2010 FAI 34

B514/08

Sheriffdom of Tayside, Central and Fife at Dunfermline

DETERMINATION

of

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

in terms of

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

into the death of

MRS MARY MacMILLAN SMITH FORREST (born 1 January 1920)

who died on 29 December 2005

within Queen Margaret Hospital, Dunfermline.

Introduction

May I firstly record my sympathy for the family of Mrs Forrest, who might not have died during her visit to Queen Margaret Hospital in late December 2005. I say "might" with good reason as will be explained later. The Inquiry has left a feeling, and her family will certainly feel, that Mrs Forrest was let down at various times and in various ways during her stay in Queen Margaret Hospital which had some degree of responsibility for her welfare, health and safety. Whether or not she was let down and, if she was, whether or not any of it contributed to her death remains a question that this Inquiry has not been able to fully answer.

One of the few positive things to come out of this Inquiry is that NHS Fife has apparently taken a long and detailed look at procedures and practices and taken some steps to try to ensure that a similar situation does not arise again. Only time will tell. However, it was significant that although some of these procedures and practices were spoken about in evidence, some witnesses seemed to have had little to do with any internal investigation or review or the preparation of the documents put to them. Their contribution, at times, seemed to be little more than a signature at the foot of a document. How new protocols or practices were prepared or by whom remains, in part at least, shrouded in mystery. I have to wonder if the Inquiry may not have been better served if some of the people who actually did the work had also given evidence.

It is also concerning that despite evidence from managers about what has been done to disseminate information, policies and procedures and their aspirations in that regard, there was clear evidence from witnesses, both nursing and medical, that some of them were unaware of some of certain policies or documents. It is also important to acknowledge that NHS Fife took steps at a relatively early date to write to the family accepting that their care of Mrs Forrest was not what it might have been (production 9). That response came following a complaint by the family and an internal investigation. Both the letter and the result of the investigation were spoken to by witnesses. They are relevant to the Inquiry and I reject any suggestion that they are not. I found the suggestion in the submission for the NHS that I should pay little heed to that letter and investigation quite puzzling.

It is not acceptable that this Fatal Accident Inquiry started more than three years after Mrs Forrest's death. I exempt from criticism in respect of this delay the current District Procurator Fiscal and Miss Yusaf, who conducted the Inquiry on behalf of the Crown as it is clear that when they became involved and got to grips with the matter, it proceeded, although not without

difficulty. Quite why those responsible up until the latter part of 2008 took few steps to hold this, or indeed, certain other Inquiries, is something which I had hoped the Crown would investigate. However it is clear to me from the court programme that this shortcoming has been addressed since we embarked on this Inquiry in February 2009.

It also became clear during the course of evidence that there were some witnesses who were not on the original list and who may have had some useful contribution to make. In the end of the day we did hear from some of these witnesses and there was further delay while they were identified and traced. In some cases there was a suspicion that their identity and the identity of "witnesses" from whom we did not hear evidence may have been known to one or more of the representatives at the Inquiry. The identity of a junior doctor from whom we did not hear despite her apparent involvement remains a mystery. Long term sick leave for two of the witnesses did not help matters progress.

If the purpose of a Fatal Accident Inquiry is to investigate **all** the circumstances pertaining to a death then perhaps there should be an obligation on **all** parties who participate in the Inquiry to disclose relevant evidence and witnesses. As it was we did not hear from a staff nurse on the previous shift who had almost certainly had something to do with admission to Ward 8 and may have been able to assist in ascertaining what was known and when about possible staff shortages and what, if anything, was done about it. He may also have answered questions about the admission documentation and, particularly what was said about risk assessment, mobility, risk of falls etc and how much attention was paid to what had been put in the A & E notes. I regard the absence of that evidence as crucial and that lack of the evidence has been a hindrance in reaching a satisfactory determination.

We did not hear from two nursing auxiliaries on the ward who **may** have seen Mrs Forrest wandering around and **may** have seen a "fall" or a slip. We did not hear from a porter who was said to have brought Mrs Forrest back to the ward after she was wandering about in a corridor. She may even have been found on the floor in the corridor. We do not know. As a result we cannot be certain how many falls, slips or trips Mrs Forrest may have had during her short stay on Ward 8, whether they were seen and, if they were, why they were not recorded. There was some evidence that various falls or slips had been mentioned to the internal investigation after Mrs Forrest's death but that is the extent of the evidence. Once again I regard the lack of this first hand evidence as a hindrance in reaching a satisfactory determination. It has a crucial bearing on matters such as risk assessment and observation.

We did not hear from a nursing expert and, given the criticism of certain nursing practices, that is, in my view, a critical omission which seriously restricts the findings and comments about nursing practice. It also limits any recommendations that might be made about nursing practice.

One of the issues raised in submissions was whether or not the death certificate accurately reflected the cause of death and there were submissions that should be changed. However, the pathologist, Dr Brooks Lim, was very clear in her evidence and would not be shifted despite some rigorous cross-examination and there was no contrary pathology evidence. Views were expressed by certain medical witnesses but none had pathology experience and some even said that they would have to defer to the pathologist which makes interference with her conclusions difficult.

Mrs Forrest's family cannot have got closure knowing that this Inquiry was on the horizon and that there were issues they wished aired. They were present throughout proceedings and I would commend them for the dignified and restrained approach they have taken to matters despite the, at times, disorganised nature of the proceedings none of which was attributable to anything they said or did.

I would also wish to express my dismay at the length of time this Inquiry has taken over so many months. Some part of the delay is attributable to the Crown's early inactivity, lack of full preparation and other factors as mentioned above but, there were other issues. It was, for example, clear to me from a very early stage that there was, at the very least, potentially, a conflict of interest in those seeking to represent NHS Fife and the various doctors and nurses. I raised this even before the Inquiry started and again several times after it was in progress. I was constantly assured by Counsel that there was no such conflict and that Counsel would and could continue to represent all of these parties. Eventually, after the doctors had given evidence, solicitors appeared seeking to represent, separately, the interests of the doctors and the nurses. That was, in my view both appropriate and necessary from the point of view of the doctors and nurses but it should have been identified earlier and it did contribute to the delay.

Equally, I have no idea why the various nurses and doctors did not take steps at an earlier stage to at least consider if they needed representation. I presume that intimation was made to them or that at the very least they may have considered their positions when witness citations were served. As I noted earlier there was also the suspicion and suggestion that there had not been in some cases much co-operation to trace witnesses whose identity had, until it emerged in evidence, been unknown to the Crown. The Crown maintained in submission it had asked for information regarding certain potential witnesses. The NHS maintained it had no record of that. The fact remains that we did not hear from certain "witnesses". The Inquiry is incomplete without

that evidence. If there has been any deliberate withholding of information regarding witnesses that would be unacceptable but I do not know whether or not that is the case.

As it is, not only will the Forrest family feel it has been let down by the system of health care in Queen Margaret Hospital in late 2005, it will also feel it has been let down by the legal system and, in so far as I can do so, I apologise to them for that. At times my frustration at the delays and lack of progress has been a little too obvious but my frustration would be as nothing compared with that which must have been felt by the family. The current system of Fatal Accident Inquiries is under review and there are many aspects of this Inquiry which I would hope might assist in that task if only to show how many things can go wrong.

It is also appropriate to commend in particular, Mrs Mary Forrest who, after giving her evidence, adopted the role of advocate for the family. It was a role she performed extremely well and with considerable skill asking many searching and important questions. It cannot have been easy for her going over, time and again, the very sad events which led to the untimely death of her mother-in-law. There were issues she wished to be aired and she made sure they were aired. I am aware that her participation meant she faced certain difficulties and inconveniences in her own life and work. I hope there have not been any unwanted consequences arising from her participation in the Inquiry. I would simply like to record my personal appreciation of the work she put into the Inquiry and the great skill with which she conducted it. Her contribution was invaluable. Her submissions were, in places, controversial and were not in their entirety relevant to the ambit of this Inquiry and in relation to certain aspects of them I would urge that she exercise considerable caution.

The fact remains that in making this determination I must rely on evidence. I cannot reach conclusions based on what we did not hear or on matters which arose purely from hearsay evidence and without any other support. This was a Fatal Accident Inquiry under the 1976 Act and not a wide reaching public enquiry and there are matters which the family felt were important and relevant which I cannot deal with in this determination. I suspect therefore that the publication of this determination may do only a little towards bringing complete closure for them.

After various preliminary hearings, the Inquiry commenced hearing evidence and sat on 23, 24, 25, 26 and 27 February, 24, and 25 March 2009. In April 2009 the very obvious conflict of interest having at last been recognised, approaches were made by solicitors representing the doctors and nurses who sought to represent their interests. We also required an interpreter to assist with the evidence of one of the nurses and this was for a dialect in which there are few interpreters. The need for that interpreter was explained by the Procurator Fiscal depute when we had the hearing on submissions and I accept the explanation. I do not think it was in any way an attempt to

prevent the witness giving evidence. He was clearly very nervous and he spoke with a pronounced stammer. I can understand why the Crown thought it appropriate to seek to make him more relaxed in order that he could give his evidence. The first attempt to get an interpreter was unsuccessful and we were unable to reconvene until 28 May.

By this time three witnesses not on any lists were identified and traced and steps were taken to have them attend to give evidence. Thereafter we sat again on 26 and 27 August after which there was an adjournment to obtain the affidavit of Staff Nurse Pringle who had been on long term sick leave and was certified by her doctor as unfit to give evidence. Consideration was given as to how her evidence might be obtained as she, apparently, had a pivotal role in Ward 8 in the afternoon and evening of 26 December. She was unfit to give evidence on commission. After much discussion it was agreed that an affidavit could be obtained with all parties reserving their position about it being allowed. At that point, having agreed how a statement should be taken and an affidavit prepared, there was, apparently, a change of heart and another management meeting was convened on 23 September at the end of which an amended procedure for obtaining that statement was agreed. The Inquiry sat again on 26 October when, there being no disagreement that the affidavit should be admitted (subject to points to be made in submissions), I directed that it be read into the recording of the proceedings. We also heard from the Crown expert witness and concluded the Crown evidence. On 27 October evidence was led from a witness for NHS Fife and evidence was eventually concluded on 8 January 2009 with evidence fro an expert for NHS Fife.

The witnesses who gave evidence at the inquiry in the order in which they were called were

1. Mrs Rosemary Forrest, the deceased's daughter-in-law;
2. Mrs Mary Forrest, another daughter-in-law of the deceased;
3. Mrs Mary Mair, who has now retired but was the Directorate Manager for medicine of NHS Fife;
4. Mrs Annette McArthur, Clinical Nursing Manager; NHS Fife;
5. Andrew Murray, Clinical Nursing Manager; NHS Fife;
6. Caroline Inwood, who was the Director of Nursing NHS Fife (Operating Division), although currently seconded;
7. John Wilson, Chief Executive of the Operational Division of NHS Fife;
8. Dr Evangelos Dalakas, then a Specialist Registrar at Queen Margaret Hospital now a Consultant at Ninewells Hospital, Dundee.
9. Dr Nicola Chapman, Consultant Physician, Queen Margaret Hospital.
10. Albert Chinyamuchiko, a staff nurse at Queen Margaret Hospital.
11. Lesley Richards, then a Staff Nurse in ward 7 at Queen Margaret Hospital.
12. Brenda Cameron, Charge Nurse at Queen Margaret Hospital.
13. Dr Diane Hildebrand, then a Junior Doctor at Queen Margaret Hospital.

14. Dr Elizabeth Brooks-Lim, Pathologist.
15. Dr James W Davie, former consultant geriatrician, Stobhill Hospital.
16. Ms Janette Owens, Director of Nursing, acute hospitals NHS Fife.
17. Dr George Rhind, Consultant Physician, Dumfries and Galloway Royal Infirmary.

The parties prepared written submissions for which I am obliged and we convened finally on 28 June 2010 to hear supplementary submissions. The submissions are voluminous and I do not propose to annexe them to this determination.

Before dealing with the evidence in the case I would state the obvious and say that the length of time between the beginning of this Inquiry on 23 February 2009 and its conclusion on 28 June 2010 is a disgrace and reflects badly on the whole system of such Inquiries. I have mentioned some of the reasons above but there were further delays while the diaries of all representatives could be found to be clear on the same day. The initial estimate of the length of time the Inquiry would take was also inadequate.

One of the consequences of the very long time between the incident and the Inquiry has been that the memories of witnesses have not been as clear as they might have been. There is a suggestion in the submission for the family that not all witnesses have been entirely truthful or frank in their evidence. I wish to make it clear that I thought that all the witnesses who gave evidence were endeavouring to do so to the best of their ability given the passage of time. I found them all to be generally credible and, for the most part, reliable. Where there was any doubt about reliability it tended to be because the witness could not remember something rather than because I thought that in some way he or she was being evasive or untruthful. Likewise there was some criticism in submission of the evidence from Rosemary and Mary Forrest. They were experiencing a traumatic time when, without any apparent reason or explanation, their mother-in-law's health deteriorated rapidly and dramatically over an afternoon and evening. I accept that they were doing their best to recall events as accurately as possible. Of course there were differences in recollection but I would expect nothing less four and a half years later.

A person who was heavily involved in the events of the day when Mrs Forrest was admitted to ward 8 and had her catastrophic fall was Staff Nurse Catherine (or Kate) Pringle. She was deemed to be medically unfit to attend court to give evidence or even to give evidence on commission. She did, however, sign an affidavit after a detailed statement had been obtained by the District Procurator Fiscal. I believe that in that affidavit she has tried her best to answer what was put to her to the best of her recollection. She was not, however, in court to give evidence.

Her statement could not be challenged. It was obtained long after many witnesses had given evidence so her position could not be put to them. In some areas there were differences between her statement and evidence given by other witnesses. Where there is such a difference I have to prefer the evidence given in court. I say that not because I do not believe Mrs Pringle but simply because there has been no opportunity to challenge her version or to put her version to witnesses.

Chronology of events

The main facts are relatively straight forward and are not contentious. Mrs Mary McMillan Smith or Forrest was a lady of 85 years who had been active and reasonably self-sufficient for her years. For example, she did her own shopping and some gardening. She was at her son's house for Christmas Dinner on 25 December 2005 and her family became concerned at her apparent confusion and drowsiness. This had not improved the next day so her daughter-in-law, Rosemary Forrest, took her to Accident and Emergency at Queen Margaret Hospital, Dunfermline. She was seen there by Dr Dalakas who diagnosed low sodium and increasing confusion. He started her on a saline drip to increase her sodium levels. It was decided to admit her to ward 8 where she went some time around 12 noon. She was seen here by, amongst others, Staff Nurse Albert Chinyamuchiko who helped to transfer her using a slide from a trolley to a bed. The admission notes were apparently completed by Staff Nurse David Cation but he did not give evidence.

There is some dispute as to her mobility at this time. Mrs Forrest said her mother-in-law could not walk unaided and had to be transferred by trolley and a slide to the bed. That was confirmed by Staff Nurse Chinyamuchiko who helped slide her on to a bed. On the other hand the admission documents assessed her to be "independently mobile". As it transpired she was, in fact, "mobile" in so far as she was later walking around the ward. Rosemary Forrest left her believing she could still not walk unaided and she was still very confused. She had a canula in her arm to deliver the saline drip. The nurse who carried out any risk assessment, mobility or falls risk assessment did

not give evidence so we will never know if the notes were accurately completed or on what basis any assessment was made.

What happened over the next three to four hours has to be ascertained partly from evidence heard and partly from productions spoken to by witnesses, in particular production 8 which is a copy of the Investigation Report. Mary Mair said she was aware of three incidents before the fall and would have expected them to have been noted in the notes. They were not noted. In her view each was minor but the pattern was disturbing. As I have indicated, those who apparently told those conducting that investigation about the three incidents did not give evidence to this Inquiry.

Sometime after 13.30 hours it is noted that Staff Nurse Chinyamuchiko did a set of observations on his return from break and noted that Mrs Forrest did not have a canula in situ. He said he asked Staff Nurse Pringle to refit it but this is not her memory. Her memory was that it was on a list for doctors. It is then noted in the Investigation that a nursing auxiliary found Mrs Forrest sitting on the floor between her bed and chair. She ascertained that she was all right and put her back on the chair. There was no direct evidence of that incident.

At around 1400 hours Mrs Forrest having been wandering about the ward was at the nursing station having been asked to sit there for a while. Another nursing auxiliary is noted in the Investigation as confirming that Mrs Forrest was not sitting for long, was walking about each end of the ward regularly and into the doctor's room. She appeared confused and was brought back to sit down at the nursing station. The Investigation goes on to say that at about 1600 hours Staff Nurse Pringle found the patient sitting on the wrong bed. At about 1600 Staff Nurse Chinyamuchiko took a further set of observations. Shortly afterwards at about 1620 Mrs Forrest was sitting on the floor by her bed having begun to slip off her chair. According to Doctor Hildebrand (who was there) she lowered her to the floor to save her slipping. No Incident Form was completed as a result of this (or any earlier) incident. On this occasion the staff nurse (Chinyamuchiko) thought an Incident Form might have been appropriate and that the doctor would complete it. The doctor did not share that view.

At about 1650 a buzzer was heard and this attracted the attention of nursing staff. Staff Nurse Chinyamuchiko heard the buzzer, looked and saw Mrs Forrest fall backwards. He shouted out to the other staff and ran to try and catch her but was unable to do so. She was lying on her back when he reached her. In evidence he said that he thought she may have hit her head on the floor but he could not be sure as he was trying to rush to her. He completed the Incident Form (production 2, page 3). He saw a marked difference in Mrs Forrest although no visible injuries. She was not talking and was, possibly, unconscious. The crash team was called and attended. It

does appear that no-one in the crash team was told that Mrs Forrest may have hit her head. It is unlikely that either Dr Dalakas or Dr Chapman was told of any other fall, slip or trip and if they had been told that there had been three or four "falls" that might have meant upgrading the observation status from general to constant. As it was, general observation was maintained.

After the crash or arrest team left, Mrs Forrest was moved to side room 4. Neurological observations had been instructed by the arrest team and the decision was taken not to perform a CT brain scan unless there was deterioration in consciousness level. That is significant when it comes to consider the evidence of the drop in GCS and what was done about it.

It is clear from the evidence that some neurological observations were taken but the sheet which records neurological observations is missing. There is little reference to such observations in the notes until Mrs Forrest was admitted to the MHDU. At the time of the ward round, which was between 1745 and 1800 hours, GCS is noted as 12/15 and other observations were unremarkable. Staff Nurse Chinyamuchiko spoke of starting to do neurological observations at about 1830 in the side room when another nurse, who turned out to be Staff Nurse Lesley Richards, arrived to assist. She had been sent from another ward by Brenda Cameron, nurse co-ordinator, after the arrest/crash call. She gave evidence that she completed the neurological observations and noted the GCS of 6/15. She said she told Staff Nurse Pringle of this reduction in GCS but then she was given a few other tasks to attend to and then went back to her own ward. Staff Nurse Pringle makes no mention of this in her affidavit but what is clear is that nothing was done by anyone as a result of this rapid deterioration in GCS. Something should have been done. Dr Dalakas had instructed that doctors were to be told if there was any change. By any standard, and even allowing for confusion or drugs, the change from 12 to 6 in such a short time was significant and should have been conveyed to Dr Dalakas. That instruction having been given by the arrest team that a doctor was to be called if there was a fall in GCS, it certainly was not done. Whether or not it would have changed the outcome is unlikely but steps might have been taken earlier to ascertain why the GCS was so low and Mrs Forrest could have been made more comfortable. According to the family they could see she was in pain and had someone been told of the reduced GCS and spoken to the family, some pain relief may have been administered.

The family gave evidence that they thought that no neurological observations were done between about 1830 and the second crash call, but I can see no reason why Staff Nurse Richards should try to mislead the Inquiry and I am inclined to accept that she did carry out these observations. What the family did note however was a fairly marked and serious deterioration in Mrs Forrest's condition. They spoke of twitching or involuntary movements of the limbs and bulging and fixing of the eyes and her face swollen and distorted. There is no doubt that they expressed their concern on more than one occasion to nurses and probably also to at least one junior doctor.

They spoke of a conversation with Staff Nurse Pringle. It seems likely that there were no further neurological observations taken between 1830 and the second arrest call which happened some time around or shortly after 2040 hours.

At that stage Mrs Forrest was seen to be much less responsive and to have some facial twitching. A decision was made to transfer to the medical high dependency unit (MHDU) which was done. There is a note on page 14 of production 2 that a CT scan to the head was instructed at 0230 on 27 December. This disclosed the skull fracture and the haematoma. There was consultation with specialists at the Western General in Edinburgh. The injury was untreatable and the family was told that Mrs Forrest would die from that injury. Some time during the evening of 27 December the notes suggest that Mrs Forrest had transferred to Ward 9. She died at 0130 hours on Friday, 29 December 2005. The Procurator Fiscal was informed and a post-mortem instructed and performed.

That sequence of events was more or less unchallenged in the evidence although there were differences on some of the detail. There are a number of issues raised which merit further comment even though some of them may not have made any difference to eventual outcome. There is some conflicting evidence which complicates the picture. Above all there is incomplete evidence.

Despite all that has been said by various witnesses and suggestions made in submissions, the fact of the matter is that Mrs Forrest **might** not have died had she not fallen in Ward 8 and hit her head. It cannot be said for certain that the death would have been avoided because the pathologist includes reference to coronary heart decease as a primary cause of death. She could not rule out the fact that Mrs Forrest had had a heart attack and that may have caused her to fall. Equally the fall may have generated some heart activity. Likewise her low sodium may have caused her to fall. She may have had a slip or trip for another reason which caused her to fall. I believe it can be said, however, that her death **might** have been avoided had she not fallen. It is unsatisfactory that I cannot provide the family with an answer but the evidence is simply not there to allow me to interfere with the finding of the pathologist. The medical notes make no mention of any concern that Mrs Forrest had suffered any form of cardiac event while in the hospital. Common sense might therefore suggest that the primary cause of death ought to have been the head injury sustained as a result of the fall in ward 8 at about 16.40 hours on 26 December 2005. However, standing the evidence of Dr Brooks Lim and the absence of any expert pathology evidence to contradict her, the conclusion she reached cannot be criticised. While Dr Davie may well have had a view on the cause of death he agreed he was not a pathologist and that he would be slow to criticise. Dr Chapman who had not seen the death certificate before she gave evidence was surprised but also conceded she was not a pathologist.

Much was said about staffing level and observation level and I would intend to comment on both as they are relevant, and, in the circumstances, interlinked. There were times during the evidence when I was unsure if the use of the word "observation" meant just that, i.e. seeing the patient from time to time, or whether its use was meant to convey the hospital's observation policy.

Amongst the issues which are relevant are the following:

1. How many falls, slips or trips or other incidents did Mrs Forrest have while she was in Ward 8? How many times was she found on the ground? By whom was she found when wandering or on the ground? Who if anybody was told if she was on the ground or had fallen? Why, if there were any such wanders, slips, trips or falls, are none noted until Doctor Hildebrand helped her to the floor from a chair? There is thereafter what I will refer to as the "fatal fall". When does an occurrence such as a slip or fall merit the completion of an Incident Form? Who is responsible for completion? What can be concluded form the evidence? Unfortunately we cannot find the answers to all these questions in the evidence.
2. Observation policy. What was the level of knowledge of the observation policy of the various doctors and nurses? Who had authority to vary the level of observation? If there had been the various incidents of slips, trips or falls, or finding on the floor, should the level of observation have been increased? Should the family have been called in to assist with observation? Should the observation level have been changed?
3. Staffing level. What was the appropriate staffing level for Ward 8 on this particular day? Given the knowledge that one staff nurse was to work a double shift to cover absence and they were one other nurse short, what steps should have been taken and by whom to ensure a full compliment of staff? What steps were actually taken and by whom? What was the role of the senior staff nurse on the ward and what was the role of the co-ordinating charge nurse in respect of obtaining additional staff? Was there any restriction on the use of agency or bank nurses at the time? Would the presence of an additional member of staff throughout the shift have made any difference?
4. Provision of intravenous fluids. They having been prescribed and set up on presentation at A&E and apparently still present on admission to Ward 8, what steps were taken and by whom to make sure that the prescription was maintained? When it became obvious that the canula was not in place, what steps, if any, were taken to replace it? When, if at all, was it actually replaced? Did the absence of intravenous fluids play any part in Mrs Forrest's fatal fall?
5. Documentation.

6. Training. What training, if any, was there to undertake the role of co-ordinating charge nurse? What training was there for nurses and doctors in the completion of Incident Forms? What training was there in relation to the observation policy? What training is there or should there be in respect of all practices and policies within the hospital? Should such training be compulsory or voluntary? Should it be across the board for doctors and nurses?
7. Communications – amongst nurses; between doctors and nurses; written and/or verbal?

Observations and "Falls".

In 2005, Fife Acute Hospitals NHS Trust had an observation policy (production 5) dated in February 2002 and signed off by Mrs Inwood, who was the Director of Nursing, but she did not compile it. That policy was reviewed and final draft is dated April 2008 (production 6). The review was said to be led by Charles Sinclair from whom we did not hear. Certain witnesses spoke to these policies but none took part in the creation of a policy document.

In 2005 there were three observation levels which are defined in the policy document which is production 4 for the Crown. These were "general" which is intended to meet the needs of most patients for most of the time. The staff on duty should have knowledge of a patient's general whereabouts at all times, whether in or out of the ward. Patients on this level of observation are considered not to pose any serious risk of harm to themselves or others and are unlikely to leave the ward area. The next level is "constant" observation which is for patients considered to pose a significant risk to self or others. An allocated member of staff should be constantly aware at all times of the precise whereabouts of the patient through visual observation or hearing. The third level is "special" observation which is rarely prescribed and would involve a member of staff being at all times within sight and arms reach of a patient. That would not have applied here being appropriate in the main in high dependency units or in certain mental health situations.

A decision to increase a level of observation is based on a variety of factors, central to which is risk assessment. There are various guidelines within the policy but importantly the decision to increase the level of observation *"should be able to made by the senior nurse in charge of the unit on their own initiative".* It should be followed up by consultation with the appropriate medical staff as soon as possible. Staff are told to feel empowered to raise levels of observation. There was clear evidence of confusion amongst staff as to who could vary observation level. In this case Mrs Forrest arrived in the ward and her admission procedures were completed. She had to be

transferred from a trolley to a bed by means of a slide. She was placed on general observation and she remained at that level throughout her stay in Ward 8.

Should the level of observation have been raised? This point was put to many witnesses and, in particular, there was considerable questioning of two expert witnesses, Dr Davie and Dr Rhind. Each gave evidence about observation policy in their respective hospitals and the terminology used was different in each case and each was in turn different from Queen Margaret Hospital. It was however possible to get a general flavour of the sort of policy operated and the types of observation. The lowest level was a general observation which applied to most patients. There was an increased level where greater observation of a patient was needed. Finally there was a level of one to one observation which was perhaps appropriate in such areas as high dependency or in certain mental health situations. Dr Davie thought there was no doubt that Mrs Forrest should have been on more constant observation than general. He made that assessment based on the fact that there had been two incidents before the fatal fall and the fact that Mrs Forrest was wandering. He felt these two previous "falls" should have been noted and that better observation might then have been done and the fatal fall avoided. As I have pointed out previously and will detail again shortly, the difficulty is that we cannot be sure whether or not there were previous "falls" or indeed slips, trips or wanderings and if there were, how many. It seems likely there were such incidents but we do not know from first hand evidence their nature, effect or consequence. During the course of cross-examination it came out that by two "falls" Dr Davie may have been referring to Mrs Forrest having been sitting on the ground and having been in the chair and been put to the ground by Dr Hildebrand as she was slipping off the chair. I am not however clear about this although he did have access to the internal Investigation Report.

Dr Rhind said that with regard to Mrs Forrest, who had no drip, was wandering and had two or more "falls", he would have expected nurses to be more aware of what she was doing but it would not justify what he referred to as "special observation" which would tie up a nurse to do nothing else. That strikes me as meaning that she should have been on a level of observation higher than "general". However he then said that he might have increased observation to constant observation if there had been wandering in the corridor or if it had happened again, but that would only have achieved the prevention of the patient leaving the room and would not necessarily have prevented falling. In his view the confused patient would have been more confused on admission to the ward and the management plan for a drip was unachievable and that in itself increased risk. It was virtually impossible to keep a mobile patient in bed. While she was at risk of a fit or seizures that led to no different conclusion on observation as most hypo-nutrenic patients do not fit. Even having been seen by Dr Hildebrand teetering in the chair at 1620 did not change his view. It was common for patients to slip off chairs on to the floor. However, the fact that she was lowered to the floor should have been noted and communicated at handover. His other comments about

any earlier falls were based to some extent on speculation as to the nature of the fall. He did not think the fatal fall was avoidable as nothing else could have been done unless someone was actually sitting with the patient. While confused and physically able, there was no way of confining Mrs Forrest to bed, especially if she did not understand why she was being made to stay in bed.

That leads on to how many incidents had there been with Mrs Forrest. We have actual evidence of Mrs Forrest wandering about the ward and being taken to sit at the nurses' station for a while. Dr Hildebrand gave evidence of her teetering on the chair and being put to the floor for her own safety and then put back into the chair. We have evidence of the fatal fall. There is reference in the Investigation Report (production 8) and in hearsay evidence to other possible incidents. She may have been sitting at or on another patient's bed at one point. She may have had another slip from a chair. She may have been found wandering in a corridor. She may have been found on the floor in the ward or corridor. Unfortunately we have no hard evidence of any of these events. Some of them are recorded in the Investigation Report and it is likely therefore they occurred and information about them must have been given to the author of the report by a relevant witness or witnesses. However the witness or witnesses did not give evidence at this Inquiry. Other than saying that the incidents referred to in the Investigation Report in all probability happened, I can go little further and can make little comment on the number or nature of such incidents or any consequences following them. There is no record of them in the notes and if they happened there probably should be. Indeed, Mrs Mair said as much in evidence. The fact that information about these incidents was given to the internal investigation means that somebody knew about them and that they should have been in the notes. There is nothing in the notes. We do not know who should have generated a note. The lack of information in the notes and the lack of communication to Dr Dalakas and Dr Chapman about any earlier "falls" meant that the examination at the first arrest call was carried out on incomplete information.

What can be taken from the Investigation Report is that certain members of staff told the author of the report that they were aware of incidents. If that is the case the incidents were known on the ward. Should something have been done about observation as a result of these incidents? If they were known to Staff Nurse Pringle who was the staff nurse in charge of that shift, then nothing was done.

There is also an issue about who was authorised to change a level of observation. The Crown submitted that although the observation policy may have existed staff were not aware of it and even now, when the policy is an actual document, staff were still not aware of the content and there was no obligation to attend training. The family were even more scathing about the observation policy and I do not intend to detail their criticisms. They do, however, highlight the

fact that Staff Nurse Chinyamuchiko said in evidence that he was unaware of an observation policy when he was on duty on 26 December 2005. He also said that constant observation would have been appropriate "probably". Various witnesses said that nurses would have been continually assessing patients on the ward. That may be so but how much continual assessment could be done when it was a busy ward, a "horrendous shift", one nurse short and, for a period, one further auxiliary short? The unfortunate thing is that we did not have hard evidence of what happened to Mrs Forrest during the three hours or so between 1330 and 1640. If she had a number of incidents (as suggested in the Investigation Report) and they were known to nursing staff then that should have acted as a trigger to alert them that this was a woman who was a risk to herself if she wandered around and therefore a closer eye needed to be kept on her. However, given the business of the ward and the staff level that was not something which could have been easily achieved.

Further, indicative of the state of knowledge of nurses about the observation policy, Staff Nurse Pringle comments in her statement which forms part of her affidavit that *"If you have somebody coming into the ward and just lying on their bed then they are generally observed in terms of the general policy. The constant level of observation is basically an allocated member of staff and they should be in visual or hearing sight. In hindsight somebody like Mrs Forrest should have been under the constant level of observation. Basically, if a patient became a threat to themselves then I would phone the nursing co-ordinator and ask for someone to be put on obs in terms of the policy. Mrs Forrest should have been on constant observation."* Staff Nurse Pringle could not be questioned on what she meant by that but it illustrates yet another interpretation of how the observation policy worked. Some witnesses thought it was a decision made by doctors, some thought a senior nurse could make and here it was thought there was a role for the nursing co-ordinator.

In the submission for NHS Fife it is suggested that the view of Dr Rhind on observation should be considered the correct view. He painted a picture that I feel many people would find slightly scary even if it was an accurate reflection of what goes on in a hospital on a daily basis. Patients wander and can't be stopped; confused patients wander; patients fall and indeed it would be unusual if they did not fall. Against that sort of background can an observation policy ever be anything more than an aspiration in the overall plan to keep a patient safe?

If it was to be accepted that there had been the various incidents before the fatal fall then there is little doubt steps should have been taken to increase observation to reduce the risk of further incidents or falls. As I have said repeatedly we were not privy to evidence of such incidents so I cannot make a formal finding about observations standing all the evidence we did hear. Dr Davie's evidence was what the ward should have aspired to and made perfect sense. However, on the

day, even if someone had decided to increase observation levels, it was unlikely anything could have been done in time to prevent the fatal fall. Those who gave evidence differed on who could make the decision in any event.

It is easy to say that increased observation might have prevented the fall which contributed to Mrs Forrest's death but the fact of the matter is that the fall was seen and Staff Nurse Chinyamuchiko ran to try to save her falling. Short of someone being by her side or trying to ensure she was confined to a bed or a chair it is hard to see that "constant observations" as defined in production 4 (even if there were staff to do it) would have made a difference. However, the comments I make shortly about IV fluids also have some relevance to observation of Mrs Forrest.

Staffing levels

Tied into observation is whether or not there would be or should have been sufficient staff to allow for an increased level of observation. That in turn raises the role of the nurse co-ordinator. The question of observation and having the staff to do it are so closely linked that there is inevitable overlap with the previous chapter and I apologise if there is some repetition. It is however an important issue and may bear some repetition if only to provide emphasis. As already stated it was known before the commencement of the shift that there would be one staff nurse not coming in and Staff Nurse Chinyamuchiko volunteered to do a second shift. That meant that the late shift comprised Staff Nurses Pringle and Chinyamuchiko and two auxiliary nurses. That was one qualified nurse short of their normal compliment. There was some evidence that it may have been known earlier in the day that the ward was aware that they would be one nurse short. Sadly we do not know if that was the case and what, if anything, Staff Nurse Cation or indeed anyone else did about that.

We do know from the evidence that during the course of the afternoon between about 1520 and 1630 one of the auxiliary nurses was escorting a patient home to a nursing home. By that time Mrs Forrest had been wandering around the ward without her canula, had been seated at the nursing station, had wandered again and then, according to the Investigation Report, had been found sitting on the floor and then returned to the ward by a porter who found her outside in the corridor. She was again taken to the nurses' station.

If all that was the case or indeed only that about which we heard in evidence, within approximately two hours of admission, common sense if nothing else suggests that Mrs Forrest

was someone upon whom staff should keep an eye in case she was a danger to herself. She had, after all, needed to be transferred from a trolley to a bed by means of a slide which might suggest there could have been some doubts in someone's mind about the exact extent of her mobility. While none of that may have been noted, someone should have noticed all this activity. Mary Mair would have expected it to have been noted. Bearing in mind that Mrs Forrest was in the ward because of confusion and low sodium, what risks, if any, were attached to her wandering?

Almost immediately thereafter for an hour and ten minutes approximately, the staff compliment was the two staff nurses and one auxiliary. The ward was busy with approximately twenty patients in the twenty five bed ward. It was admitting patients on the day. There was a female patient who was having fits/seizures and needed attention. There was a patient who was dying and who died later in the afternoon. Staff Nurse Pringle was sufficiently concerned about the level of cover that she contacted the co-ordinator and I shall deal with this later. I reject completely any suggestion that the ward was not particularly busy. It may not have been full but there was a lot happening. It was described in evidence as "a horrendous shift". During the period when they were down to three the ward was understaffed. Arguably even when all four were there it was understaffed given the pressures it faced on the day.

The fact of the matter is that even if a decision had been taken by someone that Mrs Forrest required a higher level of observation, there was no staff available to carry out such observation. That was exacerbated in the period when the auxiliary was away. Even if I interpret "observation" as keeping an eye on the patient rather than adherence to any observation policy, it would have been difficult for the three or four members of staff to keep a closer eye than they were already doing on Mrs Forrest. They appeared to have plenty to do and there simply was not enough time for one of them to devote his or her attention to keeping an eye on the bay wherein Mrs Forrest's bed was situated far less do something to physically prevent her wandering.

If all the incidents up to 1600 hours did happen then the staff ought to have been aware of a potential problem. She thereafter was put to the floor by Dr Hildebrand who saw her apparently about to slip from her chair. The evidence of Dr Rhind was that patients do slip from chairs and there is nothing particularly sinister in this. He also said that patients wander. He said that patients fall from time to time and little can be done to prevent it. That may well be a fact but it does not make it either right or acceptable. Common sense again suggests that where there is hard evidence of somebody wandering or being found on the floor, there might be a susceptibility to a fall, slip or trip and a note, even a mental note, might be made of it. This was a patient who should have been getting a saline drip through a canula in her hand. She had low sodium. The drip was to try to rectify that. She was therefore not receiving her prescribed treatment. There is no evidence that anyone did anything about that between her admission and the first arrest call.

Dr Rhind said that implementing a drip for a confused and mobile patient who was wandering was well nigh impossible and that stands to reason. He also said that reduction of fluid intake was another means of increasing sodium level. If Mrs Forrest was being "treated" by reducing fluid then that was by sheer chance as there is no suggestion in the notes or evidence that was considered by anyone.

On the basis of the evidence heard I would be entitled to conclude that there should have been better "observation" of Mrs Forrest, that would have required additional staff but given the number of staff on the ward and the busy state of the ward, it was not possible. I would also state that there was never any justification for the level of observation reaching special. There was probably enough to have justified an increase in the formal level of observation to "constant" but, possibly because everyone was otherwise so busy, it was not considered. There was also some confusion or ignorance about exactly who could make the decision to increase observation level.

I accept the evidence of Dr Rhind that it is not desirable to, effectively, restrain someone in bed. Mrs Forrest was confused but mobile even if the family thought that she may have been unsteady on her feet. There was little which could be done to prevent her wandering around the ward. If she was going to have a fall, slip or trip, then to prevent it someone would have had to have been within arms reach of her the whole time and that was simply neither achievable nor practical. The "fatal fall" was witnessed by Staff Nurse Chinyamuchiko who must have been relatively close by as he dashed to her as he saw her fall. His impression was that she had hit her head on the floor but reviewing all his evidence I wonder if that impression came from hindsight. He did not seem to say so at the time and there was no indication to the arrest or crash team that there had been any potential head injury.

Even if at some point in the afternoon a decision had been taken by someone that Mrs Forrest merited a higher level of observation, it would have taken some time to implement that decision. Consideration would require to be given to the implications for the rest of the ward (Dr Chapman). Would extra staff be needed and if so where would they come from? How long would it take to get such extra staff? Would ward working require to be re-organised to cope with the increased observation necessary? None of that could have been done in minutes or perhaps even an hour or two and, particularly, could not have been done on 26 December 2005 within a short time. Staff Nurse Pringle had already tried to get an extra member of staff and, one way or another, had either abandoned the attempt or failed. Therefore, even if she had been told about all these incidents and had made a decision to increase the observation level, she would have known from about 1500 hours after she had spoken to Brenda Cameron that nothing could be done about extra staff unless she contacted the co-ordinator again to try to persuade her to go out for agency

or bank staff. To achieve all that could have taken several hours by which time, sadly, it was already too late.

While I have reached the conclusion therefore that on the information available there might have been justification to increase the observation level and certainly commonsense suggested that it should be increased, even if it had been done it is highly unlikely that anyone would have been in place at the time the fatal fall occurred. Accordingly any failure to increase observation level is not likely to have prevented the fatal fall. Closer observation in the general sense might have meant that someone would have been paying closer attention to where she was and what she was doing but I have to bear in mind that Staff Nurse Chinyamuchiko saw the fall and rushed to try to catch her so he was relatively close by.

The issue was raised about whether family members could be used to help keep an eye on patients. The evidence suggested that there may be some role but the negatives seemed to outweigh the positives. It was never something which was considered at the time.

Role of the nurse co-ordinator

Turning to the role of the co-ordinating charge nurse who was, on the day, Staff Nurse Brenda Cameron. The role played by the co-ordinating charge nurse has, since this incident, changed quite considerably and it has to be said that the change is for the better although I am still not certain about the amount or quality of training for that role. That seems to derive from experience on the job. That in itself led to Staff Nurses Cameron and Pringle having different interpretations

of the role. The interpretation of Staff Nurse Cameron was different from that expected by management.

In December 2005 the co-ordinating charge nurse had responsibility for bed allocation and the provision of nurses in the wards outwith "normal" ward hours, at weekend and on public holidays. If a ward was short of nursing staff the nurse in charge of the ward would contact the co-ordinating charge nurse to see if further staff might be available. To find further staff the co-ordinating charge nurse should, according to management, in the first place, trawl the other wards in the hospital to see if there was any excess capacity, and thereafter try to get a bank nurse or finally an agency nurse. Staff Nurse Cameron was in some doubt about the requirement to trawl the hospital and felt she perhaps should only trawl the medical wards where the shortage was in a medical ward. That was clearly not the case and it raises an issue of training. If someone in the role has learned that was the way to operate then in the absence of any written guidelines or formal training his or her understanding will never change. If he or she then mentors someone training for the role, any misunderstanding will be passed on.

In this case Staff Nurse Pringle contacted Staff Nurse Cameron and there was a discussion about the fact that someone had not turned up for work and Ward 8 was short and busy. Mary Mair described the shift on Ward 8 that day as being "horrendous" and that same expression is used by Staff Nurse Pringle in her statement. While I accept it was not a full ward, I reject the contention of NHS that it was "far from full". There appeared to have been twenty beds occupied out of twenty five, it was admitting and there were patients who were demanding considerable attention. The nature of admission to hospital has also changed since this incident and that appears to be a change for the better. The date, 26 December, may not be insignificant as it is part of the Christmas holiday. There is a difference of recollection between Staff Nurses Cameron and Pringle over the terms of their discussion, but, regardless of which version is accepted, the upshot was that there was to be no additional help for Ward 8. There is no evidence to suggest that the co-ordinating charge nurse was under any pressure not to go out to bank or agency nurses. If that was the only option available it could have been done but clearly it might have taken have taken several hours to get such a nurse into place even if he or she was available on 26 December. There is no evidence to indicate the availability or otherwise of such nurses. Staff Nurse Cameron in fact gave evidence to the effect that Ward 8 was not scheduled to have a bank nurse on that shift. That suggests that there had been no expectation that a regular staff member might be off and there was no earlier request for a bank or agency nurse.

Unfortunately we are without the evidence of the staff nurse in charge of the earlier shift who appears to have been David Cation and we therefore do not know what he knew or did not know or what he did or did not do in relation to any perceived shortage for the later shift, except that

someone asked Staff Nurse Chinyamuchiko to work a double shift which he agreed to do. That would seem to suggest that earlier in the day there was some knowledge that there was likely to be a shortage in Ward 8 during the late shift. Even with that they were still one nurse short. There was some evidence that someone had called in sick.

Staff Nurse Cameron indicated that training for the co-ordinating role was on the job training and there was no specific training for it. It arose from experience. That seems to have been borne out by other witnesses. That on its own has clearly led to a misunderstanding of what she may or may not have been entitled to do throughout the hospital to try to get assistance to Ward 8. I would stress that is not a criticism on Staff Nurse Cameron. She was presented with the Investigation Report which makes criticism of her conduct in the role on the day. She had not seen this before and she was, quite rightly, incensed at these criticisms without having being given the opportunity to comment. It shone through loud and clear from the expert evidence that if an investigation into an incident is to have any effect at all the results of that investigation must be disseminated amongst all those who were involved and discussed with relevant parties. The failure to inform Staff Nurse Cameron of the conclusions, as far as she was concerned, raises the question of who exactly the management has discussed the conclusions of the investigation with. It lends some credence to the suggestion that regardless of what management says is its policy to educate staff on policy and procedures, it may not always happen in practice. There was evidence, as I have said, about certain medical and nursing staff not being aware of certain policies despite management evidence that should not happen.

On the basis of the evidence heard there is no basis for concluding that the co-ordinating charge nurse was difficult or obstructive or unsupportive in this particular case. This area is one which has been addressed by NHS Fife and it is to be hoped that lessons have been learned about training for the role so that there is a full understanding amongst all parties of what is required of a co-ordinating charge nurse. The improvements to an increased use of bank nursing with a reduction in agency nursing should also be of assistance in filling emergency staffing requirements. The removal of bed management from the role will also help. For the avoidance of any doubt in the future there ought to be specific training for the role of coordinating charge nurse. I understand that at all times when there is no responsible manager on site there is a duty manager on call. It is not clear in what circumstances such a duty manager would need to be involved in staffing issues and once again that is something which needs to clarified and specified to remove any doubt.

Provision of intravenous fluids.

On her presentation at A&E and on examination by Dr Dalakas there, there was a preliminary diagnosis that low sodium was causing Mrs Forrest's problems. She was to be put on to an intravenous saline drip and the appropriate canula was inserted to allow this to happen. There is evidence that when she arrived at Ward 8 and was put on to a bed from the trolley by means of a slide she was still attached to a drip. By 1330 when Staff Nurse Chinyamuchiko was doing a set of observations he saw that she had pulled out her canula. He said that he told Staff Nurse Pringle who appeared to him to have been aware of it. Her position is different and she thought that he had put this on a list of tasks for doctors. Staff Nurse Chinyamuchiko was not trained to replace it and he presumed it would be done. It is not clear when, if ever, it was replaced but what is certain was that up until the "fatal fall" she was never reconnected to an intravenous drip. It is also not clear from the charts how much, if any, of the fluid she actually received. The completion of the chart is unsatisfactory since part of it is scored out which was interpreted in different ways by different witnesses. I think it is fair to say that no witness could say with any certainty how much fluid had been given nor why there was no attempt made to deliver the prescribed fluids. The manner of completion of the fluid chart remains unexplained. That, in my view, is a significant defect in the system of working.

The question arises as to whether the lack of intravenous fluid had any effect on the outcome. It appears from Dr Rhind that in the absence of an intravenous fluid drip another means of treating low sodium is to reduce fluid intake. While that was never formally stated as being the alternate treatment, by default that is what has happened. There is no record of any alternative treatment being prescribed and no record of what fluids, if any, were taken.

It stands to reason that a patient who is wandering around is unlikely to be fitted to a fluid drip. A confused patient is even more unlikely to tolerate the fluid insertion. The fact remains however that intravenous fluid was the prescribed treatment by Dr Dalakas. By 1330 at the latest it was not being administered and that fact was known to nursing staff. It does not appear to have been conveyed to medical staff who would only become aware of it at the crash or arrest call following the "fatal fall". Otherwise it would have become known at the ward round. I agree with Dr Rhind that it would not be appropriate to try to keep someone like Mrs Forrest restrained in any way in order to ensure administration of treatment. Whether or not it would have made a difference there does seem to be a failure of communication for three to four hours in telling medical staff that the prescribed treatment was not being applied. No consideration seems to have been given by anyone to the fact that the prescribed treatment was not being administered. The fluid charts on the notes are in an unsatisfactory state. Entries are scored out and changed. There were differing views on what that meant and that is a concern. I understand that scoring out should not happen. If it does happen then there is doubt about what it means. Is it that the fluid

has been administered? Is it that the prescription has been cancelled? That doubt should not arise. That it does arise highlights another training issue for nursing staff in particular.

However, in the absence of expert nursing evidence there is little that can be concluded. We will never know how much fluid was administered before the canula was removed. We will never know what the entry in the fluid chart was meant to convey. It does seem that if, having removed the canula, fluids were reduced that could have been an alternative treatment for low sodium. But there is no suggestion in the notes that was considered and therefore if it happened it happened by chance or default. We do not know whether or not any fluids were in fact taken. In short we do not know what effect, if any, the absence of the fluid drip made to Mrs Forrest.

Documentation

There are aspects of the documentation which leave much to be desired. I have commented above about the fluid charts. As with many medical notes some of them are actually quite difficult to read and interpret. One of the main failings in this case is the fact that neurological observations having been instructed following the first crash call, the record of any such observations is missing. There was evidence from Staff Nurse Richards that the neurological observations were on a separate clip from the main nursing notes. She said that she completed them and left the clip board at the bottom of the bed. The family said that they did not think that any neurological observations had been done after 1800hrs. Staff Nurse Chinyamuchiko said that he started doing a set and that Staff Nurse Richards came into the room and took over. She confirmed that she did this. I tend to accept that. Neither of these people had any reason to lie or mislead. The family was in a very stressful situation which had moved very quickly from Mrs Forrest simply being a bit drowsy and confused to being bed bound and semi-conscious at best following an unexplained fall. It is no surprise that there were different accounts of what went on in the side room at about 1830 hrs. There was also evidence that the notes would eventually be married together. Somewhere, somehow these neurological observation notes have gone missing. Given that there were different expectations and understandings of the frequency of neurological observations and given the importance of a reduction in GCS to doctors' views on matters, the absence of the notes is important. No-one knows what has happened to them so it is difficult to make any recommendation or suggestion except that there might be less chance of loss of notes if they are all kept together rather than kept separately. I trust this is one aspect that will be considered by NHS Fife in its documentation review.

There are other minor criticisms of the documentation. As presented in production 2 (and I accept that this is an excerpt from the full notes) there is no great logical order or sequence and they were at times difficult to follow. The separation of medical and nursing notes, no cross referencing to notes for fluids, observations etc makes them difficult for the lay person and must make it time consuming for a doctor or nurse. There are pages which are headed up with the wrong name for Mrs Forrest and that is regrettable. That is, I think, simply carelessness rather than confusion of one person's notes with another.

However, to go much beyond what I have said about documentation is difficult. The medical experts made some comment on certain aspects of it and I did not take their comments to be generally critical other than some of the areas I have mentioned. The difficulty arises in respect that many of the notes were made by nurses. Two important nurses did not give evidence one of whom has produced an affidavit and statement. That itself is of limited value. There was no nursing expert to comment on either the state of the notes or the evidence of the nurses as it emerged. I am not therefore in a position to make any further comment or recommendation about documentation.

Unfortunately that means that I cannot make any further comment on the question of risk assessment or falls prevention risk assessment. There was a difference of opinion between the family evidence and the assessment of Mrs Forrest's mobility by nurses and doctors. There was also a difference in relation to falls risk assessment. Unfortunately the nurse who completed the admission notes to ward 8 did not give evidence so we do not know on what basis he assessed as he did. What we do know is that having been transferred from a trolley to a bed by means of a slide, while in the ward, Mrs Forrest was mobile. There is evidence of her wandering around and being asked to take a seat at the nurses' station. There is also evidence that she was, at best, unsteady on her feet which would tend to tie in with the need to transfer using a slide. The sort of assessment done here for mobility or falls risk is objective. There are some guidelines laid out for completion of the assessments but even there anomalies arose and without either the author of the assessments or a nursing expert it is not possible to comment further.

As part of the review of procedures carried out following this incident, hospitals in Fife now use the Fife Early Warning System (FEWS) which is a standardised form of documenting and recording general medical observations. This seems to be a major step forward and is a much more consistent means of recording information. It has the advantage that both doctors and nursing staff are using the same criteria and there is positive guidance on what should happen in specific circumstances. The question of training in its use remains a live issue. The new tools used to assess such matters as mobility are also a step forward provided there is proper and adequate training. Witnesses from NHS Fife spoke to all this but there was no independent nursing

comment. It does appear from the evidence of some of the doctors, including Doctors Davie and Rhind, that the FEWS system is a significant improvement on what was in place before and is an acceptable and approved means of assessment.

Training.

I have commented briefly on the question of training of co-ordinating charge nurses. The whole issue of training is, strictly, not something relevant to this inquiry, but it has been raised by NHS Fife who were at pains to point out what they were doing to educate staff and what was involved in the professional development of staff. The changes are encouraging and welcome. The application of national initiatives in standards in relation to the training of medical and nursing staff is welcome. There remains a lingering doubt, however, that all policies, etc are properly communicated to staff and in turn that the staff are trained on them. I have commented earlier on the observation policy and the evidence of knowledge or lack of knowledge of it. It is not clear if the new observation policy has been disseminated wider or better or whether or not there is a greater awareness of it. The existence of a document was not universally known. There is also a hint or suggestion that certain aspects like falls risk assessment are "a matter for nurses" and that doctors need to have no part in it. There is also a suggestion that there was a misconception about who could change observation status. It is important that **all** staff are aware of **all** policies which have a bearing on the treatment, health or safety of patients. If these policies are contained in documents, while it might be impractical to make sure that all staff actually have copies of documents, they should certainly be aware that the documents exist,

where these documents are kept and they should be readily accessible. There should be some means of ensuring that staff have actually read and understood them. There should be training in important policies and some documented means of ascertaining that any individual is aware of the policy concerned. If something is truly a matter for nurses or doctors then it should say so but all staff need to know what the policy is regardless of who may be responsible for implementation. Such training should be compulsory and subject to audit.

I was concerned that not all training is compulsory. Mrs Owens spoke about all that was being done to improve the delivery of health services in the hospitals in Fife and I accept that many steps have been taken and progress has been made. The Practice and Professional Development Unit (PPDU) is a team of nurses set up to ensure nursing practice is up to date, is the best practice and to issue Compulsory Professional Development (CPD) guidelines. There was now a random audit of patient records using an audit tool. As many as five records a week would be audited. There was some training in record keeping addressed through standards and initiatives like "Getting It Right". There is an attempt to standardise documentation and reduce duplication all with the object of improving care and demonstrating that improvement. There is ongoing work in the electronic keeping of patients' records. A documentation summit involving 100 charge nurses reviewed documents to avoid duplication and to decide what was wanted from unified records.

The FEWS system is now in use and that is the same as or similar to the systems used in many other health boards. The chart was colour coded and there was guidance that if the score was, or remained, high then there should be a reference to medical staff. Five such charts were audited weekly. Nationally, Fife was said to be the most improved in this area.

Training issues for individuals can be identified in their personal development plans or can be raised by a charge nurse. Some training is advertised and staff can apply to attend. There is some compulsory training in areas like handling and hygiene. There are refresher courses. However, there is no compulsion to attend "Getting It Right" and no compulsory training on documentation. There is some targeted training where staff would be made to go and there is also formal and informal training at ward level where the charge nurse feeds down appropriate information on specified topics.

Given the importance of matters such as documentation which seems to be recognised by the increased regime of auditing, I find it hard to believe that there is no compulsion to attend training on "Getting It Right" or documentation. While I accept that there are many other changes both implemented and in contemplation, I find it hard to accept that there should not be much more emphasis on compulsory training. I referred earlier to the poor state of the fluid charts. That

highlights the need for training. As a further example, three witnesses gave evidence in person or affidavit about the role of the coordinating charge nurse. All three had a slightly different view. The role has now changed but, as I understood the evidence, there is still no formal training for the role and that the nurse learns for his or her own experience and that of others. The risk there is that any misinterpretation of the role will perpetuate. The criticism in the internal investigation of Staff Nurse Cameron in her role as coordinating charge nurse and the failure to convey that criticism to her along with her non-acceptance of it highlights the need, in my view, for compulsory training for that role. The fact that she became aware for the first time when she was giving evidence that she had been subject to criticism indicates that management thought that they had identified a fault yet did nothing to train the person criticised. It is all very well to say that any issues with an individual nurse can be dealt with as part of the personal development plan and it is all very well to seek to standardise documentation but without compulsory training in crucial areas how can consistent standards be achieved and what sanction might there be for someone who declines to voluntarily train? The fact that Staff nurse Cameron had not had this issue dealt with as part of her personal development plan speaks volumes. It is also important that all staff nurses, whether likely to act as co-ordinators or not, are fully trained on what the role of the co-ordinator involves. There should be no room for doubt.

Once again my comments must be constrained due to the lack of any nursing expert but I feel that there is enough evidence that I should recommend that NHS Fife reconsiders the whole question of compulsory professional development and training with a view to having **all** staff undertake appropriate continuing and compulsory education to enable them to deliver policies to an acceptable standard.

Communication

Again the issue of communication is one which is only of passing relevance to the Inquiry and my comments on it are hampered by the lack of expert nursing evidence. However, it is clear from the evidence that there were various failures in communication along the line. Bearing in mind that this was a lady who on admission required to be moved by a slide from a trolley to a bed, a number of issues are raised. What was communicated, by whom and to whom, in relation to the various incidents of falls, slips or trips before the incident involving Dr Hildebrand remains unclear. The accident/Investigation Reports make it quite clear that auxiliary nurses had some knowledge but the Inquiry has not heard from these auxiliary nurses. Staff Nurse Chinyamuchiko had some knowledge of some incidents. It is not clear what knowledge, if any, Staff Nurse Pringle had of any incidents. She says she had none. There is nothing noted.

If these things happened then certain if not all of them of them were noteworthy and should have been entered into the notes. That was certainly the expectation of Mary Mair. Being returned to the ward by a porter, if it happened, should have been noted and acted upon especially if this happened after earlier wandering events or after nurses were alerted to her wandering and asked her to sit at the nurses station. If she was returned by a porter who had found her on the floor, regardless of how she got there, that should have been noted. There is, in my view, significant failure here; either the failure to present evidence before the Inquiry or, if we accept the content of the Investigation Report, a failure to note the various incidents and communicate any of them to medical staff.

It is clear from the evidence that the medical staff were not told of any earlier incidents. Dr Chapman was of the view that if she was aware of earlier incidents that might have changed her

view on observation status. Nor were the doctors told that Mrs Forrest may have hit her head on the floor at the time of the fatal fall. That is maybe because, as I have said, I think that Staff Nurse Chinyamuchiko may be recalling that with the benefit of hindsight. The doctors did however seem to carry out a full examination including an examination of the head and found no evidence of injury. Dr Dalakas said that he instructed neurological observations. There was differing evidence as to the frequency of such observations. What did come through, however, was that the instructions were, apparently, not fully implemented. The absence of the appropriate chart is crucial.

It is difficult therefore to be more critical of communication in the absence of expert comment. Emphasis was given time and again throughout the evidence to the necessity of a team approach and such an approach should involve free, open and frank exchanges between medical and nursing staff so that the fullest possible picture is obtained in relation to any patient. That does not seem to have operated well, if at all, in December 2005. Once again steps seem to have been taken by NHS Fife to try to encourage greater and better communication. However, parts of the evidence still contained the flavour that certain things were matters for nurses or matters for doctors and I have to wonder if despite the great aspiration to more communication and openness there still exists some demarcation between doctors on the one hand and nurses on the other. That is simply a suspicion and I would encourage NHS Fife in its aspiration and hope that doctors and nurses will actively contribute to making it work. None of it will work without proper training and I make no apology for raising that again. There are clear areas where the training of nursing and medical staff should be uniform and that training should be compulsory for doctors and nurses.

Should a CT scan have been taken earlier?

If I accept the evidence of the various doctors then the answer is no. If the doctors had been told at the first crash call that there was potentially a head injury, then the answer *might* have been yes. If Dr Dalakas had been told of the significant fall in GCS at around 1830 the answer *might* have been yes.

Unfortunately, after the fall, regardless of when a CT scan was taken, the result would probably have been the same. It is impossible to say that if there had been an earlier CT scan that might have resulted in different advice being obtained from the experts in the Western General Infirmary which might have resulted in surgical intervention. On the best interpretation of the evidence available to me once Mrs Forrest had fallen and hit her head then, sadly, the consequence was inevitable. There was no suggestion that any consideration should have been given to a CT scan on admission although the notes do state that if GCS falls it might be considered. The internal investigation which helped Mr Wilson produce the letter to Mr James Forrest (production 9) suggests that a CT scan should have been done on transfer to the MHDU. That is, however, something said in retrospect. What can be said is that if a CT scan had been taken earlier after the "fatal fall" steps could have been taken earlier to make Mrs Forrest's final hours and days more comfortable.

Conclusions

In conclusion therefore I issue this determination with a degree of frustration as the full picture has not been painted and on the basis of the evidence before me I must be constrained in the findings I can make under the various headings of the 1976 Act. There remain unanswered questions. Mrs Forrest's family will undoubtedly feel that they were let down by aspects of what happened at Queen Margaret Hospital in December 2005. Production 9, the letter to Mr Forrest, caused some comment in evidence and submissions and it is appropriate that I make some comment on it. It was produced at a time when the internal investigation was not complete. The family would have liked to have seen more or at least a follow-up on completion. Counsel for NHS Fife urged that I take care in placing too much reliance on that letter. I do think it is an important part of the evidence. It was spoken to by Mr Wilson and he was questioned on it as he was on production 8 which is the internal Investigation Report.

He conceded that a number of aspects of care had not been of the standard expected and that an action plan was being developed to address these. He acknowledged deficiencies in

communication between doctors and nurses especially in relation to the nature and frequency of observations. Poor documentation in the records and incident reporting and a lack of consistency and continuity in dealing with the family were also matters raised. The conclusions and recommendations of the Investigation are also relevant in this Inquiry.

- Ward staffed at a lower level than usual.
- (Action) Maintain ward establishment and skill mix at or above agreed minimum levels as far as reasonably practicable. There does seem to have been action here by the expansion of the nurse bank and the changed role of duty managers and coordinating charge nurses in filling urgent or unexpected need.
- Inadequate support from coordinating charge nurse.
- (Action) A review of roles and responsibilities of co-ordinators to be undertaken. That may well have been done but there was no evidence to suggest that there was now any formal training for the role or that anything had been done to make sure that all nurses were aware of what that role entailed. If not done that needs to be addressed.
- As a result – inadequate communication on the ward among staff.
- (Action) Clear written guidance to be issued to all co-ordinators and a copy contained in the charge nurse folder. We have not seen that guidance. There was evidence about folders and policies being kept in the ward but what checks are made to ensure that all nurses on a ward have acquainted themselves with the content of these folders?
- Deficiencies in communication between nursing and medical staff.
- (Action) Raise staff awareness of communication issues – identify sources of communication breakdown and facilitate identified education needs. There was not much said about this although it is to be hoped something may emerge from the various initiatives. However, what hope of achieving the aim without some compulsory training for both nursing and medical staff? How easy is it to break what seems to be a culture within the health service as a whole?
- Patient's cognitive status deteriorated throughout afternoon but this was not acted upon.
- (Action) Remind staff of importance of carrying out appropriate and regular observations. The development of FEWS should help in this area with a documented practice if there is a noted change.
- Poor record keeping making it difficult to investigate and verify actions stated to having *(sic)* been taken.
- (Action) Carry out audit of record keeping. This appears to be a work in progress and the involvement of charge nurses in the process is to be encouraged. Again, however, training, probably compulsory, for medical and nursing staff is required.
- Poor quality documentation.
- (Action) Carry out audit of record keeping. Progress is being made here. While it is right that any shortcomings are dealt with by training of the individual concerned, should

the nature and quality of documentation not form part of training under the previous head?

- Failure to escalate the Incident Management Protocol.
- (Action) Work with all charge nurses and night co-ordinators across directorates to raise awareness of Incident Management Policy and escalation procedures.

This document, production 8, was prepared by Mary Mair and given to the Chief Executive and Nursing Director. The Action plan, production 10 is a note of what was to be done following the complaint. This was updated and the update forms NHS Fife production 1. The update was drawn up by Jeanette Owens. While I have referred to some of this it is worth going through the document to see what has been done since December 2005.

There is reference to the Practice and Professional Development Unit which is a team of nurses set up to ensure that nursing practice is up to date, that best practice is in place and to issue CPD guidelines. There is reference to the documentation audit, training in record keeping and standardising documentation to which I referred earlier. When an audit is done a charge nurse will audit a record, make sure it is legible, properly signed off, accurate and that the action matched the information. A report is then made to nurse managers and the information used in personal development plans.

I have mentioned the FEWS score system which seems to be a huge improvement on what went before and now mirrors practice in many other health boards. Again there is a weekly audit. There has been a significant decrease in arrest calls with patients being referred to the critical care team to review if there is any deterioration. This is a welcome move but it does depend on staff being aware of it and having the time to carry it out and document it. Some of that will be addressed in the next development.

Some of the most significant changes have come in the area of staffing. The whole system of admission of patients has changed with the creation of a Medical Admissions Unit. This mirrors what happens across much of Scotland and seems, by all accounts, to be the accepted standard. All medical admissions are taken to the unit and, once assessed, sent to the appropriate specialist area. There are many more nurses employed across the medical directorate. Where additional staff went to a specific area, that had the effect of reducing absence, sick leave and use of bank nurses. The bank of nurses is now part of the establishment and there are now 1,000 staff on the bank. There is also a tool used to assess adequate, over or under staffing. Since June 2007 a Clinical Co-ordinator has replaced the duty charge nurse. They are all charge nurses or senior charge nurses but there is still no formal training. They rely on experience. I have commented on that earlier. Falls risk assessment is done using a new tool whereby, on admission, a patient is

given a score which is part of the record and admission documentation. There is also training for nurses on wards. Work is ongoing in other areas such as reviewing observation policy. The medical directorate team "walk the floor" every morning to make sure that there are no major problems and that there is, for example, adequate nursing cover. These are positive steps but I repeat my reservations about training.

Bearing all this in mind and allowing for the fact that whatever I determine must derive from evidence and not conjecture or speculation, where does which take us?

Section 6 (1) (a) – Where and when the death and any accident resulting in death took place.
Mrs Forrest, who was born on 1 January 1920, died at 0120 hrs on 29 December 2005 within Queen Margaret Hospital, Dunfermline.

The accident which contributed to her death happened at 1650 hrs on 26 December 2005 in ward 8 of Queen Margaret Hospital, Dunfermline.

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

The Procurator Fiscal depute in her submission invited the court to partially accept the findings of the post mortem report (production 3) but suggested that the cause of death should be amended to read "1(a) Cranial Cerebral Injuries and 1(b) Atherosclerotic Coronary Heart Disease." She does not go into any detail about the cause of the fall.

The family adopted a similar line and suggested the causes should be "1(a) Intracranial Haemorrhage, Traumatic Brain Haemorrhage. (b) Cranial Injury. Atherosclerotic Heart Disease".
The reasoning for these proposals is fully laid out in the written submissions. Broadly, however, the argument was that, on admission, the family was told that once the sodium levels were corrected Mrs Forrest would be well again (Dr Dalakas). The injuries sustained as a result of the fall were unsurvivable (Drs Chapman and Dalakas). It was difficult to establish any acute heart incident at the time of death (Dr Davie). Mrs Forrest was seen to fall backwards and hit her head (Staff Nurse Chinyamuchiko). Dr Brooks Lim confirmed that she did not find post mortem evidence to justify Atherosclerotic Heart Disease but "she had to list heart disease on a death certificate if there was any previous sign of it".
In addressing the cause of the fall the family point to incorrect assessment of the risk of falling, unsteady gait and the fact that her prescribed saline drip to remedy low sodium was not being administered.

Mrs Williamson suggested that Dr Brooks Lim gave clear evidence why she could not exclude heart disease and why she had to include it as a cause along with the head injury. From the evidence we had to take care as to what caused the fall; a convulsion related to low sodium or irregularity of the heart (Dr Davie); seizure, slow heart rate or simply a trip over feet (Dr Rhind).

Mrs Donald supported the view that the pathologist's evidence should be preferred. She would not be shifted in cross-examination. The heart disease was so significant it had to remain a cause of death. She conceded that Dr Chapman, whom she represented, was of the view that no heart attack had been suffered prior to death but Dr Brooks Lim said that whatever might or might not have been seen in life it was what she saw in autopsy that led her to her conclusion. The cause of the fall was a collapse due to an unknown and perhaps unknowable precipitator.

Mr Stuart adopted the same line and explained at length in his submission why the evidence of the pathologist should be preferred. She was the only pathologist to give evidence. The court was not entitled to conclude on the balance of probabilities that the cause of death was solely, mainly or primarily cranio cerebral injuries. The cause of the fall was that Mrs Forrest collapsed and fell backwards.

Based on the evidence and not on conjecture about any aspect of the evidence, in particular what the pathologist was or was not told, I must consider whether or not the views expressed by two consultant physicians (Drs Chapman and Davie) should be enough to allow me to change the cause of death certified by a pathologist, Dr Brooks Lim, after a post mortem examination. Both the physicians were of the view that the primary cause of death was the brain injury sustained during the fall. I can readily understand why they came to that view and they cannot be criticised for it. Without the benefit of a post mortem examination that must have been the obvious cause of death to Dr Chapman. Given the cause of death was an issue and that she was the treating consultant, it is perhaps surprising that her first sight of the death certificate/post mortem report was in the witness box. Had she been advised at the time she would have had an opportunity to comment if she felt it may have been mistaken in its conclusion. Dr Davie gave a view based on the documentation presented to him and as a result of questions during his evidence. He suggested that the pathologist received inaccurate information to the effect that Mrs Forrest had had a heart attack. That proposition was not supported in evidence and the suggestion was not put to the pathologist in her evidence. He did concede that he would normally defer to a pathologist and his conclusion was based on him not finding evidence of a coronary incident prior to death.

From the post mortem report there was ample evidence that Mrs Forrest had coronary artery disease. There had been previous heart surgery. Her medication included treatment for high blood pressure. While it may seem obvious to the layman that it was the injury from the fall which killed her, the conclusions reached in an Inquiry such as this require to be evidence based. I could speculate that if two physicians were prepared to disagree with the pathologist then another pathologist may also have reached a different conclusion. It would be difficult to see any pathologist ignoring the condition of the heart when considering the cause of death. Therefore, in the absence of any contrary expert evidence, the cause of death certified by Dr Brooks Lim must remain. It is important to note that no one ever suggested that she had reached any wrong conclusion. It was simply that she had not given priority to the injury sustained at the fall.

Accordingly, I determine *in terms of Section 6 (1) (b) that the cause of death was*
Atherosclerotic Coronary Heart Disease and
Cranio Cerebral Injuries.

The cranio cerebral injuries were sustained as a result of the fall at 1650 hrs on 26 December 2005 within ward 8 of Queen Margaret Hospital, Dunfermline.

Mrs Forrest collapsed and fell backwards. The cause of the fall is unknown and may never be known. She was seen while falling (Staff Nurse Chinyamuchiko) but he did not see her start to fall and could not offer any reason. No other witness saw the fall.

There was evidence from numerous sources about the likely cause of such a fall but all of it was speculation.

- A simple trip although this was discounted by Dr Davie who said it was unusual to fall backwards with a trip.
- A faint, fit or other intracerebral cause.
- A seizure or a partial or complex partial seizure.
- Slow heart rate.
- A heart attack or other coronary incident.

I tend to agree with Dr Rhind that to try to make any finding as to the cause of the fall would be speculation and accordingly

The cause of the fall is unknown.

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

The Fiscal suggested that it was only necessary to consider that death **might** have been avoided i.e. Not consider it a probability but a real possibility that death might have been avoided by the reasonable precautions. On admission the plan was to administer fluids intravenously to effect a gradual rectification of sodium levels. The evidence was that she received at most one bag of fluid and the venflon or canula became detached. There appeared to be no supervision of the administration of liquids. Had the administration been properly supervised it would have been detected earlier she was without a venflon and therefore receiving no fluids. That may have resulted in her being less unsteady on her feet and less confused.
She further submitted that the failure to observe Mrs Forrest in accordance with the condition she was exhibiting had a part to play. She drew attention to the wandering, falls, slips etc. Had she been observed more closely it was likely she would not have been in a position where she could suffer a catastrophic head injury. Staff were unaware of the observation policy and had they been aware and versed in it the death might have been avoided.
Failure to properly document medical records and to pass information to senior staff also contributed to her death. Specific reference is made to the neurological observations and the lowered GCS.
She also suggests that a failure to communicate to Drs Dalakas and Chapman that Mrs Forrest had banged her head as a result of the fall was a matter to be considered.

In their submission the family too draw attention to the observation policy and the failures they suggest contributed to the accident. They make reference also to the risk assessments and failures in that area. Communication or the lack of communication is also raised as an issue. The failure to ensure that the prescribed fluids were being administered is suggested as a contributory factor. They make reference to what they term a "free mobility for patients" policy and that was seen as more important than patient safety. Unsupervised mobility being favoured over receipt of prescribed IV fluids was detrimental to patient safety and care. They also suggest that inadequate staffing levels, poor documentation and record keeping had a part to play.

Mrs Williamson suggests there were no reasonable precautions which could or should have been taken into account by those whom she represented which might have prevented the death or any accident contributing to the death. She concedes that increasing staffing levels during the shift and closer observation might be suggested as reasonable precautions. She urged some caution in dealing with that given the lack of nursing expert evidence. There were also differing views from Drs Davie and Rhind.

Mrs Donald too said there were no reasonable precautions. She went through the evidence as far as it related to those she represented. Staffing levels were one of the concerns and Staff Nurse

Cameron maintained it was not her job to ensure wards were adequately staffed; that was a matter for the nurse in charge of the ward. Her role, as co-ordinator, was to ensure a coordinated approach so that one person approached the bank or agency. It was clear that was not the understanding of others.

Mr Stuart also suggested that there were no precautions. Dr Rhind said the catastrophic fall was not avoidable; it was very difficult to prevent falling and every hospital experienced patients falling. It was particularly difficult with a patient acutely confused and mobile. Restraining was not encouraged, carried risks and could increase confusion. Mrs Forrest was noted by Dr Dalakas as being unsteady on her feet, but many patients are unsteady (Dr Rhind). The unsteadiness was not enough to give rise to a concern she was at specific risk of fall.

In making a determination under this head care must be taken to ensure that the conclusions are evidence based. It is difficult to pinpoint one or two single major precautions which **might** have prevented Mrs Forrest's death. There was an accumulation of factors, many in themselves minor, which, if taken together contributed to the circumstances which led to her fall. Failure to take a number of precautions or failure to be aware of or adhere to policies therefore has a part to play. Such failures include the following:-

- Having been prescribed fluids to be taken intravenously, failure to ensure that prescription was delivered.
- Failure to ensure that the venflon was in place to facilitate delivery of the fluids.
- Lack of knowledge on some parts of either the physical existence or contents of the Observation Policy operated by the hospital or its operation in practice.
- Failure to document instances when Mrs Forrest may have wandered, been found elsewhere than in the ward or have been found on the floor.
- Failure to acknowledge that if the last matter was correct that Mrs Forrest was becoming an increasing risk of danger to herself and therefore required an increased level of observation.
- When the ward had insufficient staff, failure to understand or implement the procedures for obtaining more staff.
- Failure to communicate all that had happened to medical staff either at the arrest/crash call or the subsequent ward round.

That is not a comprehensive list. There are unanswered questions in such areas as falls risk assessment. Nevertheless the whole picture painted is of a series of events, some minor and some less so, which, when taken together played a part in this incident. Proper attention to the administration of her fluid prescription which would have meant proper attention to prevent her wandering and proper noting of all incidents involving her may well have prevented Mrs Forrest

getting into a situation whereby she was likely to fall. That inevitably means that she should have been observed more closely. If there had been earlier incidents reported, as appears from the Investigation Report, that should have been considered. Even if the only evidence was of wandering in the ward, the staff were sufficiently aware of her that she was asked to sit at the nurses' station. Even then she continued to wander and nothing was done. There was no evidence to suggest, as the Fiscal does, that the administration of the fluids would have, in the space of three hours or so, have had much effect on her confusion or unsteadiness.

Therefore, *in terms of Section 6 (1) (c) the following reasonable precautions might have been taken and might have prevented the death:-*

(1) Steps should have been taken to ensure that prescribed intravenous fluids were delivered.

(2) If Mrs Forrest was wandering around the ward or had, at any time left the ward or had been involved in any incidents whereby she came to be on the floor, these should have been properly noted and communicated both to nursing staff and thereafter to doctors.

(3) It follows therefore that steps should have been taken to ensure that staff on the ward were aware at all times of Mrs Forrest's whereabouts.

(4) It further follows that more heed should have been taken of the increasing risk she was presenting to herself and consideration given to better observation.

(5) There was a failure to ensure that the ward was adequately staffed.

(6) There was a failure to communicate all that had happened to Mrs Forrest to medical staff either at the arrest/crash call or the ward round. This resulted in the examination of Mrs Forrest after the fall being conducted on the basis of incomplete information.

Section 6 (1) (d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death.

The Fiscal repeated certain of the earlier arguments under this head, A failure to keep proper observation; a failure to keep neurological observations as instructed; understaffing; no proper course of action to be followed once staffing levels reached a critical point; the system of communication between the staff nurse in charge of the ward and the nurse co-ordinator; failure of the nurse co-ordinator to carry out her duties; failure to identify that staff were required in ward 8 and, as a result failure to act on that; poor communication within the ward and to medical staff; poor documentation.

The family highlighted many of these points in their submission without directly referring them to this sub-section but they are relevant here.

Mrs Williamson said it could be argued there was a defect in the system in place for obtaining an additional nurse but such defect as there may have been did not contribute to the death. The fall (and death) could not have been prevented (Dr Rhind).

Mrs Donald makes no great comment under this head suggesting that those she represented were working within a system and no findings should be made (with regard to them).

Mr Stuart submitted there were no defects which contributed to the death or the accident.

I have made comment on many of the areas suggested by the Fiscal and do not intend to repeat them here.
- Observation of Mrs Forrest.
- Failure to ensure delivery of prescribed intravenous fluids.
- Neurological observations.
- Staffing levels and the procedures for getting more staff.
- The role of the nurse co-ordinator.
- Communication.
- Record keeping and documentation.

There were defects in each of these areas which made a contribution to the death or the accident contributing to the death or the whole circumstances of the death.

Lack of proper observation tied in with an apparent ignorance of the detail of any observation policy meant that Mrs Forrest was able to wander at will when she should have been receiving intravenous fluids. No one seemed to accept responsibility for re-attaching the canula to enable fluids to be administered. Staff Nurse Chinyamuchiko certainly noticed it and reported it but nothing was done. He was not qualified to do it and says he asked Staff Nurse Pringle to do it. She says in her statement that she thought it was on the list for the doctors to do. That evidence in itself illustrates a problem with communication. Also, if it was to be left to the doctors that would presumably have been at the ward round four hours or so later.

The failure to either do the requested neurological observations or to record them or to lose the record, while not contributing directly to the death or accident, is indicative of the little things that were not done properly and the accumulation of little things paints an unhappy picture.

Staffing levels have been dealt with. The ward was under-staffed. We have no idea when that was known although the morning shift must have known something if Staff Nurse Chinyamuchiko was asked to work a double shift. What was known about the other "missing" nurse and when that was known remains a mystery. The ward was even more short staffed for just over an hour when

an auxiliary took a patient home. That was after Mrs Forrest had been wandering and had been asked to sit at the nurses' station and was without her canula. There may also have been other incidents before this. The ward was busy and the situation was critical.

There was then a conversation between Staff Nurse Pringle and Nurse Co-ordinator Brenda Cameron each of whom has a different recollection. Either way, there was no further help forthcoming at that stage. There was clear misunderstanding of the role of the nurse co-ordinator in obtaining assistance for a ward which was under staffed.

There is evidence that communication amongst nurses was not all it might have been. If the previous incidents, as reported to the Internal Investigation did take place there is no record in the notes. It is not clear who, if anyone, knew about them. If anyone did know then nothing was noted or done. There was no alarm bell that Mrs Forrest might be becoming a danger to herself. That too was something which, when taken with everything else, was a defect which helped contribute to the accident.

Therefore in terms of Section 6 (1) (d) the following defects in system of working contributed to the accident resulting in death:-

(1) There was insufficient regard paid to Mrs Forrest's unsteadiness and the fact that she was transferred to a bed by a slide. There was too little attention paid to her when she started to wander around the ward. There was a failure to be aware of where she was at all times.

(2) There was a failure to ensure delivery of prescribed intravenous fluids.

(3) There was a failure to properly document prescribed fluids.

(4) There was a failure to note or document all or any incidents which had occurred and involved Mrs Forrest wandering or being off the ward or being on the floor.

(5) There was a failure to ensure that the ward was adequately staffed.

(6) There was a failure to understand and implement the procedures for obtaining additional staff when a ward was short staffed.

(7) There was a failure to take and record neurological observations as instructed.

(8) There was a failure of communication between nurses and also between nurses on the one part and doctors on the other.

(9) There was a failure to respond to the lowering of the GCS to 6/15.

(10) There was a failure to respond to family concerns expressed to nursing staff between 1830 hours and the second arrest call.

Section 6 (1) (e) Any other facts which are relevant to the circumstances of the death.

The Fiscal acknowledged the steps taken by NHS Fife to make improvements in staffing, dealing with absenteeism and observation policies. However, she was critical of the fact that certain training issues relating to charge nurses and nurse co-ordinators were optional and not obligatory.

The family raised many issues and express some uncertainty that certain managers have fully understood or addressed the issues raised in the Inquiry. Specific points raised by the family include management on duty at weekends or during public holidays, accurate record keeping, staff training, the Patient Safety Initiative and the lack of any means of assessing ongoing training or improvements. They raise a number of other issues which they describe as "relevant" upon which I propose to make little or no further comments as many of them fall outwith the ambit of this Inquiry.

Mrs Williamson raised a number of topics under this head. Neurological observations and CT scan; IV fluids; Communication; Pain/Physical signs of head injury before admission to the MHDU; Nursing documentation; experience of nurses. She suggested that there should be no recommendation for any action against the nurses.

Mrs Donald said that any facts here must be relevant to the circumstances of Mrs Forrest's death and not general facts relating to the actions of those within Queen Margaret Hospital. There were no such matters concerning her clients.

Mr Stuart maintained there were no other facts which were relevant. He went on to mention a number of areas which have been raised in the evidence. The adequacy of documentation was irrelevant and the lack of a nursing expert presents particular difficulty. It was accepted that there was merit in the proposition that if a patient only receives part of a prescribed volume of intravenous fluid the amount received should be recorded. The neurological observation chart should not have been lost. Training was also irrelevant as was communication. Issues relating to care following the fall were not relevant. While it was accepted that the reduction in GCS to 6 was not properly acted upon it was not possible to say where in the chain of communication the failure occurred. The question of communications with the family was also irrelevant. He finally referred to changes made since December 2005 and these were contained largely outlined at pages 110 to 118 of his written submission.

In looking at matters under this sub-section, I disagree with the suggestion that many matters are irrelevant. The hospital itself recognised that there had been certain failings and set up an action plan to remedy these faults. There have been other local and national initiatives which have also addressed matters raised in this Inquiry. It is important to highlight what has been done and what continues to be done.

I have made mention of the closing of ward 8 as it was in December 2005 and the creation of the Acute Medical Admissions Unit into which all medical admissions are put to be assessed with a view to receiving the appropriate treatment. There is attention to skill mix and more staff on that ward. From the evidence of Drs Davie and Rhind such a unit seems to be what is operated in many hospitals across the country and is what might be termed the "industry standard". That is without doubt a positive step.

It is also encouraging to know of the changes made in relation to staff. The new AMAU has seen an additional 9 full time equivalent nurses and there has been a review of the skill mix. In addition, further nurses have been or are being recruited. This has had an effect on absence levels and has seen a reduction in complaints and in the use of bank staff. The bank itself is larger and is now part of the establishment. Accessibility to the bank has improved especially at weekends and on holidays. The fact that bank nurses are part of the establishment means they are subject to CPD and training. According to Mrs Owens the result is that the chances of a ward getting the staff it needs is now 98%.

Another change has seen wards having a senior charge nurse and a charge nurse who each try to work opposite shifts to ensure a senior person is on duty during the whole of daytime shifts. The AMAU has more senior staff. At weekends there is a charge nurse on duty within each ward. A duty charge nurse is available on public holidays. The duty charge nurse can now telephone the nurse manager at home for advice or support and there are identified on call managers. There is a new regime for medical cover in the hospital at night.

The role of the charge nurse co-ordinator has changed. S/he no longer manages beds and his/her only role is in the deployment of staff and estate and pharmaceutical requirements. Bed co-ordinators deal only with beds. There remains the issue of training of co-ordinators. The evidence from various witnesses was that coordinating charge nurses were experienced and senior charge nurses and, when they start to do the job, they are aware what is involved. There is some shadowing and they receive information about what is expected in the role. Mrs Owens said that the job did not lend itself to classroom style training. In 2005 there was training covering policies and procedures and a folder containing information showing the standard preferred ward staffing levels. Now there are guidelines and a "purple folder" with information on how to go about getting additional staff, bank nurse numbers, incident reporting and other matters. This has all been updated since 2005. The removal of bed management has helped the role. A nurse manager also walks round the hospital every day to check for issues and action them.

It has to be said that these are all changes for the better but unless and until training is uniform and compulsory there has to be a chance that misunderstandings will persist. If learning the job is done by mentoring then such misunderstandings are likely to be inherited by those learning. A written specification of the role and formal, obligatory training should be considered for all those who are currently undertaking or those who will undertake the role of nurse co-ordinator.

Patient safety is something which has attracted a national programme with the aim of reducing harm to patients as much as possible. Medical staff are involved which is good. However, according to Mrs Owens, staff are kept aware of developments by means of a notice board on each ward. That lays the onus on individual staff members to read the notice board. Patient safety is one of the major issues in any hospital. Is it enough to update staff by such notices or should there be a more formal system of information provision with some sort of audit check to ensure that staff are keeping up to date? In my view training on patient safety should be more proactive and rigorous.

The hospital recognised weaknesses in documentation and, in fairness, seems to have done something to address some of the issues. There was evidence that documentation had improved but I have seen no up to date documentation with which to draw comparisons. The auditing of records certainly seems to be more frequent and more robust. Some staff nurse time is allowed for audit purposes and there can also be spot and random checks. Inadequacies are drawn to the attention of relevant staff and failures could lead to disciplinary action. There is training for nurses in documentation and much more communication about issues in documentation. Study days and record keeping training is held. There is a national initiative on Clinical Quality Indicators and that includes issues such as falls prevention and nutrition. A unified record is being worked on with a view to all health care professionals using a single document for a patient. Electronic records are under development. There have been changes to FEWS charts based on lessons learned in this and other cases.
All of this is to be commended but it will be at its most effective only if staff training is obligatory.

According to witnesses, risk assessment documents have been developed and improved. In 2006 falls awareness training was introduced and a new risk assessment tool was put in place with training for staff nurses. It is difficult to comment on the question of risk assessment in this case as we did not have evidence form the person who carried out the assessment. Clearly any initiative designed to reduce the risk and instance of slips and trips is to be welcomed. Again, however, the effectiveness will depend on training.

Communication in some areas has improved. The fact that a nurse manager walks the floor daily gives an opportunity for ward staff to have contact with senior staff, something they did not have

in the past. Situation Background Assessment and Recommendation (SBAR) is a new tool introduced to assist verbal communication and written records. By applying a consistent standard it should make the handover at shifts more thorough. It is used by nurses in writing notes which ought to make records clearer. It should also make for much more consistency. A patient safety briefing two or three times a day brings members of the ward team together to discuss issues. That is another opportunity for communication. Mrs Owens holds a quarterly meeting with charge nurses and the Chief Executive has joined these meetings. She also said she issues a weekly "Twitter" mail although I have reservations about the effectiveness of such a means of communication and trust that it would not be used as the only means of communication for matters which might be seen as important.

The family was particularly critical of complaints handling and, it has to be said, with some justification. The hospital seems to have accepted that its complaints handling system was not as good as it might have been and taken steps to improve them. Within "normal" working hours there is a manager on site to deal with complaints as they arise. Ward staff are now better trained and equipped to handle complaints. If support is needed out of hours contact can be made with a senior nurse manager or directorate manager and a person at that level is on hand on public holidays. At the monthly meeting with nurse managers complaints now form a part of the agenda.

It is important to recognise that both Dr Davie and Dr Rhind said that what was being done was positive and moving in the right direction. As it is now so long since Mrs Forrest died and steps have been taken in many areas where there could have been criticism there is little to be achieved by making suggestions simply because the matter has arisen in the evidence. Partly due to the passage of time, partly due to the expert evidence I did hear and partly due to the lack of certain expert evidence I do not feel that it is appropriate to make any recommendation which might lead to disciplinary action being taken against any individual member of staff.

I should comment on one or two of the points made in the family's submission. They suggest that Staff Nurse Pringle may have given someone else's medication to Mrs Forrest and this may have resulted in the sudden change in her demeanour. I have re-read Nurse Pringle's statement and that part of it is open to different interpretations. Unfortunately we have not been able to clarify it. It does say "when I was giving her the medication" but there is no medication referred to in the notes, she was at the wrong bed so can we be sure who the "her" referred to? She then goes on to say she took Mrs Forrest to her own bed and told her to wait while she (Nurse Pringle) got the medicine. There is no further reference to medicine. It cannot therefore be said with any certainty at all that Mrs Forrest was given any medicine never mind wrong medicine.
On page 16 of their submission they list a number of suggested failures in meeting clinical care and for completeness I will comment briefly on these.

Failure to maintain dignity. This is not a matter for this inquiry.

Failure to keep safe from harm. In respect that she fell and sustained catastrophic injuries, under explanation, that must be correct. The explanation comes under certain other heads in this list.

Failure to correctly assess care requirements. I cannot comment further in view of a lack of evidence before the Inquiry.

Failure to provide a correct prescription for medication. I am not sure what is meant here but it is tied with the next head.

Failure to ensure receipt of a prescription in the form of IV fluids. There is no doubt that there is merit in this complaint. It did not happen and there was no explanation why it did not happen or what the consequence may have been of it not happening.

Possibly giving oral medication for another patient. I cannot find that to be established.

Failure to keep accurate clinical records. It is clear there were errors in record keeping and documentation.

Failure to react to or notice the rapidly deteriorating condition. Clearly nothing was done following the GCS score of 6/15 which should have rung alarm bells.

Failure to re-assess her care plan. There was some evidence about this and the consensus from medical and nursing witnesses seemed to be that it was not appropriate to continually re-assess care needs.

Failure to observe prior to and after the catastrophic fall. There is some merit in this criticism.

Failure to provide enough staff to ensure the observation policy was workable at all times. I have difficulty with this as it is expressed. I agree that there was a failure to provide enough staff on the day. However, given that the need for observation of any patient might change at short notice, it might not be reasonable to expect there to be extra staff "just in case".

Failure to ensure there was pain relief. On the evidence of the family that may be correct but the doctors were adamant that there was no indication of pain relief being required until quite late in the day.

Failure to communicate about falls. The absence of notes and evidence other than documents or hearsay suggests there may be something in this but there is also a lack of first hand evidence before the Inquiry. It would be reasonable to say there were probably other incidents and, if there were, the lack of communication and action is a failure.

Failure to communicate promptly and truthfully with the family. I am not prepared to comment on this except to say I do not think any witness was untruthful in his or her evidence. In particular I would make it clear that I do not accept any suggestion that Dr Hildebrand misled the court on any point.

I do not accept that there was any neglect or incompetence by doctors. There was a lack of communication and that had consequences but it did not amount to neglect or incompetence by a doctor.

I cannot comment on any criticism of Staff Nurse Pringle as she has not been able to have the criticisms put to her with a view to response. She does, however, appear to concede in her affidavit that she found it difficult to deal with the family.

One area which does cause some concern is training in its many aspects.
There should be defined rules or guidelines for nurse co-ordinators and compulsory training for them.

All staff nurses or charge nurses who are not acting in the role of nurse co-ordinator should be fully aware of the role of co-ordinators.

Much more training on procedures including risk assessment, observation and documentation should be compulsory.

There should be a means of auditing the participation of nurses in training and appropriate sanctions if there is a failure.

The training of doctors and nurses in areas such as communication, documentation and observation should be more co-ordinated so that the same training is applied across all disciplines.

In more general terms I suggest that any party represented at a Fatal Accident Inquiry should be under a duty to disclose to all other parties and to the court all information relevant to the Inquiry and the identity of all witnesses who might assist the Inquiry in reaching a determination.

Because of the steps taken by NHS Fife since this incident in December 2005 there is nothing else that I feel it appropriate to suggest. As I have said, the family may well feel that they have not got the answers they want or deserve. I hope that I have explained why I think that is the case. There is no doubt in my mind that the death of Mrs Forrest and subsequent investigation by NHS Fife disclosed a number of shortcomings and faults. Not all of them had a bearing on Mrs Forrest's death but they did expose faults and weaknesses in the system. Certain of the faults were acknowledged in the letter to the family. The whole process may have acted as a wake up call since they have taken steps to ensure their systems are tightened. There are still matters needing attention and some things are works in progress. It is essential that it is recognised that all of this must be continuing and progressing.

One thing that management of the NHS in Fife can take on board is the fact that it was apparent throughout aspects of the evidence that regardless of their aspirations about training, education or policies, the information was not necessarily getting to those on the ward floor. If this Inquiry achieves little other than an improvement in the provision of ongoing education and training it will have been worthwhile.

Formal Determination

The Sheriff finds in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Section 6 (1) as follows:

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

Mrs Mary MacMillan Smith Forrest, who was born on 1 January 1920, died at 0120 hrs on 29 December 2005 within Queen Margaret Hospital, Dunfermline.
The accident which contributed to her death happened at 1650 hrs on 26 December 2005 in ward 8 of Queen Margaret Hospital, Dunfermline.

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

the cause of death was
Atherosclerotic Coronary Heart Disease and
Cranio Cerebral Injuries.

The cranio cerebral injuries were sustained as a result of the fall at 1650 hrs on 26 December 2005 within ward 8 of Queen Margaret Hospital, Dunfermline.

The cause of the fall is unknown.

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

(1) Steps should have been taken to ensure that prescribed intravenous fluids were delivered.
(2) If Mrs Forrest was wandering around the ward or had, at any time left the ward or had been involved in any incidents whereby she came to be on the floor, these should have been properly noted and communicated both to nursing staff and thereafter to doctors.

(3) It follows therefore that steps should have been taken to ensure that staff on the ward were aware at all times of Mrs Forrest's whereabouts.

(4) It further follows that more heed should have been taken of the increasing risk she was presenting to herself and consideration given to better observation.

(5)There was a failure to ensure that the ward was adequately staffed.

(6)There was a failure to understand the role of the nurse co-ordinator in helping to achieve adequate staffing on the ward.

Section 6 (1) (d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death.

(1)There was insufficient regard paid to Mrs Forrest's unsteadiness and the fact that she was transferred to a bed by a slide. There was too little attention paid to her when she started to wander around the ward. There was a failure to be aware of where she was at all times.

(2) There was a failure to ensure delivery of prescribed intravenous fluids.

(3) There was a failure to act to replace the removed canula.

(4) There was a failure to properly document prescribed fluids.

(5) There was a failure to note or document all or any incidents which had occurred and involved Mrs Forrest wandering or being off the ward or being on the floor.

(6) There was a failure to communicate any such incidents to medical staff.

(7) There was a failure to ensure the ward was adequately staffed.

(8) There was a failure to understand and implement the procedures for obtaining additional staff when a ward was short staffed.

(9) There was a failure to take and record neurological observations as instructed.

(10)There was a failure of communication between nurses and also between nurses on the one part and doctors on the other.

(11)There was a failure to respond to the lowering of the GCS to 6/15.

Section 6 (1) (e) Any other facts which are relevant to the circumstances of the death.

(1)There should be defined rules or guidelines for nurse co-ordinators and compulsory training for them.

(2) All staff nurses or charge nurses who are not acting in the role of nurse co-ordinator should be fully aware of the role of co-ordinators.

(3) Much more training on procedures including risk assessment, observation and documentation should be compulsory.

(4) There should be a means of auditing the participation of nurses in training and appropriate sanctions if there is a failure.

(5) The training of doctors and nurses in areas such as risk assessment, communication, documentation and observation should be more co-ordinated so that the same training is applied across all disciplines.

(6) In more general terms I suggest that any party represented at a Fatal Accident Inquiry should be under a duty to disclose to all other parties and to the court all information relevant to the Inquiry and the identity of all witnesses who might assist the Inquiry in reaching a determination.