# DETERMINATION UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 INTO THE DEATH OF JAMES MAUGHLAND

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**SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNDEE**

**DETERMINATION**

**BY**

**IAN DUNCAN DUNBAR, Solicitor**

**Sheriff of Tayside, Central and Fife**

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

**Into the death of**

**James Mauchland**

DUNDEE 7 March 2003.

The Sheriff, having resumed consideration of the Inquiry, FINDS AND DETERMINES in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Section 6(1) as follows: -

- In terms of Section 6(1)(a): James Mauchland, who was born on 11 March 1943 and lived at 5 Canning Place, Dundee died in Ninewells Hospital, Dundee on 9 January 2000 at 03.15am.
- In terms of Section 6(1)(b): the causes of death were
- Acute tracheobronchitis and acute bronchopneumonia.
- Immobility secondary to (a) cervical cord syndrome and spinal injury due to hyperextension of the neck, (b) acute infection, (c) peripheral neuropathy, (d) depression and (e) malnutrition.
- In terms of Section 6(1)(c): there were no reasonable precautions whereby the death might have been avoided.
- In terms of Section 6(1)(d) there were no defects in any system of working which contributed to the death or any accident resulting in death.
- In terms of Section 6(1)(e) I find that the following facts are relevant to the circumstances of death:-
- In light of the passage of time between the death and this Inquiry and the activity of the Scottish Executive and Scottish Parliament in relation to the treatment of those with learning disability and mental illness, it is not appropriate or necessary to comment in detail on matters in this case which have been, or are currently being, addressed by the Executive or Parliament and in that regard I would refer to the Adults with Incapacity legislation and the work of the Millan Committee.

- Hospitals (other than psychiatric hospitals) should review how they deal with the admission of patients with learning disability or mental illness and devise a protocol for identifying such patients and to ensure that there is proper communication with them not only on admission but throughout their stay in such hospitals.
- Where there is a patient in a general hospital who is learning disabled or suffering from mental illness, doctors and nurses should take care to pay attention to close family members of the patient who may be the only effective mouthpiece for the patient. In such cases the fact that communication is coming from a family member should be noted in both the medical and nursing notes in such a way that anyone looking at the notes would be aware that was the case and that information regarding the patient may not be coming from the patient himself.
- What is said by family members on behalf of the patient should be carefully recorded in notes in such a way as to make it clear to anyone reading the notes in future that the information may have been obtained otherwise than from the patient direct.
- Patients with learning disability or mental illness who require to be treated in a general hospital should, where possible, be treated in open or general wards and not side rooms. This would minimise the risk of the patient, especially one who will not or cannot communicate effectively, being isolated and would reduce the risk of matters which an otherwise well patient might be able to draw to the attention of nursing staff being missed or ignored.
- Where such a patient is admitted to a general hospital more care should be taken to make sure that everyone who might be involved with his or her care is fully aware of how the patient's learning disability or mental illness presents and of any specific problems which may be encountered as a result of such disability, illness or presentation.
- Where there is a difficulty in communication with such a patient, steps should be taken as early as possible on admission to note such difficulty in a prominent place in the medical and nursing notes. Thereafter steps should be taken to ensure that the patient has access to appropriate advocacy services especially where there is no close relative who can act as advocate.
- Consideration should be given to the feasibility of specialist nurses (with appropriate training in learning disability and/or mental illness) being available in general hospitals to assist with patients who have a learning disability or a mental illness. This would be more important where the patient has no close relative or friend to assist in communication with medical or nursing staff. I understand that this may be an area which the Scottish Executive has addressed in its considerations. If it is then I would urge that it be treated with a degree of urgency.
- Where doctors or nurses become aware that nutrition is an issue in relation to a patient steps should be taken at the earliest stage to involve a dietician and to ensure that the patient receives an adequate diet. In this case the fact that nutrition was an issue was known both on the second admission and on the third admission on 15 December yet it was not until 20 December that a dietician saw the deceased. Even then feeding was problematic and it was 30 December, following an apparent failed attempt at nasal gastric feeding before a PEG tube was fitted to allow direct feeding. The medical and nursing notes in this period make little reference to the poor nutritional state (other than in the

specific area of the nursing notes dealing with nutrition). It is not clear if there is any standard practice where nutrition is an issue with a specific patient. Nurses have the closest day to day involvement with the patient and will see what he or she is eating. In this case the deceased required to be fed and his poor consumption must have been clear. In addition, if the family evidence is accepted, there were numerous comments made about his nutritional state and it was family members who completed some of the information about his nutritional intake. A protocol needs to be developed whereby nutritional issues are identified and acted upon at an early stage of admission to hospital. Someone, be that a doctor or nurse, should be given specific responsibility for monitoring a patient's nutritional status, making a proper record of same and drawing it to the attention of those responsible for treatment. Given some of the comments I make later regarding the difficulties with the nursing notes it would do no harm to identify a form of note dedicated solely to nutrition and designate an appropriate person to maintain that note and accept general responsibility for ensuring that sufficient nutrition is achieved.

- A study should be undertaken with a view to developing a standard system for the keeping of medical and nursing notes in general hospitals. While the "activities of daily living" system of note keeping may have some merit, it was clear from both evidence and the notes themselves that entries were quite regularly made in the wrong place. They appeared to my untrained eye to be complicated, perhaps unnecessarily so. They were hard to follow in any logical way. It was almost impossible to look at notes and quickly get a picture of what of relevance or importance was happening in the case of Mr Mauchland. The medical notes do seem to form a continuous record but they are only part of the picture. The system also meant that the notes file quickly became bulky almost to the extent of being unmanageable. By contrast the Liff nursing notes were more in a diary form. I can accept and understand that there may be arguments for a psychiatric hospital keeping nursing notes in a specific way. I found these notes clearer and easier to follow. Whether such a system would lend itself to use in a general hospital where many different medical disciplines may be involved is open to question. Whatever the case it seems to me that there is a strong argument for the system to be looked at with a view to producing a coherent and easily managed system of nursing notes. That may be all the more relevant when one considers the comments I make about the apparent culture amongst doctors to not look at nursing notes.
- Where possible, entries in nursing notes, particularly in the type of notes used at Liff Hospital, should contain the time the note is made and not simply a reference to the date or morning, afternoon or evening.
- It appeared from the evidence that there is something approaching a culture among doctors of not looking at nursing notes. If that is a culture then steps should be taken to eradicate the culture. I accept that time can be at a premium in many instances. Further, if the nursing notes are as difficult to follow as the Ninewells notes here I can fully understand why doctors might be reluctant to devote valuable time to looking at the notes. Where, however, the notes are in the form kept at Liff, where the problem to which a doctor is asked to attend is a medical one rather than psychiatric, I can see little reason why the notes should not be consulted by attending doctors. Here the evidence was that there was a full verbal briefing of attending doctors but a difference in what may or may not have been told to them. Certain relevant information was in the notes although it

was not possible to say what would have been there at the time of various examinations or briefings. Inspection of the nursing notes on 5 and 6 December 1999 may (and I use that word with some care) have given doctors more information and directed them more quickly to the possibility of a neck injury.

- In the interests of both patient care and risk management, appropriate and sufficient resources should be made available to allow all notes to be promptly and properly filed and thereafter kept in an easily accessible form so that they comprise an accurate, chronological and fully detailed record of all matters relating to the patient.
- It was clear that falls happen frequently in hospitals. Many such falls are unobserved. While I have no criticism of the way that the nurses in Liff acted in this case I was surprised at the apparent lack of even basic first aid equipment such as a neck collar. Some falls are bound to raise a suspicion that there may have been a neck/head injury where immobilisation is something which should be considered. We heard that it was almost standard practice if an ambulance was, for example, called to a fall in the street for a neck collar to be applied by paramedics. Dr Durward referred to it as flagging up that there may be a problem. I suggest that, if it has not already been done, attention be given to the provision of such items as neck collars in Liff Hospital and other such establishments where falls are likely to happen. It follows from this that there would also require to be appropriate training of nursing staff.
- It was also a matter of some surprise that, having heard from an expert witness brought in by the NHS Trust about the benefits of a hospital having a falls protocol, that there was no evidence to suggest that any such protocol has ever been considered far less established at Liff. If it has not been done then it should be and, standing what was heard about the number of unseen falls, it should be done with a degree of urgency.
- Where incidents occur which necessitate the completion of an Incident Report form (IR1) and supporting witness statement(s) and a doctor is called to see the patient following such incident, steps should be taken as quickly as possible after the incident to have the doctor see and initial the Incident Report form and any relative statements. I make this suggestion both in the interests of patient management and risk management within a hospital. This will allow the attending doctor to see what has been written about the incident at a time close to the incident and allow him or her to compare that with the information presented at the time of the call.
- A system should be devised which allows patients or relatives to make complaints or observations regarding any aspect of treatment in a manner that is both transparent and easily understood. It is clear that in Ninewells, if a complaint was made to a doctor about something he regarded as a nursing matter, then the complainer was referred in what the doctor regarded as another appropriate direction. There may even have been more than one direction depending upon the nature of the complaint. Patients and relatives should not be placed in the position of having to conduct some form of search to ascertain how a complaint or observation should be made. There should be a system on a ward which is capable of registering all complaints of whatever nature and which explains clearly how complaints are to be dealt with, to whom they should be directed and from whom a response is likely to be received.
- Where a patient is found to have acquired an MRSA there should be clear and easily understood guidelines and advice for the patient and any visitors in

relation to precautions which may require to be taken, hygiene and any other relevant matters regarding prevention or treatment of infection. This may seem obvious but from the evidence there is at least room for doubt if any appropriate advice was given in this case. Further, where a MRSA is found that fact should be flagged up in the medical notes rather more clearly than it was here. References to MRSA were infrequent and there was no indication of its effect or whether or not it was cured.

- Consideration should be given to the possibility of training nursing staff in appropriate wards in general hospitals in the care and management of patients with learning disability or mental illness. Again I understand that this is an area recognised by the Scottish Executive and that action is likely to follow.
- In general terms this Inquiry has caused me to look at the circumstances in which Fatal Accident Inquiries are convened and the matters covered in the course of such an Inquiry. I have a lingering doubt if this Inquiry was actually necessary. It was by no means clear that an accident caused death hence an Inquiry into Mr Mauchland's death may have been justified but it was not the proper forum to conduct some form of public inquiry into the treatment of learning disabled or mentally ill patients in general hospitals. Nor was it the forum in which to examine so many different aspects of medical and nursing practice in different hospitals across the country. The primary legislation covering Fatal Accident Inquiries is clear in its terms and it may be appropriate that guidelines be prepared covering cases where an Inquiry "might" be held as opposed to cases where it "must" be held. Consideration should also be given to procedures. As there are no written pleadings, there can, on occasions, be little to prevent an Inquiry broadening beyond the boundaries of the Act. In a situation such as this case several doctors felt obliged to arrange representation simply because they had, at some stage, been involved in the treatment of the deceased and might therefore be subject to criticism. As the Inquiry continued and the line of questioning from counsel for the family became clear, I became concerned that certain nurses should perhaps have been seeking advice on representation. It has been said before that Fatal Accident Inquiries are not reparation proofs but some of the questioning here was perhaps more appropriate for such a proof. I accept that in some cases I should perhaps have stepped in sooner but once certain lines of evidence were raised they rather assumed a life of their own and each party had to be given the opportunity to examine or cross-examine as appropriate. I would urge that some consideration be given to regulating the evidence and procedure in Fatal Accident Inquiries. Fair notice of criticism which is likely to be made would be a start. There would have to be a corresponding obligation on all parties, particularly the Crown, to disclose all evidence and likely productions at an early stage. Careful consideration should be given before allowing any late lodging of expert reports as witnesses who have already given evidence will not have had the opportunity to comment on such reports.
- If a Fatal Accident Inquiry is to be held then notice of such Inquiry should be given at an earlier stage than at present. The current "normal" timetable does not allow, in a case such as this for all parties to receive adequate notice and have sufficient time to prepare. There is almost inevitably an adjournment. There is also almost invariably, as here, a serious underestimation of the time the Inquiry might take. The initial estimate in this case of between one and two weeks was wildly wrong and meant that days had to be fitted in to an already

> busy court programme to accommodate the diaries of the court, all the solicitors and counsel appearing as well as the many expert witnesses cited to attend. This produced the entirely unsatisfactory situation where we commenced hearing evidence in July 2002 (four months after it was scheduled) and finished hearing submissions in February 2003, more than three years after the death. By giving longer notice all parties likely to be involved will be able to intimate their potential interest to the court at an early stage. I found that holding a "management" meeting before the eventual start of the Inquiry was a useful exercise, although in this case it was too late to have much effect on the timetable. Inquiries should, where possible, proceed on a day to day basis to a conclusion. Accordingly, once there is a realistic estimate of the time required, there should be allocated sufficient court resource to enable the Inquiry to proceed continuously. It is entirely wrong that it should take more than three years following death for this Inquiry to be concluded. If Fatal Accident Inquiries are to be held they should be accorded sufficient priority within the system to enable them to be held a reasonable time after death. In this case the delay must have been a concern to Miss Mauchland, clearly a caring and concerned sister. It must also have been a concern for a number of doctors including young doctors embarking on their careers.

In conclusion therefore I have reached a decision in this determination which I realise will not satisfy all submissions and which, in some ways mirrors the problems faced by the various doctors. I am in particular not satisfied from the evidence presented that there was an accident which caused death. There is no doubt that the fall caused immobility and that immobility contributed to death. The accident caused there to be a very short time later a complete cord lesion. No surgical intervention could have repaired that damage and quadriplegia was then, sadly, inevitable. Given the condition of Mr Mauchland's spinal cord column as discovered in the MRI scan, it seems clear that he was more vulnerable than most to spinal cord damage. Those with such a condition are relatively rare and here I prefer Mr Statham's figures which appear to come from some research, namely 400 in 5 million (0.008%) as opposed to Dr Durward's figures which he conceded were effectively plucked out of the air of 5% to 10% of the population. It is at least possible that the lesion process had begun prior to the fall with the fall being the final event towards completion.

I accept that the immobility arising from the lesion was permanent. But he was suffering from other pathologies which could equally produce immobility. To the best of our knowledge none of these other matters, neuropathy, infection, depression were resolved at the time of his death. It is therefore impossible to say with certainty, even on balance of probabilities that the fall led to his death.

But, as many doctors pointed out, this was a very complex if not unique case with so many different pathologies displaying so many different symptoms some of which were similar to or masked the symptoms of cervical cord damage. I would refer to the descriptions given by some of the expert witnesses as to the complexity of the problem facing treating doctors. It was a picture which baffled experienced consultants in different fields. For example, the presentation when seen by a Specialist Registrar and Consultant Neurologist still suggested neuropathy (as had been confirmed) and the MRI scan was done **to exclude** cord compression.

In short, while there may have been some things which could have been done better and while there may be lessons learned from aspects of this case, I do not believe that there were many aspects other than some relating to nursing care which merit particular criticism.

## NOTE

### Introduction

The Warrant to cite this Inquiry was granted on 15 January 2002 and the Inquiry was originally fixed for 4 March 2002. On a joint motion on behalf of some of the doctors and the NHS Trust, the Inquiry was adjourned to 11 March to allow further time to prepare. On that day, on the motion of the Procurator Fiscal the Inquiry was again adjourned for further investigation. The Inquiry eventually began hearing evidence on 8 July 2002 which was the first date which could be achieved which was suitable to the court and all parties concerned. It is a matter of regret that it took so long after the death of Mr Mauchland for the Inquiry to commence. One of the reasons for delay in matters such as Fatal Accident Inquiries being processed was the disappearance of temporary Sheriffs from the court system and the subsequent pressure on business in all Sheriff Courts including Dundee Sheriff Court. During the disruption caused by the lack of temporary Sheriffs a scheme to prioritise various forms of business was laid down and Fatal Accident Inquiries were given a low priority in that scheme. One of the consequences of this is that Fatal Accident Inquiries, including this Inquiry, are taking place some time after the death and I fully appreciate the distress that this must cause to those involved, especially the family of the deceased.

Once the Inquiry did begin I heard evidence on a total of 26 days, unfortunately not consecutively. The evidence was presented on 8,9, 10,11, 12, 15, 16, 17, 18, 19, 23 July, 14, 15, 19, 20, 23 August, 23, 25 and 26 September, 21, 25 and 28 October, 4 November, 10 and 11 December 2002 and 7 January 2003 and submissions were heard on 22 and 23 January and 21 February 2003. I was very grateful to all parties for preparing and lodging written submissions which I have found very helpful in assisting me to prepare this Determination. Hearing evidence over such a long period was particularly unsatisfactory. It was obvious to me when I received the productions about ten days prior to the commencement of the Inquiry that insufficient days had been requested to allow all the evidence to be heard. Almost as soon as the Inquiry began hearing evidence it became obvious that even more time would be required. Given the pressure on the court programme in Dundee and the difficulty in making available both a Sheriff and an appropriate courtroom, days had to be obtained by creating spaces in the diary often at the expense of other business which had to be adjourned. In addition with so many parties represented it was, on occasions, difficult to find dates which suited the diaries of all parties. It was of great assistance and, fortunately in the event not critical that Dr Abernethy agreed that some of the evidence could be led in her absence otherwise there would have been still more delay. Further, given the delays, many of the expert witnesses required to be rescheduled and, indeed, in the interests of making progress, some witnesses were taken out of order or interposed with another which again was unsatisfactory.

The delays which we have experienced in this matter are unacceptable and can only have added to the distress of those involved particularly the family of the deceased. One lesson which must be learnt from this Inquiry is that when the Crown seeks court dates for future Fatal Accident Inquiries, after appropriate consultation with representatives of interested parties, there should be an attempt made to give a more accurate and realistic estimate of the time the Inquiry will take. Only by giving such an accurate assessment can appropriate court time and accommodation be made available within an already busy court diary. Lengthy Inquiries should in so far as it is possible hear evidence from start to finish on successive days or at least with the minimum of delay.

At the Inquiry Mr S Kirk, procurator fiscal depute, appeared for the Crown; Mr P Grant- Hutchison, Advocate instructed by Enable, appeared for the family of the deceased; Mrs M. Robertson, Solicitor appeared for Doctors Mowatt, Smith, Jones**,** Pullar, Leese and Hamilton; Dr P Abernethy, Solicitor appeared for Doctors Cairns and Pritchard and Miss G Joughin, Advocate instructed by the NHS Scotland, Central Legal Office appeared for Tayside Primary Care NHS Trust and Tayside University Hospitals NHS Trust.

The sister of the deceased, Miss Elizabeth Mauchland, attended the Inquiry nearly every day of both evidence and submissions and I take this opportunity of again expressing to her my sympathy for what was clearly a very sad loss.

In laying out this note I shall firstly recount the witnesses who gave evidence, making comments on certain of them. I shall then narrate the history of events as established in the evidence insofar as it is relevant to the death. In so doing I shall endeavour to give my reasons for accepting or rejecting certain parts of the evidence. Finally I will explain what conclusions I have reached and the reasons for these conclusions. I have not considered it appropriate to make formal findings in fact. By and large the facts relating to the treatment of the deceased from the time of his admission to Liff until his death are not in dispute and I trust that it is clear from what I have to say which facts I have held to be established where there is any form of dispute. I have also not felt it necessary to narrate at length the submissions which were made to me. I received very full written submissions which now form part of the process of this Inquiry and are therefore available for scrutiny. The oral submissions made amounted in the main to amplification and clarification of the written submissions.

One of the difficulties which I faced in making this Determination was coming to a view on conflicts of opinion between different expert witnesses who had, at times, radically differing views on what should or should not have happened at different times from 5 December 1999 to the date of death but especially on 5 and 6 December. For reasons which I hope become apparent in the course of this note I have reached the conclusion that where there was a difference of opinion between Dr Statham on the one hand and Dr Durward on the other that I prefer the evidence of Dr Statham. Further, again for reasons which I hope become apparent, I feel I can take little practical assistance from the evidence of Mr Tullett.

**THE WITNESSES**

1. The first witness was Dr David William Sadler, the pathologist who had carried out the post mortem examination. His post mortem examination report forms Crown production No 1. He gave the cause of death as acute tracheobronchitis which he described as an infection in the trachea and the bronchia. Histology also showed early stages of pneumonia all of which would be expected in someone immobile who could not move or cough or clear secretions. The deceased had a rigid, stiff spine which had lost its elasticity. There was no evidence of fracture in the area of the cervical spine but some greater flexibility at the fourth and fifth vertebrae. There was damage to the spinal cord. He was found to be quadriplegic and that was consistent with the injury to the spinal cord. (I should say that the words "quadriplegic" and "tetraplegic" appear at various times in reports and evidence. As I understand that they in effect mean the same thing, namely paralysed in all four limbs, I intend to use the word "quadriplegic" throughout this determination.) In the course of cross-examination Dr Sadler said that this was the only fatality of which he was aware from this type of injury but non-fatal hyperextension was quite common. Fatalities usually occurred in falls from height on in car crashes in which case there would be other damage and it would be difficult to say if there was cord damage as death would be quick. The deceased further had evidence of osteoarthritis in his whole spine. The injury could not have occurred without the mechanical slipping of the spinal column and his theory was that arthritis at the point had been broken by the fall.

2. The second witness was Miss Elizabeth Mauchland, the sister of the deceased. She said that her brother was a slow learner who had attended a special school. He had been a regular patient in Strathmartine Hospital for about eighteen months before his transfer to Royal Dundee Liff Hospital in November 1999. He had suffered severe depression and the drug regime was having no positive effect. The purpose of his transfer to Liff was for a course of electro convulsive therapy (ECT) with a view to treating his depression. His communication latterly was poor, more so when he was depressed but he could convey what he liked or did not like or what he did or did not want to do. His communication with his family remained relatively good. He was refusing food and Miss Mauchland was concerned about his nutrition. She prepared a statement after her brother's death and this forms Crown Production 6. She read the statement in full in the course of her evidence and I do not intend to repeat it here as it is part of the record of the Inquiry.

She said that before 5 December 1999 her brother had been able to walk and use his arms. When she went with him to Ninewells Hospital on 6 December she noticed what she described as a burn on his left hand. He was operated on and the following day returned to Liff. She said that Dr Jones at Liff had told her that her brother may have had a heart attack and they were preparing to move him to Ninewells. At Ninewells she noticed his legs jerking and she never saw him walk or use his arms again. She was concerned about the lack of movement and said she told most if not all of the doctors he saw on his three admissions to Ninewells about the fall in Liff and the lack of movement. She also told Dr Smith the Consultant psychiatrist at Liff of her concerns. Her specific criticisms were that doctors and nurses did not do their job, did not take care of her brother and did not treat him with any sensitivity. He had a distressing and painful death and it should not have happened. It should not happen again to anyone with special needs. She was critical of nursing care especially in the areas of communication, personal care and general cleanliness. She also requested a specialist nurse from Strathmartine Hospital to help in the

areas of communication but said that was refused by Ninewells. The system failed her brother who had psychiatric and special needs. The lack of communication from him made it more important that doctors and nurses pay attention to what she, in effect her brother's mouthpiece had to say.

She was also concerned about the amount and nature of drugs being given and the fact that certain drugs were stopped giving him withdrawal symptoms. She disagreed with the statement in the nursing transfer letter (Production 5.2.2) that he was mainly bed bound but capable of mobilising. Prior to the fall on 5 December he had lost a lot of weight and was quite frail but she believed he still had a bit of strength. She was not aware that her brother was prone to putting himself to the floor. Her more detailed and specific criticisms are contained in her statement.

3. The third witness was Mrs Carol Maclean a staff nurse employed at Liff at the time. She spoke to the nursing notes and the way they were prepared and kept in Liff. The nursing notes in Liff form a continuous record of events regarding a patient. They are hand-written by one of the nurses responsible for the ward during a particular shift. They are kept separate from the medical notes and it was not generally the practice for doctors to look at nursing notes. Information was conveyed verbally by nurses to doctors (or vice versa) during ward rounds or meetings.

On 5 December she was on duty when she heard a noise. She looked but could immediately see nothing. A patient came and said that a man was lying on the floor. Along with other nurses she found the deceased lying on the floor face down, parallel to the skirting board, arms by his side and with his chin resting on the floor. He appeared uncomfortable and was rolled gently onto his back so he could be assessed. She noticed a small graze on his chin and some blood in his mouth. She was sure his eyes were open but he was not responsive to questions or to painful stimulus. While one of the nurses went to call the duty doctor, Dr Cairns, she and David Burns continued to speak to Mr Mauchland, ask questions and assess him, taking his vital signs. He had been put into a sitting position on the floor and his head had fallen forward. A wheelchair was obtained and he was taken to bed.

Dr Cairns arrived and said that Mr Mauchland was possibly suffering from postural hypotension which had been due to the drug, Thioridazine, which had been administered for the first time earlier that day. Mrs Maclean thought that she had spoken to Dr Cairns relaying how he had presented and she imagined that Sandra Mitchell would have spoken to as she brought him through to the ward. She remembered speaking to Dr Cairns but not what she spoke about. She felt it was significant that the deceased had got up as he seldom got up or walked any distance. She was aware of the significance of the way he was lying on the ground. She could see no reason for not moving him and indeed because of his position they could not properly assess him. If they had thought that he should not have been moved then he would not have been moved.

When Dr Jones was called on 6 December she believed that he was told of lack of limb control but he believed this was linked to his infection and raised temperature. The deceased was increasingly limp and Mrs Maclean described him as being like "a rag doll". He could not bear his weight and appeared to have no control over his limbs. He was in discomfort and wincing when moved. She felt that nurses would

have voiced their displeasure at how he was when they sought medical intervention as they were concerned something was not right.

She said that she had dealt with hundreds of patients who had fallen and that when she saw the deceased she had no worries that he had damaged his neck. There was no neck splint kept in Liff. She had received manual handling training and also training in the use of hoists. If a person was on the floor and it was thought that he was injured, then it was left to training and experience to decide what to do. Liff had no facilities for treating acute medical conditions and if there were medical concerns the practice was to contact Ninewells.

She also spoke of the deceased's habit of putting himself to the ground but she assumed that he had fallen as she had heard a thud. She said that he was being nursed for pressure sores and there was a ripple mattress on his bed. This evidence suggested to me that there was a degree of immobility for sufficient time for pressure sores to have become a problem.

4. Dr Michael Cairns at the time was a new Senior House Officer at Liff. As a Junior House Officer he had some training in general surgery, neurology and general medicine. He recalled being called to see the deceased but his memory of what took place is based entirely on the notes. When he recorded in production 4.22 that the patient "stood up, felt faint and collapsed" he believes he would have got that information from the patient and the nursing staff. Falls are not unusual and the main thing was to exclude bony injury so he did a muscular/skeletal survey. He could not recall a laceration on the chin and had no recollection of the history. He felt that the reason for the fall might have been due to the introduction of Thioridazine. He was sure that the deceased could move all four limbs at the time of his examination. If there was no sign of external injury then it would not be noted.

It was not normal practice to ask for nursing notes and he would have relied on verbal communication. If, on examination, he had concern about the deceased not moving his limbs he would have noted it.

Dr Cairns only became aware of what happened subsequently from the information given to him by his lawyers and he is now also aware of the M. R. I scan.

He was also involved in seeing the deceased on 9 December (production 4.26) and was concerned then about an underlying sepsis. He arranged to transfer Mr Mauchland to Ninewells and wrote the transfer letter (Production 5.1.16). This letter focuses on the hand wound and general sepsis. He had no recollection of meeting Miss Mauchland at that time and did not recall being told during the examination that there was loss of limb control or that he was like a rag doll. If he had been told that when found his arms were by his side and that his limbs were floppy it would have been significant and could have been indicative of cord lesion. He had not seen the nursing notes until November 2001 but accepted that in looking at these notes there would be concern that there was something going on neurologically or possibly a cord lesion. However raised temperature and low blood pressure suggested other things.

He noted from the records that Thioridazine had been commenced or authorised on 25 November and discontinued 5 December. 50mg is quite a large dose for an elderly patient but it was taken as required when someone was becoming extremely anxious. Such a dose had been given at about 1140am on 5 December. It was used as a last resort drug intended to help the patient become less anxious. There are side effects including becoming flatter or drowsy. Postural hypotension is low blood pressure and could be a cause of fainting.

Over the weekend of 5 December he was the Doctor on call for both Liff and Strathmartine Hospitals. He was the most junior member of the staff at Liff having been fully registered with the GMC only since July 1999. When asked again about his examination on 5 December he repeated that the deceased was fully conscious because if he had not been he would have done a Glasgow Coma Scale and as that is not mentioned he must have been conscious. If there was a small, mild graze he would not necessarily have recorded it but would have recorded any abnormalities. The blood pressure readings were low and he had to look for the cause of this and check the medication.

5. Dr Nicholas Jones qualified in 1995 and at that time was SHO in Liff with responsibility for Ward one. He spoke of the concern for the deceased's mental state on his transfer from Strathmartine, the feeding difficulties and the fact that ECT might benefit him. He recalled him as being frail. He did not communicate well with medical staff but seemed to communicate reasonably well with his family. As the deceased was having ECT treatment his care was above Dr Jones level but he still had some involvement in prescribing the drug regime and any changes to it.

On 6 December he referred the deceased to Ninewells after examination. Unfortunately his note of the examination is missing. He had seen him twice early in the morning, had been told of the fall on Saturday and that he had been seen by Dr Cairns. He was aware of the concern that a drug had dropped his blood pressure. In the morning he thought the deceased was fine but by 2 PM when asked to see him again he was complaining of chest pain. He believes he would have examined the heart and lungs, taken his pulse and blood pressure to try to exclude heart attack or angina. Blood pressure was low and he queried a possible stroke. Reflexes were checked and they were normal. He remembered checking the reflexes and moved the arms and legs himself to see if the muscles were floppy or stiff. He was satisfied that muscle tone was normal and on checking the reflexes with a hammer they showed nothing out of the ordinary. He does not recall the nurses telling him that the deceased was floppy. On examination he was not moving well but it was difficult to know if this was simply because he was ill. He was re checked at 4 PM by which time blood had been taken and an ECG carried out. The full blood count was normal. He was however more unwell, complaining of chest pain, looking grey, not moving well and holding himself still. He wrote the admission letter to Ninewells (production 5.2.1). He did not consider the fall to be of significance. If he had been told that he was floppy and limp in all four limbs then that would have been significant when taken along with high-temperature, low blood pressure and the fact that he was generally very unwell but he would still not necessarily relate it to a neck injury and it still could have been a heart attack or septicaemia. He was not given the mechanism of the fall nor was he told that his arms were by his side. He believed that he had fallen before.

When questioned further about his examination on 6 December he said he did not do a full neurological examination as this required co-operation. When testing with the tendon hammer there was a normal plantar reflex. With hindsight if he had known about the severity of the fall Dr Jones might have mentioned it in his letter to Ninewells but his priority was to get an acutely ill man into hospital so much so that he did not want to wait to speak to another doctor before doing so.

6. David Burns was at the time the charge nurse in Ward one at Liff and recalled the loud bang then finding the deceased lying on the floor in the corridor, hands by his side, chin resting on the floor and facing the wall and skirting board. He was sure that he got a response when he asked if the deceased was in pain. He tried to reassure him and, as he looked uncomfortable, moved him on to his back without any apparent difficulty. He was then helped to a sitting position, a wheelchair obtained, and he was assisted to bed. Significantly Mr Burns felt that there was assistance from the deceased as he was being lifted to the wheelchair and that he was able to support part or all of his weight. Mr Burns would not have been able to carry out the manoeuvre without assistance or co-operation from Mr Mauchland. There was a slight graze on his chin and also blood in his mouth. There was nothing which suggested to Mr Burns that he should not have been moved from the floor. When Dr Cairns arrived he remembers speaking to him but not what he told him.

He spoke of the nursing notes, how they are compiled and kept, the medical notes and communication between doctors and nurses. He was responsible for completing the incident report form, IR 1, (production 4.1) and thinks that the information contained in the form would be the sort of information given to the doctor. He did recall that by the time Dr Cairns arrived the deceased had been cleaned up and his vital signs taken. He thought Dr Cairns' examination was a thorough examination, he had no cause to question it and would have done so had he thought it necessary. It would have been routine after a fall to check if the patient could move his legs or arms and while he did not remember this being done he could not remember it not being done and if it had not been done he would have questioned it. He had no cause to question Dr Cairns.

He also gave evidence about the level of observations within the Ward and said that the deceased was observed more than many of the other patients and not left unattended for any period of time. There were three levels of observation, routine, constant and special. The deceased was on routine observation but that did not mean that there was no close eye kept on him. Routine observation means that staff must be aware where a patient is at any given time. When pressed he did not agree that there was any need for increased observation of the deceased.

When pressed about moving the deceased following the fall, Mr Burns said he had not thought of the possibility of a neck injury and, with hindsight, he still did not think so. The deceased was not completely or consistently unresponsive which is why Mr Burns' memory is not particularly good. As he appeared to have control of his limbs Mr Burns did not think there was a major injury. He assumed but could not remember that Dr Cairns had been told of the bang on the under chin. He did not recall the deceased going to the toilet unaided, normally going with the assistance of a nurse or in a wheelchair. He was able to move himself but showed no inclination to

move outwith the dormitory area. If he had been prone to leaving the Ward the level of observation might have been increased.

7.Dr Ann Smith is a Consultant psychiatrist of 22 years standing and was responsible for a number of areas including ward one. She said the deceased had been in Strathmartine Hospital, under her care, from late 1998 and that in November 1999 he had been transferred to Liff, again, under her care. She had been responsible for his care in Strathmartine. On transfer he was seriously mentally ill and deteriorating rapidly having developed depression. It was decided that he needed ECT and the appropriate second opinion was obtained from Professor Reid. He had received five ECT treatments, the last one being on 3 December 1999. Dr Smith was on leave and did not return until the Thursday when she was told that the deceased had been to Ninewells and was now back on the Ward. His general condition had been poor for some time and there were concerns about his health and his fitness for anaesthetic. She considered his depression life threatening, his fluid balance had difficulties, he was eating intermittently and, in the week before, he had a spiking temperature and was becoming frail. The temperature suggested he was developing an infection. In describing his mental condition as "life-threatening" she meant that he was resistant to taking fluids, to eating and refusing to take medicines all as a result of his severe depressive illness. Dr Smith went to the Ward on 9 December to deliver Section 18 papers but she did not do so as he was not well enough to understand. She was disappointed there had been no further ECT and noted that he still had a temperature, was hot and clammy and did not look well. She had a discussion with Miss Mauchland who was worried about her brother's condition but she does not recall being told that he was not moving or having difficulty moving. She had no recollection of being told that he had been found collapsed on the floor. The fact of a fall itself was not significant but if she had known of the fall and that there had been a significant change following the fall then that would in itself have been significant. She does recall reporting the continuing deterioration in his health and having a concern that a diagnosis be made. Dr Jones may have mentioned the nurses were worried about floppiness in his limbs.

She described electro convulsive therapy which induced seizure by electric current and was done under general anaesthetic with the aid of a muscle relaxant. It was usually done twice a week with six to eight treatments the norm. It is an accepted treatment for depression where a patient is resistant to treatment by drugs. The preparation for ECT had commenced in Strathmartine where she had noted an abnormality in the heart rhythm. This may have been drug induced and by the time ECT took place he was on a simplified drug regime.

On 25 November Thioridazine was introduced this being a major tranquilliser with a sedative effect and also offering treatment for psychotic symptoms. Lorazepam is a short acting powerful type of Valium.

Dr Smith was adamant that she did not say to Miss Mauchland that the lack of movement could be shock after a fall as that was an expression a layman might use and not something she would say. She was aware of the progress note from Dr Mowatt (production 4.36) expressing Miss Mauchland's concern regarding Thioridazine and Lorazepam knocking him out and being a higher dose than had been given Strathmartine. His physical state and lack of movement were a concern.

There was no detrimental effect taking the two drugs together but generally it would not be done. Thioridazine has a number of potential side-effects including tremors, stiffness, occasional lowering of blood pressure, possible sedation, cardiac risks and many more

When asked about nursing in Ninewells she said it was unlikely there were nurses there with learning disability experience or psychiatric experience. The deceased's communication difficulties were down to his depression and when well he could converse, was friendly and sociable. It did happen that a nurse could be seconded from Strathmartine to Ninewells but usually only when someone was severely handicapped and she agreed that in the absence of that happening communication with the deceased's sister was important. In the course of cross examination Dr Smith outlined her full responsibilities both in Strathmartine and Liff and confirmed that she had been treating the deceased on and off since the early 1990s.

8. Dr Jane Pritchard was a Specialist Registrar in neurology at Ninewells and first saw the deceased on 20 December 1999. It took her a long time to read the medical notes and she noted the various earlier admissions. When she saw the Glasgow Coma Scale on 15 December it rang alarm bells but the patient must have changed during examination hence the two GCS scores (3/15 and 6/15). She noted in Dr Pullar's note (Production 5.1.45) mention of a fall and possible weakness in limbs which she found significant in retrospect. As there was no elaboration on the type of fall she would have no clue that there was a potential neck injury. If she had the information contained in the Liff nursing notes (4. 143 onwards) that would have been significant. Since they describe that he was weak and limp and unable to stand it sounded as if the fall and his condition were linked. She suspected that as he was unwell the various doctors who had seen him thought of him as weak and floppy in a general way. If she had that information on 20 December it would have assisted her. By the time she saw the deceased it was late in evening and it was clear from the notes that a number of doctors had examined a number of possibilities and many tests had been taken. They were looking at the infectious process and how that affected the brain; they were worried about a possible abscess; the temperature was going up and down; there was to be a CT scan and a lumbar puncture. The deceased was not co-operative with the examination and was upset and tearful and Dr Pritchard therefore had difficulty working out what he could or could not do. She rubbed his chest to see if he could move his arms and legs and he moved his arms some and his legs a lot which she now believes to have been a reflex movement because of the strong response in the legs. She did not get response when she went back. She tapped the tendons which were symmetrical; plantar responses were normal but reflexes reduced. If there was a lesion of the spinal cord she would have expected him to go up and down but would also have expected the reflexes to be brisk. He again had spiked temperature but blood counts were normal although the CRP was high.

She returned come on 22 December and knew by then that the brain scan was normal. He was still difficult to assess and somewhat uncooperative. The arms were particularly floppy although not the legs. Reflexes were reduced especially in the knee and ankle joints. It looked like a neuropathy. At that time she knew of the fall but not a neck injury. During the examination Miss Mauchland arrived and asked if her brother not moving was related to the fall and she described how he had fallen

and landed. Dr Pritchard still had to exclude neuropathy which might have been treatable and requested a number of studies. She wanted to check for Guillain-Barre syndrome and myelopathy. The nerve studies confirmed that there was a peripheral neuropathy. She also ordered on MRI scan the result of which were obtained on 24 December and showed the cord injury.

Dr Pritchard then went on leave until 7 January 2000. Before Christmas the signs were of neuropathy and acute spinal shock but on 7 January the neurology had changed and he had stiff legs with brisk reflexes. The neuropathy could have been long term or recent. The existence of neuropathy and spinal shock complicated the diagnosis. She had never seen it before and for someone other than a specialist in neurology carrying out an examination it would have been very confusing. People could become floppy if very unwell and doctors cannot make much of isolated comments without a full examination. When asked about what was termed "a window of opportunity to operate" she deferred to a neurosurgeon but noted that Mr Page had said on 24 December that he would not operate at that point and that following the death on 9 January Mr El Jamel had said he would never have operated.

The cord injury was only confirmed after 24 December by the MRI scan. By then Dr Pritchard thought that he had a neuropathy which had been confirmed by the nerve tests but she could not say if it was new or old. He also had another illness or Guillain-Barre syndrome which Dr O'Riordan decided to treat just in case. The deceased had two conditions, axonal neuropathy and cervical cord syndrome. In acute stages they can present similarly but after a few weeks cervical cord syndrome changes and reflexes become brisk and the limbs stiffen. In her neurological examination, which was carried out to the best of her ability, she noted that he was withdrawing all four limbs to pain. If the patient has a central cord lesion he can make a reflex response and she was concerned that there was no voluntary effort. She would not expect a spinal injury to lead to reduced conscious level. The signs she got on first examination were of peripheral nerve damage but that would still not account for reduced conscious level nor would Guillain-Barre syndrome. There had to be more wrong with him. He had peripheral neuropathy and cord lesion and he clearly had something which was causing his fever (the cause never being found) and they did not know why he was having reduced consciousness. Dr Pritchard does a neuropathy clinic every week and she has never seen anything like this before.

9. Dr Donald Mowatt was specialist Registrar in psychiatry at Liff having been a GP for 13 years before commencing psychiatry in December 1996. He confirmed evidence of the deceased's mental state and ECT treatment. He was on leave until 12 December. On 15 December he arranged admission to Ninewells and wrote some clinical findings (production 5.1.43). The note describes his overall condition and Dr Mowatt described the deceased as a sick man with a constellation of symptoms. He was adamant that the details of the fall as described in nursing notes were not transmitted to him nor does he believe to Dr Smith.

He recalled discussing the drug regime with Miss Mauchland but did not recall her mentioning that her brother was suffering paralysis. His notes on this were contemporaneous and reflect his recollection. Lorazepam would not explain the

symptoms on 15 December such as high fever or cardiac murmur but might have explained some of the drowsiness.

He kept an active interest while the deceased was in Ninewells and was asked on 17 December to reassess his mental state and this was done on 20 December. His mood was good and there were no psychotic features. He was reviewed again on 30 December by which time Dr Mowatt was aware of the spinal injury and the significance attached thereto.

He was asked many questions about the fall and other entries in the Liff notes and many of his answers were not based on personal knowledge but on reading the notes themselves. He also spoke about the drug regime and suggested that Dr Smith and himself would know rather more about psychotic drugs than an SHO at Ninewells. He also said that low blood pressure was consistent with Thioridazine.

10. Nigel Page was a consultant locum neurosurgeon at Ninewells in December 1999. He had no clear memory of the case and could only recall his involvement from the notes. He saw the MRI scan before he examined the deceased. The scan showed arthritis in the spine which would affect the joints, ligaments and discs. It was degenerative arthritic damage in the cervical column. The scan also showed a lesion which fitted in with the findings of his physical examination with damage being shown at the same level as the examination suggested. He did not feel that surgery would improve the neurological state. His view was that even if he had been seen by a neurosurgeon on 5 or 6 December, if he had been quadriplegic from a traumatic cause then no recovery would occur. He did not think that if the mechanism of the lesion was the fall anything could have been done surgically at the time. The quadriplegia could have taken a day or two develop. He also spoke of the canal being narrow. He had never heard the phrase "window of opportunity" used in terms of spinal cord injury (as suggested by Dr Durward).

When asked to consider the view of Mr Statham that it could have been an incomplete lesion which progressed to a complete lesion he said that was possible but to give a view he would have to look at medical and nursing evidence regarding the state of the patient. If he had been confronted with a case of a partial lesion then three or four days later the criteria would have been stabilisation then continuing to check the stability of the patient. If there was stability surgery would not be indicated. Surgery would be indicated if there was a progression of neurological deficit. In this case it was impossible to say if three or four days after the fall surgical intervention was appropriate. With any cord injury a close eye must be kept on blood pressure. Whether or not moving a patient might cause damage would depend on whether or not there was stability. If there was no fracture, within reason, it would not cause too much of a problem to move him. When he saw the deceased there was no evidence of bone or ligament injury. Looking at Dr Durward's report he commented that where there was a complete lesion he would want to stabilise the patient but the damage had been done. Surgery may be required for stabilisation but there would be no recovery of function. If the lesion was incomplete he would want to investigate and there may be some cases he would want to operate but he believed that the consensus was that the chances of improving by immediate surgery were not good and there was also risk of rendering someone quadriplegic. His position remained that there could have been no surgical intervention. The infection would have to be

taken into account. If the blood pressure is very low then the brain and spinal cord could be affected. In the acute phase a lesion could cause drowsiness if there was also low blood pressure. Even three weeks down the line it was possible that if a patient was horizontal all of the time he could be intermittently drowsy but that could be due to something else.

11. Dr Jonathan O'Riordan was a consultant neurologist at Ninewells having specialised in neurology for 10 years. He was the consultant on call when Dr Pritchard requested an opinion after her examination on 22 December and he saw the deceased and carried out an examination. There was some sensation below C4 but nothing below the upper thoracic; it is difficult to know if he appreciated sensation below C4; there was no sensation in the upper limbs but he could shrug his shoulders; there seemed to be some movement of the hips but it was minimal and could have been reflex. There was a nerve conduction study which showed damage to the peripheral nerves affecting the arms and legs which was consistent with sensory motor axonal neuropathy. A neuropathy is a disorder of the peripheral nerves; myelopathy is a disturbance of the spinal cord. The deceased would not have had the symptoms shown on the nerve conduction study if he had a myelopathy. The original thinking had been whether the symptoms were secondary to the neuropathy but because of the sensory level he was also thinking of cord lesion. He then spoke to Miss Mauchland and learned when he had the fall and the fact that he was mobile before it. He accordingly arranged an MRI scan as suggested by Dr pritchard which was done on 24 December. This showed multiple areas of cord compression at C4 and signal change in the cord. There was evidence of degenerative disc disease. He found it difficult to say if it was something acute which had caused the compression previously. The multiple areas of degenerative disease were of long-standing as was the narrowing of the cervical canal. He was anxious to find out if something could be done about the cord compression and took the scans to a consultant neurosurgeon as a result of which Mr Page examined the deceased. He confirmed the complete quadriplegia and there was no indication for surgical intervention. Mr O'Riordan tried to optimise the neuropathy. On its own that could cause of the weakness, lack of tone, floppiness and sensory loss. He suspected that the cord compression was long-standing and present before the fall and that if the scan had been taken in mid-December it probably would not have been too different from the scan on 24 December. His spine was prone to damage and the compression could have been attributable to the spine alone without any antecedent event. The cord compression was however significant and generally an event would happen to cause it.

When asked about medical intervention and the use of steroids he said there had been some discussion in medical papers but it was not at all clear. When asked about the Liff nursing notes he confirmed it sounded like a fainting type of episode and the description given on page 145 could suggest neuropathy which could cause floppiness as indeed could myelopathy. He rejected the suggestion that the picture painted was "ringing alarm bells for neck injury" but accepted that it could be suggestive of spinal shock except that he could get up after the injury. It was easy to make conclusions in retrospect but it was hard to know what floppiness on its own might mean. On 23 December he found a neuropathy and raised temperature and he also had a compressed spinal cord. He was of the view that the deceased died of tracheo-bronchitis contributed to by the fact that he was immobile. By 23 December

he had a complete lesion. A lesion on its own would not cause drowsiness but there was a lot happening to him in addition to the spinal lesion. By that date the deceased had chronic compression, not acute and it was stable. There was no evidence of a fracture or significant ligament damage. A spinal-cord injury can cause the lowered blood pressure and it could fluctuate.

In this case it was clear there was a neuropathy but other features were not explained by the neuropathy. He was very unwell probably through infection. He had a temperature, a cervical cord lesion, possibly some malignancy causing it all and possibly lung pathology. It was not a clear and unambiguous picture but a complex one in which investigation was needed to ascertain if the neuropathy was drug-induced. A diagnosis of cervical cord lesion was not screaming out because of the neuropathy, infections and other pathologies. There was no point when there was a clear, unambiguous diagnosis of cord lesion until the MRI scan which was taken, essentially to rule out cord lesion if possible.

12. Dr Thomas Pullar is a consultant general physician at Ninewells with a special interest in rheumatology. On being asked to look at the notes on admission he said the examinations were as complete as would be expected for a patient being admitted to the acute receiving ward. The Glasgow Coma Scale is such that it was likely the patient would not be moving his limbs to command. The SHO thought that the overall picture was sepsis or infection possibly secondary to the wound on the left-hand. Other causes were a collapse and the general state shown by the GCS. He had been aware of pyrexia or fever for about a week. The SHO had planned some investigations. There was nothing at this stage to draw attention to a spinal-cord lesion either on examination or from the notes or the information arriving from Liff. He wondered about a CT scan. Some of the investigations did not support infection. On examination Dr Pullar was concerned at the lesion on the left hip and the remnants of the blister on the left palm as both previous admissions had been for infection. He thought the left hip was still infected and that was suggestive of a seeding of the infection and that might have accounted for a heart murmur. The drowsiness might cause concern that the infection had seeded to the brain with a risk of a cerebral abscess. He arranged a CT scan and further blood cultures, arranged for the opinion of a specialist in infectious diseases and looked for an echocardiogram. The index of suspicion of cord lesion was very low but the deceased was very ill with sepsis. There was an explanation for his physical state and the neurological findings by the SHO were not consistent with damage to the cervical cord 10 days previously. If nothing had been done about the sepsis then Dr Pullar suspected that Mr Mauchland would have died.

The CT scan showed the brain was normal but unfortunately a x-ray of the cervical spine was not done as the radiographer felt the deceased would have been unable to co-operate. He was seen next day by another consultant physician who wondered about encephalitis and suggested a lumbar puncture. Dr Nathwani, a consultant in infectious diseases, saw him later and wondered about meningeal encephalitis and, because of his general state, suggested an HIV test. This latter test was negative. When Dr Pullar saw the deceased later he had improved. Immobility can lead to infection most commonly a chest infection or a skin infection caused by pressure to the skin. A catheter can be required and that can also act as a site of infection. As the deceased was answering questions his GCS must have improved. On 17

December there was generally a marked improvement. Dr Pullar wanted a neurology and psychiatric assessment with a view to getting to the bottom of the lack of limb movement. While he had a history of the fall the signs were still against cord injury. As a consultant physician he would not have got a high priority had he requested an MRI scan whereas a neurologist would have much more clout. There was, further, a history of chest infection, the suggestion that there may be a concern for Guillain-Barre syndrome and the matter was referred to the neurologists. Dr Pullar was on leave until 30 December by which time the quadriplegia, peripheral neuropathy and poor mental state had been noted. The pyrexia was not away and there was still concern about the nutritional state. To assist feeding a PEG was inserted and, in the course of this, concern was expressed that there was still a seeding of sepsis plus he was not totally clear of the MRSA bug which he had picked up while in hospital. Dr Pullar saw the deceased again on 5 January 2000 and there was still concern about fluid on the left lung and still a number of matters unexplained. They were still investigating sepsis and his febrile state. Dr Nathwani saw him again on 6 January and there was no evidence of current infection.

There was never any discussion about admission to a high dependency unit or an intensive care unit. He was aware that Miss Mauchland was concerned about nutrition but not aware that she had complained about it. (That may speak volumes about the way that notes are kept). As far as admission to an intensive care unit was concerned Dr Pullar was of the view that Mr Mauchland would not have qualified for consideration as his breathing was not compromised. In the absence of any contrary view from an intensive care specialist at Ninewells, which is after all the only general hospital which concerns this Inquiry, that is a view I accept.

When Dr Pullar found out that Mr Mauchland had died he asked one of his team to contact the procurator fiscal as he noted a death certificate had been issued. He first became aware of Miss Mauchland's concerns when he read her statement for this Inquiry. He accepted that her question as to why no one was paying attention to her was a reasonable one for which he had sympathy. He recalled discussing matters with her including nutrition but he would not have used an expression like "there is no time to lose". He may have said that the deceased would not be able to fight infection if nutrition was not improved. He does not recall a request for a Strathmartine nurse but agreed it might have been appropriate. He himself has limited experience of learning difficulties and could not remember individual cases where a nurse was brought from Strathmartine. The picture here was that in the first 24 hours after admission the deceased had seen three consultants, had a chest x-ray, had a lumbar puncture, an ultrasound scan of the abdomen, a CT head scan arranged, a request made for a cervical spine x-ray, an infection screen, full blood count, had an infectious diseases consultation, HIV test, antibiotic therapy, attempted but not successful echocardiogram, IV fluids started, EEG noted, subcutaneous heparin started, blood pressure monitored and urine output charted hourly. By 17 December doctors had excluded cerebral abscess, chest infection, meningitis, encephalitis, head injury, HIV related illness and abdominal abscess. The infection was improved but not excluded. Psychiatric and neurological consultations were sought.

13. Dr Graham Leese is a consultant physician with some training in neurology. He saw the deceased quite soon after his arrival in Ward 15 on his first transfer from Liff.

He was concerned about chest pain, temperature and low blood pressure which suggested significant sepsis. The swollen left hand was a priority issue. There was nothing which might have suggested a spinal-cord lesion. His condition was all explained by sepsis and high temperature. The drowsiness could have been caused by medication or sepsis. He was generally unwell. He does not remember the deceased not being able to use his limbs. The problem with the hand looked serious and Dr Leese was concerned that if something was not done soon he might lose some hand function in the longer term. From the tests carried out he had less concern about chest pain or heart attack. Care was transferred to a surgical ward and he was not back on the ward (15) when the ward round was carried out the following day. He specifically did not remember the limbs jerking and if they were and he had noticed he would have considered a neurological examination.

14. Sandra Mitchell is a psychiatric nurse who was on duty on the day of the fall. She spoke to hearing the bang, looking and not finding anything then a patient coming to ask if they (the nurses) were aware that someone was lying in the corridor. She spoke to the deceased being rolled carefully onto his back, a pillow being put under his head, testing for blood pressure, placing him in a wheelchair and being taken back to bed in the ward. The small graze under the chin required a wipe. She contacted Dr Cairns and spoke to him when he arrived but could not remember what she had said. She went off shift at 9 PM and does not remember Mr Mauchland's condition at the time. She does not think she had any dealings with him after Dr Cairns was with him. The following day she could not recall if she was on duty or if her attention was drawn to the frail condition or lack of limb control. She recalled seeing a rash on the arm and going for a sheepskin for the elbow.

15. Dr Stewart Hamilton who is now a specialist Registrar in plastic surgery at St John's Hospital, Livingston said he had no specific recollection of this case but had seen the abbreviated form of the notes about two weeks prior to giving evidence. He noted the admission of Mr Mauchland and a degree of urgency with high temperature and infection. There was a collective decision to operate. He had no recollection of talking to the deceased's sister or of being told of a fall. In the course of the operation he was surprised not to find pus. The general anaesthetic was by intubation and there would be some neck extension. There was no diagnosis on discharge. On 9 December he was readmitted to the Burns Unit which, with hindsight, may not have been the best place for him; a general medical ward might have been more suitable. He had pain in his hand, was unwell and had a temperature; there was description of flaccid tone which might have indicated immobility. It was not understood why he was unwell and therefore a medical opinion was obtained which was pyrexia of unknown origin.

16. Sharon McGurk is now a community mental health nurse but was, in 1999, Mr Mauchland's key worker in Liff. This does not mean that she necessarily had more contact with him because the care was done as a team. He needed a lot of basic nursing care. He was difficult, had changeable moods, was irritable, could be agitated, often required feeding and care had to be taken that he had sufficient fluids. He was normally nursed on top of his bed or on a chair beside the bed. He was not very mobile and only went very short distances. He had difficulty getting off and on his bed. On 5 December she was due to go off duty at 2:30 PM but recalls seeing him in the corridor with nurses in attendance. The other nurses told her they would

manage and she should go. She returned to work on the Thursday and was told Jimmy was in hospital. He did not lack limb control before 5 December but could be resistant at times. On 9 December she arranged a meeting between Miss Mauchland and Dr Smith. She did not remember Miss Mauchland saying she was concerned about Jimmy's mobility, floppiness or a fall. If it had been said she thought she would have remembered it. She documented things well. If the limbs were floppy she would have documented that and she has not done so. She could not however recall seeing him moving his hands or getting out of bed after the fall. He could move his limbs on 5 December but she could not say on 9 December. He was responsive to touch on 5 December but there was nothing to say he was not on 9 December. Even before 5 December he spent a lot of time in bed and the fact that he did not move his arms of legs did not mean he could not do so. The fact he was being fed by nurses was not unusual.

17. Grigor Grant was a staff nurse at Liff and spoke of the ECT treatment. He could not recall the deceased's physical condition.

18. Valerie Donnachie was a staff nurse at Liff normally working night shift. She said that the deceased mainly stayed in his bed. She had no memory of him putting himself to the floor but this was recorded in the notes and she agreed that this could be suggestive of a fair degree of mobility. Overnight on 5/6 December when the notes say "on rising for toilet" (Production 4.144) this was to a commode at the side of the bed but she recalled he was able to stand and manoeuvre off the bed with minimal support. He was weight bearing but limp and pale and did not look well.

19. Agnes Stewart is a friend of the family and a retired ward clerkess in admissions at Liff. She spoke of the deceased being normally communicative, affectionate, happy and liking to dance. When in Strathmartine his condition varied, some days high other days very down. In Liff there was a marked deterioration in his condition. She was pleased when he went to ward one at Liff as there would be specialist attention and he was very ill. She saw him there twice before 5 December and was shocked at how bad he was. She also visited him in Ninewells and he was in poor condition. She took his hand and when she released it, it fell; it was obvious he could not do much by way of movement. Mrs Stewart did a show on hospital radio on Mondays and saw Mr Mauchland after her show. After 15 December he was in a side room which she felt was not clean with bits of twine and swabs around the floor, curtains and blinds often closed and, on one occasion, the window open, cold and Mr Mauchland lying without a top and with the bedding lower than she felt was necessary for decency. She could never find the call button. She felt that "a little TLC would not have gone amiss".

20. Agnes Munro is a cousin of the deceased and visited him four times a week in Liff where she found him depressed and with problems with his eating although she described the nurses as being very good. She went to Ninewells on 6 December and said that he appeared to be in a trance and his legs were jerking violently and no one seemed to notice. On the second transfer she was concerned that there was an over prescription of drugs but is not sure how she knows that. After 15 December she was at Ninewells every evening and spoke of one occasion when he had nothing on, the room was cold and the window open. Feeding was a problem. He was not moving and was saying his neck was sore. She described the side ward as "disgraceful" with

plastic containers in the sink, pieces of drips and medication on the floor, an occasion when urine was leaking from the urine bag. There was no buzzer in the room, the door seemed permanently closed and the blinds always pulled down. He was not turned in bed as required and although aware there was a MRSA there were no instructions to visitors as to hygiene and cleanliness.

In reviewing Mrs Munro's evidence I have no doubt that she was very caring and well intentioned but it was difficult at times knowing how much of her evidence came from first-hand actual knowledge and how much might have been what other people have told her. I do however accept her evidence in relation to care concerns.

21. Dr Alastair McConnachie is now a specialist Registrar in general medicine and infectious diseases and in 1999/2000 was SHO at Ninewells in wards one and two. On 16 December he was working for Dr Pullar. He could not remember discussing Mr Mauchland with Dr Pullar, had not seen the notes before and spoke only to the entries made in the notes. He vaguely remembered a meeting with Miss Mauchland and had no real memory of a complaint. It was unlikely that he examined Mr Mauchland. He was present when the lumbar puncture was done and Mr Mauchland did not respond a great deal. He did say that he was a very junior doctor at time and would not expect to be making major decisions regarding care. However, given that his recollection was, to say the least, sparse there was little that he could add to evidence that had already been given.

22. Ian Brown is a support worker with Gowrie Housing Association and became Mr Mauchland's key worker. He found him amiable with a bright personality but challenging in his behaviour. He went through periods of withdrawal and became more introverted and developed phobias with increased unreasonable expectations. At the end of November he was not well at all and fairly immobile. He visited him on 9 December and found him looking very poorly. He was less coherent, less interactive with no movement and little or nothing in terms of grip.

23. Mrs Yvette Anderson, a senior staff nurse, was named nurse in ward 2 at Ninewells. She had some training in learning disability and psychiatry. She had only a vague memory of Mr Mauchland. She did not remember him communicating, had no memory of him being mobile and that he was nursed in his bed. She did not remember Miss Mauchland making any specific complaints regarding standards of nursing care. He was in a side room and it may have been that was the only place where there was a bed although the rooms are also used for MRSA patients. She did not remember if she ever saw him wearing a top but he may have had a temperature in which case excess clothing or covers would have been removed and a fan put in or the window opened. The room would be cleaned daily and she did not remember swabs or other rubbish on the floor. She went through the various pages relating to the care plan (Production 5), said there was no practice of obtaining nursing notes from another hospital such as Liff and that she was not aware of any change of practice regarding nursing notes. She had not heard of nurses from Strathmartine being assigned to Ninewells. The call buzzer was on the wall attached with a lead.

24.After evidence from non-expert witnesses had been concluded Mr Grant-Hutchison asked to call the patient who had found Mr Mauchland on the floor. I was conscious of the sensitivity of the involvement of Stephen Donnett given that he was

a patient in Liff and had initially declined to be involved in the Inquiry after he had been cited. I decided nevertheless to allow him to be called. He said that several weeks after the incident he was approached by the police who asked him for a statement but he said that he had no recollection of events. He was unwell the time and had no nurse or friend with him. Over the following two weeks some of the nurses asked him about it and it vaguely came back to him. He had spoken to the solicitor for Enable at an earlier stage and, having said he would not appear, now thought his evidence might be helpful and he felt guilty about not appearing. In December 1999 he was suffering from a form of psychosis. He said he saw a man falling but when shown photographs of the deceased did not recognise him. He had seen a man he thought was elderly shuffling towards him and then falling face forward. It was more a collapse than a trip. His face hit the ground and he found this quite frightening. Having gone towards him, knelt down and seen a lot of blood he was quite disturbed so went to get help from a nurse. He was flat on his face with his arms by his side and moaning a bit. He conceded that he had read something in the newspaper about this Inquiry and that made him feel guilty about not participating.

That concluded the factual evidence in the matter. The remaining witnesses were expert witnesses all of whom, with the exception of Mr Michael Brown and Mrs Carol Ledingham, nursing experts, produced reports which are part of the process in the Inquiry. I do not intend therefore to narrate at length the expert evidence. I am of the view that all witnesses who gave factual evidence were, by and large, credible and reliable and endeavoured to give evidence from the best of their recollections. It is however worth noting that, largely due to the passage of time, many of the medical witnesses could not recall the case and gave evidence having refreshed their memories from the notes. It was apparent in some cases that they were simply rehearsing what was in the notes and, in effect, saying that if it was in the notes then that must have been what had happened.

I have some reservations about Mr Donnett mainly because he was, by his own admission, very ill at the time and he had told the police that he could not recollect anything.

There is one glaring area where there was an apparent discrepancy between Miss Mauchland on the one hand and many of the doctors and nurses on the other hand. That relates to the area of communication. Miss Mauchland was very clear both in her written statement and her evidence that she told virtually every medical professional involved with her brother that he had had a fall, was complaining of a sore neck, that he was unable to move his arms or legs and asking whether this immobility was related to the fall. Few of the doctors and nurses shared this recollection especially prior to the involvement of Dr Pritchard. I find it difficult to believe that so many doctors who have given evidence are either mistaken or lying about such conversations with Miss Mauchland. Many simply could not remember. Yet equally I am in no doubt that she would have expressed herself strongly when she felt that necessary or appropriate. The history which she has written and which forms Crown Production 6 is a helpful document but it is not a contemporaneous note made on a day-to-day basis in the form of a diary. It is a clear and well-prepared history drawn up after an event which must have been disturbing and traumatic for Miss Mauchland. It seems likely that she has mentioned the fall and her brother's apparent inability to move his arms of legs and the possible connection

between the two to some doctors and/or nurses but I find it difficult to say with any certainty, except where I have noted it herein, to which doctors or nurses such comments were made. Sadly, one of the matters which I must determine following this Inquiry is whether there would or might have been any difference to the eventual outcome had a doctor been told or appreciated that there had been a fall and that this might have a direct bearing on Mr Mauchland's immobility.

I was reluctant to allow the late lodging of expert reports after the commencement of the hearing of evidence. That gave rise to the possibility that witnesses might have to be recalled. I was particularly unhappy that an attempt was made some months after the beginning of the Inquiry to lodge an expert nursing report and refused to allow it. Fair notice should apply in Fatal Accident Inquiries just as it does in other forms of procedure.

I stated earlier that I would not narrate at length the evidence from the experts, with the exception of Mr Brown and Mrs Ledingham who did not prepare and lodge reports. It is appropriate however that I make a few comments about the expert evidence since there was a significant difference in the approaches taken by and the opinions of certain of the more crucial witnesses. I was grateful to the agents for agreeing to facilitate the experts in giving their evidence by taking them when they were available rather than strictly in order. Experts were led by the Crown, on behalf of the family of the deceased, on behalf of certain doctors and on behalf of the NHS Trust. The experts we heard from were as follows: -

(a) William Farquharson Durward, consultant neurologist, Glasgow Royal Infirmary.

(b) Patrick Frances Xavier Statham, consultant neurosurgeon, Western General Hospital, Edinburgh.

(c) Colin John Mumford, consultant neurologist, Western General Hospital, Edinburgh.

(d) William M Tullett, consultant, Accident and Emergency Department, Western Infirmary, Glasgow.

(e) Alistair Dorward, consultant physician, Royal Alexandra Hospital, Paisley.

(f) Michael Brown, Senior Nurse (Clinical Development), Lothian Primary Care NHS Trust, Edinburgh.

(g) Carol Ledingham, Clinical Nurse Manager and Clinical Head, Woodend Hospital, Aberdeen.

A great deal of what the expert witnesses had to say is contained within the body of the reports and in the written submissions prepared by the agents. Mr Brown and Mrs Ledingham spoke largely of nursing practice and I will refer to their contributions when I deal with the relevant areas. I do not doubt for one moment the skills and expertise of the various medical witnesses who gave expert evidence. I found Dr Statham, Dr Mumford and Dr Dorward the most helpful with Dr Statham in particular giving evidence which I found to be relevant, authoritative, relatively easily

understood and, above all, helpful. Further, where there was any conflict of evidence between the experts I have tended to prefer Dr Statham. I found the evidence of Dr Durward in many ways quite extraordinary. In his report he was very quick to criticise the various aspects of the treatment of the deceased both in Liff and Ninewells. For example, on page 1 he states *"the key event which resulted in Mr Mauchland's death some five weeks later was a fall on 5th December 1999."* On page 3 he expresses a doubt as to whether Dr Jones carried out an examination of the deceased on 6 December and if he did so it was *"intrinsically incompetent"*. He then goes on to say *"Mr Mauchland had the misfortune on 6 December 1999 to move from the care of one specialist (blinkered) group to another specialist (equally blinkered) group."*

In the course of his evidence Dr Durward was certainly forthright in his views offering strong opinions on almost every aspect of the treatment afforded to the deceased, or perhaps not afforded to him, including areas which were, by his own admission, outwith his own area of expertise. Quite how much of what he was offering by way of "expert" evidence was textbook rather than experience based was difficult to know such was the strength of his opinion. It could in fact be said that some of his view was equally, to choose his own word, "blinkered" as he repeated the mantra that an injury to the head should always give rise to suspicion of an injury to the neck and therefore an injury to the cervical cord. He seemed to either ignore or have no regard to everything else that was wrong with Mr Mauchland and which, if left untreated might well have caused him to die in any event. He spoke of there being "a window of opportunity" in which to intervene in a spinal cord injury and he also gave evidence about the use of steroids. The other expert witnesses and medical witnesses were at best sceptical about both and it may be that the evidence about the use of steroids is from little research. I was also unsure about his own experience of the use of steroids which may, in fact, have been very little.

A number of the agents expressed criticism in their submissions about the evidence of Dr Durward with Mrs Robertson perhaps expressing the strongest criticism on pages 7 and 8 of her submission. I regret to say that I agree with her criticisms and feel in the circumstances I cannot attach great weight to his evidence.

For reasons which I will come to shortly I similarly feel that I can gain little from the evidence of Mr Tullett. The fact was that Mr Mauchland never went to Accident and Emergency and in particular never went to Ninewells Accident and Emergency. Whether or not he should have done is certainly relevant but beyond that I felt there was little assistance to be gained from Mr Tullett.

## SUMMARY OF EVENTS

James Mauchland was born with learning disability and had been a patient in Strathmartine Hospital for about eighteen months up to November 1999. He became increasingly ill with a depressive illness and he was not responding to the regime of drug therapy prescribed by his consultant psychiatrist Dr Smith. It was decided to transfer him to Royal Dundee Liff Hospital ("Liff") in terms of the Mental Health Act with a view to his receiving a course of electoral convulsive therapy (ECT). The appropriate second opinion was obtained from Professor Reid. He was transferred to Liff on 17 November 1999 and the opening nursing note (Production 4.128) says *"James suffers from affective disorder and is currently depressed, refusing to*

*eat or drink, to accept medication, to mobilise. He has been fed by means of a nasal-gastric tube as per transfer letter, however he has been pulling this out and not tolerating it very well."* The note continues by saying that he required assistance with all aspects of care, feeding and personal hygiene due to his deteriorated mental state. The course of ECT treatment commenced on 19 November 1999 and the Liff notes show five treatments the last one being on 3 December. There was some evidence that one of the treatments may have taken place at Ninewells but the remainder were given under general anaesthetic at Liff.

While in Liff the deceased was receiving a number of different drugs for a number of different purposes. On 5 December there is an entry in nursing notes (4.143/4) suggesting that there were noisy outbursts and he appeared distressed at times. He was given 50 mg of Thioridazine at 11:40 AM. An entry in the afternoon, which from the evidence occurred before the shift change at 2:30 PM, states *"Jimmy was found on the floor at the side of the door, arms by his side and face against the skirting board".* The nursing staff moved him on to his back to make him comfortable and he was responsive at that time. A small cut was noted under his chin and blood in his mouth. He was assisted to a sitting position and his head fell forward. He was at that time unresponsive to staff talking to him or pain, pinched thumb. He was then assisted to a wheelchair and taken to his bed. Vital signs were taken and Dr Cairns contacted. He attended, probably between half an hour and one hour later and examined him physically. His opinion was that the deceased had postural hypotension due to the Thioridazine he had taken earlier. The prescription was reduced to 25 mg. Later in the afternoon he was noted as being *"in good spirits talking with staff and responding to banter with staff".* Overnight on 5/6 December he slept well and rose to the toilet. In evidence it was clear this was to a commode by his bed but he had supported his own weight in carrying out this exercise. He was seen to be very pale and unresponsive with a blood pressure of 60/40, pulse 66 and respiratory rate 24. Breathing shallow and rapid. There was little change ten minutes later and Dr Cairns was contacted. He was of the opinion it was postural hypotension and suggested keeping an eye on him, reviewing his readings at 7:00AM. A blood pressure reading at 6:50AM was better but his temperature was high. By 9:00AM temperature was back down and he was responsive and conversing with staff, requesting drinks. As there was an improvement Dr Cairns was not contacted again. The deceased was reviewed by Dr Jones and noted to have a red and white raised rash on his hand, left knuckles, left hip, right armpit and right inner knee. The note says at page 145 *"Dr Jones was informed of Jimmy frail physical condition and lack of all and control. Dr Jones feels this is linked up with Jimmy's infection and raised temperature".* The note says later *"remains floppy and limp in all four limbs, Jimmy also appeared to be in discomfort wincing when being moved especially when being moved into sitting position".* The next day he was again seen by Dr Jones who thought he may have had a heart attack and he was sent to Ninewells where he was admitted to ward 15. In Ninewells Mr Mauchland was operated on for a suspected infection of his hand which infection may have explained some of his other symptoms including high temperature. He was transferred the back to Liff on 8 December. It was clear that he remained in or on his bed, being turned regularly and attempts were made to keep him off certain parts of his body which was suffering from redness and sores.

In a note at 5 PM on 9 December he was said to be hot to touch and with an increasingly high temperature. He was returned to Ninewells and, it seems, admitted to the Burns Unit. This may not have been the ideal place for him but it might have been the only place with an available bed. The main concerns appeared to be pyrexia of unknown origin and a number of tests were carried out. The doctors at Ninewells were unable to produce a reason for the pyrexia and he was discharged back to Liff on 14 December. During the short time that he remained at Liff the family were expressing concern about the drug therapy. It was however apparent that he was still very unwell and on 15 December at about 12:45PM a decision was taken to transfer him back to Ninewells where he was admitted to ward 15. The notes made on admission (Production 5 vol. 1.41-43) show that there was a full examination on admission including an apparent neurological examination with GCS being marked as 3/15 and later 6/15. He is noted at page 43 as deteriorating in overall condition with fever, lesions on the left hip as previously observed, hypotension and rapid respiratory rate. Limited in co-operation with examination.

He was seen by a number of doctors before seeing Dr Pullar the admitting consultant physician at about 18:20 on 15 December. He notes *"fall in the RDLH 5/12/99 -- since then limb weakness. Currently drowsy; pyrexial."* In his note Dr Pullar wonders about cerebral access, orders a CT scan of the head and an x-ray of the cervical spine. Unfortunately the last of these was not done as the radiographer did not think the deceased would be able to co-operate. The next day Dr McConnachie raised a query about encephalitis and also noted *"? Central lesion".* There is also a note of his discussion with Miss Mauchland when she expresses problems with the nursing staff and Dr McConnachie's response. He explained that they *"may not reach a definite diagnosis and that medical technology has its limits. She would not accept this".* A lumbar puncture was done the same day. Over the next two days he was seen by a number of doctors especially Dr Pullar, who, on 17 December, asked for a consultant neurologist to give an opinion. There was no satisfactory explanation as to why it took until the evening of 20 December for a neurologist to appear. While that is an unfortunate state of affairs, there is little to suggest it would have made any difference to the eventual outcome.

Dr Pritchard attended at about 20:00 on 20 December and spent a long time reading notes. From her evidence it was clear the notes were, at best, untidy and, at worst, in a mess. She had some difficulty carrying out any form of examination but returned the following day when Miss Mauchland was present and gave Dr Pritchard a history of the fall. She said that she was aware of the fall because of Dr Pullar's note and I accept that. She noted that in view of the new history she received from Miss Mauchland a MRI scan of the neck may be needed but the signs were not those of myelopathy. Nerve conduction studies were ordered and on receipt of the results they disclosed that the deceased had peripheral neuropathy. That would certainly have explained certain aspects of his presentation. Meanwhile physicians continued to try to get to the bottom of his continuing medical difficulties and many tests were undertaken in that regard. A dietician became involved on 20 December. Again that is a regrettable delay given that poor nutrition had been a concern since the deceased had been in Strathmartine Hospital. It had been noted in the medical notes in both Liff and Ninewells and, in particular, had been noted as an issue in the Ninewells notes both for the second admission and on the third admission.

The MRI scan suggested by Dr Pritchard was authorised by a consultant and the result disclosed a complete cervical cord lesion the result of which was that the deceased was quadriplegic. The neurologists asked for an opinion from a neurosurgeon and on 26 December Dr Page examined the deceased and decided that there was likely to be no neurological improvement by neurosurgical intervention. The deceased remained pyrexial and the cause of this was still unknown. From time to time he developed an infection including, at some point, an MRSA hospital acquired infection, although it is not clear from the notes when this developed or whether it was ever resolved. He continued to be seen by a number of specialists and on 30 December Dr Pullar noted the current problems as (1) paraplegia; Dr O'Riordan was continuing to review. (2) mental state; Dr Mowatt to review. (3) Pyrexia; (4) nutritional status; nasal gastric feeding was unsuccessful and there was to be an attempt to insert a PEG under general anaesthetic. Dr Mowatt in fact assessed the same day and recommended a prescription for drugs for the psychiatric condition. A PEG tube to aid nutrition was inserted that afternoon with no major operative problems.

He had a chest infection which appeared to improve by 1 January 2000. At the request of Dr Pullar he was seen by Dr Seaton on 2 January and he again highlighted the various continuing problems and made a number of suggestions. On 5 January Dr Pullar notes that the chest is much improved compared with 4 days ago. Tests were continuing to try to discover the cause of the continuing pyrexia; the chest continued to be "rattly"; he was seen again by Dr Nathwani, the consultant in infectious diseases. On 6 January Dr Raftery, a JHO, was asked to see the deceased who appeared to be in poorer condition. While the actual figure is not noted the GCS had changed by 21:20. There was no eye opening, no vocal response and no reaction to pain. He was seen later by a SHO who noted crepitation over both lungs. He was in fact seen several times over the course of the night and during the day on 7 January including a further review by Dr Pritchard. There is no further entry in the medical notes until at 03:15 on 9 January a nurse had found him unconscious and he was pronounced dead. There was evidence that there would have been ward rounds and that he would have been seen on 7 and 8 January but the notes of such events are simply not there. Given the detail of the other medical notes I find that surprising. It is quite clear however that his condition deteriorated quickly from 7 January until his death on 9 January.

In the course of the Inquiry criticism has been made by those representing the family of many aspects of the care of the deceased from the time of his fall in Liff until his death in Ninewells just over one month later. There are many issues involved and it is not simply a matter of looking at the fall and his treatment thereafter. He was a man who had lifelong learning disability but it was clear that when he was otherwise well he was capable of living on his own albeit with support. For about eighteen months prior to November 1999 he had however been resident in Strathmartine Hospital. He was suffering from a mental illness namely depression. Drug therapy was proving unsuccessful, he was becoming increasingly unwell and it was decided that a course of electro convulsive therapy should be tried. This is regarded by psychiatrists as a treatment of last resort and, quite rightly, there are a number of protections in place before such a treatment can be undertaken. A second opinion required to be obtained and this came from Professor Reid. The deceased was moved from Strathmartine to Liff where he was detained in terms of the Mental

Health Act, Section 26. Dr Smith felt that his depression was life threatening in respect that he would not easily take food or drink and was becoming frail. The evidence from staff at the Liff painted a picture of a frail individual who did not move very much from his bed or a chair beside his bed, who continued to have nutritional problems and who was at times very resistant. He was known to put himself to the floor. At other times he could be more aggressive and almost violent. He was prescribed a regime of drugs to deal with his psychotic condition and to control his behaviour. He also clearly spent a lot of time in or on his bed as he was receiving treatment for pressure sores.

Completely unknown to anyone involved in his treatment at that time, the deceased had a narrow cervical canal. In evidence Dr Statham estimated that it was about 6/10 the size of a normal canal. This meant that there was reduced space around the spinal cord. If the spinal canal is squeezed it is in an already narrow space and consequently the blood supply, particularly to the central spinal cord is compromised. The scans taken later also showed degenerative changes in the discs of the cervical spine contributing to the narrowing of the canal and compression on the spinal cord. The size of the disc protrusion into the vertebral canal in the deceased's case is quite significant because the canal itself is small. Once Mr Mauchland was in Ninewells on the third occasion and Dr Pritchard ordered nerve conduction studies these disclosed that he had peripheral neuropathy, a condition he had had for an unknown period and could well have had when in Liff. The effect of all this was that Mr Mauchland was probably more prone and more vulnerable to cervical injury. Mr Statham felt that a fall such as that on 5 December might have caused no injuries to someone who did not have such features as Mr Mauchland. The existence of the underlying condition was neither known to those treating him nor could it be said to have been predictable.

Another complication was that there was probably little change overall in how Mr Mauchland presented to staff. He was a sick man anyway and not particularly mobile. In appearance little changed after the fall. Further it was clear that during all three admissions to Ninewells there were a number of health problems including an infection with an unknown cause. These helped to mask his neurological problems and it is reasonable to say that the infection may have been present or brewing on 5 December.

During his time at Liff he had 5 ECT treatments, all conducted under general anaesthetic. There was no evidence about how the anaesthetic was administered and in particular whether the deceased required to be intubated. The process of ECT induces a convulsion which might result in sudden movement of the neck. Such a sudden movement of the neck could have caused damage to the spinal cord but there was no evidence before the Inquiry that such damage was caused or might have been caused. There was evidence that a muscle relaxant is administered before ECT. It was suggested that a muscle relaxant might be given to prevent a convulsion but, as I understand it, that might defeat the whole object of ECT treatment. There was insufficient evidence to enable me to make any finding as to whether or not the ECT treatment contributed in any way to the incomplete and then complete cord lesion. There was also reference to the deceased having what were termed " absence attacks" after ECT treatment. There was little evidence about such

events and I am not prepared on the evidence before me to make any finding about them.

## THE FALL

On 5 December 1999 probably around 1:45/2:15 PM staff in Ward 1 at Liff Hospital heard something like a bang or thud which alerted them and they investigated. They initially found nothing but a short time later another patient came and told them that a man was lying on the floor. The deceased was found lying behind a fire door parallel to the skirting board, arms at his side and with his face down resting with his chin on the floor. Staff spoke to him asking if he was all right and there was some response. As he appeared uncomfortable he was rolled gently onto his back to that he could be properly assessed. He had a small graze on his chin with a little fresh blood and also some blood in his mouth. The on-call doctor, Dr Cairns, was summoned and nurses continued to attend to him. They continued to speak to him and received some response. They sat him up on the floor and as they did so his head fell forward. He was not at that stage responding to painful stimulus. A wheelchair was obtained, he was lifted into the wheelchair and taken to his bed. The evidence was fairly clear that he assisted David Burns who was lifting him and who said he would not have been able to lift him without assistance. Once in bed, within 30 to 45 minutes Dr Cairns arrived and carried out an examination.

The first issue is whether or not Mr Mauchland should have been moved once he had been found on the floor. On this issue a variety of opinions were expressed. Mr Brown, the nursing expert led on behalf of the family of the deceased, said that nurses were trained to make sure that breathing was unobstructed, there was a regular rapid pulse, not to move the patient and to summon help. He accepted that the nurses in Liff may have had to move him onto his back to see if his breathing was acceptable. He did not think that moving him to a sitting position was appropriate as it had been an unobserved fall. He was also concerned that there was no response to painful stimuli. He should have been made comfortable on the floor and immediate help and advice sought. As it was an unseen fall the critical point was the presentation when found and nurses should have assumed some form of serious injury. Telephoning for an ambulance as an emergency was an option for the nurses at any point. Mr Brown could not understand why nurses moved him off the floor but also conceded that training of a psychiatric nurse in 1999 may not have suggested any other course of action. He also accepted that there were many falls in geriatric, psychiatric/geriatric and neurological wards.

By way of contrast Mrs Ledingham had been responsible for producing the Falls Protocol for Grampian University Hospitals NHS Trust, Elderly and Rehabilitation Service. In that protocol, if the patient appears unhurt it is suggested that the patient should be put back on top of a bed with a view to a thorough assessment of physical condition being carried out. If the patient has sustained a bump on the head it is advisable to conduct a set of neurological observations. She found nothing unusual in the nurses' procedures following the fall in Liff. She would have sat him up to look at the cut and to look at his mouth. She had never come across hyperextension injury. She took the reference in the notes to a graze on chin and blood in the mouth to be almost the equivalent of appearing unhurt. It was reasonable to put him into a wheelchair and take him to bed. She said that blood in the mouth did not scream out

that there may be a neck injury. The fact that he was not speaking may have been behavioural rather than physical. Of the 4000 patient episodes, that is situations where persons are found on the floor, in her area in a year, half are unobserved. She had not seen this type of injury.

The medical evidence also fell into two camps, whether moving made no difference or whether he ought to have been left where he was lying until he had been assessed by a doctor. Dr Mumford said that the account of how he was found was of no significance from a diagnostic point of view. Falls in hospital are often unobserved and in his experience patients are not immobilised. He felt that the actions in this case, namely helping him back to bed, were acceptable. It was impractical to give everyone who fell a skull x-ray and CT Scan. There would have to be a high possibility of a head injury/neck injury such as in a road traffic accident. Here such a possibility was relatively small. It was the right thing to do to see if he could be helped to his feet and then watch him. They identified blood pressure and did the right things. He disagreed with the view expressed by Mr Brown. Dr Dorward said that he might not have suspected a neck injury and found it difficult to criticise the nurses for not doing so.

By contrast Dr Durward and Mr Tullett both take the view that he should not have been moved. But Mr Tullett says in his report that the deceased *"did not have an unstable injury to his neck and as such immobilisation, although accepted common practice, would be unlikely to have significantly affected the outcome."* He says however that if the injury had been sustained in a public place to which an ambulance had been summoned then the neck and spine would have been immobilised from the outset. Given his earlier statement, however, it seems likely that immobilisation would not have made any appreciable difference. Dr Durward was even stronger in his view that the deceased should not have been moved until he had been seen by a doctor. He too accepted that the outcome was not likely to have changed but insisted that was best practice and that a neck collar should have been applied not only to give stability but also to act as a warning to those subsequently involved with treatment of the deceased that there may be a neck injury.

What appears to be generally accepted is that whether or not immobilisation had taken place the outcome would not have been radically different, namely that the deceased had an incomplete cord lesion which progressed quite quickly to become a complete cord lesion. There was no fracture and no instability in the neck. The difficulty which I face is to decide whether one set of experts is right and the other wrong and the situation is far from being black and white. As I said earlier I have some difficulty in assessing precisely how much of Dr Durward's evidence comes from personal experience. I accept Mr Tullett's expertise in the area of Accident and Emergency but when dealing with a case of this sort there must be some limitations on that expertise. As I understood it, the nature of Accident and Emergency is that the Department sees, diagnoses, treats and discharges or refers to an appropriate specialist Department. Most head/neck injuries seen in Accident and Emergency are likely to have arisen from some form of trauma or high impact injury arising from an incident such as a road traffic accident. I can well understand that paramedics will be trained to immobilise and that would be the standard practice where a neck injury might be suspected. If my understanding of the role of Accident and Emergency is

correct then as soon as a neck injury has been diagnosed or suspected there, the patient will be referred either to neurosurgeons or to neurologists. The extent therefore of the involvement and experience of an Accident and Emergency consultant in such cases as this is necessarily limited.

By contrast there is evidence from a number of sources that falls in hospital are frequent occurrences. Many such falls are unobserved. Those doctors working on a day-to-day basis in wards where falls occur and Mrs Ledingham, a clinical nurse manager and clinical head of a large hospital with responsibility for 25 clinical areas suggested that the practice adopted in Liff was perfectly appropriate. Falls happen in Liff Hospital. It seems that none of the nursing staff who gave evidence had any medical training or first aid training except as part of the basic training as nurses. They had to apply their knowledge from that training along with common sense when faced with a situation where someone had fallen. There had been some manual handling training and a hoist was available if it was required. It was not required as Mr Mauchland was able to assist Mr Burns in getting himself from the floor into the wheelchair. Experienced nurses, albeit psychiatric nurses, had taken a decision that the best thing to do was to move the patient to his bed. The possibility of a neck injury had not entered their minds. There was support for their course of action from Dr Mumford and Mrs Ledingham both of whom have experience in hospitals were falls occur. There was further support from Mr Statham went I asked him if lifting from the ground to a wheelchair would exacerbate a lesion. He said that the handling side required care but the question was whether there was any reason to suspect a cervical spine injury and he thought in this context that there was not at this time. With loss of consciousness one may be more floppy than usual from the head or neck and that would probably allow the head to fall forward. That they picked him up and put him into bed was a reasonable thing to do.

I take the view therefore that the nurses in Liff on 5 December 1999 acted properly and with all necessary care when they found Mr Mauchland lying on the floor in the corridor and decided to move him with care to his bed by means of a wheelchair.

There may be something to be said for the suggestion made by Dr Durward that where there is a suggestion of a head injury which might infer a neck injury that a neck collar should be applied if only to warn others that there might be a neck injury. I was surprised at the evidence from the nurses at Liff that as far as they were aware there was no neck collar within Liff Hospital. Given the apparent number of falls in hospital it would seem to me to be both reasonable and sensible that neck collars be available as there is not necessarily any immediate access to a general medical service. It stands to reason that some falls might warrant immobilisation and the fitting of a collar.

Counsel for the Trust led Mrs Ledingham as an expert witness and as the author of the Falls Protocol. She tried to set this up as appropriate practice. Yet there was no evidence at all from any source that Liff Hospital or indeed any other hospital in Dundee has adopted a falls protocol. Given the number of falls which apparently occur in places such as geriatric, psychiatric or neurological wards it might be appropriate that all staff are aware what to do in particular circumstances. I would urge that attention be given at an early date to the adoption of an appropriate falls protocol backed up where necessary with appropriate staff training.

We shall never know what caused Mr Mauchland to fall or collapse. It has been suggested that there was a faint or that perhaps he suffered postural hypotension which was drug induced. It is difficult to say with any accuracy precisely what drugs were being administered as part of the drug cardex from Liff was missing from the productions. On 5 December he was certainly receiving Amoxycillin which appears to have been prescribed by Dr Digba and is referred to in Liff nursing notes (4.143). He may also have been receiving Lorazepam although the dosage is not clear. He did receive 50 mg of Thioridazine at 11:40AM on 5 December. This followed noisy outbursts and his appearing distressed at times. It is difficult to say when and if Thioridazine was previously administered. In production 4.75 it is said to have commenced on 25 November 1999 at a rate of 50 mg maximum four per day and it is marked as discontinued on 5 December. It also appears further down the column commencing 1 December although this is marked as "one prior to ECT". The entries at production 4.76 are slightly different in respect that there is only one reference to Thioridazine having commenced on 1 December and related to 25 mg maximum eight per day. In the absence of definite information from the drug cardex about the quantities administered and when they were administered is not possible to comment in any meaningful way on the drug regime. What can be said is that 50 mg were given about two hours or so prior to the fall. It is not clear if this was the first dose of Thioridazine (although I suspect it was not) or simply the first at the increased rate. No matter which of these, the evidence suggested that it was a relatively high dose for someone elderly or infirm. There was no evidence to suggest that it should not have been given with Lorazepam. There was also no evidence of any over prescribing of drugs in Liff. I accept the expertise of Drs smith and Mowatt in prescribing drugs for psychiatric purposes and in the absence of evidence that the drug regime was inappropriate I offer no criticism. It is also clear that Thioridazine can have side effects including a lowering of blood pressure.

Most of the medical witnesses who were asked to speculate why the fall occurred took no exception to the suggestion that it was caused by postural hypotension. That was also a possible explanation for the deceased's head coming forward when nurses sat him up in the corridor. It is also reasonable to say that the postural hypotension was caused by the administration of Thioridazine.

## MEDICAL TREATMENT IN LIFF FOLLOWING THE FALL

I now turn to the treatment of Mr Mauchland by Dr Cairns and Dr Jones in Liff following the fall. Dr Cairns was a new SHO in December 1999 and on the day in question was on call for the whole of Liff and Strathmartine Hospitals. He received a call to attend and arrived probably 30 to 45 minutes later. By the time he arrived Mr Mauchland was in bed. He obtained some information from nursing staff and some from the patient and made a note of his examination (production 4.22). His impression was that the collapse was due to postural hypotension secondary to Thioridazine. The plan was to omit Thioridazine and continue to observe.

There was some conflict in the evidence about what Dr Cairns was or was not told when he arrived at Ward 1. Dr Cairns said he had no personal recollection of the incident, that he was not told of and found no evidence of external injury. The nurses seem to say that they would have told Dr Cairns the same as they entered in the nursing notes. In any event the graze under the chin should have been obvious

although it was accepted that it was a minor mark, that there was not a lot of blood and the deceased had been cleaned up by the time Dr Cairns arrived. In reviewing the evidence of the nurses much of what they have to say is qualified by phrases such as a *"I would have" or "I think that"*. David Burns the charge nurse remembered speaking to Dr Cairns but not what he said to him. It would have been a summary of events but he could not remember the exact details. Carol Maclean at some points could not recall if she had in fact spoken to Dr Cairns but thought that she had and that she had relayed some of the information on how the deceased presented. Sandra Mitchell could not remember what she had said but thought it would be how she had found the patient, what happened to him and she hoped she would have told Dr Cairns matters of significance. After Dr Cairns had been to the ward, the Incident Report form (IR1) and supporting witness statement were completed. The nursing notes were also written up by different people at different times of the day. Reading the nursing notes and the Incident Report form and supporting witness statement together there is a reasonable picture of the information available to the nurses. All the evidence about communication between doctors and nurses suggested that most of the communication and probably the best communication was verbal communication. It is reasonable to suppose therefore that the nurses communicated information to Dr Cairns which was similar to that which they subsequently wrote.

There is something to be said for greater use being made of the information contained in Incident Report forms. They are, as I understood from the evidence, more of an administrative document than a contribution to the medical notes being required for risk management and in the event of any subsequent action. They do however provide a fully detailed description of how the incident has occurred and what happened immediately thereafter. It is as near as can be a contemporaneous note. I can see no harm and, indeed, there may be positive benefit if the Incident Report form is put before the first attending doctor as soon as possible. It should be initialled as having been seen. The benefit would be that the doctor could check what was in the form against what he was told when he attended thus enabling him to change where appropriate any treatment put in place. It would also mean that there might be less doubt about what a doctor attending in circumstances such as we have here was told at the time.

There was nothing to suggest in the evidence of any of the nurses that Dr Cairns did not conduct a reasonable and thorough examination. Mr Burns said that if Dr Cairns had not done something which he, Mr Burns, thought necessary or appropriate he would have told him. Many of the expert witnesses commented on Dr Cairns' assessment of the deceased. Dr Mumford agreed that it was reasonable to attribute the fall to postural hypotension. He felt that the assessment was a high-quality assessment bearing in mind Dr Cairns status at the time. Dr Dorward agreed that the assumption that the patient had postural hypotension secondary to Thioridazine was a reasonable assumption.

Mr Statham also agreed with that view, the examination was reasonable and the fact that he could find no major abnormality was compatible with the sort of injury actually received. Even if Dr Cairns had been told about the cut under the chin or had seen it, on examination the patient could move all four limbs and it was reasonable therefore that he was not alerted to any cervical cord injury.

On the other hand Dr Durward describes Dr Cairns' assessment of postural hypotension as *"speculative comment"*. Yet in the course of his evidence he eventually said that he had no quarrel with Dr Cairns' idea that Thioridazine caused low blood pressure and that in turn caused the fall. He had no credible alternative to offer. When invited to remove the word *"speculative"* he was not prepared to do so but at the same time said that the doctor made a reasonable assessment. I would have found Dr Durward's evidence in this area much more acceptable had he been prepared to modify his view in the light of not only his own evidence but evidence which was put to him from other people. In this area therefore I prefer the evidence of Drs Mumford, Dorward and Statham.

We also of course had evidence from Mr Tullett. Having reflected on all the evidence and the submissions I find myself in some agreement with Dr Abernethy. Mr Mauchland was never sent to an Accident and Emergency Department. To that extent therefore what may or may not have happened had he ever been under the care of Mr Tullett is to a large extent academic. He said in his evidence that he had not been given a witness statement by Dr Cairns yet he had received many other witness statements prior to preparing his expert report. Given the level of criticism that he has for Dr Cairns' examination on 5 December I find that odd. I do not of course know why he was not given a statement but if such a statement was available to those instructing the report it should have been sent. It is quite clear that many of Mr Tullett's criticisms of Dr Cairns are based on assumptions which cannot be borne out in the evidence. I cannot therefore place much reliance on the evidence of this particular expert in this area. It was clear during some of the evidence that there could have been confusion between a high dependency unit and an intensive care unit. Different criteria applied and, for all I know, different criteria applied to intensive care units in different hospitals. The relevant hospital in this case was Ninewells and if admission to the intensive care unit was to be an issue then evidence from that hospital would have been helpful. As it was Dr Pullar was clear that as far as he was concerned Mr Mauchland never fulfilled the criteria required for admission to intensive care in Ninewells. I accept his evidence. He further said that he had no recollection of it being discussed. If it was not something which entered his thought process in the care of Mr Mauchland it is not likely to have been discussed in any depth if at all.

Dr Cairns was next involved at around 6 AM on 6 December when he was contacted after Mr Mauchland was checked after having risen to the toilet and was found to have very low blood pressure. When he received the information on the telephone he thought it was again postural hypotension but could not rule out a vasovagal attack. He suggested monitoring, reviewing recordings at 7 AM and if there was no change to re-contact him. The blood pressure in fact increased to 98/45 within 50 minutes and by 7 AM the patient had a very high temperature and respiratory rate of 30 (as against a normal respiratory rate of about 12) all of which pointed to a general medical condition. Nurses did not contact him again presumably because there was an improvement and they knew Dr Jones would be on duty at 9AM.

Once again the experts take differing views of the actions of Dr Cairns at this time. Mr Tullett is again particularly critical and again I am not sure what I can make of his criticisms. It seems that he has no personal experience of the clinical signs of the symptoms of central cord syndrome or of the different types of incomplete or

complete cord lesions and he deferred to Mr Statham in these matters. He made general comments about neurogenic shock but if there was neurogenic shock here it was in association with central cord syndrome. His experience of treatment of neurogenic shock seemed to come from the treatment of patients in collapsed or shocked condition and only then for a few hours.

Mr Statham commented on these remarks and elaborated on the question of neurogenic shock. The term "neurogenic shock" means that there is a neurological cause for the shock. Where the patient has neurogenic shock from a spinal cord lesion there is always spinal shock in addition, thus there would be low blood pressure, loss of all reflexes, loss of power and loss of sensation. In addition there would be bradycardia. He felt that Dr Cairns made a reasonable assumption when called at 6 AM and it was reasonable to suggest that he be monitored and reviewed.

Dr Mumford thought that Mr Mauchland becoming unwell when rising to the toilet was another episode of postural hypotension. The course of action suggested by Dr Cairns was reasonable.

Dr Durward agreed with the presentation of neurogenic shock in patients with spinal injuries. While he talked about administration of steroids or vasopressors he did not appear to have any personal experience of them and indeed may not have seen a patient with neurogenic shock along with central cord syndrome since he had been a consultant in 1977. He agreed that the patient could not have been in spinal shock at 6 AM.

Bearing in mind all the expert evidence, the evidence of Dr Cairns, the evidence of the nurses and the nursing notes, Dr Cairns acted entirely properly at 6 AM in suggesting that the patient be monitored and reviewed an hour later. At that time there was sufficient improvement in his condition that the nurses did not call him back and waited until Dr Jones carried out his ward round at 9 AM.

Dr Nicholas Jones was an SHO responsible for ward one at Liff. He examined Mr Mauchland at about 9AM on 5 December. Unfortunately Dr Jones' note of his examination has been mislaid and is not with the productions. The nursing notes (Production 4.145) state that Dr Jones was informed of *"Jimmy frail condition and lack of limb control. Dr Jones feels that this is linked up with Jimmy's infection and raised temperature"*. Later the note goes on to say that when staff assisted him to a chair at his bedside *"his arms and legs became increasingly limp and he was unable to stand thus assisted to on top of his bed".* Following readings nurses had taken at 12:30 Dr Jones was contacted to review him and the note states *"remains floppy and limp in all four limbs. Jimmy also appeared to be in discomfort wincing when being moved especially when being moved into a sitting position".*

Dr Jones did not remember nurses telling him that the Jimmy was floppy before he examined him at 9AM. On examination at 2PM there was no evidence of floppiness and he tested for tone and reflex. He was not moving well but it was difficult to know if this was because he was too ill to move. There was little or no spontaneous movement; he was obviously unwell with low blood pressure and high temperature. Dr Jones suggested that the cause might be heart related and an ECG was taken along with blood. By 4 PM he was more unwell and he was transferred to Ninewells.

Dr Jones sent a transfer letter which is production 5.2.1. This letter does not mention the fall on 5 December and criticism has been made of this fact. It was clear that Dr Jones was aware of the fall but as far as he was concerned it was not significant in relation to this admission. His main concern was his patient's physical state and, even if he had been aware that he had been floppy in all four limbs, while significant in respect that he had a high temperature and low blood pressure and was very unwell, he might still not have related it to neck injury as it could have been a heart attack or septicaemia. He had no specifics of the mechanism of the fall and was not told that his arms were by his side.

We know from much of the evidence that falls are not uncommon in hospitals. Mr Mauchland had been examined by a doctor who had come up with a reason for the fall and a plan of treatment. There was, on 6 December, no reason for DR Jones to connect the deceased's generally unwell state, probably due to sepsis, with the fall the day before. Given the general presentation of the deceased even prior to the fall, that is one who was not generally mobile as evidenced by apparent bedsores and nursing with a ripple mattress, it was reasonable to attribute his apparent weakness to infection and general debility.

The transfer letter (5.2.1) was variously described as "comprehensive", "of high quality" and "absolutely appropriate". Dr Durward, however, is very critical of Dr Jones examination on 6 December. He states in his report *"it appears that if Dr Jones did indeed carry out a neurological examination on 6 December 1999 then that examination was intrinsically incompetent and failed to confirm weakness of all limbs".* He said that a neurological examination should have been done. In evidence Dr Jones said that he did not do a full neurological examination as that required the co-operation of the patient and in this case he had a patient who was unwell and could say nothing other than he had chest pain. A neurological examination was not therefore appropriate as he could not co-operate. He seems to have carried out reflex tests using a tendon hammer which produced a plantar reflex. The only one of the nurses who appears to have been present on 6 December was Carol Maclean and she said that she did not know exactly what was said to Dr Jones.

My conclusion therefore is that Dr Jones acted properly on the basis of the information available to him in respect that his immediate concern was for his very unwell patient who had low blood pressure, high temperature and high respiratory rate. He was aware of the fall but not the mechanism of the fall. He was aware that Mr Mauchland had been seen by Dr Cairns following the fall and aware of Dr Cairns view. His actions in getting his patient into Ninewells Hospital as quickly as possible for full medical intervention were entirely appropriate and in my view cannot be criticised.

## TREATMENT IN NINEWELLS HOSPITAL

Mr Mauchland was admitted to Ninewells Hospital on three occasions, from 6 to 8 December 1999, from 9 to 14 December 1999 and from 15 December 1999 until his death. One of the key issues in the Inquiry was the apparent delay in diagnosis of the cervical cord injury. As far as that is concerned, and leaving aside the evidence of Miss Mauchland to which I will return shortly, the first mention in the Ninewells hospital notes of a fall is on the third admission on 15 December 1999 when Dr

Pullar notes in production 5.1.45, *"fall in RDLH 5/12/99 and since then limb weakness".* On the information available to those responsible for admitting the deceased to Ninewells on the first two occasions the priority was to get to the bottom of the apparent infection and high temperature along with finding a cause for and treating these and the low blood pressure. There is no mention in any admission letter from Liff to Ninewells, be that a letter from a doctor or a nurse, of a fall or of any symptoms which on their own would suggest that the deceased had some form of cervical cord injury. The reason for that has been explained by the doctors from Liff particularly Dr Cairns and Dr Jones.

On 6 December 1999 the concern was that the deceased had generally low blood pressure, a high and spiking temperature and a high respiratory rate. He also had what is described in the Liff notes as a red and white raised rash like formation on his left hand, knuckles, left hip, right armpit and right inner knee. Dr Jones further thought it was a possibility that the deceased had had a heart attack although this did not seem to be confirmed by the ECG. He was aware of the fall but did not regarded as significant in terms of his diagnosis and accordingly it was not put into the transfer letter to Ninewells. The admission notes from Ninewells (production 5.1.33-35) appear to be a full recording and suggest amongst other things a possible allergy to Amoxycillin as he had developed the rash after exposure to the drug. The note also mentions his learning difficulties and depression. There does not appear to be from the notes a neurological examination but then again the information available to the examining doctor would not suggest at that time that it was necessary. Having been seen by other doctors he was referred to the hand service where an operation was carried out on his left hand to ascertain if this was the source of apparent infection. There is a note on the reverse of page 36 which raises a query as to whether Thioridazine can cause contact sensitisation and rashes and also neuroleptic malignant syndrome and ECG changes. This was not an area explored in the evidence. He was released back to Liff without any diagnosis.

He was again noted by the staff at the Liff to been non-specifically unwell with a marked pyrexia, hypotension and what was described as a blister-like eruption. Temperature was 39.2C and blood pressure 100/38 which was low. Having just returned from surgery at Ninewells and still displaying symptoms consistent with residual infection the medical staff at Liff decided to return him to Ninewells. At Ninewells he was admitted to the Burns Unit. It was not clear why he went there rather than to a general medical ward although it was suggested by at least one witness that that may have been the only place there was an available bed. Whatever the reason the attention on that admission seems to have been focused on the hand injury and there seems to have been little attempt to seek a diagnosis which would explain his overall condition. Once again those at Ninewells responsible for treating Mr Mauchland did not have information about a fall or immobility. It is again therefore perhaps not surprising that on admission on the second occasion there is no note of any examination of the central nervous system. Once again no cause was identified and his condition was put down to pyrexia of unknown origin. It is not surprising that Mr Hamilton focused his attention on the problems with the deceased's hand. He arranged a medical review prior to discharge and while we had no evidence from any doctor involved in that review, I presume that it uncovered no specific neurological signs which suggested a cervical cord injury or that an MRI scan should be undertaken.

Once again then Mr Mauchland was discharged back to Liff with no specific diagnosis for his poor state but almost immediately on return his condition was giving staff cause for concern. He still had a spiking temperature, low and fluctuating blood pressure, a pulse rate higher than usual and deterioration in conscious level. He was apparently unresponsive. It was decided to transfer him to Ninewells, a proper and reasonable decision in the circumstances.

At this point it would be appropriate to make a comment about Miss Mauchland's position relating to the fall and the information which she says she passed to doctors and nurses. At the time of the first admission she said she noticed that Jimmy's legs were jerking continuously so much so that the doctors had difficulty taking blood because of the jerking movements. Although doctors said that his hand must have been very painful he did not appear to feel anything during examination. He said his neck was sore and this information was relayed to the doctors and nurses. They were also told that Jimmy had fallen the previous day and banged his chin on the skirting board. No one appeared to be interested and they were concentrating on the symptoms of infection. The following day, 7 December, she noticed that her brother was not moving his arms and that his legs were still jerking although not as severely as the previous day. She says she expressed concern to a consultant, probably Mr Hamilton, about the lack of movement. Mrs Munro also spoke of the violent jerking and Mrs Stewart spoke of the immobility although it may be that she was speaking of him only on the third admission.

Miss Mauchland said in evidence that she told every doctor or nurse who was involved with her brother at Ninewells about the fall in Liff, his immobility following the fall and whether there was a connection between the two. She felt that no one paid any attention to her. It is quite clear that those responsible for treating Mr Mauchland during the first two admissions either did not know of the fall or, if they did, did not regard it as significant in terms of the diagnosis. No one who gave evidence to the Inquiry and who was involved in treatment during these first two admissions admitted to being aware of the fall nor did any of them recall being told by Miss Mauchland that there had been a fall.

Miss Mauchland's evidence regarding her brother's immobility appears to be that she did not notice it until 7 December and accordingly, if that is the case, while she may have mentioned a fall she would have no reason before then to seek a connection between the fall and his immobility. While she may have mentioned the fall I do not think it likely she mentioned immobility or a connection between the fall and immobility to either Dr Leese or Mr Hamilton on 6 December. Dr Leese had no recollection of speaking to Miss Mauchland nor did Mr Hamilton. Mr Hamilton said that he did not regard the apparent flaccid tone as significant since he noted nothing further about it. We had evidence that flaccid tone could result from the deceased's a general debility and infection and it might be reasonable to presume that was Mr Hamilton's thinking.

In saying that I am not suggesting that Miss Mauchland did not tell doctors and nurses about the fall or did not express her concern to them about her brother's immobility. I am certain that she did and as we can see from the notes on the third admission Dr Pullar was clearly aware of the fall and his entry having been placed in the notes it was there for all to see. From 15 December onwards therefore there is

no excuse for anyone not being aware of the fall in Liff and the subsequent limb weakness. The question is if the doctors were told of the fall during the first or second admissions should they have associated the fall with his general condition and apparent immobility and therefore caused investigation to be made? The secondary question is whether even if that was done was it likely to have made a significant difference to the outcome?

In dealing with the first of these questions we must consider Mr Mauchland's general condition on arrival at Ninewells on each occasion. He had a high and a spiking temperature, generally low but fluctuating blood pressure, generally an increased respiratory rate, lesions on his body but particularly on his left hand which were suspected to be infected, a severe, life-threatening depression and, in addition, although unknown at the time, peripheral neuropathy, a congenitally narrow cervical canal and arthritic spurs intruding into the canal. He had a recent history of being immobile spending much of his time in or on his bed or in a chair by the bed. Some of the raised rashes were probably bedsores and arrangements had been made in Liff for a ripple mattress to be placed on his bed to assist in treatment of these sores. There was evidence that people can become floppy if they are very unwell. Pyrexia and drowsiness do not suggest a cervical cord lesion. The peripheral neuropathy, discovered only during the third admission, could have accounted for the deceased's reduced reflexes and flaccidity. Infection could have accounted for immobility. He was a very sick man and, in the words of Dr Pullar, if the infection was not treated he could have died. It is perhaps then understandable that given his very poor state the doctors involved in treating him during the first two admissions and at the beginning of the third admission concentrated on finding a cause for the infection and high temperature.

Coming to the second question and whether it would have made any difference to the outcome, I will comment more on this later but on the basis of the evidence available to me it seems unlikely that if the cervical cord lesion had been detected even during the first admission that anything could have been done to prevent the deceased becoming quadriplegic. Given that his immobility arose from a number of causes and doctors were unable to find the cause of the continuing infection far less treat it, it may be reasonable to surmise that earlier detection of the cervical cord lesion may not have significantly affected the outcome.

Turning to the third admission to Ninewells, Mr Mauchland was sent back on 15 December 1999 accompanied by a transfer letter from Dr Mowatt on the reverse of which was a further note by Dr Jones giving the drug regime and some further comments. This seems to be a reasonably competent transfer letter although there is still no mention of a fall. The notes made on admission form production 5.1.41-42 with the admission letter forming 43. It is significant that on admission his GCS is 3/15 which would suggest that he was virtually unconscious. It later arose to 6/15 which is still low and suggestive of a reduced state of consciousness. There was an examination of the central nervous system which stated that there was no neck stiffness, the tone was down, reflexes normal, plantar down (normal) but unable to assess power. Given the GCS, especially at the beginning, this examination must have been conducted with little and probably no patient co-operation. He was seen shortly afterwards by Dr Wijenaike, an SHO, who instructed a number of tests to be carried out and outlined a plan for treatment. On seeing him again at 17:00 he noted

that a CT scan was required and that he should be seen by Dr Pullar on his ward round. Dr Pullar saw him at 18:20 and there appears in the notes for the first time reference to the fall. He wondered about a cerebral abscess and instructed a CT scan and a x-ray of the cervical spine. The CT scan showed no evidence of any haemorrhage and nothing particularly unusual. The X-ray of the cervical spine was not done as the radiographer felt it was unlikely that the patient would be able to co-operate. This was regrettable but, in the event, such an X-ray may not have assisted in the diagnosis as there was no fracture of the cervical spine and the X-ray would not have picked up the cervical cord lesion. Indeed, had it been done it might have drawn attention even further away from the possibility of a cervical cord injury as there was no evidence of bony or ligament injury which would have shown up on the x-ray, thus leaving doctors to look for other medical reasons for his unwell and immobile state.

The following morning during the ward round the question of encephalitis was raised and it was decided to ask Dr Nathwani, consultant in infectious diseases, for an opinion. Dr McConnachie discussed matters with Miss Mauchland that morning and noted four complaints about nursing staff, namely failing to dress the wound on the left arm, failing to do anything about him lying on his back when he had pressure sores, a failure to notice a non-running drip and their failure to push his oral intake. He explained that this was an issue she should take up with nursing staff and went on to explain that they were intending to do a lumbar puncture and obtain an infectious diseases opinion. He further noted *"explained that we may not reach a definite diagnosis and that medical technology has its limits. She would not accept this."* Unfortunately, I have no note of either Miss Mauchland or Dr McConnachie being asked about that entry in the notes.

He was seen by Dr Nathwani the same day and he raised a number of possibilities and suggested certain tests. A lumbar puncture was also done that day. Once the results of these tests were available and he had twice been seen again by Dr Pullar, Dr Pullar had noted that he wished a consultant neurologist to give an opinion because of the lowered conscious level. This request is noted on 17 December but the entry is untimed. It is likely to be in the late afternoon or evening as the previous entry by Dr Pullar is timed at 14:00. I have to presume that the request to neurology was made promptly but it appears that the first involvement from a neurologist was on 20 December at 20:00 when Dr Pritchard attended. She spent a considerable time sorting the notes into some form of order and reading them before trying to conduct an examination which she found difficult. She noted that he was tearful, screwed up his eyes when she was trying to check his pupils, withdrawing all four limbs to pain, no voluntary effort and reflexes symmetrical. She noted to discuss with her consultant the following day. In evidence she said quite clearly that she was aware of the fall as she had read Dr Pullar's note of 15 December. To that extent therefore the criticisms of Dr Durward regarding his perception that Dr Pritchard had failed to notice the comment made by Dr Pullar cannot be substantiated. She was puzzled by what she found but, with the benefit of hindsight, that is hardly surprising. Criticism was also made of the fact that she did not contact members of the family on 20 December. She answered that criticism by saying that it was late and it would not be normal practice for her to make contact with family members at that time of night. By the time she concluded her examination it could have been after 21:00 and I

agree that in the circumstances it was a reasonable decision to take not to contact the family at that hour.

She returned on the 22 December and found Mr Mauchland a little better but most importantly met Miss Mauchland and was given a history of the fall and the fact that he had not moved since. In view of that the new history she thought of MRI but noted that the signs were still not those of myelopathy. Nerve conduction studies were to be undertaken. The results of these studies were available on 23 December when he was seen by Dr O'Riordan and they demonstrated an axonal sensory motor neuropathy. Dr O'Riordan ordered a MRI scan **"to rule out cord compression".** (My emphasis). The signs on examination still did not point to cervical cord damage. The following day the results of the MRI scan demonstrated a complete cord lesion at C3/4. A neurosurgeon was asked to give an opinion on treatment. This review was carried out by Mr Page on 26 December and he confirmed a complete C4 cord lesion of three weeks duration. No surgical intervention was recommended.

On 30 December Dr Pullar noted the current problems as paraplegia which Dr O'Riordan was continuing to review, his mental state which Dr Mowatt was reviewing, pyrexia which were still something of a mystery but was receiving attention from a number of sources and his nutritional status. I shall deal with the question of nutritional status separately. Over the next few days he developed and seemed to recover from or partly recover from chest infections. There is an entry on 4 January 2000 made by Dr Adamson, a JHO, of a discussion with Miss Mauchland where she indicated that the still held the hope that the paraplegia would be resolved. Dr Adamson had explained that Mr Page had reviewed the MRI scans and in view of this change was unlikely. She complained that she had been given many different diagnoses by different people and would appreciate some consensus of opinion regarding the way forward.

He continued to be seen by Dr Pullar, by neurologists and by Dr Nathwani, the consultant in infectious diseases. He continued to have an unexplained infection. He died at 03:15 on 9 January 2000.

There are number of issues raised in relation to the treatment at Ninewells both in general and with regard to the third admission. The first and possibly most important of these is what is described by Dr Durward as a missed diagnosis of damage to the cervical spinal cord. This of course began in Liff where he criticised the decision to move Mr Mauchland from the floor, the failure of Dr Cairns and Dr Jones to identify signs and their failure to mention a fall in any communication with Ninewells. I have already given my view on this criticism when dealing with the part played by those in Liff and do not intend to say anything further except that in my opinion it is perfectly understandable that two relatively junior doctors working in a psychiatric hospital identified that they were dealing with a very sick man who required to be transferred to a general medical team as quickly as possible. I accept that neither had spotted any diagnosis in terms of a neck injury but, given all the other problems including those which were only found later but may well have existed on 5 or 6 December, that is hardly surprising and they acted correctly in referring Mr Mauchland to Ninewells Hospital.

On the first two admissions to Ninewells he was clearly unwell and the approach taken by the doctors and treatment received appears to have been appropriate. No information regarding the fall was available to them except possibly from Miss Mauchland but as Dr Dorward says in his report, if he had been given the history of a fall the day before, he could not see, given the presentation, how he would have acted any differently from Dr Leese.

On the third admission Dr Pullar had knowledge of a fall and a patient who had difficulty moving but who was still pyrexial and who had a lowered conscious level. Again, according to Dr Dorward, he was not displaying the classic signs of spinal cord compression and he would have looked for a cerebral cause and ordered a CT scan of the head and a lumbar puncture which is precisely what Dr Pullar did. When these shed no light on the problem he asked for an opinion from a neurologist on 17 December. He did not however stop trying to find a cause for the continuing pyrexia.

I find it difficult to see where at Dr Pullar may have missed an opportunity for diagnosis. I found him to be an excellent witness even trying to explain many matters which were outwith his direct involvement. His personal involvement in the case and his attention to the many complex matters it raised was of high quality. He faced a very puzzling and complex scenario which displayed many signs which pointed away from a central cord lesion. He identified the infection as being the priority and said at one point that if it had not been treated the patient may well have died. Within three days he had excluded a number of serious potential diagnoses including cerebral abscess, cerebral haemorrhage, encephalitis, abdominal infection and HIV. He had put in place a course of treatment for the infection and by 17 December was considering whether the reduced conscious level could be due to his depression or to a neurological cause. He took steps to instruct investigation of both. To describe this as *"a slow and clumsy attempt at diagnosis"* as suggested by Dr Durward is patently wrong. I agree with the comments of both Dr Dorward and Mr Statham who felt that Dr Pullar's approach was correct and he could not be criticised. Even if, given his knowledge of the fall, he had on 15 December, the date upon which he was first involved, contacted a neurologist who then organised an MRI scan it is difficult to see what difference there would have been to the treatment of Mr Mauchland thereafter. The lesion was complete by 15 December and it was highly unlikely that any surgical intervention would have taken place or, if it had taken place, would have had any meaningful effect. He still had all the other problems including the infection and the neuropathy. While the cord lesion on its own would have rendered him immobile, it is impossible to say if his other problems, infection, neuropathy, depression would not also have meant that he was immobile although it has to be said that all possible causes of immobility, except the cord lesion, were potentially curable.

It has never been properly explained why it took from 17 December to 20 December for a neurologist to visit Mr Mauchland. The delay is regrettable and probably should not have happened. Nevertheless given my comments in the previous paragraph it is doubtful if the delay had any significant effect on what happened.

It cannot be said in my view that Dr Pritchard missed any opportunity for diagnosis. On her first visit she spent a long time sorting out the notes and reading them. The notes and the manner in which they are kept will be a matter of comment shortly.

She then did her best to conduct an examination but could not do so properly because of the patient's tearful, low mood. She was aware of the fall but the signs on presentation of the patient were not consistent with an injury to the cervical cord. When she returned to carry out an examination there was some co-operation from the patient but, more importantly, a description from his sister of the fall and subsequent immobility. The signs, lack of reflexes, reduced muscle tone and down going plantars were all suggestive of a peripheral neuropathic disturbance and this was confirmed by the nerve conduction study. She did consider the possibility of a problem in the neck and involved her consultant, Dr O'Riordan who instructed a MRI scan *"to rule out cord compression"*. Even at that stage the presentation of the patient was such that cord compression was not obvious and the consultant was having a scan to rule it out.

Once again I find it impossible to see that there was any missed opportunity for diagnosis. I found Dr Pritchard an impressive witness who diligently approached the task of diagnosing what was a very complex set of circumstances. I do not believe she can be criticised in any way for what she did or for what she might have been perceived to have failed to do.

**NUTRITION**

Another area of criticism is failure to attend to proper nutrition. I think there may be some grounds for criticism in this area. When Mr Mauchland was transferred from Strathmartine to Liff he was suffering from severe depression and one of the ways in which this depression manifested itself was a reluctance to take food or liquid. He had been fed by means of a nasal gastric tube in Strathmartine. His poor nutrition was specifically noted on that transfer. In Liff his nutrition became a little better following ECT treatment and there were good records kept of his food and fluid intake. Information about his poor feeding and the fact that he was fed from time to time by a nasal gastric tube was passed to Ninewells on his various admissions. It is clear from the notes from Ninewells and from evidence that Miss Mauchland complained on more than one occasion about his nutrition. The Ninewells notes for the second admission identified nutrition as an issue which required to be addressed. It is equally clear from reports and evidence that the poor nutritional state may have been a contributory factor to the inability to fight infection. Yet in Ninewells he was not fed by means of a nasal gastric tube. He required to be fed so any failure to take food should have been obvious to nurses. In Dr Pullar's second note of 17 December he says nutrition is an issue and observes that there had been nasal gastric feeding in Strathmartine and it should be tried again. A dietician had been asked to see him and did so on 20 December and had a discussion on, I think, 22 December with Miss Mauchland. It is still not clear if nasal gastric feeding was taking place but I suspect that it was not since the next day after the discussion the dietician refers to such feeding to "commence overnight" and comments on previous problems of toleration. It is therefore at least a week after admission, the transfer letter stating that he was resistive to oral fluid intake, before anything is done about attending to nutrition and attempting nasal gastric feeding. That cannot be satisfactory in a situation where there is a seriously ill patient who was unable to shake off an infection and who had a history of poor nutrition and not tolerating nasal gastric feeding. On 29 December the dietician noted that nasal gastric feeding was unsuccessful and that oral intake remained minimal. The dietician asked that PEG

placement be considered. As I understand it this is a tube inserted under general anaesthetic directly into the stomach and which allows food to be passed directly to the stomach. This was in fact inserted on 30 December. There are no further notes regarding nutrition or visits from the dietician.

Mr Mauchland was still suffering from a severe depressive illness when he was admitted to Ninewells on 15 December. Other than with members of his family he did not communicate particularly well. It is clear from the medical notes that many of the doctors had difficulty communicating with him. His nutritional difficulties were or at least ought to have been known to those admitting him on 15 December. There has been no satisfactory explanation of why insufficient attention was given to this area for nearly a week. His sister had raised the issue the morning after admission. Given his depressive illness he was not going to raise the matter himself. More attention should have been paid to the question of nutrition at an earlier stage. The effect of proper nutrition was not addressed during the Inquiry and I cannot therefore say if proper nutrition would have had any effect in preventing death. I can however comment that if the lack of proper nutrition was thought to be a possible factor in the battle against infection then it is something that should have received better and more prompt attention. It is an area where Miss Mauchland is perfectly justified in saying that she was making a complaint and no one appeared to be listening. Having been alerted by the Liff doctors to a problem with nutrition and having been aware that feeding had relatively recently had to be carried out by nasal gastric tubing, doctors at Ninewells should have given greater priority to having the question of nutrition addressed. Better nutrition may have assisted in the deceased's fight against infection.

It was not clear where responsibility for nutrition lay. It was mentioned in medical notes and part of the nursing notes also dealt with it but it was difficult to follow a path relating to matters of nutrition. It is an area to which some attention might be given. It should be made clear who has responsibility for nutrition and for drawing to the attention of treating doctors any problems with nutrition. If a doctor is not reading nursing notes it is not immediately obvious how he will learn about any nutritional difficulties.

## COMMUNICATION WITH RELATIVES

By the time that Mr Mauchland was transferred to Liff he was suffering from a depression which was described as life threatening. His communication with people he did not know well was not particularly good and could on occasions be non-existent. He did however communicate well with members of his family particularly his sister. She had taken a very active part in his care throughout his life. When well, he was a social and outgoing person. In November 1999 however he was very ill and it is clear from the notes at Liff that the level and quality of his communication with staff varied greatly from day-to-day and during the course of a day. Staff at Liff quite properly involved Miss Mauchland in discussion about his care and health.

There are a number of areas where Miss Mauchland complains that no one was listening to what she was saying about aspects of her brother's illness and treatment. Prior to the transfer from Strathmartine to Liff she had been concerned about the cocktail of drugs her brother was receiving and she spoke to Professor Reid about

this. His depression had deteriorated to such an extent that drug therapy was no longer having any effect. He was refusing food, had lost a lot of weight and was fed in Strathmartine using a nasal gastric tube. On transfer to Liff he appeared to improve following ECT treatment, he was more responsive and his food intake improved. In her statement which is Crown Production 6 and which was read by her in the course of evidence, she says "*I should say that the nursing staff got to know Jimmy quickly, they discussed his care plan with me and I was involved in Jimmy's care."* She also however expressed concern at severe stomach pains and sweats and was told that as most of the drugs had been stopped it could have been withdrawal symptoms. From the statement and her evidence therefore there appears to be involvement of Miss Mauchland as the nearest relative of her brother discussing aspects of care and treatment in Liff.

After the fall she said she spoke to Dr Smith in Liff expressing concern about lack of movement. She said that Dr Smith had told her it might have been the shock of the fall or simply because he had not been moving a lot and that she would start him on gentle physiotherapy. Dr Smith recalled the discussion but did not recall Miss Mauchland saying anything about her brother not moving or having difficulty moving.

Miss Mauchland also said that after one of the discharges back to Liff she expressed concern that Jimmy was still on Thioridazine in view the fact that doctors in Ninewells suspected that this might be the source of a high temperature. Unfortunately we did not hear from the nurse to whom she spoke but she said there was a discussion about the quantities of Thioridazine and Lorazepam being dispensed. She discussed her concerns with a doctor and eventually Dr Smith who told her Thioridazine had been stopped. Dr Smith's position was that Dr Mowatt did not tell her of Miss Mauchland's concerns at the prescription of Lorazepam nor her worry about lack of movement. There were no detrimental effects of taking Lorazepam and Thioridazine together but generally they would not be taken together. Dr Smith in fact queried if a JHO at Ninewells with about six months experience in general medicine would be sufficiently competent to comment on a psychiatric drug regime.

On the whole it seems to me that communication between nurses and doctors in Liff on the one hand and Miss Mauchland on the other was reasonably good. This is probably because the staff at Liff are specialists in dealing with mental illness and they know that a close relative will very often have to act as the mouthpiece for the patient especially where the patient is not capable of understanding or giving informed consent to treatment. There are good records in the nursing notes of communications with Miss Mauchland. The discussions which she had about the drug regime or aspects of his treatment or presentation indicate that there was a regular and detailed discussion. Any difference that there may be relates to the recollection of the content of some of the discussions. Dr Smith says that she would not use some of the expressions attributed to her and, having heard her in evidence, I would be inclined to believe that. I found Dr Smith to be a good witness, careful with her choice of words. I have no doubt that she and Dr Mowatt both had discussions with Miss Mauchland particularly about the effect of drugs. Given that Dr Smith said that she had no recollection of being told that Mr Mauchland had been found collapsed on the floor she had an explanation for his relatively immobile state by saying that when someone was depressed and seriously ill for so long they could become seriously weakened and he had been in a bed or a chair for some weeks.

Turning to communications between Miss Mauchland and nurses and doctors in Ninewells. She said that every doctor her brother saw wanted a statement of the history. I have presumed that to mean that on each admission there was a separate clerking undertaken by a junior doctor and thereafter often further interrogation by a more senior doctor. Her brother was not communicating to anyone other than herself and she said that she told all of them, including nurses, that he had fallen. She felt that there was no importance being placed on that statement. She also said that she told them that he had struck his chin on the skirting board and his gums had been bleeding. No one was listening. She said she told the Dr Hamilton about the fall but he said he had no recollection of talking to her or of being told of fall. She said she told Dr Pullar of her concerns but could not remember when. It is clear from his note that Dr Pullar was aware of a fall when he first saw Mr Mauchland on 15 December.

I have already said that I accept Dr Pritchard's evidence that she read Dr Pullar's note and was aware of the fall when she carried out her first examination. On her second visit she met Miss Mauchland and was given a full description. This alerted her to the fact that there may be a problem which was connected to the fall.

I have no doubt that Miss Mauchland told some doctors and some nurses about the fall and that she was concerned about her brother's immobility. She may even have asked if the immobility was connected to the fall. As I have already said doctors were faced with a man who was suffering from a severe depression, who was physically very ill having a high and spiking temperature, a serious infection and episodes of lowered conscious level. He also had rashes about his limbs and body which were suggestive of compression or bedsores which would be indicative of someone who had been relatively immobile and had spent quite a long time in or on his bed. All the information in the Liff notes suggests that he spent most of his time in bed or on a chair beside a bed. There was accordingly a reasonable medical explanation for his immobility. In due course evidence was available that he was also suffering from peripheral neuropathy which again could have accounted for immobility. Doctors who gave evidence all said that the priority was to treat the infection. One of them said that if it had not been treated he could have died. If they were aware of the fall they did not, having regard to the deceased's overall presentation, regard it as a significant. The priority at all times was to treat the infection.

Clearly, with the benefit of hindsight, the fall was significant since it is possible that the fall was the cause of the incomplete cord lesion and if not the cause the final act in causing an incomplete lesion to become complete. If doctors had been aware of that significance then it would be sheer speculation to say what they may or may not have done, what priority would have been afforded to which area and whether or not it would have made any difference to the outcome. By the time he was admitted the Ninewells for the third time it seems likely but not absolutely certain that the incomplete lesion had become a complete lesion. In the circumstances the evidence from the expert witnesses which I accepted was that there was likely to be no surgical intervention. Treatment would have been, in simple terms, keeping him immobile and observing. From the time that the lesion was complete the chances are that quadriplegia would follow.

If indeed so many doctors and nurses in Ninewells were told of the fall then I find it surprising that nothing appears in the notes until 15 December since the notes

generally appear to be reasonably comprehensive if at times rather difficult to follow. As I have said I think all witnesses were doing their best to tell the truth as they remembered it and none of them was lying or prevaricating. With the exception of Dr Pullar and Dr Pritchard who have both noted references to the fall, it is not possible to say who else may have been told. Few other doctors were able to remember the case without recourse to the notes. I accept Miss Mauchland's evidence that she told doctors and nurses of the fall. I can however understand why at the early stage such information was not regarded by the attending doctors as important. The doctors who gave evidence all struck me as being diligent and competent. Their notes appear to be full. The actions taken and investigations made appear to be appropriate. There is no suggestion that it was done anything other than competently. It would not therefore be reasonable to criticise any individual doctor or nurse for not paying attention to anything he or she may have been told about a fall. It is not possible to identify which specific doctors or nurses were told about a fall. One of the main difficulties has been that most witnesses were speaking not from their own immediate recollections but from a review of the relevant Notes. The delay in holding the Inquiry is at least in part to blame. Further it was also clear to me that at times in evidence there was confusion in the minds of witnesses between what they may have thought at the time and what they now think with the benefit of hindsight.

What the notes do not record is whether anyone was with Mr Mauchland at the time of his various admissions and we know, for example that his sister was there on the first. It also seems likely that most of the information on the clerking notes came from a source other than Mr Mauchland, possibly from his sister. If that was the case it might have been appropriate for a note of that fact to have been made. Then there would be no doubt what was being said, by who it was said and to whom it was said. Where someone who is learning disabled or who is suffering from a mental illness enters a hospital for treatment for a medical as opposed to mental illness, there are a number of potential problems. The patient is not likely to be able to communicate properly what may be wrong and may not be able to give sufficient history to assist in making a diagnosis. Such a patient is likely to be accompanied by a friend or relative who will be available to act as a mouthpiece for the patient. Where that happens, that fact should be noted.

The second potential problem when a patient with learning disability or mental illness or learning disability enters hospital is that few if any of the doctors or nurses will have any experience in dealing with learning disability or mental illness. There was no evidence to suggest that there is any training in that area. The Scottish Executive has identified the problem by producing the paper "Promoting Health, Supporting Inclusion" but this is mainly targeted at nurses and midwives and it is not clear to me what is to be done in practice. There was no evidence to suggest what was to be done. It is also not clear what training is given to the doctors responsible for the first meeting on admission. That first consultation will usually be with a junior doctor and it is he or she who does the clerking note. That note is the base document for subsequent diagnosis and treatment. The value of the clerking note depends on the quality of information provided.

I suggest that general hospitals such as Ninewells should undertake a review of how they deal with admission of patients with learning disability or mental illness. There

should be a protocol for identifying such patients on admission then dealing with communication with them. Where a third party is involved that should be noted. Where a third party is involved it may be relevant to note everything being said, whether thought to be relevant or not, as a doctor seeing the notes at a later stage cannot be sure of the real source of the information far less the relevance of it.

## COMMUNICATION BETWEEN DOCTORS AND NURSES

There was much discussion during the course of the Inquiry about the nature and quality of communication between doctors and nurses. In Liff, medical notes and nursing notes are kept separately. The nursing notes take the form of a narrative journal entry on a day-to-day basis detailing everything relevant relating to the patient. The notes are written during the course of a shift by any one of the nurses on that shift. The notes state what treatment or drugs have been given, whether the patient has been seen by a doctor, any specific examples of unusual behaviour and sometimes what visitors have been received. They also, in the case of Mr Mauchland, give details of discussions, whether in person or on the telephone, nursing staff had with Miss Mauchland. The quality of the nursing notes in Liff and the information contained in them appears to me to be high. They are available for reference to any nurse on any shift who requires them and they would appear to give a reasonably comprehensive picture of the up-to-date position with regard to the patient.

Nurses in Liff work a three-shift pattern, early, late and night. There is a handover period from one shift to the other when the incoming shift is briefed verbally by the outgoing shift in relation to each patient and significant events. This appears to be done principally by word-of-mouth but the notes are available if required. Each shift makes sure that the notes are fully written up for that shift before the handover to the next shift. In a situation where each shift comprises a small team of nurses and they have responsibility for a relatively small number of patients, many of whom will be relatively long-term patients, the system of note keeping and verbal briefing seems to be the most appropriate way of getting relevant information regarding a patient from one shift to the next.

Doctors in Liff are entitled to have access to the nursing notes but it seems to be the practice that they seldom look at them. A number of doctors were asked in the course of the Inquiry why they did not look at nursing notes and no one was able to give a good practical reason. It is simply something which is not done or is seldom done. Doctors are aware the notes are there and some will, from time to time, look at them but generally they rely on the information given to them verbally by nursing staff. I got the impression, rightly or wrongly, both from doctors in Liff and Ninewells, that it is something of a culture that information is obtained from nurses by word-of-mouth rather than by reference to nursing notes.

The one criticism I might have of the Liff nursing notes is that individual notes, while dated and usually stating whether it is morning or afternoon, do not always have the time that the entry is made. That might have been an important matter in this case when looking, for example, at the entry for 6 December which is contained in production 4.144/5 and makes reference to his "arms and legs becoming increasingly limp and remaining floppy and limp in all four limbs." One of the issues

argued during evidence was whether Dr Jones was told about this or could have found out had he read the notes. The timing of the relevant entries would have made it easier to take an objective view of the evidence in that area. Generally however I think the Liff nursing notes are of a high standard.

The difficulty about information being passed verbally is that there is no record of what information is so passed. A great deal will depend on who is passing the information and to whom that information is being passed. For example, if we are dealing with a specialised team, an experienced nurse will be able on the basis of his or her knowledge and experience to identify and focus on matters which are important and relevant to the doctor receiving the information. That nurse should be able to filter out irrelevant information. On the other hand if there is a relatively inexperienced nurse he or she might not have sufficient knowledge to be able to tell what information is relevant or important. The same will apply to the doctor receiving the information depending on his or her level of experience.

In Liff it was clear that the nursing staff had a great deal of experience in psychiatric nursing. All were specialist nurses, none of them claiming to have anything other than basic clinical training. I would be confident that in either a nursing handover or during a ward round nurses or doctors would be well and fully briefed about all psychiatric matters relating to particular patients. Where however a patient is suffering from physical illness or has had some form of accident (and for the avoidance of doubt I regard a fall such as occurred here as an accident for this purpose) it would be important that the fullest possible information be transmitted either to nurses coming on duty or to doctors either on a requested visit or in the course of a ward round. In this case the fullest information would be obtained from verbal information and the nursing notes.

From one day to the next nursing notes at Liff are not likely to be particularly extensive and would not take long to read. I would suggest therefore that it would be good practice that nurses coming on duty and doctors visiting a ward in a psychiatric hospital, whether to see a specific patient or as part of a round, should read the nursing notes especially where a patient is suffering from physical illness or has had some form of accident. I also suggest that all entries in nursing notes should be accurately timed.

The medical notes in Liff are kept separately from nursing notes and in a different area of the ward. They can be accessed by both doctors and nurses and are generally referred to by doctors. It is impossible to say if keeping the notes together in one file would be an improvement. It would certainly mean that nursing notes were in a file which a doctor would have cause to pick up. But, balanced against that, the file would rapidly become bulky. Unless there was a rigid and disciplined policy for filing there would be a risk that a file might become untidy and even more difficult to follow.

In Ninewells the system of keeping nursing notes is different from Liff. This seems to be called "activities of daily living" and a well-established system. Mr Brown indicated that it could be that the recording system is complicated and some notes in the present case are written in the wrong places. He then went on to say that could happen. Medical notes are kept separately within the ward.

We also heard of systems where medical and the nursing notes are merged. This apparently gives rise to issues about who "owns" the notes and who takes responsibility for them. There are also issues about what is recorded and who has access to the notes. The positive feature is that all correspondence, test results and other relevant documentation is easily accessible to everyone who has a need to see them. Many of the witnesses spoke to the advantages and disadvantages of the various systems of note keeping. It is not possible on the basis of the information before me to make any recommendation about which might be the best system in a given set of circumstances. It was suggested that combining medical and nursing notes might improve communication. On the other hand finding notes within such a file could be a problem and the file could quickly become bulky. There can be a great deal written on a day when not a great deal of importance has happened. We only have to look at the extent and, to my albeit untrained eye, slightly haphazard nature of the Ninewells notes covering a relatively short period of time to see how quickly a file can become bulky.

Dr Pritchard said in her evidence that she took a long time to read the notes because a lot of things had happened before there was anything which sounded neurological. He had been back and forward between Liff and Ninewells and she found it hard to work out what had been going on. Not all the medical entries were in the proper medical part of the notes and it was not a continuous set of information from 6 December 1999. She had to chop back and forward in order to get the full picture.

Good note keeping depends on two things, good and accurate recording by the individual taking a note and thereafter good, methodical filing of the note. The content of the Ninewells notes seems to me to be good and, apart from suggestions that they do not include references to a fall or the consequences of a fall, have not been subject to criticism. It is clear that Dr Pritchard found it difficult to make her way around the notes and from her evidence that difficulty might be attributed at least in part to poor organisation of the notes.

The practice in Ninewells is for relevant information to be conveyed from nurse to doctor by word-of-mouth. The doctors will look at medical notes but rarely at nursing notes. An exception might be in an emergency where no nurse was available who had sufficient knowledge of the patient. The nurses will hand over to each other with a verbal update but there is a greater practice of nurses looking at nursing notes.

Notes are generally not transferred from one hospital to another and, except in very unusual circumstances, one hospital would not seek another hospital's notes. There was never any suggestion that Ninewells would seek Liff notes. Transfer letters were prepared and sent with the patient and most of the doctors receiving the notes and expert witnesses felt them to be at least adequate if not very good. It would in my view be completely inappropriate to transfer notes from a psychiatric hospital to a general hospital.

The question arises whether doctors should, as a matter of course, read nursing notes in a hospital like Ninewells. It did not need evidence from hard working doctors to tell me that hospitals like Ninewells are very busy places with considerable pressure on doctors and nurses alike. There simply would not be enough time in the day for doctors to read nursing notes relating to every patient on a ward. That is

particularly so when the system known as "activities of daily living" is used. No doubt those with medical training can make their way around such notes with relative ease. In examining the productions for this Inquiry I found it very difficult to move logically from one area of activity to another. That may of course be due to the way the productions were assembled for use in court but it might equally reflect the way in which they are kept on the file. That being the case it is perhaps little wonder that Dr Pritchard took so long to make her way through the file on 20 December.

I have no evidence as to the sort of resource which is currently available or which would be required to keep all notes, medical and nursing, properly filed and accordingly I cannot make any suggestions or recommendations in that regard. It would be equally inappropriate to make any suggestion or recommendation that doctors should as a matter of course read nursing notes in the form kept in a file recording activities of daily living. What I can suggest however is that in the interests of the patient and in the interests of risk management appropriate and sufficient resource is made available to hospitals to allow all notes to be properly and promptly filed and kept so that they form an accurate and chronological record relating to the patient.

## PROVISION OF STRATHMARTINE NURSES

Miss Mauchland made the point that she had asked on more than one occasion for there to be provided for her brother a specialist nurse from Strathmartine Hospital. Various witnesses from Ninewells were asked if this happened and there were varying answers. Dr Pullar was aware that it might have happened in the past. The nurse from Ninewells who gave evidence did not think that it had happened from which I can presume that she had no knowledge of it ever happening on any ward upon which she was working. Dr Smith said that she was aware that it could happen but it tended to be with someone who was extremely handicapped.

If the provision of a specialist nurse from Strathmartine was to be an issue then it would have been helpful if evidence had been led as to whether or not it was possible. I am aware from the evidence of the Liff nurses of the numbers of nurses and patients in ward one. I have no evidence whatsoever of the number of nurses or patients in Strathmartine at the time nor do I know if a nurse could have been released, nor whether that would have been for 1 hour or 24 hours a day or 1 day or 7 days a week. To produce a document issued by NHS Scotland in 2002 and rely on it to support a submission that there should have been a Strathmartine nurse available is not acceptable. No nurse was asked about fear of people with learning disabilities or about a lack of skills in communication. Mr Brown was asked about the term "diagnostic overshadowing" which is used when symptoms and illnesses are dismissed as being a result of learning disability. It was not suggested to any doctor that the symptoms and illness in this case were dismissed as being a result of learning disability. It was not suggested that anyone assumed that the deceased's immobility or lack of responsiveness was a result of his mental ill health or depression although I accept that depression was a major contributing factor to his condition and presentation.

In the absence of evidence therefore about whether or not it was possible to have a Strathmartine nurse at all I cannot possibly make any finding in that regard. However

there is no doubt that in an ideal world people with learning disability or who are suffering from a mental illness and who require to enter a general hospital should be able to do so with the assurance that there will be appropriate communication with doctors and nurses treating them. I cannot begin to speculate how that might be achieved but provision of nurses in a general hospital who have some psychiatric training might be one way forward. NHS Scotland clearly has the matter on the agenda as evidenced by the publication "Promoting Health, Supporting Inclusion." In the real world however as spoken to by those working in Ninewells, there is enormous pressure on every type of resource including human resource and I think it is reasonable to suggest that it is unlikely to say the least that a nurse from Strathmartine (or its successor hospital now that it is closed) would be provided on demand for a patient entering Ninewells suffering from learning disability or mental illness.

The availability of the resource was not an issue which was raised under this head although perhaps given the circumstances it should have been. Miss Mauchland said she asked for a Strathmartine nurse at Ninewells and was told it was not needed. The named nurse had in fact some relevant experience in dealing with patients with learning disability. However her memory of events was such that there is little I can take from her evidence. If she indeed had experience and she was the person asked then it might be understood why she thought a Strathmartine nurse was unnecessary. Equally I cannot presume that simply because Strathmartine nurses visited Mr Mauchland that they would have been provided at Ninewells for all or any part of a day or week on a one to one basis. This is a much wider issue than was addressed in the evidence and I am not prepared to make any specific finding. However as I again understand that the issue is being addresses by the Scottish Executive I would commend that and urge that it receives early attention.

## NURSING TREATMENT IN NINEWELLS

I have specified above the areas of criticism Miss Mauchland has of the nurses in Ninewells. Aside from the fact that she has a complaint that they would not listen to her, her other complaints relate to the attention which her brother received or did not receive and to the state of cleanliness and hygiene of the room in which he was placed for most of the third admission. She said that the room was often cold with the window open despite the fact it was the middle of winter. Her brother was frequently lying in a bed covered only by a sheet and wearing no top. It was a side room, which I presume contained only one bed, and the door was regularly kept closed and the blinds drawn. Mrs Anderson, the named nurse, did not remember Miss Mauchland making any specific complaints regarding the standard of nursing care. She said that the deceased was in a side room possibly because it was the only place there was a bed or it may have been that it was used because he had an MRSA. Various doctors, but Dr Pullar in particular, spoke of the MRSA but there was no evidence of where and when this was acquired or whether it had any part in the infection which was causing him to be so ill. The only explanation given by Mrs Anderson for the window was being opened or for him being without a top was that he may have had a temperature in which case the room should be kept cool. She could not remember very much about the matter however.

As far as the state of cleanliness of the room was concerned Mrs Anderson didn't remember anything about it but said if there was a leaking urine bag it would be changed. The room would be cleaned the daily. She could not remember litter or swabs on the floor.

Miss Mauchland was also critical of nursing practice in that there appeared to be regular failures to turn her brother in bed and, in treating the herpes simplex on his lips, a nurse simply dipped her finger into a pot of Vaseline with no care for possible cross infection. In addition, in the knowledge that he had an MRSA, little if any advice was given to visitors such as Miss Mauchland or other family members in relation to cleanliness or hygiene or other preventative measures.

The other complaint was that there was no call buzzer in the side room. Mrs Anderson said it was there on the wall attached with a lead. That may well be so but Mr Mauchland was immobile and was being nursed in his bed. This nursing included attending to his personal hygiene. It must have been obvious to the nurses in carrying out, for example, a bed bath that he could or would not use his arms and therefore may not have been able to use the call buzzer. Once his quadriplegia had been diagnosed there was no prospect that he could use the call buzzer. There was no indication of how he was expected to call for assistance if that was required.

I think there is something in the complaints made by Miss Mauchland and the other family members. Given that Dr McConnachie noted some of the complaints within a day of the third admission I think that it is likely that Miss Mauchland repeated her complaints. The complaints are reasonably precise and not simply about a general lack of care. It would be too easy to suggest that by putting him into a side room, shutting the door and drawing the blinds it was a case of "out of sight out of mind" but the evidence from Miss Mauchland and the other family members suggests that is at least a possibility. The nurses knew or ought to have known that Mr Mauchland was both learning disabled and suffering from depression. They knew that he was, at best at that time, a poor communicator. I accept that they were busy and had many patients to look after but they should have realised that he had certain needs and might have been unable to express them properly if at all. It is likely therefore that he did not receive at all times the attention which he, with his specific individual needs, required or deserved. Would his needs have been better recognised if he had been in the ward rather than a side room? He would certainly have been more visible to nursing staff. I am particularly concerned at the fact that he was, in effect, shut off in a side room and, because he could not use his arms, was unable to use the call buzzer. No consideration seems to have been given to this.

Dr McConnachie also noted that he advised that the complaints should be made through nursing channels. The evidence regarding the procedure for making a complaint was unsatisfactory but it seems that there are different routes to be followed depending on the nature of the complaint. In this case Miss Mauchland may well have required to make a complaint through nursing management. There is an understandable reluctance to complain to nurses in the ward where a relative is being treated in case this is perceived as a complaint against these nurses. What is not clear from the evidence is whether or not there is an established, easily understood and easily available complaints procedure. For example it is not clear to whom a complaint might have been directed or whether that complaint could be

given verbally or whether it required to be in writing. I rather suspect that there was no clear, easily understood system for making a complaint. There should be.

Complaints will happen from time to time. It can be a worrying and stressful time when a relative, particularly a close relative, is in hospital. There should be a transparent, easily understood system for logging complaints on the ward. It may be that there is such a system but if there is Dr McConnachie did not appear to know about it and Miss Mauchland was left in the position where all she could do was mention her complaints to a doctor who was prepared to listen. He could not, however, offer her a solution other than point her in another direction.

The deceased was said to have picked up an MRSA infection. As I have said elsewhere we do not know where or when it was picked up or when or if it was ever resolved. There is a reference in the nursing notes on a page which was not spoken to in evidence about it being restricted to certain areas of the body but there is little or nothing about MRSA in the general medical notes. There has been much publicity about such infections and their resistance to treatment. I accept the evidence from members of the family that they were given no advice about how to deal with the infection. If MRSA is as prevalent as it appears to be then there ought to be adequate guidance for visitors to hospitals on precautionary measures to prevent cross infection.

Complaints were also made about the general state of cleanliness of the side room and the items of medical debris lying around. As far as I can recall none of the doctors were asked about this and Mrs Anderson remembered very little of it. Once again, I accept the evidence from the family members as they have no reason to make up such detailed complaints. In the absence of complaints made or logged at the time however there could not possibly be a record. Other than evidence that the room would be cleaned daily we heard nothing about any system of checking or recording the state of cleanliness. If a relative of a patient had a complaint I presume it would be raised informally with one of the nursing staff. Once again if there was a proper procedure in place members of the public would know how to register their complaints.

Mrs Anderson explained the apparent lack of bed covers and cold conditions by saying he may have had a temperature and this was required to keep him cool. That never seems to have been explained to Miss Mauchland. Her brother was left at times with not a great deal of dignity. He was in effect helpless and could not do anything to help himself. Also, because of his severe depression, he was not communicating well if at all with people he did not know. He could not use the call buzzer. There seems to me to have been a lack of understanding on the part of nursing staff of his particular needs. It may be that the system simply does not know how to cater for people with learning disability or severe mental illness. Steps should be taken to make sure that nursing staff within wards of general hospitals are firstly, alerted when they are receiving a patient who is suffering from learning disability or mental illness and secondly sufficiently trained to be able to identify and deal with the additional specific needs of such people. The nursing of people with mental illness in a general hospital will undoubtedly give rise to its own particular problems. Communication and compliance are, for example, areas where there might be difficulties. Those who have a mental illness and find themselves in a general

hospital are entitled to expect the same treatment as anyone else. It is for the nursing and medical regime to adapt in order that that goal can be achieved. I suggested therefore that the Hospital Trust take steps to ensure that nursing staff in appropriate wards received training in the management of patients who have learning disability or are suffering from learning disability or mental illness.

**SECTION 6(1)(a) and (b)**

There is no dispute that James Mauchland, who was born on 11 March 1943 and who resided at 5 Canning Place, Dundee, died at 0315 hours on 19 January 2000 in Ninewells Hospital, Dundee.

Various submissions were made in terms of Subsection 6 (1) (b) as to the cause of death and I would summarise these as follows: --

By the procurator fiscal

- consolidation of the lungs
- infection - immobility due to quadriplegia, depression, malnutrition, sepsis and pyrexia.

By Dr Abernethy

- 1 a acute tracheobronchitis

1 b immobility

1 c depression/malnutrition, peripheral neuropathy and cervical cord injury.

By Miss Joughin

-bronchopneumonia

sepsis

by Mr Grant-Hutchison

-1 a acute tracheobronchitis

b cervical spine and cord injury

c simple fall (hyperextension of neck)

by Mrs Robertson

-1 a acute bronchopneumonia and acute tracheobronchitis

b acute infection

2 cervical cord syndrome and spinal injury due to hyperextension of the neck.

There seems little doubt to me that the main cause of death was acute tracheobronchitis but I think there is sufficient information and evidence to add acute bronchopneumonia. The post mortem report indicates the presence of pneumonia. We simply do not know how the infections arose but the deceased was unable to shake off the infection largely due to his immobility. The immobility is in itself not a cause of death but the factors which helped to contribute to the immobility themselves contributed to the death. I therefore find that the secondary cause of death was immobility secondary to cervical cord syndrome and spinal injury due to hyperextension of the neck, acute infection, peripheral neuropathy, depression and malnutrition.

The cervical cord injury itself caused immobility and this was permanent immobility but there was sufficient evidence to suggest that any one or a combination of the other factors may also have caused immobility. These were all, however, potentially curable even if it seems likely that none were in fact cured at the time of death. I am not prepared to say on the basis of the evidence that the fall was the sole cause of the cervical cord injury but it was certainly a significant factor in it and may have been the only cause. However given the congenital narrowing of the cervical canal and the arthritic changes on the cervical spine, I cannot rule out the suggestion that other, earlier events may have contributed to the lesion. I am not prepared to say however that the administration of general anaesthetic for ECT treatment or the convulsion experienced during such treatment has been established to have contributed to the lesion.

It was equally clear from the evidence from the various doctors at Ninewells that the infection, if not treated, might have been fatal. The psychiatrists thought that the depression was life threatening. As a result of the depression nutrition was bad. Studies conducted by Dr Pritchard disclosed that the deceased had peripheral neuropathy. It was not possible to say how long he had suffered from this or the effect this may have had on his presentation especially when in Liff.

We are left therefore with the picture of a very sick man, suffering from a number of pathologies any one or more of which could have been fatal and whose immobility compromised his ability to recover from infection. Even if the immobility as a result of the cord lesion was incurable, the fact remains that at the time of his death all the other factors, although in themselves curable, were still present. It is not possible to say if the death might have been avoided had any of these conditions been resolved.

**SECTION 6(1)(c)(d) and (e) of the 1976 Act.**

I have found dealing with this aspect of the Determination difficult and I greatly appreciate the detailed submissions prepared by various agents in case.

In looking at Section 6 (1) (c) of the Act I am obliged to set out to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided.

The only party seeking to have a finding made under this sub-section was Mr Grant-Hutchison for the family who said that the condition should have been noticed during

triaging or shortly afterwards, failing which admitting staff and consultants responsible for his care should have listened to Miss Mauchland.

The first and most obvious question is whether the fall on 5 December 1999 was an accident which resulted in the death. There is no doubt that it was an "accident". Mr Mauchland fell, probably as the result of a faint, which faint may have been caused by postural hypotension secondary to the drug Thioridazine. Where there is doubt is whether that fall led to his death. On 5 December before the fall Mr Mauchland was frail, suffering from depression and with poor, if improving, nutrition. He had a number of rashes which were probably bedsores. He had a generally high and fluctuating temperature. His blood pressure was quite low. His respiratory rate was quite high. He had an infection which, on his third admission to Ninewells, was regarded by Dr Pullar as being sufficiently serious that he might have died had it not been treated. Unknown to anyone on 5 December he also had a congenitally narrow cervical canal and arthritic spurs around the cervical spine. He probably had at that stage peripheral neuropathy.

He had undergone 5 ECT treatments under general anaesthetic. We do not know if the anaesthetic required intubation but if it did there was a possibility that the neck would be hyperextended. The ECT treatments cause a convulsion. Even allowing for a muscle relaxant there was a risk of extension to the neck.

There was a suggestion from at least one expert and supported to some extent by others that there may have been a cord lesion before the fall. There was certainly a cord lesion which was incomplete after the fall. In all these circumstances I do not think it is possible to say that the accident, the fall on 5 December, resulted in death. Mr Mauchland was significantly immobile in any event as a result of neuropathy and infection. It was infection which led to death. The source of that infection was never found. The accident was a contributory factor but did not itself lead directly to death.

I have explained in the course of this Note why I feel that those responsible for examining Mr Mauchland on admission acted properly. However to repeat I would say that on both the first and second admissions the information conveyed from Liff to Ninewells made no mention of a fall. There were things specifically and urgently wrong which needed attention. There is nothing in any of the Ninewells notes or in the evidence of the various doctors which would suggest that the procedures on admission were anything other than competent. There were explanations for the way he was presenting. While none of the doctors could remember being told of a fall, I accept that it was mentioned by Miss Mauchland but those treating her brother had other priorities which needed treatment as a matter of urgency.

On the third admission it is clear that there was an examination of the central nervous system during triaging as the GCS is 3/15 then 6/15, clearly a picture of a very unwell man. Dr Pullar was aware of the fall and noted it but also had other possible, and in his eyes, more likely explanations for the immobility and lowered conscious state. He was diligent in carrying out tests and having further investigation made. Within two days of admission when other avenues were drawing a blank he asked for a neurologist's opinion. I can see nothing which merits criticism in what Dr Pullar has done.

Further, even if a fall had been recognised as being potentially significant, the steps taken would have been precisely what Dr Pullar organised namely, a CT Scan and a cervical spine X-ray. We know that these would have disclosed no bony fracture and shown nothing to alert doctors that there was anything wrong. If these were clear was it likely that neurologists would have been involved at once? Probably not. Would a MRI scan have been taken? Again, probably not.

In all the circumstances I cannot say that there were any reasonable precautions whereby the death, or any accident resulting in death might have been avoided and I make no findings under sub-section 6(1)(c).

In terms of sub-section 6(1)(d) I require to set out the defects, if any, in any system of working which contributed to the death or any accident resulting in the death.

Once again, the only party who asked me to make a finding under this head was Mr Grant-Hutchison for the family of the deceased. His submissions were: -

- There was a defect in the system for training or otherwise instructing nurses in what should be done in caring for patients who have an unobserved fall which resulted in neck injury.
- There was a failure in communication between nursing staff and Dr Cairns. Such failure would have had less serious consequences if doctors responsible for a ward had developed the practice of reading the nursing notes.
- There was a failure in the triaging system and a failure in treatment in the Ninewells Plastics Unit and a failure to listen to the deceased and Miss Mauchland.

I find that the first of these submissions is too vague and uncertain to enable me to make any finding. How, for example, is a nurse to know that the fall has resulted in a head or neck injury? Is it to be presumed? All the evidence pointed to there being a large number of falls in hospital. I have taken "fall" to mean a situation when a patient has been found on the ground. The patient may have got there in a variety of ways. He may have fallen over as a result of a faint or a trip; he may have fallen out of bed or off a chair; he may have put himself to the floor. The evidence also suggested that a high proportion of falls in hospital are unobserved.

We have evidence from some witnesses that what the nurses in Liff did was perfectly acceptable. They used what training they had and common sense from years of nursing experience. The suggestion that all patients who have unobserved falls should go to Accident and Emergency was regarded as unrealistic and I agree.

I have commented that there should be a falls protocol such as that produced by Mrs Ledingham and I will comment more on that in the next sub-section. Even if there had been a falls protocol, I understood Mr Grant-Hutchison to be critical of the suggestion that a patient should be moved.

I am also surprised that, given that there are a lot of falls in hospitals such as Liff that there was, for example, no neck brace. A fall might cause a neck injury and there might be situations when a neck should be immobilised. The provision of a neck brace would seem to me to be a sensible part of risk management in dealing with

falls in non-general hospitals where there is no immediate access to appropriate medical care.

The next criticism relates to failures in communication at Liff. I do not consider that there was any failure to communicate. Given the passage of time it was hardly surprising that witnesses could not remember precisely what was said, when or to whom. But we had evidence from experienced psychiatric nurses who were quite clear that they had told Dr cairns what had happened and that what they told him would be similar to what they wrote in the notes and the Incident Report forms (IR1). Dr Cairns was aware that Mr Mauchland had been found on the floor as he referred to him as being "found collapsed". The system of briefing doctors is one which seems is in practice throughout large areas of the health service. Doctors do not, as a matter of course read nursing notes. Nursing notes and medical notes serve entirely different purposes although both relate to patient care.

There was no failure in communication between nursing staff at Liff and Dr Cairns and certainly none which contributed to the death or any accident resulting in death. It would be wrong to generalise under the head of this sub-section about the practice of doctors looking at nursing notes. In Liff they are written up daily but there is no guarantee that they would be written up to the actual time when a patient was seen by a doctor. They may be written up towards the end of the shift. The nursing notes will, in Liff, inevitably deal mainly with the reason for the patient being there, namely mental illness. It is clear that patients are seen regularly by doctors, mainly psychiatrists. The doctor/patient ratio seems to be very good. The nurses are specialists and, in this case had a good deal of experience. There is no reason why, given the close relationship between doctors and nurses in Liff, operating in a specialist area, there should be any general rule about doctors reading nursing notes.

Where, however, a patient becomes otherwise ill or requires non-psychiatric medical treatment there may be a case for a slightly different procedure. During the normal hospital day there seems to be access to a doctor who has general medical training. Here Dr Jones was the SHO for ward one and in addition Dr Mowatt had many years experience as a GP. There is a relatively small number of patients and, while we did not get evidence of the amount of non-psychiatric medical care required, it did not seem to be a problem to get a doctor to attend to a sick patient. The situation at night and weekends was different and here we had Dr Cairns on call and responsible for both Strathmartine and Liff. He did not know Mr Mauchland and how he generally presented. It would have done no harm for him to look at nursing notes for the day but it is not clear what they might have told him. The IR1 was probably completed after he had been and, in any event, this is more of an administrative requirement in connection with risk management. I do not know how much of the nursing note had been written when he saw Mr Mauchland. Even if he had been able to read about the cut under the chin and blood in the mouth his evidence was that there was nothing obvious on examination. His examination was regarded by Mr Burns as being thorough. Had it not been, he, Mr Burns, would have told Dr Cairns. It is difficult to say therefore that reading the notes even if they had been fully written up would have advanced Dr Cairns' knowledge a great deal. It would seem to me to make good sense both in the interests of patient care and management and risk management for a doctor who is called to attend an incident which requires

completion of a IR1 form to see the IR1 form and initial it. That would mean that the doctor has seen what witnesses have documented a very short time after the incident and would be able to compare or contrast that with what was said at the time. In this case had Dr Cairns seen the IR1 form there would have been a full explanation of what happened. Even after the event he could then have alerted others if he felt that what he had been told had been in any way incomplete. If the IR1 form is initialled by the attending doctor it would put beyond peradventure the state of the doctor's knowledge.

While I can fully understand that pressure of time and the sheer volume of notes may make it impractical for doctors to read nursing notes as a matter of course, there may be an argument for doctors on call in hospitals such as Liff, when they are called to a non-psychiatric emergency, to read what has been noted, if anything, by the nurses regarding the circumstances giving rise to the call.

The evidence suggested that there was almost a culture in the medical profession of not reading nursing notes. If that is so it is a regrettable culture. Nursing notes do contain valuable information which may be of relevance in the diagnosis or treatment of the patient. While I have no doubt that in most cases most relevant and necessary information is passed verbally, situations could arise where it was not, such as where there was a very junior or inexperienced nurse or doctor. In the present case information about nutrition was on the nursing notes. I have already said that the delay in addressing this issue in Ninewells was unfortunate. It is not clear what, if anything, was conveyed by nurses to doctors about nutrition and lack of feeding etc. A look at the notes might have helped.

I have commented in connection with sub-section 6(1)(c) about the criticism of triaging and communication. I have therefore concluded that there were no defects in any system of working which contributed to the death or any accident resulting in death.

Sub-section 6(1)(e) invites me to determine any other facts which are relevant to the circumstances of death. Having gone through the various written submissions I have noted the following points which parties would wish me to address: -

- Treatment of patients with learning disability (Miss Joughin). She went on to say however that the matter had been addressed by the Scottish Executive.

From Mr Grant-Hutchison.

- Nurses at Liff should, having read their own notes and spoken to Miss Mauchland, have made the connection between the fall and immobility and advised physicians accordingly.
- Nursing and medical staff in Ninewells should have paid greater attention to Miss Mauchland's continuing complaints.
- Between 6 and 8 January 2000 his condition was so serious and volatile that some discussions should have taken place between Miss Mauchland and an Intensive Care consultant and the responsible treating consultant about the possibility of the deceased being admitted to intensive care.

- The deceased should have been assessed by a dietician at an earlier stage of his final admission to Ninewells.
- It was likely, that if there had been a reasonable standard of nutrition and nursing care, that his death would have been made more comfortable and more dignified.
- A nurses with experience of nursing patients with learning difficulties should have been seconded from Strathmartine to Ninewells to act as a key or named nurse for the deceased during his final admission from soon after 15 December 1999 until his death.

From Mrs Robertson.

- The delay in diagnosis of central cord lesion did not affect the deceased's chances of survival. Earlier diagnosis did not afford "a lively possibility" that his death might have been avoided.
- Was it a high standard of medical care?

At the outset I commented upon the length of time between the death and the holding of this Inquiry. In the intervening period it is quite clear that the Scottish Executive has had the issue of mental illness very high on its agenda. There has been legislation dealing with Adults with Incapacity. More legislation is in the pipeline and under active consideration by the Scottish Parliament with the benefit of the deliberations of the Millan Committee. I have already made reference to the publication of the document "Promoting Health, Supporting Inclusion" in 2002. While it may well have been appropriate had this Inquiry taken place soon after the death of Mr Mauchland to have made some comment about the particular difficulties which might arise in dealing with patients with learning disability who are admitted to general hospitals, it is not in general appropriate to do so now as many recommendations or suggestions which might have been made have either been put in force or are under active consideration.

Having said all that it is quite clear that Miss Mauchland spoke to a number of doctors and nurses and, in so doing, mentioned the fact that her brother had had a fall. Bearing in mind that Mr Mauchland was very ill and was not communicating very well with people other than his immediate family, doctors and nurses dealing with him, especially during the first two admissions to Ninewells, should perhaps have recognised and noted that information was coming not from the deceased but from another source namely his sister. I think it is reasonable to suggest that not much information was given to doctors or nurses by the deceased. Where the information is coming from a third party then that should be appropriately noted.

As I have said earlier the nurses at Liff were not dealing with a man who was in robust good health. They had a patient who was not in the habit of moving around and who was nursed generally on top of his bed. He also, from time to time, put himself to the ground. Immediately after the fall he was not completely immobile, giving some assistance to put himself in a wheelchair and, overnight, weight bearing when assisted to the toilet. The following day nurses clearly noted his frail and floppy condition and said that they told Dr Jones. He gave them an explanation for that condition. I do not think that nurses can be criticised in these circumstances for

failing to make any connection between the fall and immobility. They noted him as frail. They alerted a doctor.

I have commented earlier on the question of communication between nurses and doctors at Ninewells on the one hand and Miss Mauchland on the other. Given the likely lack of communication with the deceased, conversations with Miss Mauchland should have been noted better. Searching through the Ninewells notes, some conversations are noted but finding them is not easy. I would commend, for example, the note made by Dr McConnachie of his discussion with Miss Mauchland on 16 December about twenty-four hours after the third admission. Dr Pritchard also made a clear note of a discussion with Miss Mauchland. Given however that few of the witnesses could recall discussions with her it is difficult to reach any judgement or how much or how little attention really was paid to what she was saying.

The question of admission to Intensive Care is an interesting one. Dr Pullar was asked at the length about the circumstances in which a patient would be considered for admission to Intensive Care at Ninewells. We did not have the benefit of any Intensive Care specialists from Ninewells but it appeared from Dr Pullar's evidence that admission to Intensive Care would only be considered where the patient required support with breathing. That was never a consideration in the case of Mr Mauchland although he did appear to be receiving oxygen towards the end. "Support with breathing" was not defined but I presume it must therefore mean more than the simple giving of oxygen. There were never circumstances which gave rise to the possibility of him being admitted to Intensive Care. Between 6 and 8 January 2000 his condition fluctuated. He still had an infection and it is clear from the notes that he had a chest infection. He was receiving oxygen. He was seen by different doctors in this period and none of them of noted that this was a case which should be considered for Intensive Care. Dr Pullar had involved a number of different specialist consultants. He had clearly given a great deal of thought to the treatment of Mr Mauchland. He was adamant that Intensive Care was not an option in respect that he would not have been considered by an Intensive Care consultant to be a suitable candidate for admission and I accept that position. I am not prepared therefore to find that an Intensive Care consultant should have been involved at that stage.

I have already commented that it is not satisfactory that it took so long for a dietician to be involved and for something to be attempted about nutrition. His poor nutritional state was or ought to have been known from a very early stage. From the evidence it was clear he was looking frail and poorly when seen by family members and care workers. It is impossible to say if prompt attention to his nutritional needs would have had any effect on the outcome. There was evidence that he resisted nasal gastric feeding. Clearly the belated attempt at such feeding in Ninewells was not successful. Proper nutrition may have assisted him in his battle with infection. This should have been addressed immediately on admission on 15 December especially as there are notes about nutrition in the previous admission.

It is not clear if the area of nutrition is dealt with by nurses in drawing up activities of daily living or by doctors in carrying out examination and assessing a patient or by a combination of both. There should be a clearly identified practice where poor nutrition is either drawn to the attention of admitting staff or noticed in the course of the triaging process. If nutrition is an issue then steps should be taken immediately

to make sure that it is attended to either by monitoring feeding or by referring at once to a dietician. Medical notes should contain more information about nutrition where nutrition is an issue. Responsibility between doctors and nurses for the monitoring of diet and nutrition may require to be more clearly defined.

I find it difficult to comment on Mr Grant-Hutchison's submission that it was likely that if there had been a reasonable standard of nutrition and nursing care his death would have been more comfortable and more dignified. I simply do not have enough information about the effect that poor nutrition had on Mr Mauchland's ability to fight infection. It is likely that better nutrition would have assisted that fight.

I have made some criticisms of certain aspects of the nursing care in particular the apparent shutting off of Mr Mauchland in a side room with the doors closed and blinds drawn, the temperature within the room, his bedding and state of clothing and the general state of cleanliness of the room. I would make it clear that I see no room for criticism of the nursing care generally. I do however accept some of the family's criticisms in the areas which I have mentioned. There were times when members of the family were concerned about the apparent lack of dignity afforded to Mr Mauchland. He would not speak for himself and due to his immobility could not do things for himself. While I accept that nurses are busy a little more care and attention to someone whose needs were greater than other patients would have been appropriate and would certainly have made Mr Mauchland's eventual death more dignified. Unfortunately there has never been a proper explanation as to why he was shut off in side room. Had he been in the body of the ward then he would have been more easily seen and his needs could perhaps have been better taken care of.

I have addressed the issue of a specialist nurses from Strathmartine earlier in this Determination.

In an ideal world there is no doubt that there would be benefit to any patient who has learning difficulties or who is suffering from a mental illness for that patient to have a specialist nurse with appropriate psychiatric experience with him or her in a general hospital. All medical professionals who were asked spoke about the health service being under pressure. There quite simply does not appear to be adequate resource to do everything that the doctors and nurses would like to do. Realistically it has to be doubtful if there is resource to allow a specialist nurse to go with each patient with learning difficulties or mental illness to act as the key or named nurse in a general hospital even when illness has reached a critical stage. To be in a position where such patients have access to appropriate specialist nurses would be a worthy aim. It appears that the treatment of such patients is something which the Scottish Executive has under consideration and I do not think it appropriate or necessary to make further comment.

I have said earlier that I feel it is doubtful if earlier diagnosis of central cord lesion would have had much effect on the eventual outcome. As I said, even if there had been a CT scan and cervical spine x-ray at the time of the first admission these would have disclosed nothing by way of bony injury. He presented as a very complex picture. His diagnosis baffled even experienced consultants. I regret to say that even with earlier diagnosis it seems to me unlikely that death might have been avoided.

When I look at the standard of medical care as a whole I think it is quite high. It is easy to be critical of individual parts of the whole picture when one has the benefit of hindsight. For example it would be easy to criticise the first two discharges from Ninewells as being premature and perhaps unjustified. The doctors at Liff acted perfectly correctly in sending him straight back to Ninewells when they saw that he remained unwell. On the third admission it is difficult to see what more Dr Pullar might have done. I have criticised the delay in involving a dietician. From the medical point of view however he acted with diligence and competence involving a number of other specialists to help with what was an extremely complex diagnosis with many symptoms possibly masking other illnesses or problems. The short delay between 17 and 20 December when Dr Pritchard appeared remains unexplained and is regrettable. By that time however the final piece of the medical picture was completed namely the complete cervical cord lesion. Her appearance on 17 December would have been unlikely to have made much, if any, difference.

I was particularly impressed in evidence by Dr Pullar and Dr Pritchard both of whom came across as thoroughly professional and caring. They were faced with a set of circumstances which could truly be described as complex and unique. Many of the expert witnesses went to great trouble to say just how complex this case was. Dr Pullar seemed to me to be becoming more frustrated at the fact that his patient was not improving despite his best efforts. His notes are full and informative and I think indicative of the level of care which he afforded to the case.

Having now spent some time both in conducting the Inquiry and in preparing this Determination considering the range of evidence led, I find myself asking whether this Fatal Accident Inquiry was either necessary or justified. I can fully understand that Miss Mauchland had a number of questions which she felt deserved answers in relation to the treatment of her brother following his fall in Liff and his subsequent death. It may be that had there been better communication with her, especially in Ninewells, that some of her questions may have been answered. But I have a lingering doubt about whether the Inquiry was necessary. Clearly it is a matter for the procurator fiscal and I do not criticise his decision to hold an Inquiry. The difficulty which I have is that the Inquiry, as it went on, involved more and more hypothetical questioning and moved away from looking at the circumstances of the death and became more of a public inquiry into the way people with learning disability or mental illness should be looked after in hospital. As I have said the treatment of such people is quite clearly high on the agenda of the Scottish Executive and Scottish Parliament and it has moved on considerably since late 1999 and early 2000. It must have been obvious to all concerned when full medical information was available that Mr Mauchland painted an extremely complex medical picture with a number of aspects which could have led to or significantly contributed to his death. There was in my view no major issue which required to be explored as the single cause of death.

The sheer length of the Inquiry together with the number of expert witnesses will have meant that the exercise has been carried out at considerable cost. There is firstly cost to the public purse by the provision of the court service, the procurator fiscal and legal aid. It was proper and necessary that several of the doctors were represented no doubt at the expense of a medical defence union. It was also proper and necessary that the two health trusts were represented, another area where the public purse is covering the cost. I have no desire to seem unfeeling about the death

of Mr Mauchland or the strong feelings displayed by his sister or the wider issues raised about treatment of people with learning disability or mental illness but I do feel that it is appropriate to note in this Determination that I have serious doubts if the likely very high cost of this exercise can be fully justified. It might be appropriate for the legislature to look again at the circumstances in which a Fatal Accident Inquiry is necessary, the procedures adopted, the scope of such an inquiry and the apparent requirement for nearly everyone who might have been involved at any stage with the care of someone who has died to feel the need to be represented. As long as we have Fatal Accident Inquiries in their present form there should not be such a delay as we had here between the death and the inquiry into the death. Memories have faded with the passage of time thus rendering much of the evidence of limited value. Here much of the medical evidence was predicated by the statement that the witness based his or her recollection on a review of the notes. There was also a considerable input from the benefit of hindsight. For the family of the deceased person the delay in holding an inquiry means that the memory of their sad loss will linger. In this case too, standing the criticisms made of the various health professionals, the delay must have been worrying particularly for the young doctors involved.

In a court procedure where there are no written pleadings to give fair notice of potential criticism, we have seen doctors whose treatment cannot be criticised feeling compelled to have legal representation simply because they, at some stage, had some involvement with the treatment of the deceased and might be subjected to criticism. There may be an argument for requiring potentially interested parties to submit in writing before an Inquiry the nature of their interest and what criticisms they may wish to make.

Finally, it is necessary that I comment on a matter which arose immediately after the close of the Inquiry on 21 February. I was surprised to hear that evening on BBC Radio and see in the course of BBC Television news a report to the effect that the deceased had been taken to Ninewells Hospital three times and the hospital had failed to diagnose his "broken neck". Anyone who had heard the evidence during the course of the Inquiry would know that the deceased did not have a broken neck. I am concerned that a news broadcaster should be given information which was so clearly wrong and which caused a report to be issued which suggested that a hospital may have missed something which ought to have been obvious. The true position here was anything but obvious and I would be very concerned if anyone connected in any way to the Inquiry had misrepresented that position to the broadcaster.