there was a physiotherapy note (timed at 9.40am) that she was using a mobilator (zimmer frame) with the assistance of one member of staff. A nursing note later that same day (15.00) recorded that she was mobilising with a zimmer under supervision. A further nursing note on 28 February (2.30pm) recorded that Mrs Hattie was "mobile using zimmer to toilet". Witnesses assumed that, in the context of the earlier and later notes, this would have been when accompanied by a member of staff. On 1 March 2006, it was noted that Mrs Hattie's mobility was improving and a physiotherapy note (at 10.20am) again noted that she was mobilising with a zimmer with supervision. A further nursing care note on 1 March 2006 (11.00am) noted "mobility improving - using zimmer + requires 1 nurse for assistance". There was also a note that Mrs Hattie had complained of a sore ear, and of feeling dizzy on standing. There was an appointment made for the next day with ear, nose and throat specialists.

32. On 2 March 2006 it was noted (in a physiotherapy note at 10.20am) that Mrs Hattie was willing to mobilise, but complained of feeling dizzy due to ear pain. She was able to use a wheeled zimmer frame, only requiring supervision and she had a good gait pattern. There was an observation that she had become slightly panicky and short of breath on her return from the toilet. Her zimmer frame was changed to a smaller one at that time. The final note in Mrs Hattie's hospital records in relation to her mobility was a nursing note at 11.15 that morning which noted that she was mobile with the aid of a zimmer and one nurse assisting. (The notes referred to in the foregoing paragraphs are at CP3 pgs1620 to 1625.)

33. Aspects of the care and treatment by nursing and physiotherapy staff and of the medical records are discussed further below in the context of section 6(1)(d) of the 1976 Act.

- Evidence concerning the night of 2/3 March 2006

34. I heard evidence that on the night of 2 March 2006 the nursing staff on nightshift in Ward 5 of Stobhill Hospital, were the witnesses Staff Nurse Catherine McDaid,

Staff Nurse Lorraine Reid, Nursing Auxiliary Lia Clark and Nursing Auxiliary Lesley McGill. They started at 7.45 pm. The Staff Nurses were professionally trained and qualified nurses and the Nursing Auxiliaries worked under their supervision.

35. Nursing Auxiliary (N/A) Clark gave evidence that at the start of the shift, when there was the usual handover from day shift nursing staff who passed on relevant information about patients in the ward, she was given information that Mrs Hattie was able to walk to the toilet with the use of a zimmer frame and the assistance of one member of staff, and that she was to use a commode at her bedside during the night.

36. On the evening of 2 March Mrs Hattie was visited by family members. I heard from her daughter, Mary Shepherd, that she was in quite good spirits, talking about a forthcoming family wedding and getting an outfit for it as there was now an expectation that she was on her way home. Mrs Hattie said that she needed the toilet but would wait for the night staff to deal with that. The family visitors left at about 7.35pm.

37. According to N/A Clark, at about 9.30pm Mrs Hattie called to go to the toilet. (The witness did not clearly recall the exact time.) N/A Clark helped her out of her bed. Mrs Hattie was willing to walk the short distance to the toilet with the zimmer and was able to do so. N/A Clark's recollection was that she walked to the side of, or just behind, Mrs Hattie, with her hand behind her back, although she did not recall there being any physical contact. She stated that she walked very close to Mrs Hattie – close enough, she said, that if Mrs Hattie had fallen she would have been able to catch her. On the way to the toilet Mrs Hattie told her that she had a sore ear and her balance was a bit off. However, the witness Clark's assessment was that Mrs Hattie was walking "perfectly fine" and she accompanied her into the toilet without incident or any apparent cause for concern.

38. N/A Clark stated that once in the toilet she steadied the zimmer for Mrs Hattie to sit on the toilet. After Mrs Hattie had used the toilet, witness Clark decided to change Mrs Hattie's colostomy ("stoma") bag. She asked Mrs Hattie to stand up as this was the easiest way to do it. She lifted Mrs Hattie's nightwear to gain access to the stoma bag, opened it, and emptied its contents into a cardboard bowl. Mrs Hattie stood with her left hand on the zimmer and used her right hand to help N/A Clark empty the bag. N/A Clark gave the bowl to Mrs Hattie to hold while she rolled up and sealed her stoma bag. Mrs Hattie stood, holding the bowl in her right hand with her left hand on the zimmer frame. She took one step forward. The zimmer was in front of the toilet bowl. N/A Clark stated that she was not concerned that Mrs Hattie may be unstable with just one hand on the zimmer.

39. N/A Clark then took the bowl from Mrs Hattie and turned round to put it on top of a bin which was on the wall to the rear and left of the toilet – looking from in front of the toilet. Mrs Hattie was standing in front of the toilet with both hands free to put on the zimmer frame. N/A Clark stated that she had turned her back on Mrs Hattie for "just seconds, two seconds" (which I understood to mean a very short period of time, rather than literally two seconds). She heard a slight rattle, which she thought must have been Mrs Hattie's zimmer, and when she turned around Mrs Hattie had fallen to the floor. She did not see Mrs Hattie actually falling. Mrs Hattie was lying on the floor with her top half slightly arched, resting on the toilet bowl. Her feet were facing

straight in front of her on the floor. She was conscious, but slightly distressed. The zimmer frame was still there, slightly forward away from the toilet. N/A Clark asked her if she was ok. Mrs Hattie simply said that she was fine. She did not ask Mrs Hattie what had happened. N/A Clark could not explain how Mrs Hattie ended up in the position on the floor which she described.

40. N/A Clark's evidence was that there was no other person in the toilet apart from herself and Mrs Hattie and therefore no other witnesses to the fall. She activated an alarm and called for help. Staff Nurse McDaid came to the toilet, in response to her calls for help, and together they got Mrs Hattie to her feet and took her back to her bed.

41. Nurse McDaid's evidence was that she was doing the drugs round elsewhere in the ward when she became aware of N/A Clark's calls for help. She went to the toilet to assist. When she opened the door of the toilet she saw Mrs Hattie sitting on the floor on the right hand side of the toilet pan (viewed from a position facing it). Her legs were straight out in front of her, with her back close to or against the toilet pan. According to Nurse McDaid, N/A Clark explained to her what had happened, saying that she had been emptying the stoma bag, she had asked Mrs Hattie to stand while she took away the mess, she believed that Mrs Hattie had flushed or tried to flush the pan, although she had said not to, or that she would do it. Nurse McDaid spoke to Mrs Hattie, who was conscious and talking and was trying to get up.

42. Mr Sarhang Hussein, the Senior Surgical House Officer gave evidence that he was at the nursing station in the ward at the time, when he heard a buzzer and saw and heard nurses (he thought there were two or three) rushing to the toilet. He remembered nurses coming back into the ward with Mrs Hattie.

43. N/A Clark and Nurse McDaid gave evidence that together they helped Mrs Hattie up to her feet and then assisted Mrs Hattie the short distance back to her bed in the ward. There was some inconsistency in the witnesses' accounts of how Mrs Hattie was taken back to her bed. N/A Clark initially thought that Mrs Hattie was taken back in a chair, but Nurse McDaid gave clear evidence that Mrs Hattie walked back with the use of the zimmer frame, with the two nurses walking one on either side of her. This accorded with Mr Hussein's account.

44. The evidence was that Mr Hussein and Dr Wong (the Junior House Officer) attended very shortly after Mrs Hattie was back at her bed. Mr Hussein examined her and diagnosed her as having broken a rib. Dr Wong's recollection was unclear, but it was confirmed that he wrote the note about the examination that was recorded in the medical records Communication Sheet at 10.00pm (CP3 at pg 1625).

45. Mr Hussein instructed a portable x-ray. This x-ray was taken by the radiologist at Mrs Hattie's bed in Ward 5 at 10.35pm. The x-ray confirmed that Mrs Hattie had a fracture of the 9th rib on the right hand side, there was no pneumothorax, and she had clear lung fields.

46. Analgesia is also recorded as having been instructed at this time. However, the medical records show that no analgesia in addition to Mrs Hattie's usual prescription was offered at this time, and that Mrs Hattie refused the analgesia. The reasons for

this refusal were not clarified in the evidence to the Inquiry.

47. The matter of subsequent observation of the patient was explored in evidence. Although it was not noted in the medical note of 10.00pm that regular observations were instructed, it was Dr Wong's evidence that such regular observations were instructed, as recorded in the Incident Record "IR1" Form (CP 14). He stated that such observations would ultimately be the responsibility of the nurses.

48. Reference was made by witnesses to the records on Mrs Hattie's "Patient Observation Chart" (CP3 pgs1678 to 1680). This document noted a reading at 5.30pm on 2 March 2006, before Mrs Hattie's fall. There was little comment about this as it gave no cause for concern. The next reading was at 10.10pm (after Mrs Hattie's fall) which showed a raised pulse rate of 142 beats per minute (bpm) and lowered blood pressure (85 over 54). Staff Nurse Lorraine Reid gave evidence that she noted this reading and this was her last involvement with Mrs Hattie. The next recording was timed at 11.20pm which showed a lower pulse (assumed to be 120 bpm) and an even lower blood pressure. (Although not noted clearly, this seemed to show a reading of 60 to 70 over 36.) There were further readings timed at midnight and hourly thereafter until a reading recorded as having been at 3am on 3 March 2006. Further reference will be made to the evidence about observations below under sections 6(1)(c) and (d).

49. There was evidence about the administration of fluids intravenously to Mrs Hattie. The IV Fluid Chart (CP4 pg1666), to which reference was made, recorded that the first fluids were administered to Mrs Hattie at 11.50pm. This is considered in more detail below under section 6(1)(c).

50. Mrs Hattie's condition deteriorated after a period of time during which her condition did not give cause for concern. The evidence about the precise timing of this deterioration was not entirely clear.

51. The relevant blood pressure and pulse chart (CP3 at pg 1679) records a substantial drop in blood pressure at 11.20pm, this being the next reading recorded after 10.10pm. Mr Hussein said in his evidence in chief that he was "bleeped" about 11 o' clock. He said he received a call to attend Mrs Hattie due to a drop in blood pressure. Other evidence from Mr Hussein was open to the interpretation that the call to him was earlier. There was also other evidence suggesting that Mr Hussein was called earlier than 11.20pm. However, I have doubts about the reliability of the evidence suggesting that the call was significantly earlier, as the only recorded evidence of a drop in blood pressure is that noted above, timed at 11.20pm.

52. There was evidence that following Mrs Hattie's deterioration Nurse McDaid telephoned Martin Hattie, Mrs Hattie's son, to inform the family of the deterioration in Mrs Hattie's condition. The witness Martin Hattie timed that call at 11.30 pm. Mr Hattie's evidence was that Nurse McDaid told him that Mrs Hattie had had a "wee turn" and the doctors were with her. Mr Hattie said that the nurse had referred to a "wee fall", and also said Mrs Hattie had had a "slight fall" earlier. Martin Hattie and various other family members went to the hospital soon after that call.

53. Mr Hussein attended at Mrs Hattie's bed and examined her. He noted symptoms

that he said in evidence were suggestive of a cardiac event/heart attack. Mrs Hattie's blood pressure had dropped, she was cold and clammy, had a very weak pulse, and was tachycardic (ie heart rate over 100 bpm). She was fully conscious and complaining of tightness in the chest and pain in her left jaw. An examination with an electrocardiogram (ECG) was therefore carried out, which showed multiple ventricular ectopy (explained as extra heart beats originating in the lower chamber of the heart), and that there was no sign of ischaemia. Mr Hussein noted that he prescribed morphine, cyclizine and nitroglycerine.

54. Mr Hussein called the medical Senior House Officer, Dr Aileen Helps. Dr Helps' evidence to the Inquiry was based on a better recollection of this incident than that of some of the other hospital witnesses who spoke to the events of the night in question. Dr Helps confirmed that she arrived at Mrs Hattie's bedside at midnight, as recorded in her note in the medical records (CP3 at pg1628). In her evidence she estimated that she may have been with Mrs Hattie for a period of between an hour and a half and two hours. On her arrival she thought Mrs Hattie was still conscious, but soon afterwards Mrs Hattie became unresponsive and the cardiac arrest team was called and attended. This included Dr Allan Cameron, the Senior House Officer for Intensive Care. It was established in evidence that, although the cardiac arrest team was called, there was no cardiac massage carried out at any point.

55. All the medical witnesses were clear that Mrs Hattie's condition was very poor at this time and her prognosis was not good. However, there was a lack of clarity at the time as to the medical reason for the deterioration in her condition.

56. As indicated above, Mr Hussein had initially considered a cardiac event. This was on the basis of the symptoms noted by him, and described to him. These symptoms could not be explained on the basis of a rib fracture. It was on the basis of his diagnosis that he instructed the further action of ECG examination, drugs including nitroglycerine, IV access. Mr Hussein had also considered a pulmonary embolism.

57. The evidence was that the other doctors who were called to advise or assist (Dr Helps and Dr Cameron) did not support this diagnosis of a cardiac cause. Dr Helps recalled that a cardiac cause had been considered. Head injury was excluded as a cause. There had been a discussion of whether the fall had implications – whether the injury may have resulted in intra-abdominal bleeding from say a liver injury. Although there was no reference to liver injury in her notes Dr Helps said in evidence that she thought that she would have come to the conclusion that a liver injury and internal bleeding was the cause of the deterioration in Mrs Hattie's condition. In any case, an ultrasound scan was instructed to check for an intra-abdominal cause for the deterioration in Mrs Hattie's condition.

58. Dr Cameron was only with Mrs Hattie for short period. He had a reasonable recollection of the key points of his limited involvement. He gave evidence that he was fairly confident from the information available to him and his observation that the deterioration in Mrs Hattie's condition was not caused by a cardiac event and he further considered that a pulmonary embolism was unlikely. Referring to what he described as the close time association between the trauma and Mrs Hattie's deterioration his evidence was that he thought the most likely explanation of Mrs Hattie's condition when he saw her was liver laceration causing internal bleeding. It

was for this reason that an ultrasound scan was instructed. It would be for further consideration by the consultant surgeon whether surgical intervention would be appropriate.

59. The treatment plan was to continue administering fluids, to repeat blood tests, instruct the ultrasound scan, and discuss the case with the consultant surgeon.

60. During the time that Dr Cameron attended at Mrs Hattie's bedside, a decision was taken that Mrs Hattie she should not be referred to the Intensive Care Unit (ICU). This was a decision taken after discussion between all the senior doctors present (Mr Hussein, Dr Helps, Dr Cameron), but the decision was ultimately made by Dr Cameron, as the Intensive Care SHO. The other doctors did not disagree with that decision.

61. The consultant surgeon, Mr Chong, remembered being called by Mr Hussein around this time (although Mr Hussein could not remember calling Mr Chong). Mr Chong's evidence was that he was of the clear view that there was no merit in surgical intervention at that time.

62. The evidence is, in my view, clear that from the time of the attendance of Dr Helps and Dr Cameron there was no further active treatment other than fluids carried out in relation to Mrs Hattie.

63. There was evidence that a portable ultrasound scan was carried out on Mrs Hattie in the early hours of 3 March 2006. The handwritten note by the radiologist (CP3 at page1630) is timed at 01.30. The scan confirmed there was free fluid around the liver, but was not able to identify what this was, noting that a CT scan would be required to do so. However, Mrs Hattie was noted as not being sufficiently stable for a CT scan.

64. Mrs Hattie had been moved to a single room in Ward 5 of Stobhill Hospital. There was evidence that she died there in the presence of members of her family at about 2.40am. Martin Hattie, who is a qualified nurse, gave evidence that he was in the room with Mrs Hattie and noticed at about 2.40am that she had died. He waited for about 5 minutes before he went out of the room and spoke to Mr Hussein, who was nearby and Mr Hussein then examined Mrs Hattie and confirmed her death, recording the time as 2.45am. Although Mr Hussein stated at points in his evidence that he stayed with Mrs Hattie after her sudden deterioration until she passed away and that he was at her bedside all the time except when he was speaking to the family, his evidence about his movements at the relevant time was somewhat vague and his evidence about being at the bedside was at odds with the evidence of the family witnesses, which I prefer. There was also a difference of opinion between family witnesses and Nurse McDaid about whether she was personally present in the room at the time of death.

65. For completeness, I would add that there was evidence that a post mortem examination was carried out by Dr John Clark, Forensic Pathologist, Glasgow University, on the instructions of the Procurator Fiscal, on 7 March 2006. Dr Clark's report was Crown Production 2 in the Inquiry. It was agreed in the Joint Minute of Agreement.

Section 6(1)(a): Where and when the death and any accident resulting in the death took place

Determination re Death – Catherine Hattie died in Ward 5 of Stobhill Hospital, Glasgow at about 2.40 am on 3 March 2006.

66. I have noted above the evidence relating to Mrs Hattie's death. Martin Hattie, who is a qualified nurse, noticed at about 2.40am that Mrs Hattie had died. After a delay of about 5 minutes he spoke to Mr Hussein, who then examined Mrs Hattie and confirmed her death, recording the time as 2.45am. Mr Hussein's recollection of this seemed unclear and, as with much of his evidence, he largely relied on the medical records (CP3 at pg. 1631). For purposes of my determination I accept Mr Martin Hattie's evidence about the time of death.

Determination re Accident - An accident resulting in the death of Catherine Hattie occurred between 9.30pm and 10pm on 2 March 2006 in the toilet in Ward 5 of Stobhill Hospital, Glasgow, when Mrs Hattie had an accidental fall.

67. There was only very limited evidence about the circumstances of the incident that resulted in Mrs Hattie's death and there was in fact no evidence of what exactly happened as regards the circumstances and mechanism of her fall.

68. Nursing Auxiliary (N/A) Lia Clark gave evidence about the events of the night of 2 March 2006. She was able to give a reasonably detailed account, but her recollection of some of the events and timings was unclear, particularly after the incident which occurred in the toilet. She was shown a signed statement which she had provided to the hospital authorities on 7 March 2006 (Crown Production 32) and confirmed that it was generally accurate, having been typed by another person on the basis of the account she had supplied.

69. I have outlined N/A Clark's evidence above. It is not necessary to repeat it here. In summary her evidence was that Mrs Hattie fell in the toilet, her fall was not actually witnessed by her, although she was present, and it was accidental.

70. N/A Clark could not explain how Mrs Hattie ended up in the position on the floor which she described (see above). She did not ask Mrs Hattie what had happened. She said that she did not know if Mrs Hattie tripped on her zimmer. At one point (during cross examination for the family) she expressed as a personal view that Mrs Hattie was going to flush the toilet, but later she said that she did not now believe that she was going to flush the toilet. She was asked about the Notes of a Meeting that she had had with the General Manager and the Ward Manager at Stobhill Hospital on 26 May 2006 (FP13.1/13.2), which recorded that "N/A Clark had her back to Mrs Hattie at this time and assumed she had attempted to flush the toilet and lost her balance and fell." Asked if she did not remember telling anyone about the matter of Mrs Hattie flushing the toilet she said she must have, as it was recorded in the note of the meeting. However, it was not N/A Clark's evidence at any point that as matter of fact Mrs Hattie was trying to flush the toilet. The witness Clark also stated in evidence that she did not think that the floor of the toilet was wet.

71. N/A Clark was asked in cross examination on behalf of the family if, when she turned away from Mrs Hattie, she had had any physical contact with Mrs Hattie. The witness Clark said no, and that was also her answer to a question about whether it was possible that she bumped Mrs Hattie or the zimmer frame.

72. N/A Clark's evidence was that there was no other person in the toilet apart from herself and Mrs Hattie and therefore no other witnesses to the fall. In particular she stated in answer to a question that Staff Nurse Catherine McDaid could not have witnessed the fall. Her evidence was that Nurse McDaid came to the toilet, in response to her calls for help, and together they got Mrs Hattie to her feet and took her back to her bed.

73. However, I heard evidence from several family witnesses that suggested that Nurse McDaid had witnessed the fall.

74. There was evidence from members of Mrs Hattie's family – her son, Edward Hattie, her son-in-law, Stephen Shepherd, and her grand-daughter, Clare Shepherd - that Staff Nurse Catherine McDaid said to them when they attended at the hospital on the night in question that she had seen Mrs Hattie fall in the bathroom. According to Stephen and Clare Shepherd Nurse McDaid said she saw this through the open bathroom door. Stephen Shepherd's evidence was that Nurse McDaid said that she saw Mrs Hattie "just slip to the ground". Both Stephen and Clare Shepherd described a sweeping hand gesture made by Nurse McDaid when she said to them that she had seen Mrs Hattie fall in the bathroom. Both said that Nurse McDaid had stated that the floor was not wet. The witness Edward Hattie's evidence in this connection was less detailed, but he was clear that Nurse McDaid said that she had seen Mrs Hattie fall in the bathroom.

75. That was not Staff Nurse Catherine McDaid's evidence at the Inquiry. She said that she had not seen Mrs Hattie fall. She denied saying that she had seen the fall. That had been her position from the stage soon after Mrs Hattie's death when she was asked to provide statements about the matter.

76. As I have noted above, her evidence was that she was doing the drugs round elsewhere in the ward when she became aware of N/A Clark's calls for help. She went to the toilet to assist. When she opened the door of the toilet she saw Mrs Hattie sitting on the floor beside the toilet pan. Her legs were straight out in front of her, with her back close to or against the toilet pan. N/A Clark explained to Nurse McDaid what had happened.

77. Catherine McDaid was clear in her evidence that she did not see the fall herself and she was adamant that she did not make any statements to members of Mrs Hattie's family about having seen the fall herself.

78. It was Nurse McDaid's evidence that the account of the incident that she recorded in the NHS Incident Record (Form IR1 - CP14) on 3 March 2006 was the account given her by Lia Clark. What Nurse McDaid recorded in the form was: "WHEN A/N CLARK TURNED TO PUT THE USED BOWL (WITH STOMA OUTPUT) AT SINK, CATHERINE TURNED TO FLUSH THE TOILET, LETTING GO OF

ZIMMER AND APPARENTLY SLIPPING ONTO FLOOR." She was shown a statement she provided on 6 March 2006 (CP 29/30) and said there was nothing in that statement that she would now disagree with, although she did not recall every detail. The statement recorded that she heard N/A Clark calling for help and she went to her assistance in the toilet. She found Catherine sitting in front of the toilet pan. N/A Clark informed her that Catherine had turned to flush the toilet and had slipped/fell while doing this.

79. Nurse McDaid confirmed that she had spoken to members of Mrs Hattie's family when they came to the hospital. It was her position that in speaking to them she "re-iterated" what N/A Clark had told her. Asked specifically if she had told the family about the fall she said that she was asked about this and she told the family members what N/A Clark had told her. She was clearer then than now.

80. It is appropriate that I deal at this point with the credibility and reliability of the witnesses Clark and McDaid, as issues about that featured prominently in the Inquiry.

81. N/A Clark's account was tested fairly intensively in cross examination on behalf of the family. Her evidence was clear in relation to events leading up to Mrs Hattie's fall, and its immediate aftermath. Her evidence was more confused in relation to events thereafter. She admitted that she was not clear at all about the timings on the night. It was apparent to me that this incident had had a significant impact on her. She told the Inquiry that she had never experienced anything like this in 35 years as a nursing auxiliary. The main focus for her was the events leading up to Mrs Hattie's fall when she, alone, was directly involved with Mrs Hattie; thereafter, according to her own evidence, she became very upset, and her involvement with Mrs Hattie was more peripheral.

82. One matter about which the witness Clark seemed somewhat confused in her evidence was about how Mrs Hattie was taken back to her bed. Initially she said she and Nurse McDaid put Mrs Hattie into a chair in order to take her back to her bed. Nurse McDaid's evidence on this was that she asked Mrs Hattie if she was ok to walk back and she was happy to do so. She recalled Mrs Hattie walking back with the use of the zimmer frame, with the two nurses walking either side of her. The witness Hussein also gave evidence that he saw the nurses walking Mrs Hattie back to her bed. When asked in cross examination on behalf of the family about the difference in accounts the witness Clark said that she did not remember. She did not know why they walked Mrs Hattie, she would normally get a chair. She did seem to me to be genuinely confused about this, but accepting of the possibility that the other accounts were correct. I consider that the evidence of the witness Clark was not reliable on this matter and I believe the other accounts to have been correct.

83. As I have mentioned, there was a short signed statement by N/A Clark dated 7 March 2006, which was available to the Inquiry (CP 32). I am satisfied that there was nothing in this short statement which was inconsistent with the account the witness gave in her evidence. I note that the statement did not in fact contain any mention of the suggestion about Mrs Hattie trying to flush the toilet. The statement did not assist on the question of how exactly Mrs Hattie was taken back to her bed. The witness Clark could recall only giving this one statement.

84. In addition, reference was made to Family Production 13, a note of a meeting between Nursing Auxiliary Clark, Pat Burns (Ward Manager) and Mary McGinley (General Manager) on 26 May 2006. I heard from Mary McGinley that she had spoken to N/A Clark on or just before 26 May 2006. Mary McGinley's account of N/A Clark's description of the event appeared to me to be very largely consistent with witness Clark's evidence at the Inquiry, the only difference being that N/A Clark had said she and Nurse McDaid had walked Mrs Hattie back to her bed. As I have remarked above, that is the account I have preferred. There was no evidence that the witness Clark had herself seen the note at any time before the Inquiry.

85. There was evidence from family members of other accounts they said were attributed to N/A Clark by NHS managers, which accounts it was suggested demonstrated inconsistencies in her evidence. In my view there was no satisfactory evidence about the alleged making of such statements. The witness Clark denied making a statement in which she said not only that she was in the toilet with Mrs Hattie and she did not see her fall, but also that she did not see her get up.

86. As I have said, N/A Clark's account was tested fairly intensively in cross examination on behalf of the family. At no time, however, was it suggested to her on behalf of the family that her evidence about being in the toilet with Mrs Hattie when Mrs Hattie fell was untruthful and that she had not in fact been in the toilet at the time. I was therefore surprised to find that the submissions made on behalf of the family include a submission to that effect.

87. I have had to consider that submission without the benefit of it being explored in examination of the witness herself, while giving evidence on oath. I regard that as very unsatisfactory – both for the court and for the witness, who has not had an opportunity to respond to the serious accusation that she told lies in her evidence.

88. Clare Shepherd (Mrs Hattie's granddaughter) in her evidence at an early stage of the inquiry made a suggestion that Mrs Hattie had been left alone in the toilet. Questioned about this she acknowledged that this was speculation by her and not based on any direct evidence. The proposition to the same effect in the family submissions is not in my view supported by any evidence, but rather is speculative, based on what appears to be a questionable interpretation of evidence. For example, it is suggested that support for the submission is to be found in the evidence of the witness Staff Nurse Lorraine Reid about what is suggested to be the normal practice in Ward 5 when taking a patient with a zimmer to the toilet. Nurse Reid's evidence, when asked in cross examination by the family about the meaning of "assistance of one plus zimmer", included that you would get the patient safely in the toilet, then go back and get her when she buzzed. Asked if that meant that you would usually leave the patient in the toilet and then go back and get her when she buzzed she answered "yes".

89. This witness gave evidence that she was told on her arrival back in the ward on the night in question that Mrs Hattie had fallen in the toilet and that N/A Clark had been with Mrs Hattie in the toilet. At no time in her evidence did she express surprise about N/A Clark being in the toilet with Mrs Hattie, nor did she state that such a situation was contrary to normal practice, and she was not asked for an opinion about that. When asked by the PF about standard practice she said it would depend on the

patient and whether it was safe to leave them in the toilet.

90. By contrast with what is suggested to be the normal practice based on the witness Reid's evidence, the evidence of the other Nursing Auxiliary, witness Lesley McGill, was that her practice most of the time was to stay in the toilet with the patient. She said that in the toilet she would help the patient to sit down on the toilet and probably stay with them. It would depend on the patient. Some patients do not like you staying, so you would stand outside. She was asked in cross examination by Ms Shepherd for the family if the normal practice in Ward 5 was to leave the patient in the toilet. She said it would depend on the patient. She would decide whether it would be safe to leave the patient and she would stay if necessary. I understood her to say that she would usually stay.

91. Having carefully considered all the witness Clark's evidence, other evidence that was relevant or was suggested to be relevant to her evidence and parties' submissions I am satisfied that Nursing Auxiliary Lia Clark was attempting in the Inquiry to give her evidence honestly and to the best of her ability after the significant passage of time since the incident she was asked to describe. I found her to be a credible witness, although not entirely reliable about certain aspect of the events, which were not key issues. I accept her evidence about Mrs Hattie's fall in the toilet on 2 March 2006. Her position about the circumstances was consistent, both in her evidence to the Inquiry and in her accounts at and shortly after the time of the incident.

92. Turning to the evidence of the witness Staff Nurse Catherine McDaid, I did not gain the impression from the way she gave her evidence that she was deliberately setting out to mislead the Inquiry. She clearly felt herself under pressure at times when giving her evidence, particularly in Ms Shepherd's cross examination on behalf of the family, which Mr Ross for GGHB described at one point as aggressive. She also had to give her evidence over two days, with a gap of over two months between.

93. Staff Nurse McDaid's position was clear and consistent throughout her evidence on two particular matters – firstly that she did not herself see Mrs Hattie fall and secondly that she do not say to members of Mrs Hattie's family when they were at the hospital on the night of 2 March 2006 that she had seen Mrs Hattie fall.

94. A decision about which evidence is to be preferred on the matter of what was or was not said by the witness McDaid to family members is, in an important sense, not necessary for purposes of this Inquiry. What is relevant is the evidence to the Inquiry of who, if anyone, witnessed the fall and the evidence about the circumstances of the fall as described by any such witness.

95. I accept Mr Ross's submission that the only possible relevance of the conversation episode is in relation to Nurse McDaid's credibility. However, I understand the submission on behalf of Mrs Hattie's family to be that Nurse McDaid was not a credible witness, that what was alleged to be her untruthful evidence about what she told the family about having seen the fall herself tainted all her evidence, so that all her evidence should be disregarded by the court as being lacking in credibility. In the circumstances I think it necessary to deal with the matter.

96. In summary, as I have noted above, Nurse McDaid's evidence at the Inquiry was that she told the family members what Nursing Auxiliary Clark had told her about the fall and the information about the fall that was recorded by her shortly after Mrs Hattie's death was information she had received from N/A Clark. She had not herself been in a position to see the fall. She had not seen the fall. She had not told family members that she had seen the fall.

97. I have noted and considered the points made by Mr Ross in support of his submission that I should find that Catherine McDaid did not tell members of the family that she saw the accident happen. These are recorded in the Supplementary Submissions for Greater Glasgow Health Board, which are annexed. I have also considered the Procurator Fiscal's submissions.

98. I also note the following points – Stephen Shepherd remarked that Nurse McDaid's statement about seeing the fall was "unsolicited". Edward Hattie described her statement as "gratuitous information". Stephen Shepherd's account and that of Clare Shepherd were consistent to the effect that Nurse McDaid said she saw the fall through the open bathroom door. They both spoke of a sweeping hand gesture made by Nurse McDaid in describing the fall. They interpreted the gesture as indicating a slipping motion. They both said that Nurse McDaid had stated that the floor was not wet. They both recalled Clare Shepherd asking the nurse why she did not go to help – perhaps not such an odd question as it may appear, if Nurse McDaid had not yet said that she had gone to help. The GGHB submission that the family version is a composite (and therefore untrue, or at least unreliable) account resulting from discussion does not in my view fit with the reaction of the family to the early discovery of Nurse McDaid's reported position in the period soon after the death. Nor, if it is suggested that discussion has produced a composite view, does it explain why Edward Hattie's evidence was not as detailed or complete as the accounts of Stephen and Clare Shepherd, or why there were some small points of difference between the accounts of Stephen and Clare Shepherd.

99. I note that there was also a further point of conflict between the evidence of Nurse McDaid and that of family witnesses, which was about whether or not Nurse McDaid had been present in the room when Mrs Hattie died.

100. I have thought it necessary to consider the evidence in some detail. The only references I have found in the evidence before the Inquiry to the descriptions of the circumstances of Mrs Hattie's fall involving expressions about Mrs Hattie slipping to the ground or floor were in Stephen Shepherd's evidence about what Nurse McDaid said to him, the IR1 form (CP 14) completed by Nurse McDaid on 3 March 2006 and Nurse McDaid's brief statement dated 6 March 2006 (CP29/30). The account of the incident that Nurse McDaid recorded in the NHS Incident Record (Form IR1) refers to Mrs Hattie "apparently slipping onto floor" ("apparently" being inserted before "slipping"). Nurse McDaid's statement of 6 March 2006 reports that Nurse McDaid "was informed" that Mrs Hattie had "slipped/fell" while turning to flush the toilet. Both Stephen and Clare Shepherd also described a gesture by Nurse McDaid which they interpreted as indicating a slipping motion.

101. As I have noted above, it was Nurse McDaid's position that in speaking to the family she "re-iterated" what N/A Clark had told her. It was also Nurse McDaid's

evidence that the account of the incident that she recorded in the NHS Incident Record (Form IR1 - CP14) on 3 March 2006 was the account given her by Lia Clark. This was elicited in answer to a question I asked for clarification at the end of Nurse McDaid's evidence. Her original account in her evidence to the Inquiry of N/A Clark's explanation of what happened (given to her when she, Nurse McDaid, arrived at the toilet) did not include any reference to N/A Clark saying anything about Mrs Hattie slipping to the ground.

102. N/A Clark's evidence to the Inquiry about the circumstances of the fall did not include any mention of Mrs Hattie slipping to the floor. N/A Clark said her back was turned to Mrs Hattie. N/A Clark's statement of 7 March 2006 (CP32) did not include any reference to Mrs Hattie slipping to the floor. In the statement N/A Clark said she turned away from Mrs Hattie.

103. Also, in relation to the recording of information in the IR1 form by Nurse McDaid, I note that while the reference to Mrs Hattie slipping onto the floor is qualified by "apparently", the statement - "Catherine turned to flush toilet, letting go of the zimmer" - is not. It is recorded as an apparent statement of fact. I understood from the evidence that Nurse McDaid was aware that N/A Clark had turned away from Mrs Hattie just before the fall and Nurse McDaid's evidence about N/A Clark's explanation when she (Nurse McDaid) arrived in the toilet was that N/A Clark stated that she "believed" that Mrs Hattie had flushed or tried to flush the pan. Nurse McDaid also included in the IR1 form as a statement of the circumstances that Mrs Hattie let go of the zimmer. The basis for that statement is not clear. Neither circumstance is mentioned in N/A Clark's brief statement of 7 March 2006 (CP32), although her assumption about Mrs Hattie attempting to flush the toilet is mentioned in the note of the meeting on 26 May 2006 (FP 13.1/13.2) and her personal view about that was part of her evidence in cross examination. There was no mention of Mrs Hattie letting go of the zimmer in N/A Clark's evidence.

104. Nurse McDaid was asked about the source of the information recorded by Dr Wong (CP3 at page 1625) in the medical notes (and also in the IR1 form) to the effect that Mrs Hattie "fell forward". She said that she could not remember saying that, but she may have. Then she said she did not think she would have said that as there was no reason to make that assumption and no-one else said she fell forward. Why this statement, which was clearly not consistent with any other evidence about the fall (or the pathologist's opinion), was part of the medical record about the circumstances of the fall remained unexplained.

105. As I have already noted, in her evidence in chief Nurse McDaid told the court that when she went to help N/A Clark, Lia Clark explained what happened. Nurse McDaid's initial position was that she did not think that she asked Mrs Hattie about what happened and she could not remember if Mrs Hattie said anything. She continued by saying that Mrs Hattie did not disagree with anything Lia said and that Mrs Hattie could have said or disagreed with Lia. In cross examination for the family, as I have noted Nurse McDaid's evidence, she said that when she went into the toilet Mrs Hattie gave an explanation of what had happened. Questioned further she said that Mrs Hattie or Lia gave an account, or Lia gave an account and Mrs Hattie agreed. She then said, as I have noted – "I am sure she said she slipped", referring – as I understood - to Mrs Hattie. Later in her evidence she said that Mrs

Hattie was able to say if something untoward had happened. I have also noted that she said – "Nurse Clark later said about flushing the toilet".

106. Aspects of Nurse McDaid's evidence, as outlined above, have caused me to have doubts about how careful she was about accurately recording or recounting circumstances, including in the course of her evidence, about her memory of events, and consequently about the credibility or reliability of some of her evidence.

107. On reviewing the evidence it is difficult to see that a reasonable explanation of the different position of Nurse McDaid and the family members is simply that there was confusion about this aspect of the communications. I am unable to find any persuasive reason why the witnesses Stephen and Clare Shepherd and Edward Hattie would have been mistaken in their firm belief that Nurse McDaid said to them that she had seen the fall, far less why they would have given deliberately untruthful evidence about this. I accept their evidence about this matter. I am satisfied that Nurse McDaid did describe Mrs Hattie's fall to the family members in a way that included a statement that she had seen it. Whether Nurse McDaid's evidence to the Inquiry about this point was deliberately untruthful or reflected a genuine but mistaken belief, I cannot say.

108. I have mentioned above that I understand the submission of the family to be that all Nurse McDaid's evidence should be disregarded as being lacking in credibility. Although I have not accepted Nurse McDaid's evidence about the particular matter of what she said to the family members, it does not necessarily follow that all Nurse McDaid's evidence requires to be rejected. I am not prepared to accept the family submission on this and adopt the suggested approach to this witness's entire evidence. I do not regard the question of which version of what was said by Nurse McDaid to members of the family was correct as central to establishing the facts of Mrs Hattie's death. It does not follow that rejection of one part of a witness's evidence requires a court in determining the facts to reject a witness's evidence in its entirety. It is a standard approach, and one that I intend to follow, that part of a witness's evidence may be rejected and other parts of the witness's evidence accepted.

109. I am prepared to accept as credible and reliable Nurse McDaid's evidence that she was not present when the fall happened, that she did not see the fall and that she went to the toilet to assist N/A Clark after the witness Clark had called for help, following the fall. That evidence is consistent not only with the witness Clark's evidence, but also evidence from Mr Hussein about nurses (he thought there was more than one) running to the toilet in response to the call for help. I noted that in his evidence Stephen Shepherd also stated that he suspected that Nurse McDaid did not in fact see the fall.

110. In making a determination about the questions of an accident resulting in the death and the cause of such accident it would have been helpful to the Inquiry to have heard clear evidence about what Mrs Hattie said herself about the circumstances of the fall. However, no such evidence was available to the Inquiry. There was no clear evidence that any account or explanation of the fall was obtained from or given by Mrs Hattie. She was fully conscious after the fall and would have been able to describe what had happened.

111. The only evidence from N/A Clark that I have noted about this was when, in answer to a question in cross examination on behalf of the family, she said that Mrs Hattie did not say anything about the fall afterwards. I have referred above to Nurse McDaid's evidence about this, which does not assist in reaching a clear conclusion about the matter.

112. There was no clear evidence from Mr Hussein or Dr Wong that they asked or obtained from the patient an account of the circumstances. Mr Hussein gave conflicting evidence about this. He said he had spoken to Mrs Hattie. When asked if he had asked her what had happened he said that he did not go into details, he asked about symptoms and pain. He said Mrs Hattie pointed out the site of pain. Shown the junior house officer's record in the notes "exact mechanism unknown" (CP3 at page 1625) he said "I assume we didn't ask her." When asked in cross examination on behalf of the family whether in the case of a fall he would have asked the patient how she fell his reply was "Not normally. With a fall in a toilet I don't go into detail." However, when cross-examined by Mr. Ross for the Health Board he said "you would ask the patient, normally." The Junior House Officer, Dr Wong, gave evidence that he could not remember if he spoke to Mrs Hattie or if she said anything. Dr Wong frankly admitted that his recollection of the night in question was very limited.

113. Overall I consider that I am justified in taking from the evidence that the doctors probably did not ask Mrs Hattie for an account of the fall and that they were not given an account by her.

114. Family witnesses expressed concern about the apparent failure of the medical staff to obtain information from Mrs Hattie about what had happened in the toilet. It is unfortunate that there has not been available to this Inquiry any clear evidence of the deceased person's own account of what happened. Had information been obtained directly from Mrs Hattie that would have been likely to assist the Inquiry in relation to determinations concerning the accident. It might also have avoided allegations about the conduct and truthfulness of the witness, Nursing Auxiliary Clark.

115. What can be said is that there is clear evidence that Mrs Hattie was conscious and talking to doctors who examined her after her fall. She had an opportunity and was in a fit condition to communicate information to the doctors about any aspect of the incident which caused her concern, such as, for example, that she had been pushed, bumped or manhandled - or that she had been left unattended. She did not do so. Mr. Hussein, in response to my questions, said that he would have recorded and remembered if a patient had said that something untoward or inappropriate had happened, such as mistreatment by a member of staff. He did not record Mrs Hattie saying any such thing and he remembered that she did not give any such account.

116. There was also evidence from the witness Nurse McDaid that immediately after the event Mrs Hattie was embarrassed at falling. That too was, in my view, consistent with the fall being accidental.

117. I recognise that I have dwelt on the question of "accident" at some length. That in part is because I have thought it necessary to deal in some detail with the issues concerning the credibility of the witnesses Clark and McDaid. But I have also had regard to statements made by family members in their evidence to the Inquiry. Mrs

Hattie's daughter, Mary Shepherd, said she had no idea what happened to her mother - whether it was neglect, an accident, or if she was pushed. Her mother's injuries were severe and she had questions in her head about what happened, she said. Clare Shepherd expressed concern that the family had not been told the true explanation and so she was thinking the worst.

118. In concluding this part of my determination I am satisfied on the evidence I heard that the only person who was present at the time of the event was the witness Nursing Auxiliary Lia Clark. I accept N/A Clark's evidence that although she was in the room at the time she did not in fact see the fall. Therefore, although the fall occurred in N/A Clark's presence, she was not directly an eye-witness to the actual circumstances of the fall and there was no-one who actually saw what exactly happened.

119. The evidence was that the fall was an accident. I accept that evidence. There was no evidence that what happened was anything other than an accident. I am satisfied from the evidence that what happened was an accidental fall.

Section 6(1)(b): The cause or causes of the death and the accident resulting in death –

Determination re Death –
The Cause of Catherine Hattie's death was:
primary cause
1a Chest and abdominal injuries,
due to
b Fall,
due to
c Post-operative hemi-colectomy,
due to
d Carcinoma of sigmoid colon.

120. In a Joint Minute of Agreement lodged at the beginning of the Inquiry all parties agreed the Post Mortem Report, dated 10 April 2006, of Dr John Clark, Forensic Pathologist, University of Glasgow (CP2). It is right, therefore, that I find the cause of death to be as set out in the Post Mortem Report. Dr Clark in fact gave evidence in terms of his report, confirming the cause of death as recorded in his report and noted above.

121. The report, as also confirmed in Dr Clark's evidence, recorded fractures to one rib to the front and double fractures to two ribs to the rear. Liver lacerations had resulted in bleeding into the abdominal cavity. In the course of his evidence Dr Clark stated that the injuries he found were consistent with a fall by Mrs Hattie in the bathroom. The injuries, which were severe, were caused by what he described as a heavy fall, involving substantial impact. They were consistent with falling to the floor and could have been caused by Mrs Hattie hitting something when she fell – such as the toilet pan, but not necessarily. The fall having been heavy it was not likely that Mrs Hattie had simply "slipped" to the floor. In Dr Clark's view the findings were not consistent with falling forwards – although this information was

included in the description of circumstances in the report, having been provided to Dr Clark. His opinion was that Mrs Hattie had fallen backward and downward.

122. Dr Clark's evidence was that the fact that Mrs Hattie suffered from osteoporosis would make her more prone to fractures. He also stated that her liver may have been more likely to suffer damage in the fall because of Mrs Hattie's slow post-operative progress and residual changes in the liver. While a younger, fitter person may have survived the injury, Mrs Hattie was someone who was already clearly debilitated.

Determination re Accident – No determination

123. Having reviewed all the relevant evidence I have concluded that the cause of the accident has not been established.

124. I have rehearsed the evidence concerning Mrs Hattie's accidental fall in some detail in the previous section of my Note. I have done so in order to deal comprehensively with the question of whether the death resulted from an accident.

125. I have mentioned evidence about a suggested cause of the fall – namely, that Mrs Hattie had tried to flush the toilet. However, it was in my view clear that any such suggestion was only conjecture or an assumption on the part of N/A Clark, as she had not actually seen the fall. As I have noted, in her evidence this witness having expressed a personal view that Mrs Hattie was going to flush the toilet, later said that she did not now believe that she was going to flush the toilet. I have also noted the reference to N/A Clark's assumption about Mrs Hattie flushing the toilet in the note of the meeting on 26 May 2006 (FP13.1/13.2). As I have mentioned above, Nurse McDaid included reference to this in the brief statement she prepared on 6 March 2006 (CP29/30) and in the Incident Form IN1 (CP14) which she completed after the accident. According to her evidence, that was because of what she was told by N/A Clark.

126. Dr Clark in evidence stated that the injuries found at post mortem would be consistent with Mrs Hattie having reached behind her and lost her balance.

127. There has, however, been no evidence in this Inquiry that would allow a finding, as a matter of fact, that there was such an action by Mrs Hattie and that the fall was caused by an attempt by her to flush the toilet.

128. The witness Nursing Auxiliary Lia Clark was also asked in cross examination on behalf of the family if, when she turned away from Mrs Hattie, she had had any physical contact with Mrs Hattie. She denied that, and also the possibility that she bumped Mrs Hattie or the zimmer frame.

129. The position of the Procurator Fiscal in his submissions, is that the specific physical cause of the fall remains unascertained. The relevant submission for the GGHB is that the court is not in a position to make any definitive findings in fact as to what caused Mrs Hattie to fall to the floor. The family, however, submit that "the cause of the incident was a misjudgement by the nursing auxiliary, Lia Clark, who did not offer Mrs Hattie adequate support to keep her safe while mobilising and did not

follow the care plan."

130. In the circumstances, my conclusion on reviewing all the relevant evidence and considering the submissions is that the cause of the accident that led to Mrs Hattie's death is not established. The family submission is one that in my view is more relevant to my determination under section 6(1)(c). In the absence of clear evidence about exactly how the fall happened I do not consider that I can make a determination that N/A Clark's "misjudgement" caused the fall.

Section 6(1)(c) – The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided

Death - No determination

131. The Procurator Fiscal's submission proposes the following determination: "The reasonable precaution whereby the death might have been avoided was that intravenous fluids should have been set up and administered as soon as possible after Mrs Hattie's death."

132. The submissions for the GGHB propose no determination under this section and oppose the proposed determination above. The submission for Dr Wong and Dr Helps proposes no determination and comments on the above determination only to the extent of submitting that the decision to administer fluids immediately after the fall was not a matter for Dr Wong or Dr Helps. I accept that submission. For the family a number of proposals are made under section 6(1)(c). As I understand them they include support for the above determination, but otherwise largely relate to the accident.

133. The determination proposed by the PF rests on the evidence of the witness Dr William Primrose, Consultant Geriatrician, who was adduced by the Procurator Fiscal for the purpose of giving independent, expert evidence to the Inquiry. He was in my view an impressive witness, who gave helpful and well-considered evidence, based on his experience and expertise. His report to the Procurator Fiscal (dated 22 October 2008) was before the Inquiry as Crown Production 4.

134. I have outlined above the evidence about the medical treatment given after the fall. I do not intend to repeat the evidence in detail, but I shall refer to relevant parts of it, concentrating on the evidence relevant to the determination. Evidence about Mrs Hattie's care and treatment before her fall has also been outlined above and will largely be dealt with further in a subsequent section.

135. There was some criticism from family members of the actions of Nurse McDaid and Nursing Auxiliary Clark in picking Mrs Hattie up and walking her back to her bed. However, there was otherwise no significant criticism of this by any medical witnesses to the inquiry. In particular, Dr Clark gave evidence that these actions would not have exacerbated Mrs Hattie's injuries.

136. There was clear evidence that Mr Hussein and Dr Wong attended very shortly after Mrs Hattie was back at her bed and Mr Hussein examined Mrs Hattie. The speed

of medical response was not open to criticism.

137. The precise timing of Mrs Hattie's later deterioration was somewhat unclear, as I have noted above. However, I do not understand there to be any real issue about any delay in the medical staff responding to that deterioration, such as would be relevant to any determination under this section of the Act.

138. I have noted that the question of the adequacy of observations was explored in evidence. The recorded readings after Mrs Hattie's fall were timed at 10.10pm and 11.20pm. In the course of Dr Primrose's evidence he expressed surprise that no records were made on the Patient Observation Chart between 10.10pm and 11.20pm. He stated that he would have expected readings to be more regular and he would have expected such readings to have been recorded somewhere.

139. There was evidence, including from Nurse McDaid, that observations were taken more frequently, even though they were not recorded in the medical records. Nurse McDaid agreed that there should have been more regular readings recorded, but she gave the demands of patient care on the ward as her explanation for why this was not done. There was evidence that the readings were monitored and, as necessary, acted upon.

140. In relation to the later observations recorded from midnight onwards, Dr Helps, the medical Senior House Officer, gave evidence that, in the period she was there (between about midnight and 1.30am or 2am), very frequent checks of Mrs Hattie's readings were being taken, but they were not all being written down. The recorded timing of those readings that were noted does not appear to have been particularly accurate. I accept the doctors' evidence that where the situation in relation to a patient is acute, the priority is to treat the patient, and nurses would note down the recordings on the relevant chart when they were free to do so. That does not, however, excuse the clearly inaccurate recording of a reading as being timed at 3am – which was after Mrs Hattie's death.

141. The lack of accurate records is unhelpful to an Inquiry of this kind. However, on the evidence presented I am not able to conclude that Mrs Hattie's condition was not being adequately monitored. The evidence would not support a determination under section 6(1)(c) that more frequent observation would have been a reasonable precaution whereby the death might have been avoided.

142. I turn now to the issue of diagnosis after the deterioration in Mrs Hattie's condition as shown by the recorded drop in her blood pressure at 11.20pm.

143. As noted in the summary of evidence, all the medical witnesses were clear that Mrs Hattie's condition was very poor at this time and her prognosis was not good. However, there was not a clear, agreed view about the medical reason for the deterioration in her condition. As indicated above, Mr Hussein had initially considered a cardiac event. Dr Helps and Dr Cameron did not support this diagnosis of a cardiac cause. Dr Helps in her evidence said that she thought that she would have come to the conclusion that a liver injury and internal bleeding was the cause of the deterioration in Mrs Hattie's condition. Dr Cameron referred to what he described as the close time association between the trauma and Mrs Hattie's deterioration and said

he thought the most likely explanation of Mrs Hattie's condition when he saw her was liver laceration causing internal bleeding.

144. In his evidence during cross examination for the family Mr Hussein accepted that he had made a wrong diagnosis. He accepted that the post mortem showed that.

145. As noted above, at post mortem Mrs Hattie was found to have suffered a liver laceration which resulted in an internal bleed. There was no criticism that this was not identified at the time of the fall. It was, on the evidence, an unusual injury. As regards the diagnosis by Mr Hussein of a cardiac event I note that the pathologist, Dr Clark, said at one point in his evidence under cross examination that in his view it was not entirely unreasonable to think Mrs Hattie had had a cardiac event.

146. Turning to the decision that Mrs Hattie should not be referred to the Intensive Care Unit (ICU) – as noted, this was a decision taken after discussion between all the senior doctors present (Mr Hussein, Dr Helps, Dr Cameron), but the decision was ultimately made by Dr Cameron, as the Intensive Care SHO. The other doctors did not disagree with that decision.

147. Dr Cameron's evidence was that there was no treatment which could be offered in the ICU that Mrs Hattie could benefit from at that time. She was bleeding internally, losing blood and the only way to stop that would be an operation, which in Dr Cameron's view Mrs Hattie would not survive. It was for her consultant surgeon to decide whether Mrs Hattie would be appropriate for surgery.

148. The decision not to admit Mrs Hattie to the ICU after her deterioration was explored in some detail by the family during the inquiry. I do not consider that this decision can reasonably be criticised. Dr Primrose did give an opinion that it was possible that referral to the ICU could have made a difference in the outcome, particularly in the earlier period. However, there would have been no justification for such earlier referral before Mrs Hattie deteriorated. Dr Primrose accepted that after she deteriorated, those doctors present were in the best position to make such a decision. Attempting to second guess such a decision when not present was, in his view, "a dangerous situation of conjecture". At the conclusion of their dealings with Mrs Hattie, both Dr Cameron and Dr Helps were of the opinion that her prognosis was very bleak. Dr Helps stated as her view that there was a 95% certainty at that time that Mrs Hattie would die.

149. The evidence of the consultant surgeon, Mr Chong, was that he was of the clear view that there was no merit in surgical intervention at that time. He considered that Mrs Hattie would have been unlikely to survive surgery.

150. I am satisfied that the evidence about the difference of opinion between the doctors about diagnosis after Mrs Hattie's deterioration does not lead to any conclusion that there was any reasonable precaution available at that stage whereby Mrs Hattie's death might have been avoided. That is also my conclusion in relation to the evidence about the decision not to admit Mrs Hattie to the ICU, the evidence about the decision not to operate on Mrs Hattie, and the evidence (outlined in the summary of evidence) about further treatment being limited to administration of fluids. Consequently no determination under section 6(1)(c) is appropriate in regard

to any of these matters.

151. I shall deal now with the issue of the administration of fluids. Two particular aspects require to be considered. The first is whether the administration of fluids at an earlier stage of the treatment of Mrs Hattie after her fall would have been a reasonable precaution and the second is whether taking that precaution might have avoided her death.

152. As mentioned above, fluids were only first administered at 11.50pm. There was therefore a significant time delay after Mrs Hattie's fall before that action was taken.

153. In his evidence Dr Primrose, the independent, expert witness, was of the clear opinion that intravenous fluids should have been set up soon after Mrs Hattie's fall when it was established she had a broken rib. He expressed surprise that no action in the form of administering intravenous fluids was taken after the observations made at 10.10pm. In his view this was a simple precautionary measure to take and an opportunity was missed in not setting up fluids at that time. Administering fluids at that time was the "medically obvious" thing to do. It was not acceptable not to set up fluids just because there was no clear diagnosis at this time. The failure to set up fluids at 10.10pm was “not good practice”. At another point, when asked if it was a misjudgement by the doctors, he said “yes”. Dr Primrose also described the setting up of fluids at 11.50pm as “late in the day”.

154. Dr Primrose was asked to comment on Mr Hussein’s evidence disagreeing with the suggestion that fluids should have been set up after Mrs Hattie's fall, when Mr Hussein gave as his reason the fact that Mrs Hattie was on drugs (frusemide) to decrease fluids which had been building up in her body. Dr Primrose did not accept that reason and suggested that the fact that Mrs Hattie was receiving frusemide was a further reason why fluids should have been set up earlier as she may have been at greater risk of dehydration.

155. Dr Primrose also dealt with a suggestion that, if a cardiac event was suspected, it might have been considered that giving fluids would precipitate a pulmonary oedema. His response to this was that there was no reason to suspect a cardiac cause immediately after the fall, and that in any case fluids should have been administered earlier.

156. Mr Chong, the surgical consultant, also stated the opinion that it would have been desirable for fluids to have been set up earlier, although he understood why the attending doctors did what they did. Dr Cameron was also asked to comment about the administration of fluids at the earlier stage. I noted him as saying that that was “too big an inference”. He did not think that the decisions of the Surgical SHO at the time were “daft” or “wild”.

157. I accept the expert opinion of Dr Primrose that administering fluids soon after Mrs Hattie’s fall would have been a "reasonable precaution". I have greater difficulty with the question of whether administering fluids at an earlier stage of Mrs Hattie’s treatment might have avoided her death. Before a determination may be made about a reasonable precaution I require to be satisfied that there was a real or lively possibility that Mrs Hattie's death might have been avoided had fluids been set up soon after her

fall. I accept that this must be established on the basis of evidence and reasonable inferences from the evidence, as opposed to speculation about remote or unlikely possibilities for which there is no evidential basis.

158. The submission by the Procurator Fiscal and the family that I should make a determination that the reasonable precaution whereby the death might have been avoided was that intravenous fluids should have been set up and administered as soon as possible after Mrs Hattie's death is also founded on the evidence of Dr Primrose. Dr Primrose expressed his opinion about a different outcome, namely Mrs Hattie's survival, at a number of points during his evidence. In his evidence-in-chief he said, "we won't know what the outcome would have been if fluids had been started immediately". During cross examination on behalf of the family his answer to a question about a different outcome if fluids had been administered earlier was that it was "conceivable". At another point in his evidence Dr Primrose said in relation to earlier administration of fluids that it was not easy to quantify the chances of that making a difference – the outcome could have been the same, but it could have been different. I noted that Dr Primrose said in terms that whether better hydration would have made a difference to Mrs Hattie's prospects of survival was "conjectural" and he subsequently confirmed to Mr Ross for GGHB that in terms of Mrs Hattie's possible survival had fluids been administered earlier "we are in the territory of conjecture", as Mr Ross put it.

159. Other medical witnesses were asked to comment on Mrs Hattie's survival prospects. Mr Chong expressed the opinion that this was probably only going one way after the fall. Dr Helps' response to the question whether anything could have been done differently was - only if Mrs Hattie had not fallen in the first place. Dr Cameron answered a similar question by saying that once Mrs Hattie sustained the injuries her prognosis was bleak. He also said that after the fall and the injury she was unlikely to survive. Mr George Welch, Consultant Surgeon and Director of Surgical Services (who was a witness led by the family) gave as his opinion that he did not think that fluid resuscitation would have made a difference to the eventual outcome.

160. I have noted the submission by Mr Ross for GGHB that agreement about the potential benefit in establishing IV access "is based upon knowing the injuries which Mrs Hattie sustained in the fall". My understanding of Dr Primrose's evidence was that he was stating an expert opinion about good practice in the prevailing circumstances as known to the doctors at the time. Dr Primrose said in terms in the course of cross examination by Mr Ross about the position at 10.10pm that he was not suggesting that the doctors should have known that the cause was liver laceration, but they should have started fluids. He gave a clear explanation of his reasons in response to a question from Mr Ross about what he would have said if asked why, if he set up IV fluids.

161. The Procurator Fiscal's submission includes the submission that even if fluids had been set up when Mrs Hattie fell (which I take to mean shortly after the fall when she was first examined by Mr Hussein), the very strong probability is that she would unfortunately still have died. Mr Ross, on behalf of GGHB, supported that statement, viewing the evidence as a whole.

162. I have considered whether evidence that a different outcome was "conceivable",

as Dr Primrose put it, is sufficient to establish that there was a "real or lively possibility" that the death might have been avoided. In my view the expression is more suggestive of a remote than a real or lively possibility. I believe there is force in Mr Ross's argument that a strong probability that death would have occurred in any event – as submitted by the Procurator Fiscal – does not equate to a real or lively possibility that it could have been avoided. Also, an expert opinion that was accepted by the expert witness to be conjecture does not provide a firm basis for a finding that there was a real or lively possibility that the death could have been avoided.

163. In all the circumstances, therefore, although I am satisfied that the earlier administration of fluids would have been a reasonable precaution I am not sufficiently satisfied, applying the appropriate test to the evidence before me, that it might have avoided Mrs Hattie's death. Consequently I am not persuaded that I should make the determination proposed by the Procurator Fiscal and the family.

164. I do not therefore make any determination about a reasonable precaution whereby Mrs Hattie's death might have been avoided. Standing my view about the earlier administration of fluids I shall, however, follow the alternative course suggested by Mr Ross and include reference to the matter of earlier administration of fluids in a determination under section 6(1)(e).

165. I turn now to the question of whether there were any reasonable precautions whereby the accident resulting in the death might have been avoided.

Section 6(1)(c): Determination re Accident – The reasonable precautions whereby the accident resulting in the death might have been avoided were that Nursing Auxiliary Clark should have remained in a position in the toilet to continue to observe Catherine Hattie, in sufficiently close proximity to Catherine Hattie to be able if necessary to render her assistance and prevent her from falling or catch her if she did, or Nursing Auxiliary Clark should have returned Catherine Hattie to a sitting position while she briefly turned away from her and left her side.

166. The Procurator Fiscal and Mr Ross, for the GGHB, submit that it would not be appropriate for me to make a determination about any reasonable precaution that might have prevented the accident. I understand the submissions for the family to be supportive of a determination under this section. The family submissions also cover matters relating to the mobilising arrangements which seem to me to be concerned more with the issue of possible system defects than reasonable precautions whereby in the particular circumstances the accidental fall might have been avoided. I propose therefore to deal in more detail with the evidence about the mobilising arrangements and issues relating to those in the next part of my determination, under section 6(1)(d). I do not consider a determination under this section of the Act to be appropriate in respect of that evidence.

167. For present purposes it will suffice for me to say that the evidence does not, in my view, justify a conclusion that the decision to mobilise Mrs Hattie to go to the toilet was a mistake. I accept the GGHB submission that the very fact of the accident does not of itself require me to conclude that Mrs Hattie should not have been mobilised in the way she was. Mrs Hattie safely made the journey to the toilet with

N/A Clark in attendance. Any assistance was apparently limited to a hand behind Mrs Hattie's back, but N/A Clark was attentive to Mrs Hattie's needs and in a position to assist as required. Her evidence was that when she walked with Mrs Hattie to the toilet she was walking very close to her and would have been able to catch her if she fell.

168. I have outlined the evidence about the circumstances of the accident above. I shall review what I consider to be relevant evidence below.

169. N/A Clark's evidence was that having got to the toilet without difficulty she helped Mrs Hattie to sit on the toilet and she thought it appropriate to remain with her in the toilet. That was her usual practice, unless the patient was fit and able. When she got Mrs Hattie to stand up she seemed stable. Asked – "She didn't seem dizzy?" - she replied: "She seemed fine. If she had been dizzy I would not have taken her to the toilet". In answer to questions in cross examination for the family she said that Mrs Hattie had said that she had a wee bit of a sore ear and felt a wee bit unsteady. Maybe she felt unsteady, but she didn't look it. She also said "assistance" means that you stay with the patient and she went on: "You stay - she needs assistance." When it was suggested to her that assistance and staying with someone are not the same she said: "If they trip or fall you are there to catch them."

170. In relation to N/A Clark's evidence I should mention that my note of her evidence about events in the toilet at the relevant time appears to differ from the Procurator Fiscal's in one respect. The PF states in paragraph 56 of his submission that "if Mrs Hattie had both hands on her zimmer (as was the account of Nurse Clark)". My note of N/A Clark's evidence was that, at the point when she went to turn away from Mrs Hattie, Mrs Hattie was standing in front of the toilet. Both her hands were free at that point, she said. Asked by the PF if there was anything stopping her from having two hands on the zimmer, the witness Clark replied – "There was nothing stopping her." I do not have a note of the witness saying that Mrs Hattie in fact had both hands on the zimmer.

171. I found it interesting to consider the evidence of the other Nursing Auxiliary on duty that night, Lesley McGill, about her practice, which I thought relevant. I have referred above to her evidence about staying with a patient in the toilet. In her evidence she was asked about changing a patient's stoma bag and said it is easier when the patient is standing up, it depends on the patient and if you thought the patient was ok standing up holding onto the zimmer. She would keep asking the patient if she was all right and if they wanted to sit down. She would be pretty close to the patient. Asked if when changing a stoma she would always keep the patient in her sight she said yes. Asked if she would keep close so that she could assist if necessary she replied that she would sit them down again. Asked about care for a patient standing while she was changing a stoma she said: "I'd keep asking – are you all right standing or do you want to sit down?" If they were all right she would empty the bag and clean it.

172. I have no note of any evidence suggesting that N/A Clark asked Mrs Hattie if she wanted to sit down or that she had considered sitting Mrs Hattie down while she dealt with the bowl and stoma contents. N/A Clark replied to questioning by Ms Shepherd about her failure to catch Mrs Hattie and whether her assistance had been adequate to

prevent an accident only by saying: "What was I to do? I had a bowl which I had to empty." That suggests that the disposal of the bowl had become the immediate priority for N/A Clark.

173. On reviewing the evidence I was interested to note that at no point in the examination of N/A Clark does she seem to have been asked whether she could not just have emptied the bowl of stoma contents into the toilet pan, while remaining close to Mrs Hattie.

174. In his evidence to the inquiry Professor Primrose characterised N/A Clark's action in turning away from Mrs Hattie and leaving her side very briefly to place the bowl with the stoma contents on a shelf as an error of judgment. He explained the statement in his Report (CP4) about a "major" error of judgment as meaning an error of judgment which had major consequences. In my view that was a fair clarification. There was also evidence that the late Professor Tim Cooke, Associate Medical Director, was also of the view that there was a misjudgment by N/A Clark. In a letter to Martin Hattie of 13 October 2006, which was before the Inquiry as Crown Production 23, Professor Cooke stated that he had come to the conclusion on a review of all the documentation that "a misjudgment on behalf of the auxiliary nurse assisting your mother resulted in her fall in the bathroom of Ward 5." Family witnesses also spoke to Professor Cooke expressing that opinion.

175. The Procurator Fiscal and Mr Ross, for GGHB, both supported their submission that it would not be appropriate for me to make a determination about any reasonable precaution that might have prevented the accident by reference to a statement made by Sheriff Braid in his determination in the Fatal Accident Inquiry into the death of *Marion Bellfield* [*Sh Court (Kirkcaldy) 2011 FAI 21*]. Having considered the Sheriff's full statement in the relevant part of his determination, I do not regard the statement of the Sheriff's opinion in that particular case as a reason for not making a determination about a reasonable precaution or precautions in this case. I am not prepared to follow the PF's and Mr Ross's submissions in that regard. I do not accept the submission that a determination under this heading in this case would be contrary to the public interest. The primary public interest clearly in my view relates to patient safety.

176. I consider that there was clear evidence to justify a determination in this connection. On the evidence I believe the accident might have been avoided by precautions that could have been taken that were reasonable and were not out of line with existing practice, and that a determination in that regard would not have unreasonable implications for future practice.

177. N/A Clark's decision to deal with Mrs Hattie's colostomy ("stoma") bag while in the toilet was described by Dr Primrose as a move towards a more complicated level of care than that involved in walking Mrs Hattie to the toilet. However, it does not seem to me that the evidence suggested that this decision was out of line with accepted practice. Dr Primrose's statement about the ideal situation being for N/A Clark to have another nurse assisting with the procedure does not, in the circumstances disclosed by the evidence, lead me to conclude that it would have been a reasonable precaution for N/A Clark to have called for assistance to carry out the procedure.

178. I note the family submission that stoma care could have been carried out in a sitting position and that if this had been done Mrs Hattie would have been less likely to have fallen and if she had done so, less likely to sustain injuries of the kind she did. I agree that this would seem to have been an option that was open to N/A Clark and that a fall would have been less likely and any injuries from a fall less serious. I have given serious consideration to a determination to that effect, noting also the evidence of Dr Primrose about preventing a fall happening. He said that the added factor of stoma emptying involved a nurse doing two things at the same time and he suggested having two nurses or taking other action like sitting the patient down. However, the evidence, including the evidence of N/A Clark about Mrs Hattie's condition and attitude at the time, does not lead me to conclude that the decision to carry out the stoma procedure while Mrs Hattie was standing is one that of itself is open to serious criticism. On the evidence that appears to be a regular and preferred practice. The problem, as I see it, is that having undertaken that procedure with Mrs Hattie in the standing position N/A Clark moved away from her and lost sight of her, albeit for only a very brief time, without taking adequate steps to ensure Mrs Hattie's continuing safety. Her attention was directed temporarily to the disposal of the stoma bowl, not to her patient.

179. Having regard to N/A Clark's own evidence it appears to me that her action in turning away from Mrs Hattie and leaving her side very briefly to place the bowl with the stoma contents on a bin involved a departure from her own stated view of her role in providing assistance to a patient in Mrs Hattie's position. As I have noted, she described providing assistance to a patient by staying with them in the toilet as being - "If they trip or fall you are there to catch them." I note Dr Primrose's view was that, for the short period of time when she turned away, N/A Clark was not supervising or assisting Mrs Hattie – albeit that Dr Primrose thought that the period during which N/A Clark turned away must have been more than a couple of seconds. Dr Primrose also expressed the opinion that this lady required close observation and for that brief time did not receive it. He spoke at one point of N/A Clark taking her eye off the ball in terms of keeping a watching eye on the patient. Also, N/A Clark was aware of Mrs Hattie's complaint of having a sore ear and that she had said she felt a wee bit unsteady. It would have been appropriate for her to have that in mind, even though she thought that Mrs Hattie did not look unsteady.

180 A reasonable precaution whereby the accident might have been avoided would therefore, in my view, have been for N/A Clark to have remained in a position in the toilet to continue to observe Catherine Hattie, in sufficiently close proximity to Mrs Hattie to be able if necessary to render her assistance and prevent her from falling or catch her if she did.

181. I accept, in the absence of evidence about the feasibility of just emptying the bowl into the toilet while N/A Clark remained in close proximity to Mrs Hattie, that that may have made it necessary for Nurse Clark to leave the bowl with stoma contents on the floor. I consider that reasonable in the circumstances.

182. I have referred above to the evidence of N/A McGill about sitting a patient down or asking the patient if she wanted to sit down. Drawing on her evidence, and to some extent the family submission and the evidence of Dr Primrose which I have

mentioned, I believe that another precaution that would have been reasonable and that might have avoided the accident would have been for N/A Clark to have returned Mrs Hattie to a sitting position on the toilet while N/A Clark left her side, turned her back on Mrs Hattie to deal with the bowl with stoma contents and was briefly inattentive to her patient.

183. I recognize that a determination to the above effect is made with the benefit of hindsight. I consider that it is appropriate for a Fatal Accident Inquiry to be an exercise in applying hindsight.

Section 6(1)(d): the defects, if any, in any system of working which contributed to the death or any accident resulting in the death - No determination

184. The Procurator Fiscal's submission contains a thorough analysis of the evidence concerning various aspects of the system of care in relation to mobility that may be relevant to this Inquiry. This analysis leads to submissions by the PF that no determination should be made under this heading. That is also the submission for GGHB, which is in general agreement with the PF's analysis. The submissions for the family invite me to make determinations about aspects of the care arrangements in relation to mobility.

185. There was a considerable amount of evidence presented to the Inquiry in relation to the assessment of Mrs Hattie's mobility, the ongoing treatment she received to improve her mobility, and the progress she made in this regard throughout her time in Stobhill Hospital.

186. In this Inquiry the principal question for consideration under this heading of the determination is essentially whether there were any defects in the system of working in place in relation to Mrs Hattie's mobility which contributed to the accident (Mrs Hattie's fall on 2 March 2006) that resulted in her death. It is important to emphasise that even though a defect or defects in a system may be identified, a determination under section 6(1)(d) may only be made where it is established on the balance of probabilities that any such defect contributed to the accident or death.

187. I heard evidence from various medical witnesses, including the expert witness Dr Primrose, that falls are a recognised risk in hospital, that there are also recognised risks and dangers associated with immobility and that achieving the right balance between these two risks requires ensuring the patient receives the appropriate level of supervision and assistance in the hospital according to their ability to move themselves and carry out functions safely. I accept the PF's description that the aim of the multi-disciplinary team (principally physiotherapists and nurses, but including other health professionals) which was concerned with Mrs Hattie's mobility might be summarised as being to assist her in regaining as close as possible her previous level of mobility without exposing her to unnecessary risks.

188. In his submission the PF seeks to identify whether there were any defects in the system in relation to the extent to which staff involved in moving Mrs Hattie within the ward had both the relevant skills and information available to be able to do so in a manner appropriate to her particular level of mobility and independence at any given

time and, if there were defects, whether any defects contributed towards Mrs Hattie's fall and death.

189. The family submission contains criticism of what is said to be the system of allowing decisions about mobilising patients to be made by untrained staff. This appears to relate to nursing auxiliary staff, as the training, experience and skills of the physiotherapy staff and trained nursing staff did not seem to be called into question. Nursing auxiliary staff, who would typically be involved in moving patients around the ward, are not professionally trained and it was a nursing auxiliary, Lia Clark, who accompanied Mrs Hattie to the toilet when she fell. I have considered the family submission in this connection.

190. I note that N/A Clark's evidence was that she had received training in lifting and handling, to avoid injuring the patient or yourself – including using different mechanical aids, but not zimmer frames. She did not recall having received specific training in mobilising patients with zimmers. However, as the submission for GGHB points out, Dr Primrose said that he would not be concerned if a nursing auxiliary who had been assisting patients for many years, including using zimmers, had not received training on zimmers, which are common routine equipment. There was evidence that nursing auxiliaries were supervised in their performance by professional nursing staff. N/A Clark also stated that she was assessed every six months by the Ward Manager.

191. I accept the PF's submission that there was clear evidence that tasks such as moving patients around the ward, taking them to the toilet, and emptying their stoma bags were not only within the competences of a nursing auxiliary, but were routine tasks which constituted a large part of their daily duties. N/A Clark had worked as an auxiliary nurse for 35 years, and had developed her skills and experience in these duties over that period. Having regard to the nature of the tasks N/A Clark was carrying out at the time Mrs Hattie fell and N/A Clark's evidence about the circumstances, I accept the PF's submission that N/A Clark had the necessary skills and experience to carry out the duties she was performing in relation to Mrs Hattie before she fell.

192. I am satisfied that there was no evidence that would lead me to conclude that there was a defect in the system of training of N/A Clark that contributed to the accident. I also accept that no determination is appropriate in relation to the fact that Mrs Hattie was accompanied by member of staff at the level of nursing auxiliary.

193. I turn now to the issue of the care and treatment of Mrs Hattie by the physiotherapists. This is criticised in the family submission and characterised in one respect as "bullying". It was suggested in the evidence of Mrs Mary Shepherd and is repeated in the submission that the physiotherapy team pushed Mrs Hattie too hard, in that she was made to mobilise beyond her capabilities. Mrs Shepherd said that her mother told her that she felt that she was being pushed beyond her limits. I noted Stephen Shepherd (in his evidence at the beginning of the Inquiry) as saying in relation to what he described as the problem of mobility that Mrs Hattie was keen to recover, but she had to take her time and would not be pushed.

194. There was evidence about this from the witnesses Julie Bridgewater and Shona Manson, who were the qualified physiotherapists who dealt with Mrs Hattie. Shona

Manson did not really remember Mrs Hattie and largely relied on the medical records. Both witnesses gave evidence that Mrs Hattie sometimes required encouragement. They explained the role of the physiotherapists in encouraging patients in their mobility, speaking to the patient, and taking into account their state of mind. Shona Manson's evidence was that no mention was made to her of pushing Mrs Hattie too hard. She would have recorded that, but there was no such record. She described this as a common complaint in physiotherapy. Physiotherapists have to work patients hard to try to get them as close as possible to previous independence, but she would only encourage a patient, never force them. Julie Bridgewater had also not been told of any complaint that Mrs Hattie felt she was being pushed too hard. Her evidence on the question of whether Mrs Hattie was being pushed too hard was that Mrs Hattie was achieving, so they were not asking her to do something that she was not capable of doing. Ms Bridgewater stated that she did not consider that Mrs Hattie was mobilising too fast in the days immediately before her fall.

195. I have referred above to evidence about previous falls that Mrs Hattie had had. There were incidents reported in the medical records (on 13 and 15 February 2006; CP3 pgs1597 and 1601), although it was not entirely clear whether these related to separate incidents. In addition, Mrs Mary Shepherd gave evidence of being told about another fall. There was a suggestion that Mrs Hattie had had an x-ray as a result of this fall. However, as noted above, the medical notes did not support this. I do not consider that the evidence has clearly established that there was such a fall. The evidence of Julie Bridgewater was that, even if it were established that Mrs Hattie had fallen twice on the occasions noted, she would still have attempted to progress Mrs Hattie's mobility as was recorded in the communication sheets towards the end of February. I accept that this was consistent with the evidence heard from witnesses throughout the Inquiry that a patient's mobility could vary quite considerably over relatively short periods of time. It was noted that at the time of the recorded fall on 15 February Mrs Hattie was not properly mobile. Julie Bridgewater commented that there was quite a gap in time between that recorded fall and the fatal fall. There had been quite a significant improvement in Mrs Hattie's mobility in the days prior to 2 March 2006. Julie Bridgewater was happy that this improvement had been managed appropriately, and Dr Primrose gave evidence that such apparently quick improvements in the mobility of patients such as Mrs Hattie were not at all uncommon. He found no fault in the actions of the physiotherapists.

196. Having considered the submissions and the evidence I do not consider that the relevant evidence would justify a conclusion that there was a defect in the system of management by the physiotherapy team of the progress in Mrs Hattie's mobility.

197. In considering whether there was any defect in the system relating to the mobilising of Mrs Hattie, it is necessary to examine also the appropriateness and effectiveness of the arrangements for communication of information, advice or direction from the relevant professionals (the physiotherapists) to the member of the hospital staff routinely involved in mobilising a patient on the ward – in this case Nursing Auxiliary Clark.

198. I heard evidence about the relationship between physiotherapy staff and nursing staff regarding the mobility of a patient. Some physiotherapy notes record what had been achieved in a particular session; others give some form of instruction as to how

the patient should be moved within the ward. It was expected that nursing staff would act in accordance with the opinion of physiotherapists. There was also evidence that there was significant oral communication between physiotherapy staff and nursing staff. Although everything that was discussed in the ward would not be written down in the notes, the important points relating to a patient's mobility should be recorded in the medical notes. The passage of time between Mrs Hattie's death and the Inquiry meant that there was probably less evidence available about oral communication and greater reliance on the medical records. (I mention above, for example, the witness Shona Manson's position about having to rely largely on the records.)

199. Physiotherapy staff were generally only present on the ward from 9 to 5 on weekdays. A patient's mobility would vary over the course of the day and it was clear from the evidence that the nursing staff had to exercise some discretion when dealing with a patient as to the most appropriate way to mobilise them at any particular time. In my view the evidence about this was clearly to the effect that such discretion would only be exercised in the direction of greater caution and not to get patients to mobilise beyond what the physiotherapists had advised.

200. The PF in his submissions deals with the various medical records, to which reference is made above. He identifies a failure to keep the Care Plans up-to-date. As was indicated during the Inquiry and is repeated in their submissions, GGHB acknowledges and accepts that these plans were not updated as they should have been. That failure was unsatisfactory and is deserving of criticism. However, the evidence did not suggest that the staff involved in Mrs Hattie's care were operating on out of date information. Evidence given under reference to the communication sheets showed that Mrs Hattie's mobilization was kept under regular review. The failure to keep the Care Plan documents up to date did not prevent the communication sheets being kept up to date. The communication sheets would typically be updated a number of times each day by nursing and physiotherapy staff and they therefore provided an up to date record of the variations in a patient's mobility. I accept the submission that the information contained within the communication sheets accurately set out the assessment of Mrs Hattie's mobility at the relevant time, and particularly on 2 March 2006.

201. The evidence was that guidance about mobility was taken from the communication sheets and verbal reports at handover meetings. The latter were of particular importance so far as the position of N/A Clark was concerned. Her evidence was that she did not herself look at the communication sheets. Her evidence about how she received information in relation to Mrs Hattie's mobility was that she received this by oral communication at the handover at the start of her shift. This was supported by the other nursing witnesses who were working that night and all the nursing witnesses gave evidence of a system that involved information relating to a patient's mobility being communicated orally at the handover at the end of one shift and the start of the next shift. Dr Primrose described the nursing handover as a "key process" in communicating up to date information.

202. N/A Clark stated that she would keep her own written note of the relevant information passed to her at the handover. The evidence was that such a handover took place at the start of the evening shift on 2 March 2006. As noted above, N/A Clark gave evidence that the information she was given at handover in relation to Mrs

Hattie was that she was able to walk to the toilet with the use of a zimmer frame and the assistance of one member of staff. This reflects the information contained in the last nursing note in the communication sheets (CP3 pg 1625).

203. I have considered the relevant submissions in this regard. My conclusion is that, although the failure to keep the Care Plans up to date was a failure in the operation of the record-keeping system, the evidence about the communication of information did not disclose any defect in the system of communication of necessary, up to date information which contributed to the accident that resulted in Mrs Hattie's death.

204. The PF in the relevant part of his submissions discusses in some detail the use of particular terms in relation to mobilising arrangements – namely "assistance" and supervision". This is also discussed in the family submissions. It was explored with various witnesses to the Inquiry. For purposes of my determination the question is whether the way in which the terms were used amounted to a defect in the system, which was a defect which contributed to the accident that resulted in Mrs Hattie's death.

205. The evidence outlined above refers to the use of the terms in the various entries in the records. There was also evidence from various witnesses who were asked to explain their understanding of the terms. There were some indications from that evidence that the terms were interchangeable in the minds of some staff – as is suggested in the family submissions – but overall there seemed to be a consistent view that "assistance" involved a higher degree of support than "supervision". The witnesses tended to comment that "assistance" (in the context of assisting a patient to walk) would typically involve the nurse physically helping the patient in some way; "supervision" would involve less, if any, physical touching of the patient, but the supervising nurse would be there to assist physically if necessary.

206. The last physiotherapy note on 1 March 2006 indicated that Mrs Hattie required "supervision" mobilising with her zimmer. The nursing note on 2 March 2006 indicated that Mrs Hattie was mobile with the aid of a zimmer and one nurse for "assistance". Whatever the reason for the difference in the two notes (which could have been variability in Mrs Hattie's mobility), the nursing note afforded Mrs Hattie a greater level of support when moving. As has been noted, N/A Clark's understanding was that Mrs Hattie was able to walk to the toilet with the use of a zimmer frame and the assistance of one member of staff.

207. N/A Clark's evidence about taking Mrs Hattie to the toilet did not suggest to me that any lack of clarity about the practical application of the terms in question caused her to misunderstand her duties in that regard. N/A Clark described walking closely with Mrs Hattie to the toilet, with her hand behind her back, close enough to catch her if she had fallen. This was consistent with the understanding of other witnesses to the Inquiry of the term "assistance" in that context.

208. In relation to this important aspect of patient safety, if two different terms are in use in relation to the degree of support for mobilising patients, relevant staff clearly need to have a sufficient understanding of the meaning of the terms and their application to practice. So far as concerns this Inquiry, I do not consider that the evidence has shown a lack of clear definitions which constituted a defect in a system

of working in this case. I am quite satisfied on the evidence that there was no defect in the system of mobilising patients, in relation to the meaning and application of the terms "assistance" and "supervision", which contributed to the accident that resulted in Mrs Hattie's death.

209 For all the reasons set out above, I have concluded that no determination should be made under section 6(1)(d) in relation to the care provided to Mrs Hattie by the hospital staff relating to her mobility.

210. I have dealt in the foregoing section of my determination with the question of the post-accident observations of Mrs Hattie and concluded that no determination under section 6(1)(c) is appropriate in that regard. The arrangements for observation and for recording observations were a system of working, which is therefore also relevant for consideration under this head of the Act. I refer to my discussion of this matter above. Although the evidence suggests that the operation of the system of recording observations on the night in question was unsatisfactory there is in my view no basis for any finding that there was a defect in the system which contributed to Mrs Hattie's death.

Section 6(1)(e): Any other facts which are relevant to the circumstances of death - intravenous fluids should have been administered to Catherine Hattie soon after her accidental fall

211. No determination under this head is sought in the submissions for the Procurator Fiscal, other than as a fall-back in relation to intravenous administration of fluids at an earlier stage in the treatment of Mrs Hattie after her fall. The position of GGHB in that regard has also been noted above under section 6(1)(c). The principal position of GGHB in their submissions is that no determination is proposed. I accept the submission on behalf of Dr Wong and Dr Helps that there are no other relevant facts which require reference to them under section 6(1)(e). I have considered the various submissions for the family under this head, but I have not identified in those submissions any matter on which I think it appropriate to make a determination. I do, however, consider that the point about earlier intravenous administration of fluids is a fact relevant to the circumstances of the death, which is appropriate for inclusion under this head of my determination. I accept the clear and unshaken view of the expert witness, Dr Primrose, that intravenous fluids should have been set up and administered soon after Mrs Hattie's fall, rather than at 11.50pm when they were first recorded as being administered. This would have been a reasonable course of action in the circumstances, albeit that any potential benefit in terms of outcome was only remote, and not a real or lively possibility.