

SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

2013 FAI 15

Determination

by

Colin William Pettigrew, Esquire,

Sheriff of North Strathclyde at Paisley

in a

FATAL ACCIDENT INQUIRY

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

Concerning the death of

**JOHN WILLOCK (DOB 02/08/1966),
residing latterly at 6 Parkhill, Erskine**

INTRODUCTION

THE FATAL ACCIDENT INQUIRY

Fatal Accident Inquiries in Scotland are held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. Section 1(1)(b) of the Act provides that where it appears to the Lord Advocate to be expedient in the public interest that an inquiry under the Act should be held into the circumstances of a death on the grounds, among others, that the death was sudden or unexplained or has occurred in circumstances such as to give rise to serious public concern, the procurator fiscal may apply to the Sheriff for the holding of an inquiry. In this case, having regard to the fact that Mr John Willock died at home having made repeated telephone calls to NHS 24, at a time of the year when his own General Practitioner’s surgery was closed due to holidays, requesting medical advice and assistance prior to his death, the procurator fiscal took the entirely appropriate step in applying for a Fatal Accident Inquiry into his death.

Section 6 of the Act provides, so far as relevant to the Inquiry, that the Sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:

- a) where and when the death took place,
- b) the cause or causes of the death,
- c) the reasonable precautions, if any, whereby the death might have been avoided,
- d) the defects, if any, in any system of work which contributed to the death, and
- e) any other facts which are relevant to the circumstances of the death.

The purpose of this Inquiry was restricted to the circumstances relating to the death of Mr John Willock. It was to enlighten and inform those persons who have an interest in the circumstances of his death. An Inquiry is to ensure that members of the deceased person's family are in possession, so far as possible, of the full facts surrounding the death. The broader function of the Inquiry, within the scope of the Act as I have outlined, can be additionally to ensure that the circumstances are fully examined and disclosed in the public domain.

The Inquiry was not a general inquiry into the workings of NHS 24. The Court proceeds on the evidence before it. My powers do not go beyond making a determination in relation to the circumstances relating to the death of Mr John Willock as established to my satisfaction by the evidence led before me. Mere speculation is to be avoided. There has to be material evidence, proved on the balance of probabilities, which satisfies the Court on the material

points. At an Inquiry under the Act it is for the Crown and the other parties to call such witnesses as they consider appropriate, not for the Inquiry itself to do so.

REPRESENTATION

At the Inquiry the Crown was represented by Ms Elizabeth Ross, Senior Procurator Fiscal Depute. The partner of Mr John Willock, Ms Carolann Rogers, was represented by Mrs Laura V. M. Ceresa, Solicitor, Glasgow. Drs Murray MacPherson, Tracey Hanley and Patrick Branchfield were represented by Mr James Stewart, Solicitor, Edinburgh. Nurse Advisors, Fiona McCulloch and Pamela Scally were represented by Ms Catriona Watt, Solicitor, Edinburgh. Ms Helen Watts, Advocate, instructed by the Central Legal Office, Edinburgh appeared on behalf of the Greater Glasgow and Clyde Health Board Out of Hours Service. Lastly, NHS 24 were represented at this Inquiry by Mr Douglas Ross, Advocate, also instructed by the Central Legal Office, Edinburgh.

Numerous productions were lodged and referred to during the Inquiry. All parties lodged detailed written submissions following the conclusion of evidence. I am indebted to the Solicitors and Counsel for their very obvious careful and voluminous preparation and for the way in which they elicited the evidence before me. Their actings have greatly assisted me in coming to my Determination.

WITNESSES

The following witnesses were led on behalf of the Crown:-

1. Ms Carolann Rogers, partner of the late Mr John Willock.

2. Mr Alfred Thomas Rogers, her father.
3. Mrs Gwen Kettles (formerly Blanche), an NHS 24 Call Handler. Mrs Kettles received the telephone call to NHS 24 made by Mr Willock on 27th December 2009 at 8:14pm.
4. Dr Patrick Joseph Branchfield, a General Practitioner in private practice engaged by Greater Glasgow and Clyde Health Board Out of Hours Service. Dr Branchfield spoke by telephone with Mr Willock on 27th December 2009 at 8:24pm.
5. Mrs Ann McDermid, an NHS 24 Call Handler. Mrs McDermid received the telephone call made by Mr Willock on 28th December 2009 at 8:48am.
6. Ms Fiona McCulloch, a Nurse Advisor with NHS 24. Nurse McCulloch received the call made by Mr Willock passed through to her by Call Handler, Ann McDermid.
7. Miss Carolyn Fergie, an NHS 24 Call Handler. Miss Fergie received the telephone call made by Carolann Rogers on 28th December 2009 at 16:28pm. She subsequently spoke to Mr Willock during that call.
8. Mrs Pamela Margaret Scally, a Nurse Advisor with NHS 24. Nurse Scally received the call from Mr Willock passed through to her by Call Handler, Carolyn Fergie.
9. Mr Robert M. MacDonald, Practice Nurse, Mains Medical Practice, Erskine. Nurse MacDonald took a call from Carolann Rogers to the Practice on 29th December 2009 at about 9:30am.
10. Dr Murray James MacPherson, the deceased's General Practitioner, Mains Medical Practice, Erskine. Dr MacPherson telephoned Mr Willock's home and spoke first to Carolann Rogers and then Mr Willock on 29th December 2009 at about 11:08am. Dr MacPherson subsequently visited Mr Willock at his home later that day.

11. Dr Tracey A. Hanley, General Practitioner, Mains Medical Practice, Erskine. Dr Hanley took a telephone call from Carolann Rogers on 29th December 2009 at about 5:45pm.
12. Dr John Clark, Consultant Forensic Pathologist. Dr Clark conducted the post-mortem examination on Mr Willock on 11th January 2010.
13. Dr David G. A. Willox, General Practitioner in private practice. Dr Willox provided an independent GP Report for the Crown.
14. Dr Alan N. Shepherd, Consultant Physician and Gastroenterologist. Dr Shepherd provided an independent Expert Report and a Supplementary Report for the Crown.
15. Ms Louise MacDonald, Paramedic, Scottish Ambulance Service. Ms MacDonald attended Mr Willock's home on the evening on 29th December 2009 following an emergency services telephone call by Ms Rogers.
16. Mrs Janice E. Houston, Associate Director of Operations and Nursing, NHS 24 based at the Cardonald Centre, Glasgow
17. Dr Robert B. S. Laing, Consultant Physician in Infectious Diseases at Aberdeen Royal Infirmary. Dr Laing provided an independent Expert Report for the Crown.
18. Dr Norman Gaw, General Practitioner in private practice and also Clinical Director of Greater Glasgow and Clyde Health Board Out of Hours Service.

No additional witnesses were adduced on behalf of any other party to this Inquiry.

In the next section of this Determination I set out the relevant factual background as established to my satisfaction by the evidence and provide a summary of the testimonies of the various expert witnesses led.

Thereafter, I endeavour to summarise the parties' submissions to place my findings in context. Lastly in the Conclusion I consider the legal framework and issue my Determination in respect of the matters required of me in terms of Section 6 of the Act explaining my reasons therefor and analysing where appropriate the evidence led from the various expert witnesses in so far as it pertained to the issues raised at this Inquiry.

SUMMARY OF EVIDENCE

In their written submission the Crown very helpfully set out a Summary of the Evidence heard at the Inquiry. Apart from a very few points this was in the main accepted by the other parties to the Inquiry. In endeavouring to précis the voluminous evidence led before me during the 21 days of evidence I have adopted the Crown Summary where appropriate and had regard to the criticism thereof by other parties. I set out the relevant background as established to my satisfaction and provide a summary of the testimonies of the various expert witnesses led.

1. Mr John Willock (DOB 2/8/66) was 43 years old when he tragically died at his home address, 6 Parkhill, Erskine in the early evening of 29 December 2009. The evidence I heard from his partner, Carolann Rogers, her father and from the presence of his partner and other family members throughout the Inquiry made it clear that John Willock was a much loved partner, father, brother and son.

2. At approximately 7pm on Boxing Day evening i.e. 26 December 2009, John Willock told his partner Carolann Rogers that he was feeling unwell. At that time, John Willock and his family were at his partner's parents' home in Erskine. He told his partner he had twisted his knee on Christmas Eve while walking down an icy, slippery path. He said he had not mentioned it to her so as not to spoil Christmas. Mr Willock told his partner on Boxing Day that he felt "fluish". He complained of being cold and shivery and of feeling sick. He returned to his home address at about 9.30 pm. Ms Rogers returned to their home at about 1:00am on 27 December 2009. She discovered Mr Willock in their son's bedroom. He was sick. He informed his partner he had been sick a few times before she returned home. During that night, John Willock vomited on numerous occasions and also started having diarrhoea.
3. On 27 December 2009, John Willock's symptoms deteriorated. His partner, Carolann Rogers described his sickness and diarrhoea as being 'constant' and said he was "totally drained". His sickness, which was more watery, and diarrhoea continued all day. He was unable to keep any food or fluids down. He was cold and shivery and very clammy.
4. At 2014 hours on 27 December 2009 John Willock made a telephone call to NHS 24. This call was answered by Mrs Gwen Kettles (then Gwen Blanche). She was a Call Handler for NHS 24, having held that position for a period of 6 years. She explained, to the Inquiry that the role of a Call Handler was to take all incoming calls to NHS 24. Call Handlers have access to the Community Health Index database. Although this contains names, dates of birth, addresses and details of at which GP Practice individuals are registered, it does not provide access to a caller's past medical

history. Mrs Kettles explained that when taking a call, the Call Handler was required to ascertain a reason for the call from the caller (referred to as the main call reason), create a record on the PRM (patient record system), to thereafter ask a series of scripted questions (referred to as call streaming) which the system would interpret. The system would then direct the Call Handler to where to direct the particular call (referred to as the disposition). Call Handlers are required to follow that process. They cannot utilise their own knowledge to handle the call. There is a call structure. The call is process driven and cannot be overridden although a Call Handler can take advice from a Team Leader if something concerns him/her. Mrs Kettles did not remember taking the call from Mr Willock. She said she had listened to the recording of the telephone call subsequently on four separate occasions, but had not had sight of the transcript thereof prior to appearing as a witness at the Inquiry. Based on the information provided by Mr Willock, she noted the main call reason on the system as *'D and V 4 days'* which she explained as meaning that he had had diarrhoea and vomiting for 4 days. The Inquiry, however, heard evidence which made it clear that, in fact, at the time of this, his first call to NHS 24, Mr Willock had been suffering from diarrhoea and vomiting for less than 24 hours. Mrs Kettles also noted in the Ad View box that he was *'aching all over! sore neck! hot and cold flushes'*. The Ad View box (sometimes referred to as the AV box) is a box on the system, within the standard call report, where the Call Handlers record any additional symptoms and relevant information.

5. The system generated a disposition of *'CS- Priority 3'* which meant that the call was to be put in a queue for a nurse to phone Mr Willock back within 3 hours. Mrs

Kettles concluded the telephone call by providing John Willock with a “worsening statement”, advice that if his symptoms changed or anything new developed he was to telephone back to NHS 24 to inform them. The call was subsequently taken out of the queue and sent to the Greater Glasgow and Clyde Health Board Out of Hours Service (OOHS) for a GP to phone Mr Willock back within 1 hour.

6. At 20:23 on 27 December 2009 the call was allocated to the OOHS by NHS 24. At 20:24 Dr Patrick Branchfield, a GP employed by OOHS telephoned Mr Willock. Dr Branchfield carried out a telephone consultation with Mr Willock lasting some 2 minutes 47 seconds. The OOHS Records confirm that it took Dr Branchfield a period of 5 minutes in total, to open the Call Record, read it, dial Mr Willock’s telephone number, speak to Mr Willock, make an entry in Mr Willock’s clinical record and close off the case on his computer screen. The summary of Dr Branchfield’s consultation with John Willock was recorded by him as follows:

General malaise for 3 days, weakness, myalgia, sore throat, some D and V, all sounds viral, offered to get him seen at PCEC for reassurance but declined, was looking for house visit, advised would not be appropriate as symptoms sound viral and self-limiting, agreed to observe.

7. Dr Branchfield testified that he did not remember the telephone call with Mr Willock. He had however listened to the recording of the telephone call on four or five occasions between May 2010 and February 2012 and had had sight of the transcript thereof prior to appearing as a witness at the Inquiry. During the telephone triage with John Willock, Dr Branchfield formed the view that John Willock wanted to be

seen by a Doctor for reassurance. Dr Branchfield offered Mr Willock to be seen at a Primary Care Emergency Centre (PCEC) for reassurance. At no point in the call with Mr Willock did Dr Branchfield determine that Mr Willock required to be seen by a Doctor. In his opinion Mr Willock was not ill enough to then require a visit from a Doctor. Dr Branchfield noted that John Willock 'declined' to attend the PCEC. Dr Branchfield accepted that during the consultation he did not pick up on the fact that John Willock was essentially housebound, due to the extent of his diarrhoea. Upon reflection Dr Branchfield accepted that John Willock did not 'decline' to attend the PCEC but was unable to attend. Dr Branchfield accepted that he ought to have spoken to John Willock for longer and to have asked more detailed questions. Dr Branchfield omitted to give Mr Willock a worsening statement. He conceded that at the end of the consultation he had not put himself in a sufficiently informed position to make a safe clinical decision with regard to John Willock. He accepted that if he had spoken to John Willock for longer and asked more detailed questions then he may have instructed a Doctor to go round to see John Willock. Dr Branchfield accepted that he did not carefully evaluate the potential risk with regard to John Willock. He stated that there were two reasons for this, firstly that he had only 6 minutes to evaluate a patient and secondly because he was not as thorough as he could have been.

8. Dr Branchfield formed the opinion that Mr Willock did not sound unwell when he spoke with him. Dr Branchfield said if someone was particularly unwell he would expect to hear signs of pain in the voice or breathlessness, neither of which was present in Mr Willock. The symptoms Mr Willock described to Dr Branchfield were

viewed by the Doctor as particularly common in December when approximately half of his calls related to patients with diarrhoea and vomiting. At the conclusion of the consultation with John Willock, Dr Branchfield told him that he had a viral infection and that it should get better with time. He advised him to take it easy and that the infection should pass. Dr Branchfield said that if he thought Mr Willock needed to be seen for clinical reasons then he would have arranged for a GP to visit him.

9. During the night of 27/28th December 2009, Carolann Rogers stated that John Willock started to become breathless. She said he continued to have sickness and diarrhoea and his symptoms were becoming worse. He became faecally incontinent.
10. On 28th December at 0848 hours, a second call was made to NHS 24 by John Willock. Carolann Rogers stated that the reason why John Willock phoned again was due to the fact that his symptoms were becoming worse. Christmas day was a Friday. Accordingly, Monday 28th December was a public holiday. GP surgeries were closed from 25 until 28 December inclusive and reopened on the 29 December 2009.
11. Mrs Ann McDermid, a Call Handler with NHS 24, took the call from John Willock at 0848 hours on the 28 December 2009. She recorded that the main call reason for John Willock's call was *'burning sensation in chest 10 hours — see A/V'*. In the AV box she recorded *'feels awkward to breathe, same symptoms before, diarrhoea, sickness, sore head, sore throat, few days'*. Mrs McDermid call streamed John Willock's call on the symptom 'chest pain'. The outcome of the call streaming was that the disposition stated *'CS- Advise and refer protocol SU'* which effectively meant that John Willock's

call was being passed straight through to a Nurse Advisor as a serious and urgent call.

12. At the beginning of the telephone call, John Willock told Mrs McDermid that he had phoned NHS 24 approximately 12 hours previously and that he had been told to phone back if he was getting any worse. Mrs McDermid stated that John Willock fell into the category of a “return caller.” She stated that a “return caller” was any patient calling NHS 24 on a second (or further) occasion within a few days of the first occasion with the same symptoms. She advised the Court that NHS 24 had a process called Process 18 in respect of return callers.
13. Process 18 is an NHS 24 clinical process with regard to patients ringing NHS 24 during the same episode of care. It provides guidance around dealing with callers who contact NHS 24 during the same episode of care. The Process recognises that the caller may have contacted NHS 24 multiple times or contacted other parts of the Health Service within this same episode of care.
14. Mrs McDermid stated that she would establish if a call was within the “same episode of care” as the previous call. In order to do so she said she would enquire if the symptoms were the same. She was unclear as to the significance of the symptoms being different. She stated that her role was simply to gather information and that it was for others to process that information.
15. Mrs McDermid stated that the practice in December 2009 when a patient told her that they had telephoned NHS 24 before was to

- Record in the AV box that the patient was a return caller;

- Record within the drop down menu box that the patient was a return caller;
and
- When handing the call over to the Nurse Advisor, advise the Nurse Advisor that the patient was a return caller.

16. In respect of her telephone conversation with John Willock on 28 December 2009 Mrs McDermid failed to follow that practice. She did not record in the AV (ad view) box that John Willock was a return caller. She did not record in the drop down menu box that he was a return caller. Further, Mrs McDermid did not advise the Nurse Advisor, Fiona McCulloch in her verbal hand over of the call, that John Willock was a return caller. Mrs McDermid said she had been trained in and should have carried out those three actions. She was clear in her evidence that she did not follow Process 18. The reason she gave for not doing so was her anxiety to put John Willock through to a nurse. Mrs McDermid agreed that it was important to note the information about what the patient was telling her was wrong with him, that 'a good quality of handover' by her to the Nurse Advisor was important, and that she was aware of the guidance provided by NHS 24 with regard to the content of the handover. She accepted, however, the said numerous failings on her part with regard to the entries in the AV box and drop down menu and in the content of her verbal handover to Nurse Advisor, Fiona McCulloch. Not only were there omissions, in particular her failure to inform the Nurse Advisor that Mr Willock's call had been passed the previous evening to the OOHS for a GP to call him back, Mrs McDermid also conceded that information given to her by the patient, Mr Willock, the information she inserted in the AV box and the content of the information she passed verbally at

the handover to Nurse Advisor, Fiona McCulloch were all “a little bit different”. Mrs McDermid accepted that she ought to have mentioned to Nurse McCulloch in her verbal handover all of Mr Willock’s symptoms then known to her.

17. During her verbal handover to Nurse Advisor Fiona McCulloch, Mrs McDermid advised Fiona McCulloch that John Willock was on the telephone and that “the patient’s got burnin’ sensation” and “he’s got a burning sensation in his chest for about 10 hours and “an awe the other symptoms ok?” (Crown Production 6, page 1).

When this call was passed to Nurse Advisor Fiona McCulloch, she was unaware that John Willock had called the previous evening and was calling with worsening symptoms. Nurse Advisor Fiona McCulloch then input John Willock’s patient number into the system and brought up his patient record. Within the patient record, Fiona McCulloch noted the call reason as recorded by Mrs McDermid and the information she had recorded in the AV box. (cf. paragraph 11 supra).

18. Nurse McCulloch accepted that if she had gone into the call history she would have ascertained that John Willock had called the previous evening and that his call had been passed to a Doctor to call him back. An examination of the call history would have revealed the main call reason having been recorded as ‘CB D AND V 4 DAYS see AV’. She advised that in December 2009 Nurse Advisors only checked the call history in relation to calls when they were aware that the patient had called NHS 24 within the previous few days.
19. Nurse McCulloch stated that had she known that John Willock had phoned the previous evening and was phoning back with worsening symptoms then this would

have made a difference as to how she dealt with the call. She advised that she would have asked John Willock details with regard to his conversation with the GP and additionally she would have clarified what his worsening symptoms were. She stated she would have applied the Process 18 guidance and if she had established that his symptoms were worsening then she would have arranged for him to be seen by a doctor. If John Willock had been too unwell to visit a PCEC then she said she would have arranged for him to be seen at home by a doctor.

20. During her telephone triage of Mr Willock, Fiona McCulloch chose the algorithm for indigestion. She chose this particular algorithm as she considered that his main concern was the burning sensation in his chest. The algorithm brought up a series of questions. With reference to Crown Production 19, page 4 of 5, question 1 details a list of options for the nurse advisor to consider. Nurse McCulloch answered “no” to all of the options. In particular, in relation to option 1, she did not consider John Willock to have a ‘burning pain in chest’ as she was of the view that the pain was lower down — at the top of his abdomen. In relation to the options, Nurse McCulloch stated “no” to the option ‘nauseated’. Her explanation for this was that she understood the question to refer to a cardiac nausea rather than a diarrhoea and vomiting nausea. In relation to the last option, she answered “no” to the option of ‘persistent abdominal upper abdominal discomfort’. Again, she stated that she interpreted this question to be in relation to cardiac discomfort as opposed to indigestion discomfort. In relation to this last option, Nurse McCulloch advised that if she had ticked “yes” then the disposition would have been for an emergency ambulance. Thereafter, she completed the algorithm and noted the disposition was

for 'routine appointment with GP'. Exercising her clinical judgement, Nurse McCulloch determined to override this disposition and replace it with the disposition of 'self-care'. The symptoms reported during the call suggested to her that Mr Willock's problems could be managed at home. Had all the information been accurately conveyed to Nurse McCulloch by the Call Handler, Nurse McCulloch felt it could have altered the way in which she dealt with the call. She said she might have referred Mr Willock to a PCEC or arranged for a home visit.

21. It was Nurse McCulloch's clinical opinion that John Willock had indigestion. As a result of her clinical opinion, she recommended that John Willock took some cold milk and in addition tried Gaviscon. In recommending cold milk Nurse McCulloch was thinking only of "the burning sensation". She agreed that the provision of cold milk was inappropriate for someone who was suffering from vomiting and diarrhoea.
- 22.1 Nurse McCulloch accepted that during the telephone triage she should have asked an open question when asking about John Willock's worst symptom. She accepted that she did not ask sufficient questions to establish the frequency of his diarrhoea. Additionally, she did not establish if he had been able to keep fluids or food down. She assumed incorrectly that as Mr Willock's urine was orange in colour he was possibly a bit dehydrated but still managing to keep fluids down. She accepted it would have been appropriate to ask such questions. She accepted that she asked a number of closed questions and that it would have been better practice to ask open questions. She accepted that she should have asked more in depth questions about

the extent of John Willock's diarrhoea and vomiting. She stated that had she known how severe his diarrhoea had been she would have referred him to a doctor.

22.2 Fiona McCulloch stated she was subject to a review by her Line Manager. She said her Line Manager advised that she should have arranged for Mr Willock to be seen by a doctor. Following the review her Line Manager listened to 10 of her other calls at random and informed her there were no issues.

22.3 Mrs Janice E. Houston, an Associate Director of Operations and Nursing at NHS 24 based at the Cardonald Call Centre, Glasgow was led in evidence by the Crown as she was "professionally accountable" and responsible for the Nurse Advisors and Call Handlers who operate at the Cardonald Call Centre. She explained the Investigation Team which she led into the care of NHS 24 for Mr Willock found the handling of the call by Nurse McCulloch to not be of the normal standard. She informed the Inquiry that based on her call with Mr Willock a full, robust coaching plan was put in place for the Nurse by her Line Manager. This is normal practice if any telephone call is found to be below normal standards. Mrs Houston advised that it was decided Nurse McCulloch was fit to practice. She continued to do so whilst simultaneously undergoing the said coaching plan.

23. Following the telephone triage with Fiona McCulloch, Carolann Rogers stated that John Willock's condition continued to deteriorate. She described his sickness and diarrhoea becoming discoloured. She said that he was becoming "more clammy". She described him as being cold to touch but that his head was warm and he was feeling very shivery. She stated that he was unable to lift his knee and accordingly

unable to get out of bed. She described his injured knee as being about double the size of his other knee. She said that he was being sick and having diarrhoea in his bed. She said that John Willock stated that he had had diarrhoea about 40 times and had been sick about 10/20 times. Carolann Rogers was of the view that he needed to be seen by a doctor.

24. At 16:28 on 28 December 2009 Carolann Rogers telephoned NHS 24 because she was very concerned about John Willock. She was of the view that he was not assertive enough when speaking on the telephone and did not insist that a doctor came out to see him. Carolann Rogers spoke with Call Handler, Miss Carolyn Fergie and told her that John Willock's condition had deteriorated since he last telephoned NHS 24, that he was still being violently sick, that his diarrhoea was constant, that he had hurt his knee and that she was very worried about him. She told the Call Handler that he had called twice before. Carolann Rogers advised the Inquiry that Carolyn Fergie would not speak with her and insisted on speaking to John Willock. Carolann Rogers said she thereafter passed the telephone to John Willock to speak with Miss Fergie.
25. Miss Fergie stated that she was tired when she took the call. She stated that she rushed the call and accepted she did not pay attention to what she was being told. She was abrupt. She gave evidence that she looked at the call history and recalled noting that John Willock had called earlier that day. She did not recall noting that he had also called the evening before although she accepted that that information would have been contained within the call history.

26. Miss Fergie noted on the standard call report that the call reason for John Willock calling was *"hurt behind L/knee 5/7 - see A/V"* In the A/V box she typed "had a fall".

Miss Fergie accepted that she should have;

- recorded in the A/V box that John Willock had phoned NHS 24 on the 2 previous occasions;
- recorded in the drop down box that he was a return caller; and
- put more specific information in the A/V box regarding John Willock's symptoms and the fact that his condition was deteriorating.

Miss Fergie's explanation for not recording these details was due to the fact that she was tired.

27. Miss Fergie stated that Mr Willock sounded breathless on the telephone. She said she should have asked him more questions in relation to his breathlessness. On the basis that she considered the reason for John Willock's call was his sore knee, she call streamed on the complaint "knee". The system's disposition was that John Willock should speak to a nurse within 3 hours. However, due to the fact that she was concerned about his breathing. Miss Fergie changed that disposition and passed the call straight through to a nurse advisor as a serious and urgent call. She stated that one of the reasons why she rushed the call was that she was concerned about his breathing and wanted to pass the call through to a nurse advisor as quickly as possible.

- 28.1 When Miss Fergie passed the call through to the Nurse Advisor, Pamela Scally she failed to mention her concerns regarding his breathlessness in the verbal handover. She did not note them in the A/V box. Miss Fergie accepted that her verbal handover to the Nurse Advisor was not in accordance with the NHS 24 guidance in which she had been trained and that she should have informed the Nurse Advisor of the details of John Willock's previous calls and provided her with a summary of his symptoms. She said that she passed the call to Pamela Scally as a "return caller" i.e. a call within the same episode of care. Miss Fergie accepted however, that she had not recorded on the system that John Willock was a return caller and in the verbal handover had informed the Nurse Advisor, Pamela Scally that he was calling back about a different complaint. Further she did not make the Nurse Advisor aware she was passing the call to her as "serious and urgent". Nurse Scally was unaware of this categorisation.
- 28.2 Miss Fergie was subsequently subject to an on-going review of her calls. She told the Inquiry she had received no negative feedback on other calls.
29. Nurse Advisor, Pamela Scally noted that the main call reason, as noted by Carolyn Fergie was "hurt behind left knee 5 days ago". She accessed the call report for the call earlier that day and noted that that call was in relation to a burning sensation in his chest. She also accessed the call report in relation to the previous evening and noted that the main call reason was diarrhoea and vomiting for 4 days and that the disposition was "partner to triage". From the information in the call report from 27th December she was aware that this call had been passed for either a nurse practitioner

or a doctor to telephone John Willock back but that the call report did not provide her with any additional information.

30. Nurse Scally stated that she treated this call as a new/fresh call on the assumption that this call was in relation to a trauma/sore knee and appeared to be unrelated to the previous calls. Had Nurse Scally been advised Mr Willock was a return caller she said she would have arranged a face-to-face consultation with a GP on the basis that the 'self-care' disposition had not been effective. Upon reflection, following a process of 'self-education', Nurse Scally considered she should have specifically raised with Mr Willock the call reasons for his two earlier calls.

Nurse Scally started her triage by asking John Willock about the pain Mr Willock had behind his left knee. Initially she focused on John Willock's pain in his knee and established that he had a very painful swollen left knee. During the triage, which was not pace appropriate in parts, she asked him about his breathing and established that Mr Willock had intermittent chest pain which he stated was similar to the symptoms he got when he had acid reflux. She established that he had on-going sickness and diarrhoea, had been sick 10 times that day and had diarrhoea about 40 times that day. She also established that he had brought up brown bile, was not able to keep fluids down, had a fever and was last sick about 3 hours previously. She concluded that he was not a return caller. Had she treated the call from John Willock as a return caller, as someone telephoning back within 'the same episode of care' with worsening or deteriorating symptoms, she said this would have acted as a 'red flag', heightening her assessment and the chance that Mr Willock will probably require 'onward referral' to OOHS, a home visit, or the Accident and Emergency department

of the hospital, depending upon how his symptoms have changed. Nurse Scally did not know why she did not 'refer Mr Willock on'. She had no explanation other than that she was focused on his knee. She conceded she ought to have made more enquiry of Mr Willock about the nature and extent of his diarrhoea given its stated frequency. Notwithstanding it was the normal practice to do so in the event of brown bile, Nurse Scally did not arrange for Mr Willock to have a face-to-face consultation with a Doctor. She had no explanation for not following normal practice. With hindsight Nurse Scally accepted that Mr Willock was 'a return caller', that she should have followed Process 18 and arranged for him to have a face-to-face consultation with a Doctor.

31. Nurse Scally chose to use the algorithm for "knee pain or swelling". Having done so she was distracted from looking at Mr Willock's other symptoms.

Question 3 of the algorithm asked; was he "completely unable to stand or weight bear on the side of the affected knee?" She answered "no" to the question. Her evidence was that she answered the question in this way as while she accepted that she had been advised by him that he could not weight bear on that knee she had assumed it was because he had not taken sufficient painkillers. She stated if she had answered the question affirmatively the disposition would have been that John Willock would have to go to A & E as soon as possible and she did not think that that was the appropriate disposition.

32. Nurse Scally completed the algorithm and advised the disposition was for Mr Willock to contact his own GP practice within 36 hours. At no time did Nurse Scally

give Mr Willock any advice about drinking and the frequency thereof, which with hindsight, she agreed she ought to have done. Nurse Scally advised Mr Willock to take Ibuprofen for the pain in his knee. She agreed this was inappropriate for Mr Willock as one of the common side effects of taking Ibuprofen is gastrointestinal upset, vomiting and gastrointestinal bleeding. She agreed it was also an error on her part to advise Mr Willock, as she did, to take a glass of milk. Nurse Scally accepted the 'worsening statement' she gave to Mr Willock may have been interpreted by him only in relation to his knee. She said Nurse Advisors are encouraged to give worsening statements specific to the patient's presenting symptoms and accepted she did not follow all the advice recommended when imparting advice to Mr Willock. She could not explain why she had not done so. Nurse Scally conceded she should have given Mr Willock "a general" worsening statement. She acknowledged she failed to follow her training, which she considered satisfactory prior to and following December 2009 when dealing with Mr Willock's call.

33. During the night of the 28th/29th December 2009, Carolann Rogers' evidence was that her partner's condition continued to deteriorate.
34. On the morning of the 29th December 2009, Carolann Rogers telephoned her partner's GP Practice, the Mains Medical Practice in Erskine. She initially spoke to the receptionist and then at about 09.30am to the triage nurse, Robert MacDonald. Robert MacDonald noted in John Willock's medical notes, *"slipped and twisted leg on Christmas Eve, nauseated, shivery & D & V since - both green, leg very swollen at & around knee. Can't weight bear. Incontinent of faeces in bed. d/w dr on call, dr mac re-called now*

states headache, ?temp sore neck s/l. bothered by light - ask dr to assess please see ooh sheets as well."

- 35.1 Nurse MacDonald spoke to Dr Murray MacPherson and appraised him of the content of the telephone call from Carolann Rogers. He said he informed Dr MacPherson that he was not absolutely convinced a home visit was necessary as he felt Mr Willock was probably suffering from gastroenteritis. Following discussion with Dr MacPherson, Nurse MacDonald gave advice to Carolann Rogers to administer pain killers for Mr Willock's knee, for Mr Willock to "rest the stomach and let the vomiting subside substantially". Nurse MacDonald said he informed Carolann Rogers he would ask the on-call Doctor within the Practice to telephone later after his morning surgery finished. Nurse MacDonald concluded his telephone call with Carolann Rogers by giving her a worsening statement to telephone back to the surgery if any of Mr Willock's symptoms worsened or if anything concerned her. Thereafter, Nurse MacDonald spoke again with Dr MacPherson and asked him if he would telephone after surgery.
- 35.2 Nurse MacDonald told the Inquiry that diarrhoea and vomiting is caused by gastroenteritis or food poisoning, both of which are fairly self-limiting. He agreed a Doctor would not normally make a home visit in respect of a complaint of diarrhoea and vomiting.
36. At about 11:08am Dr Murray Macpherson from the Mains Medical Practice telephoned and spoke to John Willock. Dr MacPherson said he believed as a result of that telephone call that Mr Willock had significant diarrhoea and vomiting, also

some form of injury or swelling to the leg and was suffering significant pain from the injury to the leg. He said he did not think Mr Willock sounded particularly distressed but perhaps tired. He was aware that Mr Willock had telephoned NHS 24 on three occasions within the past 20 hours, in addition to the telephone call from his partner to the surgery that morning. Although he was not particularly concerned at the time, Dr MacPherson decided he needed to see Mr Willock and advised him that he would visit him at home. Carolann Rogers recalled Dr MacPherson attending at approximately 1pm on the 29th December. Dr MacPherson recalled his visit as being at approximately 12 noon, being the first of three patients to whom he made a home visit.

37. John Willock was in bed when Dr MacPherson attended. Carolann Rogers' evidence was that she was present in the bedroom for the entire period that Dr MacPherson was with John Willock. Carolann Rogers stated that they gave Dr MacPherson a history of the illness. She recalled that at the time of the consultation with Dr MacPherson, John Willock looked clammy, as if he had a temperature, was very, very breathless, bothered by light and his speech laboured. She recalled Dr MacPherson asking John Willock about the sickness and diarrhoea and examining his knee. Carolann Rogers was clear in her evidence that Dr MacPherson did not examine his stomach, take his blood pressure, take his temperature and did not use a stethoscope. She said John Willock's skin colour looked almost grey, yellow.
38. Dr MacPherson gave evidence which was contradictory to that of Carolann Rogers, in respect of John Willock's condition at the time of his visit and his examination of him. Dr MacPherson stated that John Willock looked ill, that he was able to keep

fluids down, that he did not look dehydrated and that his skin colour was fairly normal. He observed no difficulty in Mr Willock's breathing. Dr MacPherson did not think Mr Willock's speech was laboured, nor that he was clammy, flushed or "hot to touch". He said Mr Willock did not show signs of being bothered by light so, having undertaken a visual examination, Dr MacPherson did not ask him about any discomfort to light. Dr MacPherson said he examined Mr Willock's abdomen and concluded that he had no obvious tenderness, listened to his bowel sounds with a stethoscope and they sounded normal. He stated he checked for dehydration by lifting a pinch of skin and concluded no dehydration. The Doctor informed the Inquiry he checked Mr Willock's blood pressure using a blood pressure cuff and stethoscope and the result was "normal" and examined his knee which he concluded was a soft tissue injury. Further, Dr MacPherson said he checked Mr Willock's pulse by placing his fingers on his wrist. He found it to be "normal". Dr MacPherson said he checked Mr Willock's temperature with an electric digital thermometer and also found this to be "normal".

39. After the consultation Dr MacPherson concluded that John Willock had gastroenteritis. He gave him an anti-sickness injection during which time it was his evidence that he asked, as is his practice, for his partner, Carolann Rogers, to step out of the bedroom which he thought she did. Dr MacPherson prescribed some tablets for sickness -- Prochlorperazine. He also prescribed loperamide for his diarrhoea and cocodamol for the pain in his knee. Dr MacPherson said that Carolann Rogers returned to the bedroom whilst he was writing out the prescriptions. He said they had a discussion regarding her assertion that John Willock was getting short of

breath. Dr MacPherson said he took his stethoscope out of his bag, having previously put it away, to listen to Mr Willock's chest. He said Mr Willock's breathing sounded normal. Dr MacPherson said that once he had seen Mr Willock at home he did not think Mr Willock needed to go to hospital. In his opinion Mr Willock was not so significantly or critically unwell that he needed to go to hospital.

40. On his return to his surgery he commenced at 13:06 making entries in the records of the three patients to whom he had made a home visit. Dr MacPherson recorded an entry in John Willock's medical notes, at 13:09, concluding at 13:11 as follows:
"diarrhoea and vomiting for a couple of days, also fell and twisted L knee which is swollen and tender. Abdo soft. BS (Bowel Sounds) ok. Rx (Treatment/Provide) loperamide, Stemetil and cocodamol. given IM prochlorperazine 12.5mg BN A9004 Exp 05/2014". Dr MacPherson explained that his then practice was not to record "normal" findings in his medical note if he considered them not to be relevant or necessary.
41. At approximately 17:40 hours on 29 December 2009, Carolann Rogers telephoned the GP Practice as John Willock had further deteriorated and had developed a "red blotchy rash" and requested to speak to a doctor. At approximately 17:45 Dr Hanley, having accessed Mr Willock's medical notes and read the entries made earlier that day by Practice Nurse MacDonald and her colleague Dr MacPherson, telephoned her back. Dr Hanley agreed that Dr MacPherson's entry in Mr Willock's notes made no mention of blood pressure, temperature or pulse rate. She said she assumed that as nothing was recorded Dr MacPherson had found them all to be normal. Dr Hanley did not conduct a full assessment of Mr Willock, her reasoning being that Dr MacPherson had seen Mr Willock only a short time earlier and there was nothing in

his note to indicate the seriousness of Mr Willock's condition. Carolann Rogers described Mr Willock's condition and Dr Hanley advised her to give him an additional 2 cocodamol tablets. With hindsight Dr Hanley wishes she had undertaken a home visit although logically she knows it would not have made any difference to the outcome for Mr Willock.

42. John Willock's condition continued to deteriorate and at 18:05 Carolann Rogers telephoned 999 and requested an ambulance. The paramedics arrived at 18:08 and found John Willock to be unresponsive. They conducted CPR but unsuccessfully. At approximately 18:20 they advised Carolann Rogers that there was nothing further that they could do for him.
43. John Willock was certified dead by the Police Casualty Surgeon at 21:25 on the 29th December 2009. At approximately 23:00 on 29 December 2009 Mr Willock was removed from his home and taken to the mortuary at the Royal Alexandra Hospital, Paisley.
44. Dr John Clark, Consultant Pathologist conducted a post mortem examination on 11th January 2010. He spoke to his post-mortem Report and testified that it was only upon microscopic examination of tissues that the nature of Mr Willock's illness became clear with widespread bacterial infection throughout his body – septicaemia – almost certainly originating in the liver. He certified the cause of death as: acute cholangitis with septicaemia.
45. Dr Clark's certification of the cause of death was initially unchallenged. During the course of the Inquiry, those acting for OOHS obtained two further medical reports

commenting upon cholangitis as a cause of Mr Willock's death. In his undated Report Mr James Powell, a Consultant Hepatobiliary and Transplant Surgeon said he did not think Mr Willock had acute cholangitis on 27 December 2009. He was unconvinced that Mr Willock had acute cholangitis at any stage of his final illness. In a subsequent Report dated 9 May 2012 from Dr Christopher Bellamy, a Reader in Hepatic and Renal Histopathology and Honorary Consultant Pathologist at Edinburgh Royal Infirmary, Dr Bellamy concluded that "whilst there is a significant inflammatory reaction in the liver, this is not specific for cause, does not specifically diagnose a suppurative cholangitis and could reasonably be secondary to a severe systemic infection or reaction originating in a different tissue". Dr Bellamy opined that "the histology does not define a clear cut cause for death, or define an organ-specific cause for Mr Willock's final clinical presentation".

46. Copies of the said Reports were sent by the Crown to Dr Clark. Having considered the Reports Dr Clark wrote to the Depute by letter dated 18 June 2012 stating that he was "happy to accept that the evidence for a specific diagnosis of acute cholangitis is not particularly strong". Dr Clark was recalled to testify at the Inquiry. When he reappeared he said he remained of the view that Mr Willock died from infection of some sort, ultimately from generalised infection throughout his body, i.e., septicaemia. Dr Clark said he was sure Mr Willock died from septicaemia because of the lack of any other explanation given his medical history and because of the albeit limited finding he made at post-mortem. He stated that the source of the septicaemia will have to remain undetermined. He indicated that the cause of Mr Willock's death might be better worded as "*Septicaemia, source uncertain*".

47. Dr David G. A. Willox, a General Practitioner in private practice, provided an independent Report for the Crown dated 13 September 2010 (Crown Production 24). He has both the ability and qualifications to comment upon GP practice. While Dr Willox had previously worked in out of hours care and in the Glasgow Emergency Medical Service - the forerunner of NHS 24 - he had no recent experience of the OOHS not being involved therein for about 8 years, had no experience or knowledge of the workings of NHS 24, and was not an expert in the use of algorithms or the use thereof within NHS 24.
48. Dr Willox considered that Dr Branchfield reached the “point of diagnosis slightly early”. While he opined that Dr Branchfield conducted the telephone triage empathically, was helpful throughout, and had sympathy for Dr Branchfield, Dr Willox said Dr Branchfield “quickly triaged to outcome”. He said Dr Branchfield gave the most probable diagnosis based on the information available to him. Diarrhoea and vomiting was likely, he said, to be due to a viral form of gastroenteritis. He agreed with Dr Branchfield’s concession that he had not asked sufficient questions of Mr Willock to make a safe clinical decision with regard to Mr Willock being seen by a doctor. Dr Willox felt Dr Branchfield should have asked more specific questions. Dr Willox said at the point Dr Branchfield decided for Mr Willock not to be seen in a face-to-face consultation, the lack of information he then had meant that he was not in the best position to make that judgement. He said Dr Branchfield, at the time of the said decision, had insufficient information to make the decision. Dr Willox noted Dr Branchfield omitted to give Mr Willock a worsening

statement. As subsequent events established, Mr Willock was not, however, prevented from calling back (to NHS 24).

49. Dr Willox said if the telephone call by Mr Willock to Nurse Advisor Fiona McCulloch had been his first call, he felt Mr Willock should have, on balance, been seen by a doctor. That being said, Dr Willox stated it was very difficult to say what a GP would have found during a home visit with Mr Willock on 28 December 2009. Dr Willox thought the more probable diagnosis would have been viral gastroenteritis. There were, in his view, a range of possible options depending upon the GP's diagnosis. If the doctor felt Mr Willock had gastroenteritis and some form of dehydration, then the doctor might, he said, have prescribed fluid replacement or encouraged the patient to drink. Dr Willox would have expected a doctor of reasonable competence to inform Mr Willock by means of a worsening statement how to react if his condition failed to improve within a reasonable timescale. Dr Willox said it was also possible that if Mr Willock was found to be unwell with severe diarrhoea, ongoing symptoms of vomiting and significant signs of dehydration, a doctor may have arranged for Mr Willock to be admitted to Hospital for intravenous fluids to be administered. Dr Willox emphasised that, as no such examination of Mr Willock by a doctor on 28 December 2009 occurred, it was difficult to determine what would have happened following upon a home visit.

50. Dr Willox was of the view that, following Nurse Advisor Pamela Scally's telephone call with Mr Willock, a face-to-face consultation with a doctor should have been the outcome. He adhered to the view expressed in Paragraph 4.35 of his Report wherein he states "It is hard not to conclude that the presence of vomiting, diarrhoea,

laboured breathing and knee pain should have led to Mr Willock being offered an assessment by a doctor at this point". He said by the time of that call only a home visit would have likely have been successful. Had a doctor of reasonable competence attended Mr Willock's home on the evening of 28 December 2009, Dr Willox thought it possible that the doctor would not be able to reach a certain diagnosis at that time. He said on the basis of the information provided by Carolann Rogers it was slightly more likely that Mr Willock would be likely to be sufficiently unwell and dehydrated that a doctor would have considered his admission to hospital quite strongly.

51. If the evidence of Carolann Rogers of Dr MacPherson's home visit to Mr Willock on 29 December 2009 is accepted, Dr Willox said he did not consider Dr MacPherson's examination of Mr Willock to have been adequate. Dr Willox said it was Dr MacPherson's duty to place himself in a proper position to make a diagnosis. If the evidence of Carolann Rogers is found to be established, he said Dr MacPherson had not done so. Dr Willox went further and stated that if Carolann Rogers' account of Mr Willock's condition is accepted, a doctor of reasonable competence, in the knowledge of the three previous calls to NHS 24, in addition to his examination of Mr Willock, on the balance of probability, would have considered Mr Willock severely ill and would have removed him to hospital. Dr Willox said he would not claim expertise in deciding how quickly someone would die from septicaemia and when and how the septicaemia process develops. Had Mr Willock been referred to hospital following Dr MacPherson's visit and examination, Dr Willox observed that it is possible that he might have been in the Accident and Emergency department of the hospital by about 2 hours later. Dr Willox was not, however, certain if this would

have been early enough to have saved Mr Willock's life. He would not claim expertise in deciding how quickly someone would die from septicaemia. He stated if Mr Willock had been admitted to hospital after being seen by Dr MacPherson his chance of survival would have been improved.

52. Dr Willox said that a competent examination of Mr Willock by a doctor of reasonable competence could be carried out in about 5 minutes. Given the additional checks on the patient's abdomen and his knee, Dr Willox opined that the total time might be approximately 7 minutes.
53. If, however, the evidence of Dr MacPherson of his visit to and examination of Mr Willock on 29 December 2009 is accepted, Dr Willox viewed same as a reasonable assessment. He said Dr MacPherson's diagnosis of gastroenteritis was a probable diagnosis on the basis of what Mr Willock had said. He had appropriately put himself in the position to make the diagnosis. Mr Willox stated Dr MacPherson's treatment of an injection to halt the vomiting and prescription to resolve gastroenteritis in a non-vomiting patient was both appropriate and reasonable. On the basis that Dr MacPherson's findings are accurate, Dr Willox would not criticise what Dr MacPherson did. Dr Willox stated it was unfortunate but no fault of Dr MacPherson that he had not diagnosed Mr Willock correctly.
54. Although Dr Willox felt that Dr MacPherson should have enquired of Mr Willock about his aversion to light and his complaint of a sore neck, he agreed it would suffice for a doctor to satisfy himself on these points by means of a visual examination.

55. Dr Willox viewed the content of Dr MacPherson's note in Mr Willock's medical records as "brief". He said it appeared inadequate, although he was aware it was common practice not to record "normal reading" results. If Dr MacPherson's account of his examination of Mr Willock is accurate, Dr Willox said he would have expected "a better note" to be inserted into Mr Willock's medical records principally because it would have confirmed why he had reached his decision to manage Mr Willock in the way he did and secondly because it would have provided a useful record for anyone who had to manage Mr Willock's care subsequently.
56. Dr Willox concluded by summarising his evidence and opinions thus:
- (i) Dr Branchfield, in his view, correctly described that Mr Willock needed to see an advisor but fell short of the standard expected of him by failing to arrange a home visit when Mr Willock was unable to attend a PCEC.
 - (ii) Mr Willock should have been attended by a doctor at OOHS. In his view this could have increased the chances of him being diagnosed accurately. It is quite likely that on 27 December 2009 a doctor might have diagnosed Mr Willock as suffering from gastroenteritis. It is possible, however, that the doctor would not have found his condition to be so serious as to warrant Mr Willock's hospitalisation.
 - (iii) Nurse McCulloch on the morning of 28 December 2009 incorrectly ordered Mr Willock to take Ibuprofen and failed to arrange for him to be visited by a doctor, which Dr Willox considered should have been undertaken at that time.

- (iv) It would have been appropriate for Nurse Scally, given that by that point on 28 December 2009 Mr Willock had been vomiting and had diarrhoea for several days, had problems with breathing and a swollen leg, to arrange for him to be seen by a doctor. Dr Willox could not say with any degree of confidence what a GP examining Mr Willock on 27 or 28 December 2009 would or should have done by way of treatment, and whether or not he/she would have arranged for Mr Willock to be admitted to hospital. He said he would be speculating.
 - (v) Dr Hanley's lack of action had no bearing upon the outcome for Mr Willock.
57. Dr Alan Shepherd, a Consultant Physician and Gastroenterologist, Perth Royal Infirmary (now retired), provided a Medical Report dated 21 April 2011 (Crown Production 22) at the request of the Crown. Following the Crown's receipt of the further Reports from Mr James Powell, Consultant Hepatobiliary and Transplant Surgeon, and from Dr Christopher O. C. Bellamy, Reader in Hepatic and Renal Histopathology and Honorary Consultant Pathologist in which each author opined that cholangitis was not a cause of Mr Willock's death, and from Dr Martin Connor, Consultant Microbiologist, Dumfries and Galloway Royal Infirmary dated 5 August 2012 in which he opined that Mr Willock did not die from bacterial septicaemia but did suffer from a severe viral infection (probably H1N1 Swine Influenza) and succumbed from resulting complications, and the acceptance by the Crown, following the revised opinion of Dr John Clark, Consultant Pathologist, that the cause of Mr Willock's death ought to be more properly stated as "septicaemia, source uncertain", Dr Shepherd was requested by the Crown to provide a Supplementary

Report on whether or not the fact that the source of Mr Willock's septicaemia is uncertain made any difference and whether or not Mr Willock's swollen knee is connected to the septicaemia. Dr Shepherd issued his Supplementary Report on 17 July 2012 (Crown Production 30).

58. The alteration in the cause of death of Mr Willock to and the acceptance by parties that it was accurately stated as "septicaemia, source uncertain" rendered irrelevant large tranches of Dr Shepherd's initial testimony to the Inquiry (prior to him being recalled). It is, therefore, unnecessary for that evidence to be recorded.
59. Dr Shepherd was adamant, when giving his evidence, that he was not an expert in and "could not speak for primary care". He stated he would accept the opinion of a suitably qualified GP in terms of management of primary care. Dr Shepherd's expertise lay in the hospital environment.
60. Dr Shepherd said septicaemia is a systemic illness caused by the microbial invasion of normally sterile parts of the body, referred to as "sepsis". He advised that occasionally sepsis causes diarrhoea and vomiting but that on its own, diarrhoea and vomiting is unlikely to be a symptom of severe sepsis. The degree of diarrhoea and vomiting experienced by Mr Willock was such that he thought it was separate from sepsis. He described it as being contributory, creating the environment for the sepsis to enter Mr Willock's system. Dr Shepherd, referring to his Supplementary Report, stated that most septicaemic patients' diagnoses begin as a clinical suspicion needing collaboration rather than specific signs. He said the clinical parameters that fit with severe sepsis include a temperature rise or fall, a raised heart rate, breathlessness and

altered mental state and signs of some oedema (swelling under the skin). Other signs of which he spoke are laboratory based and such investigations can only be undertaken, he said, within secondary care once the suspicion of severe sepsis has been identified.

61. Dr Shepherd opined *“In Mr Willock’s case, the possible sources of infection leading to severe sepsis (given that his post mortem showed no evidence of a pneumonic or respiratory problem) include urinary, gastrointestinal (including hepatobiliary) and his injured knee. Given that he had no peritoneal signs (signs of inflammation in the peritoneal cavity) this does make the diagnosis of an abdominal cause for his infection more difficult but not unusual. The combination of his dehydration related to his diarrhoea and vomiting exacerbated the effects of his sepsis as the mainstay of treating severe sepsis is fluid replacement and appropriate antibiotic therapy”*.
62. Dr Shepherd said that on the evening of 27 December 2009 it may have been the case that Mr Willock did not have sepsis. If Mr Willock did not have sepsis but a diarrhoeal illness, involving vomiting, it was likely to be self-limiting. Patients, he explained, were not usually admitted to hospital but managed at home. Dr Shepherd said that as far as 28 December 2009 was concerned, it was difficult to be sure when sepsis had started. If it had not commenced and Mr Willock was able to keep fluids down, his ill health could be managed at home. If, however, the diarrhoea and vomiting continued, Mr Willock would have been dehydrated and needed fluid replacement. Dr Shepherd said he was not in a position to say when severe sepsis developed in Mr Willock. He “speculated” it was more likely to have started around about 27 or 28 December 2009 and was almost certainly present by 29 December

2009. While diarrhoea and vomiting created the environment in which sepsis was more likely to occur, Dr Shepherd said it was difficult to say that Mr Willock had diarrhoea and vomiting when sepsis occurred. As he had not been able to determine when the background of infection occurred he was unable to put a timeframe on the sepsis.

63. Dr Shepherd agreed with Dr John Clark and Dr Laing, and thought it unlikely, contrary to the view of Dr Connor, that Mr Willock died from swine flu particularly given the absence of respiratory difficulties and inflammation of his lungs.
64. Dr Shepherd stated *"In summary, therefore, throughout the telephone conversations and on the history already given in court, Mr Willock showed some signs of sepsis which included a temperature with fluctuating breathlessness, concentrated urine and some swelling of the leg; latterly confusion and altered consciousness. The vomiting and diarrhoeal illness undoubtedly contributed (probably viral in origin) to his illness by virtue of dehydration and possible changes in electrolytes such as hypokalaemia (low potassium in the blood). It is impossible to be absolutely sure as to the cause of death of Mr Willock because of the lack of investigations that were carried out along with the delay in the post mortem which might have thrown further light on the cause had it been carried out earlier. The main features of his illness are consistent with a possible diagnosis of severe sepsis (although influenza cannot be ruled out). He did not, however, depart from the cause of Mr Willock's death being "septicaemia, source uncertain".*
65. If the account given by Carolann Rogers of the condition and examination of her partner, John Willock, on 29 December 2009 by Dr MacPherson is accurate, Dr

Shepherd felt that if Mr Willock had been admitted to hospital, his death might have been prevented but he said “it is becoming less as time moves on”. He stated it was likely that Mr Willock was critically ill at lunchtime on 29 December 2009 and became so critically ill sometime during the afternoon of 29 December following Dr MacPherson’s visit and before the paramedics arrived that he would not have survived even if he had then been admitted to hospital.

66. Dr Shepherd advanced percentage figures for survival rates if Mr Willock had been admitted to hospital on 27 December, in the morning or early evening of 28 December, in the early afternoon of 29 December following the home visit by Dr MacPherson or following Dr Hanley’s telephone conversation with Carolann Rogers at about 17:45hrs on 29 December 2009. He conceded, however, that the percentages which came from published literature were predicated on the basis that Mr Willock had sepsis. He acknowledged that the lack of a starting point for sepsis in Mr Willock placed the percentages in doubt. Applying the balance of probabilities test Dr Shepherd said, due to the absence of a diagnosis of sepsis, he was not in a position to state Mr Willock might have survived. To give survivability rates for Mr Willock, on the balance of probabilities, would, Dr Shepherd stated, be in the realms of speculation.
67. Dr Robert B. S. Laing, a Consultant Physician in Infectious Diseases, Aberdeen Royal Infirmary testified before the Inquiry by means of video-link. He spoke to his Report dated 19 September 2012 (Crown Production 31).

68. Dr Laing agreed bacterial sepsis was the most likely explanation for Mr Willock's death. He said the clinical history was in no way typical of cholangitis. He agreed that the source of the sepsis remained unknown. He said Mr Willock's knee was a possible source of the sepsis. It was, however, only a possibility. He could not say, on the balance of probabilities, that it was more likely than not to be the source of infection. He described sepsis as a physiological description of the body's reaction to bacterial infection. He said sepsis – severe sepsis – septicaemia was a "continuum". The body's initial response was to increase breathing, increase heart rate and increase temperature. As that continued untreated the condition progresses to severe sepsis where, he explained, there is evidence of poor blood supply to some of the organs resulting in confusion because of poor supply to the brain or the onset of kidney problems. Septic shock, he advised, is when a patient with severe sepsis has low blood pressure which cannot be lowered by fluid replacement alone. Typical symptoms of severe sepsis, he said, were breathing quickly, evidence of some confusion, passing smaller volumes of urine and of feeling cold in hands and feet. He stated someone with severe sepsis would be expected to exhibit some or all of these changes.
69. Dr Laing said it was not unusual for patients with bacterial sepsis to suffer diarrhoea and vomiting as part of the body's reaction to it. Dr Laing agreed that, as Dr Shepherd had opined, the degree of diarrhoea and vomiting suffered by Mr Willock, if it be thirty or forty occasions of diarrhoea and vomiting, was such that it was separate from the sepsis. He stated it would point more to gastroenteritis.

70. Dr Laing thought it unlikely that the cause of Mr Willock's death was swine flu. He said he would have expected some sign of pneumonia at post-mortem if Mr Willock had succumbed to a fatal episode of swine flu.
71. Dr Laing said while it was not clear cut when sepsis was likely to have developed in Mr Willock, he noted that by the afternoon of 28 December 2009 Mr Willock noticed feeling very cold. While he said sepsis could then have started to develop, Dr Laing also agreed that the symptoms exhibited by Mr Willock, as evidenced in the transcripts of his telephone calls on 28 December 2009, could have been caused by a viral infection.
72. Dr Laing, as Dr Shepherd had done, advanced percentage figures for survival rates of a patient who suffering from sepsis, from severe sepsis and from septic shock is admitted to hospital. As, however, Dr Laing was unable to gauge the physiology in this case, he said it would "be very speculative to try and give the likelihood of survival in this case".
73. Dr Laing thought it unlikely that Mr Willock had septic shock on 27 December 2009. He said he could not identify sufficient evidence to make him confident that Mr Willock had sepsis on 27 December 2009. He advised his symptoms were then consistent with a viral infection. He agreed that the vast majority of patients with viral infections do not require admission to hospital. Subject to his aforementioned caveat re speculation, on the evidence available to him, Dr Laing said it would be fair to say that Mr Willock's survival rate had he been admitted to hospital on 27 December 2009 would have been somewhere between 60 and 85%. He said it was

difficult to say anything, however, that was not very speculative without more physiological parameters.

74. After 27 December 2009 all Dr Laing could say was that Mr Willock's chances of survivability had he been admitted to hospital were likely to reduce through time – to put any figure upon Mr Willock's chances was "extremely speculative", he said.
75. Dr Norman Gaw, a GP (since 1983) and the Clinical Director of the Greater Glasgow and Clyde Health Board Out of Hours Service (since 2005), explained that the function of the Service was to provide unscheduled primary care to the population covered by the service during the period when GP surgeries were no longer responsible for looking after their patients, which includes public holidays. Dr Gaw explained he had a managerial, operational, strategic and governance role in the OOHS. He said he divided his time 50/50 as between being a practising GP and Clinical Director of the OOHS.
76. Dr Gaw explained that the OOHS is structured in a hub within a contact centre. OOHS have 9 PCEC's and also a visiting service with visiting cars. He informed the Inquiry that the contact centre receives enquiries for home visits from NHS 24 and dispatches that requirement to the most appropriate home visiting car depending upon geography. Within the contact centre there are GPs and Team Leaders. The GPs are there to take calls from NHS 24 as "appropriate speak to doctor calling". During public holidays OOHS also service un-triaged calls and carry out telephone consultations.

77. Dr Gaw advised that OOHS operate a pool of GPs who conduct consultations. They have 400 GPs available for sessions. Dr Branchfield, he said, was one of the GPs in the pool in 2009 and remains so.
78. Having become aware of Mr Willock's death in May 2010, Dr Gaw instructed an investigation be undertaken regarding the involvement of the OOHS. Dr Gaw explained he wished to investigate the consultation between Dr Branchfield and Mr Willock. He said he listened to the recording of the consultation personally, met with Dr Branchfield, and asked two colleagues in the OOHS, fellow GPs, to also listen to the recording and proffer their opinion.
79. Dr Gaw said having listened to the recording and obtained feedback from his two colleagues he wrote the Significant Event Analysis (Crown Production 9). He explained a Significant Event Analysis is a management tool used to document what happened, thoughts as to why it happened, then anything which might be learned and anything which might require to be changed as a result of the event.
80. Dr Gaw, when pressed, conceded that the use of the word "declined" to describe Mr Willock's response to Dr Branchfield's offer to arrange for him to be seen at a PCEC was simply pejorative. He said Mr Willock was offered but did not take up the offer because he did not feel well enough to come out.
81. Dr Gaw, as an experienced GP, was of the opinion, contrary to that of Dr Willox, that Dr Branchfield had put himself in a position to fully assess Mr Willock's presenting symptoms and having put himself in that position was able to exercise his clinical judgement and decide whether or not a home visit was indicated due to the risk

presented by Mr Willock's predicament. He said he thought it was a reasonable decision for Dr Branchfield, having carried out the assessment, not to ask another doctor to visit. While there were some things he, Dr Gaw, might have done differently, that, he said, was not the test. Dr Gaw thought Dr Branchfield was in a position to make a decision. Although Dr Gaw thought there were certain questions it might have been helpful for Dr Branchfield to ask to reinforce his decision, Dr Branchfield's conclusion that Mr Willock was likely to be suffering from a viral illness likely to be self-limiting was, according to Dr Gaw, a reasonable conclusion to reach. He described Dr Branchfield's decision at the time as being a "safe clinical decision". Dr Gaw was, however, critical of Dr Branchfield omitting to give Mr Willock a "worsening statement". He said it would have been very different had Mr Willock not telephoned back to NHS 24 the following morning.

82. Dr Gaw's two colleagues, experienced GPs, differed in their view of what Dr Branchfield ought to have done. One was of the view that upon being offered a consultation at a PCEC, the only safe option when Mr Willock was unable to attend was to arrange a home visit. The other had an alternative view being of the opinion that Dr Branchfield had put himself into a position where he could make a reasonable clinical assessment. Dr Gaw stated he took account of both views in a situation in which the judgements were finely balanced before stating in the "What has been learned" section of the Significant Event Analysis that "it could be argued that having decided a face-to-face consultation was indicated that, in the event of the patient not being able to attend, a visit should be performed".

83. Dr Gaw explained that he wrote to all triage doctors by letter dated June 2010 (Crown Production 10). This, he said, was left on the table within the hub. In June 2010, there was no monitoring system to check whether triage doctors had actually seen the said letter. Nowadays the OOHS IT system allows an email to be sent to each GP. Additionally, a paragraph was inserted in the Newsletter which is distributed to every doctor and every clinician in the OOHS. Dr Gaw said “guidance” was issued to the effect that in circumstances where a patient has been offered a PCEC consultation but has declined because he/she is unable to attend, the doctor must be absolutely sure that the clinical decision he/she makes is the correct decision, that a home visit is not needed. If in doubt, Dr Gaw said, a home visit should be performed.
84. Dr Gaw said that in 2009 a Nurse Administrator from NHS 24 was and is still today unable to access Dr Branchfield’s note of his consultation with Mr Willock. He did not think there would be “some value” for a Nurse Advisor in a subsequent triage to be able to access Dr Branchfield’s note. If a Nurse Advisor was able to access the Doctor’s clinical note he said it could influence her in how she dealt with the call. He stated it could influence her detrimentally. While it was important for the Nurse Advisor to be aware that the patient on the telephone has had a prior consultation with a doctor from the OOHS, he said, she need not have access to the doctor’s findings. A Nurse, he said, is not trained to interpret a doctor’s findings. Such findings could provide false reassurance to the Nurse. A Nurse had to assess the patient on the basis of what was happening there and then at the time of the assessment. He added that if the system was to be altered to permit Nurse Advisors

to have access to the doctor's clinical findings, Nurses would require to receive training in the interpretation of a GP's clinical findings. If the Nurse feels she would like a doctor to speak with the caller, because he has spoken to a doctor before, that, Dr Gaw explained, can be arranged by the Nurse directing the call to a GP Advisor who would then be in a position to assess the doctor's note.

85. Dr Gaw said that, had Dr Branchfield arranged for Mr Willock to receive a home visit from a GP and had that GP visited Mr Willock on the evening of 27 December 2009, he would have been very surprised if the GP would have sent Mr Willock to hospital. Dr Gaw stated he would not have expected someone to require hospitalisation due to a viral illness or untreated case of diarrhoea and vomiting after 24 hours if there is no sign of dehydration. He said it was not usual practice for a 43 year old man previously sick with diarrhoea and vomiting to be admitted to hospital. Additionally, Dr Gaw was aware of the difficulties which can be caused by such a patient potentially infecting others in hospital, to the extent that he postulated that it would not be in the patient's best interests and it is likely that a doctor in secondary care at the hospital would be seriously enquiring why the GP wished such a patient admitted.
86. Dr Gaw informed the Inquiry he had assessed the amount of time Dr Branchfield actually spent on the telephone call with Mr Willock. Dr Gaw said there is no time constraint upon the length of any OOHS Doctor's consultation. He noted from OOHS records that Dr Branchfield had picked up a number of un-triaged calls. Dr Gaw said he was not particularly busy. Dr Branchfield was not, in his opinion, under pressure,

overworked, or overstretched. Had he felt under pressure, Dr Branchfield had the facility to speak with his Team Leader (which he did not).

87. Dr Gaw said that having listened to the call with Mr Willock and having listened to other calls performed by Dr Branchfield he did not feel Dr Branchfield was practising dangerously or that his standard of telephone consultation was that of a doctor who was struggling.
88. Mrs Houston, in leading an investigation team into the care of NHS 24 for Mr John Willock, did not interview the Call Handlers and Nurse Advisors personally. As part of the investigation Mrs Houston prepared a Patient Safety Incident Report dated March, 2011 (Crown Production 13). The objective of the Report, an internal document, was to thoroughly investigate Mr John Willock's journey within NHS 24, to identify concerns, if any, and to look at where the service may improve.
89. Mrs Houston was asked for her conclusions in respect of each of the Call Handlers and Nurse Advisors who had spoken to John Willock.
90. Mrs Houston said that upon contacting NHS 24 and following the capture of relevant information from Mr Willock the Call Handlers in the three calls on the evening of 27 December and in the morning and early evening of 28 December should have routed the call to a Nurse Advisor for immediate assessment. Mrs Gwen Kettles (then Blanche), the Call Handler who handled the call from Mr Willock on 27 December 2009 did not, according to the Investigation Team, use call streaming appropriately. Mrs Houston said that had she done so the call would have been routed

immediately, on the basis of chest pain symptoms presented, to a Nurse Advisor for full assessment.

91. In respect of Mrs Ann McDermid, Call Handler, Mrs Houston said she did not inform Nurse Advisor Fiona McCulloch that Mr Willock was a return caller, did not record the call in the drop down menu as a return caller and did not note this information in the AV box. She said Mrs McDermid did not follow Process 18. The Investigation Team, with the benefit of hindsight, and all available information, disagreed with Nurse Advisor McCulloch overriding “the disposition” for Mr Willock to one of “self-care”. The Investigation Team, Mrs Houston said, would have considered onward referral at that time. This would have meant onward referral to a GP within a 4 hour timeframe, either by means of a home visit or offering the patient a consultation at a PCEC.
92. Mrs Houston said that the performance of three Call Handlers, in this case, was not NHS 24 standard performance. She stated Mrs McDermid and Miss Fergie failed in some parts of the handover as she would wish it done. Mrs McDermid’s verbal handover to Nurse McCulloch was, Mrs Houston accepted, not of the standard expected in NHS 24. She did not inform Nurse McCulloch of Mr Willock’s other symptoms. Mrs Houston said the Investigation Team considered Miss Fergie had not appropriately completed “the call reason” in respect of Mr Willock’s call. The Team considered Miss Fergie asked insufficient, open questions of Mr Willock to correctly ascertain “the main call reason”. Mrs Houston categorised the information which Miss Fergie placed in the AV box as “totally inadequate”. She said none of Mr Willock’s symptoms were listed, nor was he mentioned as a return caller. She said it

would also have been best practice for her to make mention of this to Nurse Pamela Scally during the verbal handover. Miss Fergie's verbal handover to Nurse Scally was viewed by Mrs Houston as inadequate and unprofessional and not reflective of NHS 24 training. Mrs Houston advised that Miss Fergie's request for Mr Willock's consent was not in line with any NHS 24 guidance. She said she should have taken all the information from his partner and then enquired if Mr Willock, as the patient, was well enough to come to the telephone.

93. Mrs Houston, observed that the initial assessment in the Calls to the Nurse Advisors on 28 December 2009 to exclude serious and urgent symptoms was not completed. She said Mr Willock had multiple symptoms and provided additional worsening symptoms which should have resulting in a referral to a GP on each occasion. Mrs Houston said that, even excluding the detail of the clinical symptoms presenting, the correct application of Process 18 would have indicated the need for referral on each occasion.
94. Mrs Houston said the root cause identified was firstly a focus upon Mr Willock's individual symptoms without a holistic view of his overall health and secondly the incorrect application of Process 18.
95. Mrs Houston advised that an algorithm is a support tool, part of the clinical judgement process. She said that in the assessment and use of algorithms a Nurse Advisor is exercising her clinical judgement. Mrs Houston told the Inquiry Nurse McCulloch had erred in her response to some of the questions posed in the algorithm chosen by her. The Investigation Team felt, Mrs Houston said, Nurse McCulloch

failed to exercise her clinical judgement appropriately. They felt she should have adopted a more holistic view of Mr Willock. Mrs Houston further informed the Inquiry that the Investigation Team's analysis "was that there were other algorithms (other than for knee pain or swelling) that [Pamela Scally] could have chosen". Looking to the algorithm Nurse Scally chose, Mrs Houston agreed she had failed to complete same accurately. She agreed that it was inappropriate for Nurse Scally to anticipate "the disposition" and ask a question in a particular way to avoid resulting in that disposition.

96. Each of the Nurses ought, in Mrs Houston's view, contrary to what actually occurred, to have spent the first 90 seconds of their telephone call with Mr Willock asking open questions. It was part of their training and good practice to do so. Mrs Houston said that the Investigation Team felt it would have been more appropriate for Nurse Advisor Pamela Scally to have made an onward referral to a doctor of the OOHS as opposed to the disposition she reached of "own GP within 36 hours". Neither Carolyn Fergie nor Pamela Scally, she said, had fully taken on board the thought process about "separate episode of care" to reach an outcome. Mrs Houston acknowledged, however, that the Investigation Team had had the benefit of considering Mr Willock's entire patient journey through NHS 24. She said their decision was reached by means of a 'holistic view', the fact the patient had contacted the Service several times and was not getting better and the correct application of Process 18. Mrs Houston said the telephone triage by both Nurse Advisors fell below their own professional standards and her expectations of their practice. It fell below the standards Mrs Houston expected NHS 24 "to evidence", notwithstanding, she

indicated, that it did not fall below the standard of the Nurses National Council. Mrs Houston said no organisational causes of poor documentation by both Nurse Advisors could be identified from the individuals concerned. In response to whether or not the outcome of the call streaming system was appropriate, Mrs Houston said the Investigation Team found that safety questions within call streaming are appropriate and would have indicated the need for immediate transfer to a Nurse Advisor in all calls. She said the Report stated the recording of incorrect/inaccurate information given by Mr Willock in relation to his symptoms by Mrs Kettles (Blanche), Call Handler, Miss Caroline Fergie, Call Handler, and Nurse Advisor Pamela Scally hindered a more urgent patient journey for Mr Willock. The Team, Mrs Houston said, felt a more urgent referral would have been the appropriate outcome.

97. Mrs Houston spoke to the content of Process 18 dated 19 November 2007, the version in force in December 2009, a copy of which had been lodged with the Inquiry by those acting for NHS 24. Mrs Houston explained that there were three ways whereby a Nurse Advisor will discover that a patient is a “return caller”, firstly because she is informed, secondly by accessing call history to reveal if the patient has contacted NHS 24 before or thirdly, by looking in the Add View (AV) box (into which details ought to have been inserted by the Call Handler).
98. In December 2009 Mrs Houston explained that accessing the call history was not part of Process 18. While it was, she said, part of NHS 24 core induction training it was not in December 2009 part of Process 18. Nurse Advisors were trained to look at the call history. Mrs Houston said Process 18 has since been altered by the insertion of

an appropriate provision, at the instigation of the Investigation Team following the Patient Safety Incident Report, whereby Nurse Advisors are now directed that they must review the patient's past medical history and call history. Although in December 2009 it had not been mandatory for a Nurse Advisor to look at the call history of every return caller, Mrs Houston said it was "good practice" to do so. She advised it was now mandatory for Nurse Advisors to do so in terms of the amended version of Process 18, dated 23 November 2011.

99. Mrs Houston informed the Inquiry that the Call Handler Process, as part of the amended Process 18, had been altered to provide that in every case where a Call Handler is aware a patient has called NHS 24 before and the Call Handler determines the call falls within the same episode of care, the Call Handler is now required to discuss the call with her Team Leader. The Call Handler no longer has an option on whether or not to discuss the call with the Team Leader. She is now required to do so. NHS 24 felt, Mrs Houston advised, that the additional step of requiring Call Handlers to check with Team Leaders would mitigate against the Call Handlers making the mistakes made by Mrs Ann McDermid.
100. Mrs Houston recognised that determining whether or not a call falls within the "same episode of care" is a very challenging process. An episode of care had been defined in the General Guidance Notes for the version of Process 18 dated 19 November 2007. The Investigation Team, she said, discovered that if the definition was too specific, a slight variance therefrom may create a difficulty. They, therefore, decided, Mrs Houston advised, to issue a general guidance, including a fresh definition of "episode of care" in the General Guidance Note for the amended

Process 18 dated 23 November 2011. The patient's symptoms now may be the same as before or different, whereas in 2009 Mrs Houston acknowledged the patient had to have the same symptoms to fall within the definition.

101. Mrs Houston said that in 2009 and also now, a Nurse Advisor is able to override what the Call Handler has told her. The patient can be made a return caller by the Nurse Advisor or have that status removed as the Nurse Advisor determines.
102. Towards the end of Mrs Houston's initial appearance before the Inquiry in 2012, she said it was not possible then to prevent a Nurse Advisor moving on in Process 18 without checking the patient's call history. When she was recalled Mrs Houston told the Inquiry NHS 24 had recently procured a new application to be uploaded in 2013, in terms of which Process 18 callers will be electronically identified and by June 2013 Nurse Advisors will be unable to proceed through Process 18 without having reviewed the patient's past medical history and call history.
103. Mrs Houston stated the Investigation Team made various recommendations for consideration at the National Patient Safety Meeting. These are set out on page 9 of the Patient Safety Incident Report. Mrs Houston said recommendation (3) that if a patient has called before, an automatic alert will come up on the Advisor's screen has been agreed. The alert will inform all Advisors that the patient is a 'return caller'. It will "self-generate", not be reliant upon input from the Call Handler. She understood that the timing is critical. She said initially that NHS 24 had still to define the timeframe. When she was recalled to complete her evidence, Mrs Houston advised that there are to be two timeframes, 48 hours and 5 days. Return callers

would be seen by all staff if there was a first call within a 48 hour period or they called 6 times within 5 days. This would be visible on the screen and would remain visible to Nurse Advisors following handover. Mrs Houston added that NHS 24 were currently in “proof of concept” that, if a patient has called twice within 48 hours and a third call is made by him, a Nurse Advisor will not be able to give self-care advice.

104. Recommendation (2) to consider updating Process 18, so that a patient re-contacting the service, with additional worsening or changing symptoms on more than 2 occasions should be unable to receive self-care without a second clinical opinion, was considered and discussed, Mrs Houston said, but rejected. It was rejected as it was felt such a mandatory requirement could increase demand inappropriately. When Mrs Houston, however, was recalled to complete her evidence she explained that this recommendation had been reconsidered and was now in the pipeline. She said NHS 24 had “moved on” and “signed off” on the alert.

SUBMISSIONS

All parties lodged very careful and detailed written submissions. As it was agreed that the Crown would produce their submissions in advance, the other parties' submissions took the form of, in the main, observations upon and criticisms of those presented by the Crown. It would be unnecessarily cumbersome to incorporate the lengthy submissions (running to 196 pages in total) *ad longum* into this Determination, or to simply annex them by way of Appendices. That would be inappropriate. Having exchanged their written submissions, parties attended a Hearing and made further oral representations. Where relevant these ought to be reflected in this Determination. I therefore seek to summarise the various parties' positions to enable my Determination in terms of Section 6 of the Act to be viewed in context.

A. Submissions for the Crown

- 1) Section 6(1)(a) of the Act – when and where the death of Mr John Willock took place.

All parties were agreed that Mr John Willock died at home at 6 Parkhill, Erskine on 29th December 2009. The Procurator Fiscal Depute submitted I should find that he died at 18:20hrs per the evidence of Ms Louise MacDonald, the Paramedic from the Scottish Ambulance Service notwithstanding that Mr John Willock was not formally certified dead until 21:25hrs by the Police Casualty Surgeon.

- 2) Section 6(1)(b) – Cause of death.

Although the Inquiry initially heard evidence from Dr John Clark, Consultant Forensic Pathologist, who performed the post-mortem, that the cause of Mr John Willock's death was acute cholangitis with septicaemia, when he was subsequently

recalled to give evidence after having had sight of further Reports which had been obtained from Dr Christopher Bellamy, a Consultant in Renal Histopathology and Mr James Powell, a Consultant Hepatobiliary and Transplant Surgeon (Productions numbers 2 and 3 lodged on behalf of the Greater Glasgow and Clyde Health Board Out of Hours Service), Dr Clark was of the opinion that the evidence for a specific diagnosis of acute cholangitis was not particularly strong. He said the cause of death may be better worded as “septicaemia, source uncertain”.

The Depute drew my attention to the evidence of Drs Laing and Shepherd in support of her submission that, on the balance of probabilities, the cause of Mr Willock’s death has been established and should be recorded as “Septicaemia, source uncertain”.

In the event, all parties to the Inquiry were in agreement with this submission as, on the basis of the evidence led, accurately reflecting the cause of Mr Willock’s death.

- 3) Section 6(1)(c) – the reasonable precautions, if any, whereby the death... might have been avoided.

The Depute acknowledged I should only make a finding in terms of Section 6(1)(c) where I am satisfied that the reasonable precaution might have avoided Mr Willock’s death.

The Depute identified, as she saw it, eleven individual events as follows:-

- 3.1 The Depute highlighted the divergent views of the four experienced General Practitioners, whose opinions on this issue were elicited for the Inquiry and stated that as the result of their differing opinions “it cannot conclusively be said that it would have been a reasonable precaution for Dr Branchfield to have requested a doctor visit Mr Willock”.

Alternatively, the Crown suggested that if it was considered a reasonable precaution for Dr Branchfield to have requested a doctor’s visit, then such action may have prevented Mr Willock’s death. While the preponderance of evidence was that it would have been unlikely for Mr Willock to have been sent to hospital at that time, had a doctor attended upon him at home (it being likely that Mr Willock had not developed sepsis on the evening of 27th December 2009) and treated his symptoms, the Depute said there was a “lively possibility that Mr Willock would have survived”.

- 3.2 The Crown submitted that it would have been a reasonable precaution for the NHS 24 Call Handler, Mrs McDermid, to have followed the NHS 24 guidance in respect of return callers – Process 18, to have recorded in the Additional View (AV) box that Mr Willock was a “return caller”, failing which to have informed the Nurse Advisor, Ms Fiona McCulloch during their verbal handover that Mr John Willock was a “return caller”. Had Mrs McDermid followed Process 18 the Depute submitted it is likely that Nurse Adviser

Fiona McCulloch would have arranged for Mr Willock to be seen by a doctor at home.

The Depute stated there was a realistic possibility that a doctor visiting Mr Willock would have found him to be significantly unwell. She said there is a “realistic possibility” that such a doctor would have arranged for Mr Willock to be admitted to hospital. Founding in the main on the testimony of Dr Laing, supported by Dr Shepherd, the Depute submitted that having been admitted to hospital, Mr Willock may well have survived. There was, she maintained, a “lively possibility” that his death may have been prevented.

- 3.3 The Crown submitted that a reasonable precaution would have been for Nurse Advisor Fiona McCulloch to have adopted “a more holistic approach” when conducting her telephone triage with Mr Willock and to have asked more open, detailed and appropriate questions. Had Ms McCulloch asked more open questions of Mr Willock, it was likely she would have received more information from him regarding the extent of his ill health, which further information may have affected her clinical judgement and resulting in her arranging for Mr Willock to be seen, face to face, by a general practitioner. Had that occurred, then with reference to her aforementioned submission 3.2 “ultimately John Willock’s death may have been prevented”.

- 3.4 The Depute stated it would have been a reasonable precaution for Nurse McCulloch to have checked “the patient call history” when she took over Mr Willock’s telephone from Mrs Ann McDermit, the Call Handler.
- 3.5 The Crown made a further criticism of Nurse McCulloch submitting that it would have been a reasonable precaution for her to have accurately completed the algorithm for “indigestion” following upon the information received from Mr Willock during her telephone triage.
- 3.6 The Crown submitted a reasonable precaution would have been for Nurse McCulloch to have arranged for Mr Willock to be seen by a general practitioner in a face to face consultation, even if the telephone call from Mr Willock with which she was dealing was his first call to NHS 24, not that of a “return caller”.
- 3.7 The Depute argued that a reasonable precaution would have been if Miss Carolyn Fergie, the NHS 24 Call Handler, had completed the Ad View box appropriately and additionally given an appropriate verbal handover to Mrs Pamela Scally, the Nurse Advisor, in accordance with NHS 24 guidance generally and Process 18 in particular. The Depute stressed that in the opinion of Mrs Houston, Miss Fergie’s verbal handover to Nurse Scally was inadequate. Further, she noted that the Investigation Team set up by Mrs Houston had concluded that the details inserted by Miss Fergie in the AV box

were totally inadequate. The Depute stated that Nurse Scally told the Inquiry that had the verbal handover contained the appropriate information, she would have formed the opinion Mr Willock was a return caller, and in terms of Process 18, would have arranged a face to face consultation with a general practitioner.

With reference to the evidence given by Dr Willox, the Depute said it was “most likely” a doctor would have considered Mr Willock to be sufficiently unwell with possible underlying dehydration and sepsis as to require admission to hospital. In that event, the Depute referring again to the evidence given by Drs Shepherd and Laing submitted that had Mr Willock been admitted to hospital, his death might have been prevented.

- 3.8 The Crown further submitted that it would have been a “reasonable precaution” for Nurse Advisor Scally to arrange for Mr Willock to be seen by a doctor. The Depute said it was Dr Willox’s opinion that Mr Willock had significant diarrhoea and vomiting, laboured breathing and knee pain. The combination of all these symptoms should have led Nurse Scally to conclude Mr Willock required to be seen by a doctor. The Investigation Team of NHS 24 thought that Nurse Scally was mistaken in her judgement in offering self-care advice. Had a general practitioner visited Mr Willock, the Depute submitted there was a “lively possibility” that his death may have been prevented.

3.9 The Depute further criticised Nurse Scally's handling of the telephone triage. She submitted it would have been a reasonable precaution for her to have taken a "holistic view" of Mr Willock's illness, to have asked more appropriate questions during the telephone triage and to have applied Process 18 on the basis that he had a worsening condition. But for Nurse Scally's failings during her triage, which, according to Mrs Houston fell below the standard that NHS 24 expected of her, it was the Crown's position that Mr Willock would have been seen by a doctor in a face to face consultation. Had that occurred for the reasons set out earlier in her submissions, the Depute argued there was a "lively possibility" that Mr Willock's death may have been prevented.

3.10 The Crown submitted that it would have been a reasonable precaution for Nurse Scally to complete the algorithm for "knee pain or swelling" in accordance with the information she obtained from Mr Willock during her telephone triage. Had she done so, the result would have been a "disposition" that Mr Willock should go to the Accident & Emergency Department of a hospital as soon as possible with the result that there was a "lively possibility" that his death may have been prevented. It was inappropriate, according to Mrs Houston, for Nurse Scally to anticipate that disposition and answer the questions posed in the algorithm to avoid a disposition she did not want.

- 3.11 The Depute submitted that it would have been a reasonable precaution for Dr Murray MacPherson to have arranged for Mr Willock to have gone to hospital.

The Depute acknowledged that the Inquiry had been provided with two conflicting accounts of Mr Willock's condition at the time of Dr MacPherson's examination on 29th December 2009 and of the examination itself. If the account given by Ms Rogers is accepted the Depute said Dr Willox was of the opinion that Dr MacPherson's examination of Mr Willock was inadequate. He said Dr MacPherson failed to put himself in a position to make an accurate diagnosis. Dr Willox was of the view, accepting Ms Rogers' account, a doctor of reasonable competence would have concluded that Mr Willock was seriously ill and would have arranged for him to be removed to hospital.

Alternatively, if Dr MacPherson's evidence is to be preferred, his diagnosis of gastroenteritis could be said to be the most probable diagnosis. Dr Willox considered that the injection he gave to Mr Willock and the prescriptions prescribed were reasonable treatment of Mr Willock. In such circumstances Dr MacPherson's actions were reasonable. He carried out an appropriate examination and assessment.

The Depute invited the Court to prefer the evidence of Ms Rogers. If, as she stated, the Inquiry accepted that Dr MacPherson should have arranged for Mr

Willock to be admitted to hospital, the issue to be determined is whether at that stage his death may have been prevented. Dr Shepherd stated Mr Willock's chances of survival at that point were very low. He was unlikely to have survived, although admission to hospital would have afforded an opportunity for survival. Dr Laing said his opinion of the chance of survival was speculative. He said that around lunch time on 29th December 2009 Mr Willock's chances of survival were less than 50%.

The Depute submitted that, considering the evidence of both Drs Shepherd and Laing together, there was a "real or lively possibility" that Mr Willock's death might have been avoided had he been admitted to hospital on 29th December 2009.

- 4) Section 6(1)(d) - consideration of the defects, if any, in any system of working which contributed to the death.

At the Hearing on submissions the Depute accepted, on behalf of the Crown, that the Court has to be satisfied that there was a defect in the system of work and that if so satisfied, that there is evidence to establish on the balance of probabilities that the defect contributed to Mr Willock's death.

The Depute referred to the well known passage in Ian H. B. Carmichael's book on *"Sudden Deaths & Fatal Accident Inquiries"*, 3rd Edition, para. 5.76 highlighting that the evidence must be sufficient on the balance of probabilities to justify the findings.

In an Inquiry, the Depute submitted, the defect need not be the principal cause of death. While it would not be enough to establish a defect which might have contributed to the death, it would be sufficient, the Depute argued, to show on the balance of probabilities that the defect "helped cause or bring about the death". It can "contribute" to the death in the sense of helping to bring it about. The Depute said this constitutes "a lower level of causation" than actually causing the death. On the balance of probabilities the defect has to have at least contributed to the death, she said. This was not the same as saying that but for the defect Mr Willock's death is likely to have been avoided.

It was the Crown's position that if the defect deprived Mr Willock of say a 20% chance of recovery, then it can be said on balance that the defect helped cause or bring about his death. For a finding in terms of Section 6(1)(d) the Crown do not accept that is necessary for there to be evidence that Mr Willock had a better than 50% chance of survival.

4.1 The Depute submitted that there was a defect in a system of work with regard to the system of training and the supervision of the Call Handlers and Nurse Advisors. The Court could infer from the evidence led before the Inquiry and

the “numerous mistakes that occurred” that the system of training and the supervision of the Call Handlers and the Nurses “may have on balance” contributed to these failings. The Depute said that, to differing degrees, each of the four NHS employees (the two Call Handlers and the two Nurse Advisors) failed in their performance. She submitted that it would be an unlikely coincidence for each of the failings to be attributed to four different employees without any defect in the system of training, coaching and supervision.

Notwithstanding the testimony of Mrs Houston, who did not accept there had been a systematic failure in NHS 24 processes, the Depute submitted there was a defect in a system of work in relation to the system of training and supervision. She said it was likely that the defect in the system of work – training in Call Handling – resulted in the failure of a General Practitioner to see Mr Willock. Following on from that the Depute said it was not necessary for the Crown to say on the balance of probabilities that Mr Willock was likely to survive – the evidence of Drs Shepherd and Laing of less than a 50% chance of survival was sufficient.

- 4.2 In December 2009, Process 18 within NHS 24 existed for patients calling NHS 24 on a second or additional occasion as a “return caller”. The Depute submitted there was a defect in the system of work in relation to how Process 18 was applied and implemented. She highlighted the incorrect application

by the NHS 24 employees who spoke with Mr Willock on 28th December 2009, that the term “same episode of care” where it appeared in the Process was not understood by the two Call Handlers, that new guidance was issued in November 2011 subsequent to Mr Willock’s death and concluded that this defect in the system of work contributed to his death.

The Depute referred to the evidence of Drs Laing and Shepherd and their comments upon the chances of Mr Willock surviving. She submitted it was clear from the evidence of Dr Laing that Mr Willock’s death might have been prevented “at all stages”. Dr Shepherd, she said, was of the view that if Mr Willock had been admitted to hospital on the evening of 27th December, on either on the morning or afternoon of 28th December, his death might have been prevented. The Depute said that whether or not Mr Willock would have survived upon reaching hospital, it was the Crown’s position that the “realistic and likely possibility test” to which she had referred when commenting upon Section 6(1)(c) was equally applicable to the circumstances of Section 6(1)(d). There had, she said, to be a realistic possibility of Mr Willock’s survival “the chance of survival”. She stated the “balance of probabilities was in regard to the defect contributing towards the death rather than the consequences thereof”.

5. Section 6(1)(e) – other facts relevant to the circumstances of Mr Willock’s death.

- 5.1 The Depute said the guidance from NHS 24 to Nurse Advisors to explore the main call reasons, as given to them by the Call Handlers, is unduly restrictive and detrimentally influenced the Nurse Advisors when conducting their triage. The Depute submitted that Nurse Advisors should ask a general open question at the commencement of talking to the patient to establish for themselves the main reason for calling.
- 5.2 The Depute said there was evidence before the Inquiry that it may be reasonable for a patient to assume the information he had given to a Call Handler was passed on to a Nurse Advisor. As it appeared that, in fact, only a limited amount of what Mr Willock had told the Call Handler was passed on to the Nurse Advisor, the Depute submitted that had this been made clear to Mr Willock, that the Nurse Advisor did not have a full picture, he may have given the Nurse Advisor more detailed information. Mr Willock may have informed Nurse Fiona McCulloch he had telephoned before and his symptoms were deteriorating. The Depute said he may also have given Nurse Pamela Scally more information about his “worsening” symptoms.
- 5.3 The Inquiry, the Depute observed, had heard from Mrs Houston that, in December 2009, whilst it was “good practice” for a Nurse Advisor to check the call history when taking a call from a “new caller” or “return caller”, it was not mandatory.

Mrs Houston also explained that there had been changes to Process 18 instituted since Mr Willock's death. When a Nurse Advisor takes a call from a return caller it is now mandatory for the Nurse Advisor to check the call history. While this change was to be welcomed, the Depute advocated that it may be of benefit to go further and for the Court to recommend in respect of every call (my emphasis) to a Nurse Advisor, whether a return caller or not, it is mandatory for the Nurse Advisor to check the call history.

B. Submissions on Behalf of Carolann Rogers

- 1) Section 6(1)(a) Mrs Ceresa submitted the actual time of Mr Willock's death at his home on 29th December 2009 was sometime between 18:10 and 18:20.
- 2) Section 6(1)(b): Mrs Ceresa agreed that the cause of death was established by the totality of the evidence led to be "septicaemia, source uncertain".
- 3) Section 6(1)(c) The reasonable precautions, if any, were by the death and any action resulting in the death might have been avoided.

Mrs Ceresa stressed that it is not necessary to show that precautions, if reasonable, would have avoided Mr Willock's death, only that his death "might" have been avoided. She advanced the following reasonable precautions:-

- (1) A reasonable precaution would have been for Dr Branchfield to arrange for a doctor to visit John Willock.

- (2) A reasonable precaution would have been for Call Handler Mrs McDermid to have established that Mr Willock was a return caller and thus invoke Process 18.
 - (3) A reasonable precaution would have been for Nurse Advisor McCulloch to have arranged for a doctor to visit John Willock.
 - (4) A reasonable precaution would have been for Call Handler Miss Fergie to have recorded more information and provide Nurse Advisor Scally with more information about Mr Willock.
 - (5) A reasonable precaution would have been for Nurse Advisor Scally to have correctly recorded Mr Willock's symptoms in her use of the knee algorithm.
 - (6) A reasonable precaution would have been for Nurse Advisor Scally to have arranged for a doctor to visit Mr Willock, and
 - (7) A reasonable precaution would have been for Dr MacPherson to have arranged for Mr Willock to be admitted to hospital.
- 4) 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.

Mrs Ceresa submitted the following defects in the system contributed to Mr Willock's death:-

1. NHS 24 training and supervision of staff was defective. She said it was an unlikely coincidence for each of the failings to be attributed to the Call Handlers and Nurse Advisors within NHS 24 without any defect in the system of training, coaching and supervision contributing.

2. There was a defect in the system of work in relation to the application of Process 18.
3. It was not mandatory for a Nurse Advisor to check the call history of every caller.
4. Nurse Advisors in NHS 24 could not access Out of Hours GP records. There is a defect in the system if Nurse Advisors are expected to look to see what is held regarding the caller's record of previous contact within NHS 24 but part of the information in the form of the Out of Hours GP records is not accessible.

Mrs Ceresa stated that if the said defects are found not to have contributed to Mr Willock's death, and there is no causal connection therewith, the Court should make findings relative to same in terms of Section 6(1)(e).

C. Submission on behalf of Drs Branchfield, MacPherson and Hanley

Mr Stewart submitted that for the Court to establish there was a reasonable precaution which should have been taken whereby the death might have been avoided, there requires to have been evidence led to the effect that a particular act or omission of one of the parties involved was not reasonable. If no such evidence has been led (i.e., that an action or omission was not reasonable) then he submitted it would be difficult for the Court to find that there was a reasonable precaution which that party should have taken whereby the death might have been avoided.

In relation to a finding in terms of Section 6(1)(a), Mr Stewart suggested that the time of Mr Willock's death was shortly after 18:05hrs on 29th December 2009. He agreed that the cause

of Mr Willock's death, for a finding in respect of Section 6(1)(b), could be accurately stated as "septicaemia, source uncertain".

Mr Stewart moved the Court to make no findings in relation to the Doctors in terms of Section 6(1)(c) & (d) & (e). He said that any observations the Court wished to make could be confined to the Notes section of my Determination.

In relation to Section 6(1)(c) Mr Stewart submitted there are two distinct parts to its consideration:-

- (i) a consideration of the reasonableness of a precaution (or someone's actions), and
- (ii) a consideration of whether there is a "real and lively possibility" the precaution (or action) could have avoided Mr Willock's death.

1. Dr Branchfield

- (i) Mr Stewart submitted that Dr Branchfield's actions were reasonable given the symptoms as described to him and the way Mr Willock presented on the telephone. He said the only doctors appropriately qualified to comment upon Dr Branchfield's actions were Dr Willox and Dr Gaw. Dr Willox was of the opinion that Dr Branchfield did not put himself in a position to make an accurate or safe diagnosis. Mr Willox felt Dr Branchfield should have asked more questions of Mr Willock before reaching any decision. Nevertheless, Dr Willox agreed the symptoms described by Mr Willock were common ones and he understood on the basis of that (and the telephone call) why Dr

Branchfield reached the conclusions he did. Dr Willox accepted Dr Branchfield's provisional diagnosis of viral illness could well be accurate.

Dr Gaw, by contrast, thought Dr Branchfield put himself in a position to assess Mr Willock's presenting symptoms. He was of the view that Dr Branchfield's decision not to request a home visit was reasonable given the information gathered. While Dr Gaw considered that Dr Branchfield's conclusion of a viral illness was reasonable, he thought there were several other questions that it might have been helpful for Dr Branchfield to ask to reinforce that diagnosis.

Despite saying that he personally would have arranged for a home visit from an Out of Hours General Practitioner, Dr Gaw disagreed with the suggestion put that Dr Branchfield did not put himself in a position to safely manage his patient. Dr Gaw considered that Dr Branchfield had made a satisfactory assessment in concluding that Mr Willock was well enough not to require a visit. Dr Gaw stated that not all patients with diarrhoea and vomiting for several days will require to be seen. Dr Gaw consulted with two senior colleagues whose opinions over the requirement of a home visit differed. Dr Gaw concluded that the judgement of a home visit was finely balanced. It was an exercise of clinical judgement by the Doctor.

Mr Stewart invited the Court to prefer the evidence of Dr Gaw, to find that, albeit not perfect, Dr Branchfield's handling of Mr Willock during the telephone call was reasonable, as was the decision not to refer Mr Willock for a home visit. There were no

symptoms present to give Dr Branchfield undue cause for alarm when he spoke with Mr Willock. Expert physicians testified that it was likely it was a viral infection that Mr Willock was suffering from when he spoke with Dr Branchfield. There was no evidence to the effect that, if in fact Mr Willock was suffering from a viral illness, Dr Branchfield's treatment of him was inappropriate.

- (ii) A real and lively possibility the precaution may have avoided Mr Willock's death.

Mr Stewart emphasised that, from the evidence led before the Inquiry, it cannot be stated with any certainty whatsoever when Mr Willock developed the sepsis that ultimately led to his death. If one cannot identify the sepsis, it follows, Mr Stewart said, that it is difficult to assess what effect any given precaution might have had, reasonable or otherwise. Mr Stewart submitted the Court should find Dr Branchfield's actions to be reasonable and further should not find there were any other reasonable precautions he should have taken.

Mr Stewart stated that even if Dr Branchfield had arranged a home visit by a General Practitioner, there is no evidential basis to find that Mr Willock would have been referred to hospital on the evening of 27th December 2009. Given Mr Willock's symptoms at that time the evidence is that it is more likely than not he would have been managed at home, potentially in the exact same way as Dr Branchfield.

Even were Mr Willock to have been admitted to hospital on 27th December 2009, Mr Stewart argued it was far from clear what effect, if any, this would have had on the development of his septicaemia.

While it may be thought that Dr Branchfield could have asked more detailed questions of Mr Willock in his telephone conversation with him, Mr Stewart stated that it could not be said in light of the evidence that such a reasonable precaution might have avoided Mr Willock's death. He argued that more questions were likely to have convinced Dr Branchfield even more of his diagnosis. Additionally, while Dr Branchfield accepted he did not pick up that Mr Willock was unable rather than unwilling to attend a Primary Care Emergency Centre, he did not accept Dr Branchfield would necessarily have ordered a home visit if he had.

2. Dr MacPherson

- (i) Mr Stewart recognised that Dr MacPherson did not record all his findings as he ordinarily did not record those that were normal. He said Dr MacPherson accepted, with hindsight, it might be better to record "normal findings" and had changed his practice to this effect as a direct result of his case.

Mr Stewart submitted that the reasonableness of Dr MacPherson's actions depends on whether the Court accepts Ms Rogers' account of Dr MacPherson's account as accurate. If the Court accepts Dr MacPherson's account, then Mr Stewart submitted he acted

reasonably and his actions cannot be criticised with reference to the evidence of Drs Willox and Gaw.

Mr Stewart was of the opinion that whilst the scenario presented by Dr MacPherson might in some respects be unlikely, the alternative as presented by Ms Rogers was incredible. He argued that while Ms Rogers was undoubtedly doing her best in very trying and difficult circumstances to assist the Court, that her credibility was not in issue, there were some aspects of her evidence *“that were demonstrably incorrect and must therefore call into question her reliability”*. Mr Stewart adopted the Depute’s observation that Ms Rogers’ recollection may, not surprisingly, have been adversely affected by events. He invited the Court to prefer the evidence of Dr MacPherson where it was in conflict with that of Ms Rogers. That being the case he said Dr MacPherson’s actions were reasonable given the circumstances. Reiterating evidence I had heard he submitted that the vast majority of viral illnesses are self-limiting and individuals are managed at home and concluded it would not have been a reasonable precaution for Dr MacPherson to have called an ambulance or referred Mr Willock to hospital as he had no valid reason to do so.

- (ii) Mr Stewart drew to my attention that there was uncontroversial evidence led that a septicaemia infection is a continuum that can progress from the initial infection to a fatal condition rapidly. Although evidence was led from expert physicians, their answers, he said, were speculative as there was no way of telling when or where the septicaemia began and “baseline observations” for Mr Willock were not available.

Mr Stewart submitted the “real and lively possibility” test was not met in relation to any precaution that might have been taken by Dr MacPherson on 29th December 2009. He said the pessimistic figures provided by the experts, combined with the high degree of speculation involved, do not make the chance of Willock’s survival “a lively one”. He observed that the repeated use of the word “speculative” does not sit easily with the wording of Section 6(1)(c) and a “real and lively possibility”.

3. Dr Hanley

Mr Stewart acknowledged Dr Hanley conceded she should have dealt with the telephone call from Ms Rogers differently and wished she had done so. Dr Hanley accepted that she should have asked more questions of Ms Rogers and should have made a note of the telephone call. While the Doctor’s actions were not to a standard they should have been, they were, Mr Stewart maintained, nevertheless reasonable given the circumstances. It would not have been a reasonable course of action for Dr Hanley to undertake an assessment over the telephone, or in person, or call an ambulance as from her point of view there was no justification for doing so. Sadly, there was no evidence that Dr Hanley could, in any event, have done anything which would have made any difference to the death of Mr Willock.

D. Submissions on behalf of Nurse Advisors, Fiona McCulloch and Pamela Scally

Pamela Scally

Ms Watt said the usual approach to findings under Section 6(1)(c) is to attempt to identify a reasonable precaution (or precautions) that could have been taken, but were not, and then to

consider if any such reasonable precautions might have avoided the death. It is not enough that a precaution is reasonable. It must lead to the conclusion that such a reasonable precaution might (in a *“lively possibility”* sense) lead to the death being avoided.

In her submission, the approach, which is more useful in this particular case, is to ascertain, first of all, when and by what means Mr Willock’s death might have been avoided. In other words, to examine the medical evidence and work out what outcome was needed, and when it was needed, for Mr Willock to have had a *“lively”* or *“realistic possibility”* of surviving, and from there identify if there were any reasonable precautions which lead to that. By adopting this approach she suggested it would be more straightforward for the Court to work out what, if any, reasonable precautions ought to have been taken to achieve that outcome.

Ms Watt challenged the Depute’s assertion that there were 11 separate possible reasonable precautions. She criticised the Crown’s approach as adopting *“a broad sweep”* to the *“reasonable precaution”* test.

Commenting upon the causal chain, Ms Watt said that, based on the medical evidence, the only way in which the death of Mr Willock might have been avoided was for him to have been sent to hospital. She maintained it has to be shown at which point that hospital admission was required, in order for there to be a *“realistic possibility”* of Mr Willock’s death being avoided. It has to be shown that at the point there was such a *“realistic possibility”*, a GP would have sent Mr Willock to hospital.

Further, it has to be shown that at the point there was such a “*realistic possibility*”, a GP would have been sent to see Mr Willock.

Therefore, she submitted, the causal chain which can lead to a finding under Section 6(1)(c) is (i) a GP is sent to see Mr Willock; (ii) that GP would have sent Mr Willock to hospital, and (iii) when Mr Willock is sent to the hospital it is at a point where there is a “*realistic possibility*” his death might have been avoided.

Given that analysis, Ms Watt said the evidence suggested, as far as those she represented, that a General Practitioner might properly have been sent to see Mr Willock as a result of the telephone call with Nurse Advisor Fiona McCulloch and as a result of the telephone call with Nurse Advisor Pamela Scally. She argued that there was insufficient evidence to demonstrate that on either of those occasions a General Practitioner visiting Mr Willock would have sent him to hospital and that accordingly the Court should not find there was a reasonable precaution under Section 6(1)(c) which either Fiona McCulloch or Pamela Scally could or should have taken which might have avoided Mr Willock’s death.

Based on the evidence she said Mr Willock would most likely not have been admitted to hospital following a home visit by a General Practitioner, had either Fiona McCulloch or Pamela Scally arranged one. While the third limb of the test, whether or not following an admission to hospital after the visit by a hypothetical GP on the morning of 28th December there being a realistic possibility of Mr Willock’s death being avoided, did not fall, in her view of the evidence, to be considered she nevertheless submitted that in any event the

conclusions of the medical experts, Drs Laing and Shepherd, was “speculative” as to whether or not Mr Willock would have survived. Such speculation did not put the Court in a position of being able to determine there was a “*realistic possibility*” whereby Mr Willock’s death might have been avoided.

Ms Watt focused upon the evidence of Dr Laing and said that the signs of sepsis are sufficiently general so as not to lead to bedside diagnosis in the community. Most cases of viral illness do not lead to hospital admission. A diagnosis of sepsis and treatment of it requires hospital admission. The evidence did not lead to a GP being called at a time when Mr Willock would have been admitted to hospital. It was admission to hospital, she said, that was required to save his life – that admission would have to have been at a time when a General Practitioner would actually have seen him, whereas the evidence bore out that the General Practitioner who did, Dr MacPherson, had thought about the possibility of hospital and excluded it as an outcome based on his assessment and examination of Mr Willock.

E. Submission On Behalf Of NHS Greater Glasgow & Clyde Health Board Out Of Hours Service (OOHS)

Ms Watts, Counsel, submitted that the difficulties in establishing what caused Mr Willock to develop sepsis should be borne in mind when the Court considers whether or not to make any findings in terms of Section 6(1)(c). Given that the Inquiry has been unable to establish what led to Mr Willock’s sepsis, Ms Watts submitted a cautious approach should be adopted to identify measures which might lead to that sepsis being identified or treated sooner and to Mr Willock’s life being saved. She said that, as Dr Shepherd gave clear evidence that

different sources of sepsis require different treatment and result in very different survival rates, in the absence of being able to identify the source of the sepsis, the Inquiry is very much in the realms of speculation.

Although Mr Willock eventually died from sepsis of an unknown origin, Ms Watts said he was not suffering from sepsis on 27th December, 2009 but rather from the undoubtedly severe symptoms of a viral infection. At some point after the evening of 27th December Mr Willock went on to develop sepsis. She said he was extremely unlucky because the evidence was that the development of a serious infection following a viral illness is very rare indeed.

Ms Watt suggested that there are two potential circumstances which justify the making of a finding in terms of Section 6(1)(c) in a case such as this, namely:-

1. Where the medical witnesses concerned have conceded that a different course of action ought to have been taken.
2. Where the Court has accepted the evidence of an expert witness who has stated that a different course of action ought to have been taken.

Ms Watt said that where, as in this case, there is a divergence of view in the evidence suggesting a range of reasonable options available – in this case evidence that it would have been reasonable for Dr Branchfield to arrange a home visit and evidence that it was reasonable not to – the selection of one of those reasonable options (in this case not to carry out a home visit) should not form the basis for a Section 6(1)(c) finding, even if the selection of a different course of action might have prevented the death which subsequently occurred.

In any event, Ms Watt stated that if a home visit had been arranged, there was no evidence to indicate that would have altered the outcome whereby Mr Willock's death might have been avoided. The "real and lively" possibility test would not have been satisfied.

Ms Watts said the Crown's submission that the arranging of a home visit by Dr Branchfield was a reasonable precaution, a precaution which might have saved Mr Willock's life was contradicted by the evidence, in particular that of Dr Gaw, whose testimony she commended to the Inquiry. She stated that on the basis of the views expressed by Dr Gaw, not only would a visiting General Practitioner have thought it unnecessary to admit Mr Willock to hospital on 27th December but they would likely have considered doing so to be a clinically risky decision given the likelihood of him infecting other patients and staff with his viral illness. Further, as Dr Gaw pointed out even if presented for treatment, Mr Willock may well not have been admitted to the hospital.

Counsel stressed Mr Willock received a home visit on 29th December from Dr MacPherson. That visit did not result in his admission to hospital and sadly did not alter the eventual outcome. It was, therefore, as she put, "counterintuitive" to suggest that an earlier home visit, arranged by Dr Branchfield, would have created a "real and lively possibility" that Mr Willock's death might have been avoided.

In order to justify a finding under Section 6(1)(c) Ms Watt said that the Inquiry would have to be satisfied that treatment (with anti-emetics) would have been administered by a visiting doctor, as well as establishing that there was a real and lively possibility that this might have

affected the outcome. This would call for speculation far beyond that which the evidence led before the Inquiry might reasonably justify. There was insufficient evidence to conclude either that the reasonable GP would have given an anti-emetic injection, given that such treatments do not always work and have no effect upon the underlying illness and insufficient evidence to conclude that there was a “real and lively possibility” that such a treatment would in any event have made a difference, with the experts asked to opine describing it as “unlikely” and “improbable”.

Counsel submitted that if Dr Branchfield had spoken to Mr Willock for longer and asked him more detailed questions about his symptoms, as he said in his evidence he ought to have done, the outcome would have been the same. She said either Dr Branchfield would have confirmed his initial view that a home visit was not clinically indicated, or he would have arranged a home visit and the visiting General Practitioner would have diagnosed Mr Willock as suffering from a self-limiting viral illness.

E. Submissions for NHS 24

1. Section 6(1)(a). Mr Ross, Counsel, said it is likely that Mr Willock died sometime between Ms Rogers’ 999 call at 18:05 and the arrival of the ambulance crew at 18:08. If, however, the Court considers it appropriate to fix the time of death by reference to the time at which resuscitation attempts ceased, the time of death would be about 18:20hrs.

2. Section 6(1)(b). Mr Willock's case was, in any view, an unusual and difficult case.

The cause of death should be recorded as "septicaemia, source uncertain".

3. Mr Ross submitted that most of the findings under Section 6(1)(c) proposed by the Crown proceed on the hypothesis that:-

1. A General Practitioner examining Mr Willock on 28th December might have decided to refer him to hospital, and
2. Treatment in hospital might have avoided his death.

Counsel stressed that while the Nurse Advisors did not arrange for Mr Willock to be examined by a doctor, he was, in fact, examined by his own General Practitioner, Dr MacPherson at about lunchtime on 29th December 2009. Dr MacPherson did not consider Mr Willock to be so unwell as to require hospital admission. There was no evidence to conclude that a hypothetical doctor carrying out a hypothetical examination on 28th December would have taken a decision to refer Mr Willock to hospital which an actual doctor conducting an actual examination did not consider necessary a day later. Even if Mr Willock had been referred to hospital, Dr Gaw's evidence was to the effect that he may not have been admitted. It is likely that Mr Willock would have been managed at home even if a doctor had visited him on 28th December.

Counsel highlighted what he saw as the cause of Mr Willock's death being "surrounded by uncertainty". While eventually there was an evidential consensus around septicaemia being, on the balance of probabilities, the cause, the source of the septicaemia remained

uncertain. So too, as Counsel put it, the timescale within which the septicaemia might have developed. Against that background expert witnesses invited to opine upon Mr Willock's prospects of survival had he been admitted to hospital expressed their views with considerable caution. Dr Laing, in particular, explained he could not determine Mr Willock's physiological condition from the transcripts and stated that it was "very speculative to try to gauge the likelihood of survival".

Even if Mr Willock had been admitted to hospital, there remained the further question of what would have been the effect of hospital treatment. He said that involves a high degree of speculation, the more the later the hypothetical admission would have taken place.

When considering the issue of causation Counsel submitted that the likelihood of a doctor on 28th December having Mr Willock admitted to hospital, and the likelihood that hospital treatment would have avoided his death are both material considerations. When they are taken together, he argued, the suggestion that referring Mr Willock to a doctor on 28th December might have avoided his death is in the realm of speculation. The findings proposed by the Crown under Section 6(1)(c) which proceed on that basis should not be made.

While Mr Ross acknowledged that Mrs Ann McDermid, the Call Handler, accepted she ought to have recorded that Mr Willock was a return caller and mentioned this during the handover to the Nurse Advisor, Fiona McCulloch, such matters, he maintained, were "causally remote" from Mr Willock's death. They would in themselves, he said, not have

avoided Mr Willock's death. What effect, if any, such steps would have had on the subsequent sequence of events is high speculative.

The shortcomings accepted by Nurse Advisor Fiona McCulloch when giving her evidence formed part of the background to what may arguably fall to be considered as a reasonable precaution under Section 6(1)(c). While NHS 24 accepted that, looking at the call as a whole, arranging to have Mr Willock seen by a doctor would have been a reasonable disposition, the suggestion that a GP who saw Mr Willock on 28th December would have taken steps that would have avoided Mr Willock's death is entirely speculative. Similarly, while NHS 24 concede, in view of the guidance in force at the time, it would have been good practice for Nurse Advisor Fiona McCulloch to have checked the patient call history after taking the call from the Call Handler, Mr Willock's death would not, Counsel submitted, have been avoided by her taking such a step. It was misconceived to characterise this failure as a "reasonable precaution" in terms of Section 6(1)(c).

Mr Ross observed that the Crown argue that had Nurse Advisor Fiona McCulloch answered question 1 in the "indigestion" algorithm in the affirmative, as Mrs Houston testified she ought to have done, Mr Willock's death might have been prevented as an emergency ambulance may have taken him to hospital. Any such finding would, however, be entirely speculative and is not supported by the evidence. The Inquiry heard unchallenged evidence that suggested dispositions can be and not infrequently are overridden by Nurse Advisors in the exercise of their clinical judgement. None of the witnesses expressed the view that

Nurse Advisor Fiona McCulloch should have arranged for Mr Willock to be taken to hospital by emergency ambulance.

With the benefit of hindsight, NHS 24 accepts that it would have been reasonable for Nurse Advisor Fiona McCulloch to have arranged for Mr Willock to be examined by a doctor. As, however, Mr Willock's only realistic prospect of survival would have been through admission to hospital, and as the suggestion that a GP seeing Mr Willock on 28th December would have arranged for him to be admitted to hospital is speculative, the evidence, Counsel said, does not support the view that for Nurse Advisor McCulloch to have arranged a GP visit would have given rise to a lively possibility that Mr Willock's death might have been avoided.

Counsel also conceded that Call Handler, Miss Carolyn Fergie's handling of her telephone call was deficient in a number of respects. However, as Mr Willock's death would not have been avoided by Miss Fergie taking steps such as entering further information in the AV box, to categorise its appropriate completion as a reasonable precaution in terms of Section 6(1)(c), as the Crown seek to do, is misconceived. The purpose of the AV box is to ensure that information comes to the attention of the Nurse Advisor. The telephone conversation between Nurse Advisor Pamela Scally and Mr Willock confirmed that whatever the shortcomings of Miss Fergie's handling of the call, Nurse Advisor Pamela Scally obtained the relevant information.

Counsel noted that Nurse Pamela Scally herself agreed with the NHS 24 internal investigation that she should have arranged for Mr Willock to be seen by a doctor. As the Crown acknowledge, Mr Willock's only prospects of survival by this point would have been through hospital admission, accordingly for the reasons previously set out Counsel argued that the evidence did not support the view that arranging for Mr Willock to be seen by a doctor would have given rise to a lively possibility that his death might have been avoided.

Counsel continued that Nurse Scally's appropriately made concessions with regard to her handling of the call also formed part of the background to what may arguably fall to be considered as a reasonable precaution under Section 6(1)(c). Mr Willock's death would not, he submitted, have been avoided by Nurse Scally taking "a holistic view of [his] illness" or "ask [ing] more appropriate questions". Nurse Scally's acceptance that she should have answered "yes" to question 3 in the knee pain or swelling algorithm would not have avoided Mr Willock's death unless, at the very least, it had been followed by other steps leading to his admission to hospital. The Crown's submission that "he may have been referred to the Accident & Emergency Department of a hospital" was entirely speculative and unsupported by the evidence. Counsel noted that the Depute did not suggest how the Crown arrive at this view, nor did she explain what the evidence suggests would be Mr Willock's response had he been told that he should go to the Accident & Emergency Department of a hospital as soon as possible. Further, Counsel said there was no explanation in the evidence of what would likely have happened had Mr Willock attended Accident & Emergency on 28th December on the basis of his being unable to stand or weight bear on the affected knee.

4. Counsel submitted that in considering findings under Section 6(1)(d) the Court requires to address two questions:-
 1. Does the evidence establish there was a defect in the system of working?
 2. Does the evidence establish, on the balance of probabilities, that any such defect contributed to the death?

Counsel said a “lively possibility” of avoiding death is not sufficient for a finding under Section 6(1)(d). It must be proved on the balance of probabilities that the defect in a system of working actually contributed to the death. The test of balance of probabilities to be applied in Section 6(1)(d) relates to both the defect and the contribution to the death. Counsel said the “lively possibility test” could not be read across from Section 6(1)(c) to Section 6(1)(d) as suggested by the Crown. That having been said, he accepted it was not necessary to establish the defect as the singular or sole cause.

Counsel observed that while the Call Handlers and Nurse Advisors acknowledged a number of errors and shortcomings in their handling of Mr Willock’s calls, they did not attribute the errors or shortcomings to inadequate or inappropriate training. Indeed, as he highlighted, on several occasions witnesses said in terms they had failed to act in accordance with their training. In such circumstances where evidence about an apparently thorough system of training and supervision has not been contradicted by other evidence, the Court cannot, as the Crown requests, infer simply from the fact that certain mistakes were made that there was a “defect in a system of work with regard to the system of training and the supervision of Call Handlers and Nurse Advisors”. Counsel made mention of Mrs

Houston's evidence that in carrying out their own internal review, NHS 24 had found no systemic failure. If, he stated, the Crown considered there were reasons to believe that there were defects in the system of training and supervision, it could have led expert evidence. If the Crown had wished to explore the further training of the individual employees, it could have called their supervisors (who were on the list of witnesses). In the event the Crown chose to take neither of these steps. The evidence did not establish that any defect in the system of training and supervision of Call Handlers and Nurse Advisors (which is denied) contributed to Mr Willock's death. The evidence did not establish any such causal connection.

NHS 24 acknowledge that the two Call Handlers failed to act in accordance with Process 18. There were individual, not systemic errors. In any event, to support a finding in terms of Section 6(1)(d) the Court would require to be satisfied on the balance of probabilities that the alleged failings actually contributed to Mr Willock's death. The evidence led did not establish any such causal connection.

Mr Ross challenged any finding that there was a defect in a system of work in relation to the fact that it was not mandatory for a Nurse Advisor to look at the call/user history on each occasion that they took a call from a patient. Even if the Court was satisfied that there is evidence of a defect in a system of work he reiterated that it had to be established on the balance of probabilities that any such defect actually contributed to Mr Willock's death. There was no evidence to establish any such causal connection.

Mr Ross submitted the Court should not make any findings under Section 6(1)(e) in the terms suggested by the Crown. Before making a finding that Nurse Advisors should advise the patient calling to “start from the beginning” so that he/she might provide more information, which, Counsel submitted, would represent a substantial change to the way in which NHS 24 is organised, the Court would require to be satisfied there was evidence to support the view that such a change would be generally beneficial. There was, he said, no such evidence led.

Counsel accepted that errors and shortcomings had been made in the handling of Mr Willock’s calls by NHS 24. With the benefit of hindsight, however, mistakes were recognised and best practice seen not to be followed. Any observations the Court wished to make about such matters could be appropriately included in the Note to accompany the formal Determination.

At the Hearing of Submissions Counsel made further submissions in response to the request by Mr Ceresa on behalf of Ms Rogers that the Court should make a finding under Section 6(1)(d) that there is a defect in the system of work in relation to the fact that NHS 24 employees cannot see the comments made by doctors at the OOHS or that there is no communication between the two services. Firstly, he noted that the Crown do not seek such a finding. Secondly, he said the fact that NHS 24 staff cannot directly access notes by doctors in OOHS does not amount to a defect in a system of work. He reminded the Court that the Inquiry had heard evidence, in any event, from both Mrs Houston and Dr Gaw which doubted whether it would even be desirable for such a system to be established. Mrs

Houston had spoken of false reassurance. Dr Gaw did not think there would have been value in Nurse Advisors being able to access clinical notes made by a doctor. Thirdly, there was insufficient evidence the alleged defect contributed to Mr Willock's death. Lastly, even if the Court was prepared to engage in speculation to the extent of concluding that but for the alleged defect this would likely have led to a home visit being arranged, there remained, Counsel stressed, the question of where that would have led.

CONCLUSION

The Legal Framework

In considering the parties' submissions and what findings to make it is necessary to bear in mind the functions of this Inquiry. It is an Inquiry into the circumstances of Mr Willock's death. The parameters of the Inquiry are controlled by the terms of Section 6(1) of the Act. Thus, as all parties agreed, reasonable precautions may be identified if they might have avoided the death, defects may be identified in any systems of work providing they contributed to the death and other facts may be identified if they are relevant to the circumstances of the death.

A fatal accident inquiry is not the proper forum for the determination of criminal or civil liability. It is well known that it is not a function of the Court in a Fatal Accident Inquiry to make findings or express opinions on questions of fault or liability or to attempt to apportion blame. In *Black v Scott Lithgow Limited*, 1990 SLT 612, page 615, Lord President Hope said, in relation to Section 6(1) of the Act, "*There is no power in this Section to make a finding as to fault or to apportion blame between any persons who might have contributed to the*

accident. This is in contrast to Section 4(1) of the 1895 Act, which gave power to the jury to set out in its verdict the person or persons, if any, to whose fault or negligence the accident was attributable. It is plain that the function of the Sheriff at a Fatal Accident Inquiry is different from that he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, insofar as this can be done to his satisfaction. He has before him no Record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required”.

I agree with the view expressed by Sheriff Reid, Q.C. in her determination in relation to the death of Sharman Weir issued on 23rd January 2003 where she said *“In my opinion a fatal accident inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death might have been avoided... The purpose of a fatal accident inquiry is to look back, as at the date of the inquiry, to determine what can now be seen as reasonable precautions, if any, whereby the death might have been avoided and any other facts which are relevant to the circumstances of the death... The purpose of any conclusions drawn is to assist those legitimately interested in the circumstances of the death to look to the future. They, armed with the benefit of hindsight, the evidence led at the inquiry, and the Determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future”.*

In determining whether or not to make a finding in terms of Section 6(1)(c) that there were reasonable precautions whereby Mr Willock’s death might have been avoided, the precise wording of Section 6(1)(c) must be kept in mind. As Ian H. B. Carmichael in his book

*"Sudden Deaths and Fatal Accident Inquiries" 3rd Edition, paragraph 5.75 states "what is required is not a finding as to a reasonable precaution whereby the death... "would" have been avoided, but whereby the death... "might" have been avoided. Certainty that... the death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a "probability" but a **"real or lively possibility that the death might have been avoided by the reasonable precaution"** (my emphasis).*

Like Sheriff Liddle in his determination in the inquiry into the circumstances of the death of Kieran Nicol issued on 3rd June 2010 I agree with and adopt the observations of Sheriff Kearney in his determination in relation to the death of James McAlpine issued on 7th January 1986. As Sheriff Kearney observed *"In relation to making a finding as to the reasonable precautions, if any, whereby the death... might have been avoided (Section 6(1)(c)) it is clearly not necessary for the Court to be satisfied that the proposed precaution would in fact have avoided... the death, only that it might have done, but the Court must, as well as being satisfied that a precaution might have prevented the death..., be satisfied that the precaution was a reasonable one"*. Sheriff Kearney continued subsequently: *"the phrase "might have been avoided" is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than "would on the balance of probabilities have been avoided" and rather directs one's mind in the direction of the lively possibilities"*.

In the context of an inquiry into the circumstances of a death, involving as in this case, very detailed consideration of evidence from a number of medical witnesses, the observations of Sheriff Stephen as she then was (now Sheriff Principal Stephen) in her determination into

the death of Lynsey Myles issued on 27th February 2004, to which I was referred by Ms Watts, Counsel for OOHS are instructive. Sheriff Stephen stated *“Again lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is clear appropriate testimony which challenges the treatment a patient receives. The view I take of this matter is that for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff. Before I can find a precaution to be reasonable in the context of a medical issue, there must either be an admission by the treating doctor that he failed to take a precaution or course of action which he clearly ought to have taken, or to the course of action which, in the exercise of ordinary care, ought not to have been taken. Failing that there would require to be established by independent evidence the manner in which the doctor in a particular area of expertise, and with the particular experience, ought to have acted. This clearly requires there to be a standard by which the actings of doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification...”*

Further, considering the issue of “reasonable precautions”, Sheriff Peter Braid in his determination into the death of Marion Bellfield issued on 28th April 2011 made the following comments: *“that is not to say that every single thing which might have been done and which might have avoided the death should, if it was a reasonable step to have taken, make its way into a finding under Section 6(1)(c). Not only would that not be helpful in avoiding future deaths, but it would involve placing an unjustifiably wide construction on the word “precaution”. Whatever that word means, it must place some limit on the sort of acts or events which should be included in a Section 6(1)(c) finding. The natural meaning of “precaution” is an action on measure taken before*

hand against a possible danger or risk. Further, since one purpose of a fatal accident inquiry is to inform those with an interest of what precautions should be taken in the future, a finding under Section 6(1)(c) must carry with it the implication that the precaution ought, with the benefit of hindsight, to have been taken in the case which resulted in the death, albeit without any necessary implication that the failure to take it was negligent. That being so, I agree that when one has a situation which solely involves the exercise of clinical judgement, where a range of reasonable actions might be taken, and the choice as to which to take rests on the skill and experience of a doctor based upon such information as is available to him at the time, and the doctor happens to choose a course which results in death, it would be wrong to hold that the selection of another options within the range, which might have prevented the death, was a reasonable precaution which ought to have been taken. Not only does that involve straining the meaning of precaution, but such a finding would be of no real practical benefit to others in the future. A fatal accident inquiry cannot prescribe how doctors and nurses should exercise their judgement”.

Having regard to all of the foregoing it can be seen to be settled law that the correct approach is to interpret “might” for the purposes of Section 6(1)(c) as a reasonable precaution which would give rise to a “real and lively possibility” that the death of Mr Willock would have been avoided. The causal connection need not be as strong as is required in a civil proof where it would have to be demonstrated that the death “would” have been avoided. Nevertheless, where witnesses cannot say the death might have been avoided, the test is clearly not made out.

For a finding to be made under Section 6(1)(d) there must be defects in any system of working which contributed to the death. There must be evidence on the normal civil standard, that of balance of probabilities, to justify any findings. As Sheriff Kearney observed in his said determination in relation to the death James McAlpine issued on 7th January 1986, to which the Procurator Fiscal Depute referred me *“In deciding whether to make a determination under Section 6(1)(d) as to the defects, if any, in any system of working which contributed to the death..., the Court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof and rules of evidence is that applicable to civil business... and accordingly the standard of proof is that of the balance of probabilities”*.

There requires to be a clear causal connection between the defect and the death.

The wording of Section 6(1)(e) of “any other facts which are relevant to the circumstances of the death” although apparently wide means that any facts established under this heading must be relevant to the circumstances of Mr Willock’s death. There is, as Ian H. B. Carmichael observed in Paragraph 5.77 of his book “a distinction between findings under Sections 6(1)(c) and (d) where there is required to be a causal connection, and under Section 6(1)(e) where no such connection is required”.

Discussion

Section 6(1)(a) of the Act – where and when Mr Willock died

Parties were agreed that Mr John Willock died on 29th December 2009 within his home at 6 Parkhill, Erskine.

Although he was certified dead by the Police Casualty Surgeon at 21:25hrs it is evident from other evidence led before the Inquiry that Mr Willock had died sometime earlier. Ms Rogers, his partner, testified that Mr Willock had “passed away shortly” after the paramedics from The Scottish Ambulance Service arrived at her home. The Ambulance records disclose their arrival at 18:08:47hrs. The evidence from the one paramedic led in evidence was that Mr Willock was then showing no signs of life. Attempts were made to resuscitate Mr Willock to no avail. While it may therefore be thought that the appropriate time of death would be after Ms Rogers’ 999 telephone call at 18:05hrs but prior to the attendance of the paramedics, I accept that it is normal practice, in a hospital setting, to record the time of death as the point when attempts to resuscitate a patient are stopped. The evidence established that the paramedics spent some time attempting to resuscitate Mr Willock, having commenced at around 18:10hrs. With that in mind I accept the Crown’s submission and determine that Mr John Willock died at 18:20hrs on 29th December 2009.

Section 6(1)(b) – the cause or causes of Mr Willock’s death

This was a complex and unusual medical inquiry. It considered three potential causes of death. Evidence as to the cause of death was led from the Consultant Pathologist, who carried out the post-mortem, and who was recalled to give further evidence, eventually

revising his cause of death, a Consultant Physician and Gastroenterologist, and a Consultant Physician in Infectious Diseases. Reports from these medical professionals were spoken to and considered as were other Reports from other eminently qualified medical practitioners.

Towards the beginning of the hearing of evidence Dr Clark, the Consultant Pathologist, testified per his post-mortem Report that the cause of Mr Willock's death was acute cholangitis with septicaemia. His testimony was initially unchallenged. During his subsequent examination-in-chief Dr Alan Shepherd, Consultant Physician & Gastroenterologist, gave certain evidence to the effect that had Mr Willock been treated at home with anti-emetics then he may not have developed the cholangitis which, at that time, was thought to have ultimately led to his death. This evidence came as a surprise to parties at the Inquiry, and as it represented a potential line of criticism not previously advanced and of which interested parties had had no prior notice, I acceded to a motion to adjourn the hearing of evidence before the Inquiry for further investigations to be undertaken.

In the event Mr James Powell, a Consultant Transplant and Hepatobiliary Surgeon at the Royal Infirmary of Edinburgh was identified as someone with suitable expertise in the treatment of acute cholangitis. Mr Powell, in his Report lodged for the Inquiry, was firmly of the view that anti-emetics do not prevent cholangitis. He added, with considerable import for the Inquiry, that he did not consider there was any evidence at all that Mr Willock had ever had cholangitis. Mr Powell recommended that the advice of a further specialist, an expert Pathologist with a specialist interest in liver pathology, be obtained. A further Report was therefore obtained from Dr Christopher Bellamy, a Pathologist

specialising in hepatic and renal pathology and lodged in Court. He also did not consider there was any evidence to support the diagnosis of cholangitis.

Dr Clark was presented with these further Reports and upon being recalled changed his view of the cause of Mr Willock's death. He opined that the evidence for a specific diagnosis of acute cholangitis was not particularly strong. He agreed with Dr Bellamy's conclusion in his Report which reads: "I conclude then that whilst there is a significant inflammatory reaction in the liver, this is not specific for cause, does not specifically diagnose a suppurative cholangitis, and could reasonably be secondary to a severe systemic infection..." Dr Clark remained of the view that Mr Willock died of a bacterial infection of some sort, ultimately from a generalised infection throughout the body. He explained that an infection which enters the bloodstream is septicaemia.

Various sources of sepsis were considered by the Inquiry. It is unfortunate for the Inquiry and particularly concerning for Ms Rogers' and Mr Willock's family that so many potential causes of death were postulated and that there is still insufficient evidence to conclude what the cause of the sepsis was (or when it commenced).

As Sheriff McSherry explained in his determination in the Inquiry into the deaths of Joanne Winsborough and William Anderson issued on 8th August 2011 *"It is a sad inescapable fact, possibly not understood by some persons in modern times, that otherwise healthy people can become ill and die. What stimulates the actual cause of death is frequently not understood by the medical profession, as in these cases. That is the reason we have medical research"*.

Having listened to and carefully considered all the evidence led before the Inquiry I am satisfied that on the balance of probabilities the cause of Mr Willock's death should be properly recorded as "septicaemia, source uncertain".

Section 6(1)(c) – the reasonable precautions, if any, whereby Mr Willock's death might have been avoided

I agree with the Crown that it has not been established by the evidence led at this Inquiry that it would have been a "reasonable precaution" within the terms of the sub-section for Dr Branchfield to have requested a doctor to visit Mr Willock on the evening of 27 December 2009.

There was a divergence of opinion as between Drs Willox and Gaw, the two expert GPs from whom I heard testimony. Dr Willox, while critical of Dr Branchfield's telephone consultation, said Dr Branchfield gave the most probable diagnosis based on the information available to him. Diarrhoea and vomiting, he said, was likely to be due to a viral form of gastroenteritis. It was, however, his opinion that a doctor from OOHS should have attended upon Mr Willock on 27 December 2009, even if it is possible the doctor would not have found Mr Willock's condition to be so serious as to warrant hospitalisation.

Dr Gaw was of the contrary opinion. He felt Dr Branchfield had put himself in a position to fully assess Mr Willock's presenting symptoms. He thought it was a reasonable decision for Dr Branchfield, having carried out his assessment of Mr Willock, not to ask another doctor

to visit. He described Dr Branchfield's conclusion that Mr Willock was likely to be suffering from viral illness, likely to be self-limiting as a "safe clinical decision".

I heard further from Dr Gaw that his two colleagues both experienced GPs in OOHS management differed one from the other, one supporting his analysis, the other being of the view that upon being offered by Dr Branchfield a consultation at a PCEC (for reassurance) the only safe option when Mr Willock was unable to attend was to arrange a home visit. Dr Gaw described the judgement as "finely balanced" and wrote in the Significant Event Analysis for OOHS that "it could be argued that having decided a face-to-face consultation was indicated that, in the event of the patient not being able to attend, a visit should be performed".

As a result of the divergent opinions of four experienced General Practitioners, the Crown submitted that it cannot conclusively be said it would have been a reasonable precaution for Dr Branchfield to have requested a doctor visit Mr Willock. I agree with that submission. Expert physicians testified that it was likely it was a viral infection that Mr Willock was suffering from when he spoke with Dr Branchfield and there was no evidence led which established that, if in fact Mr Willock was suffering from a viral illness, Dr Branchfield's treatment of him was inappropriate. In any event the evidence established that had a doctor attended upon Mr Willock at home on the evening of 27 December 2009 it would have been unlikely for him to have been referred to hospital at that time. The evidence was that it is more likely than not he would have been treated at home. It would not have been a

reasonable precaution to admit to hospital on 27 December 2009 everyone who presented with the same symptoms as Mr Willock.

I do not require to list all precautions however numerous, only to set out those that fall within the ambit of “reasonable precautions” as provided for in the sub-section. I do not consider that it can be said to be a reasonable precaution for Dr Branchfield to have requested a doctor visit Mr Willock on the evening of 27 December 2009, there being a lively possibility that his death might have been prevented. I am satisfied from the evidence I heard that, in any event, had a doctor attended upon Mr Willock at home on the evening of 27 December 2009 it would have been unlikely for him to have been referred to hospital at that time.

In reaching that view I have had regard to the precise wording of the sub-section. I have to set out, so far as they have been established to my satisfaction, the reasonable precautions, if any, *whereby the death might have been avoided (my emphasis)*. Having analysed and considered all the medical testimony led before the Inquiry I have come to the view that Ms Watts, acting on behalf of the Nurse Advisors, was correct when she submitted the only way in which the death of Mr Willock might have been avoided was for him to have been sent to hospital. As it would have been unlikely for a doctor attending upon Mr Willock on 27 December 2009 to have referred him to hospital it cannot be said that in the exercise of his “clinical judgement” Dr Branchfield ought to have taken the reasonable precaution of arranging for a doctor to visit Mr Willock, as it cannot be said that there was a lively possibility this “might have avoided his death”.

The Depute criticised the actings of the Call Handlers and Nurse Advisors within NHS 24 and submitted it would have been a “reasonable precaution”:-

- 1) for the Call Handler, Mrs McDermid, to have followed NHS 24 guidance – Process 18 – in respect of return callers, to have recorded the information in the AV box appropriately and to have informed Nurse Advisor Fiona McCulloch during their verbal handover that Mr Willock was a “return caller”;
- 2) for Nurse Advisor Fiona McCulloch to have adopted a “more holistic approach” when conducting her telephone triage with Mr Willock, to have asked more open, detailed and appropriate questions, to have checked the patient call history, to have accurately completed the algorithm for “indigestion” and to have arranged for Mr Willock to be seen by a GP in a face-to-face consultation;
- 3) for the Call Handler, Miss Carolyn Fergie to have completed the AV box appropriately and given an appropriate verbal handover to Nurse Advisor Pamela Scally;
- 4) for Nurse Advisor Pamela Scally to have taken a “holistic view” of Mr Willock’s illness, to have asked more appropriate questions of him during her telephone triage and to have applied Process 18;
- 5) for Nurse Advisor Pamela Scally to complete the algorithm for “knee pain or swelling” to produce the disposition of a referral to the Accident and Emergency Department of a hospital and not to anticipate the said disposition and answer the questions posed in the algorithm to avoid the said disposition which she did not want; and
- 6) for Nurse Advisor Pamela Scally to arrange for Mr Willock to be seen by a doctor.

In all of these submissions the Crown was supported by Mrs Ceresa, acting on behalf of Mr Willock's partner, Carolann Rogers.

In his submissions to the Inquiry on behalf of NHS 24, Mr Ross, Counsel, submitted that the findings being sought by the Crown in terms of this sub-section proceed on the hypothesis that

- 1) a GP examining Mr Willock on 28 December 2009 might have decided to refer him to hospital; and
- 2) treatment in hospital might have avoided his death.

He stressed that while the Nurse Advisors did not arrange for Mr Willock to be examined by a doctor, he was in fact examined by his own GP, Dr MacPherson, at lunch time on 29 December 2009 when Dr MacPherson did not consider him to be so unwell as to require hospital admission. There was, he said, and with this observation I find myself in agreement, no evidence to conclude that a hypothetical doctor carrying out a hypothetical examination on 28 December 2009 would have taken the decision to refer Mr Willock to hospital when an actual doctor conducting an actual examination a day later did not consider it necessary. Furthermore, there was the evidence of Dr Gaw, who impressed me with the manner and content of his testimony, that Mr Willock may not have been admitted to hospital even if he had been referred. The evidence, which I accept, is that it is likely Mr Willock would have been managed at home even if he had been visited by a doctor on 28 December 2009.

Counsel's second point was that the cause of Mr Willock's death was "surrounded by uncertainty". In effect, he agreed with the submission of Ms Watts, Counsel for OOHS, that the difficulties in establishing what caused Mr Willock to develop sepsis and the absence of evidence as to when the sepsis commenced should be borne in mind when considering whether or not to make any finding in terms of this sub-section. It is not for the Court to engage in speculation but deal with the evidence as presented. Before a finding can be made in terms of this sub-section it is generally accepted that there must be something more than mere speculation that the death might have been avoided. In the case of Mr Willock's death there is not. Dr Shepherd testified that different sources of sepsis require different treatment and result in very different survival rates. I have found that Mr Willock died from "septicaemia, *source uncertain*" (my emphasis). In the absence of being able to identify the source of the sepsis, I agree with Ms Watts that the Inquiry is very much in the realms of speculation.

In his submissions on behalf of Dr Branchfield, Mr Stewart submitted that it could not be stated with any certainty whatsoever when Mr Willock developed the sepsis that ultimately led to his death. Dr Shepherd was unable to put a timeframe on the sepsis. His views on the timing of the commencement of severe sepsis were speculative as regards 27 or 28 December 2009, although he felt it was almost certainly present by 29 December 2009.

Dr Laing said that he was not confident Mr Willock had sepsis on 27 December 2009. He said his symptoms were then consistent with a viral infection and stated that the vast majority of patients with viral infections do not require admission to hospital. In such

circumstances Mr Stewart submitted that if one cannot identify the sepsis, it falls that it is difficult to assess what effect any given precaution might have had reasonable or otherwise. I find myself in agreement with these submissions.

Even if Mr Willock had been admitted to hospital, the effect of any hospital treatment is unknown. Consideration of any effect would involve me in speculation, the more so the later the admission would have taken place. There was insufficient evidence led before me to conclude that, even if a GP had visited Mr Willock (prior to the visit of Dr MacPherson) and given him an anti-emetic injection and arranged for his admission to hospital there was a “real and lively possibility” that such treatment and admission to hospital would in any event have made a difference.

I therefore find that the correction of the numerous failings of the Call Handlers and Nurse Advisors, which were conceded in evidence, as suggested by the Crown, do not constitute “reasonable precautions” whereby Mr Willock’s death might have been avoided. Although their suggestions may be thought to be reasonable the evidence does not establish to my satisfaction that any or all of the suggestions proposed by the Crown amount to “reasonable precautions” in terms of the sub-section of the Act “whereby the death (of Mr Willock) might have been avoided”. The Crown’s “broad brush” approach, to an extent contrary to the wording of the sub-section, does not find favour with me. While it is undoubtedly true to say that Mrs McDermid ought to have followed Process 18 in respect of return callers, to have recorded that Mr Willock was a return caller in the AV box and to have advised Nurse

Advisor Fiona McCulloch of that fact in her verbal handover, I agree with Mr Ross that such matters are “causally remote” from Mr Willock’s death.

Further, while it may be thought that Nurse Advisor Fiona McCulloch, in particular, ought to have checked the patient call history and to have arranged for Mr Willock to be seen by a GP in a face-to-face consultation, the proposition which is inherent in the Crown’s submission that a GP who saw Mr Willock on 28 December 2009 would have taken steps to have him admitted to hospital and that such actions might have avoided his death is without foundation in the evidence. It is mere speculation.

I agree with the submission of Mr Ross that it cannot be said that it was a reasonable precaution whereby Mr Willock’s death might have been avoided for Nurse Advisor Fiona McCulloch to answer the first question in the indigestion algorithm in the affirmative thereby resulting in a disposition of an emergency ambulance to convey him to hospital. I heard evidence, which was not contested, that Nurse Advisors not infrequently override dispositions in the exercise of their clinical judgements. No evidence was led to suggest that Nurse Advisor Fiona McCulloch should have arranged for Mr Willock to be taken to hospital by emergency ambulance, nor was any evidence led to establish to my satisfaction what would have occurred had Mr Willock been presented at the Accident and Emergency Department. There was no evidence produced of what would have been likely to have happened.

Call Handler, Miss Caroline Fergie's handling of Mr Willock's third telephone call to NHS 24 was undoubtedly deficient in many aspects. Nevertheless, I am not prepared to make a finding in terms of this sub-section in respect thereof. How the adequacy of the medical records and the following of certain procedures in the special circumstances of Mr Willock's death can be regarded as a reasonable precaution whereby his death might have been avoided has not been established. The evidence was that despite Miss Fergie's shortcomings, Nurse Advisor Pamela Scally obtained the relevant information in any event.

I acknowledge that the Investigation Team of NHS 24, led by Mrs Houston, felt it would have been more appropriate for Nurse Advisor Pamela Scally to have made an onward referral to a doctor from OOHS as opposed to the disposition she reached of "own GP within 36 hours". I also note that Nurse Scally accepted this position during her testimony. As Dr Willox concluded in his Report "it is hard not to conclude that the presence of vomiting, diarrhoea, laboured breathing and knee pain should have led to Mr Willock being offered an assessment by a doctor at this point". Nevertheless, for the reasons I have already alluded to, the evidence led at this Inquiry does not substantiate a conclusion that arranging for Mr Willock to be seen by a doctor on the evening of 28 December 2009 would have given rise to a "lively possibility" that his death might have been avoided. What a doctor would or should have done by way of treatment and whether or not he/she would have arranged for Mr Willock to be admitted to hospital was speculation according to Dr Willox.

I do not consider that it can be right for a Nurse Advisor to intentionally insert an incorrect answer into an algorithm with a view to influencing the outcome (disposition) produced. However, had Nurse Advisor Pamela Scally answered question 3 in the knee pain algorithm, as she conceded she ought to have done, it is unclear from the evidence I heard what would have occurred. There is no basis in the evidence for the Crown's assertion that had she answered the question correctly the disposition would have been for Mr Willock to go to the Accident and Emergency Department of a hospital as soon as possible with the result that it was a "lively possibility" that his death might have been prevented. Again it seems to me the Crown are "speculating" and any such speculation cannot play a part in my Determination.

The Crown and Mrs Ceresa submitted it would have been a reasonable precaution for Dr MacPherson to have arranged for Mr Willock to be admitted to hospital.

I heard conflicting evidence regarding the state of Mr Willock during the visit of Dr MacPherson and his examination of his patient from Carolann Rogers and Dr MacPherson himself. Dr Willox testified that if the evidence of Carolann Rogers is accepted, Dr MacPherson's examination of Mr Willock was inadequate. If her evidence is accepted, Dr Willox was of the opinion that Dr MacPherson did not place himself in a proper position to make a diagnosis. He added that if Carolann Rogers' account of Mr Willock's condition is accepted, a doctor of reasonable competence, in the knowledge of the three previous calls to NHS 24, in addition to his examination of Mr Willock, on the balance of probability, would have considered Mr Willock seriously ill and would have removed him to hospital.

Alternatively, Dr Willox was of the view that, if Dr MacPherson's account of his visit to and examination of Mr Willock on 29 December 2009 is accepted, Dr MacPherson's assessment was a reasonable one. Dr Willox felt Dr MacPherson had appropriately put himself in a position to make a diagnosis and his diagnosis of gastroenteritis was a probable diagnosis on the basis of what Mr Willock said. On the basis that Dr MacPherson's findings are found to be established, Dr Willox said he would not criticise the actions Dr MacPherson took.

The Depute and Mrs Ceresa advocated I should prefer the evidence of Carolann Rogers to that of Dr MacPherson. If her evidence is accepted and Mr Willock ought to have been admitted to hospital, the issue then to be determined is whether or not even at that stage, i.e., early afternoon of 29 December 2009, his death might have been avoided. Referring to the testimonies of Drs Shepherd and Laing, the Depute submitted that there was "a real or lively possibility" that Mr Willock's death might have been avoided had he been admitted to hospital following Dr MacPherson's visit.

In response, on behalf of Dr MacPherson, Mr Stewart, in conceding that the reasonableness of Dr MacPherson's actings depended upon which account of events the Court accepted, invited me to prefer his evidence to that of Mr Willock's partner. If the Court was so persuaded, he founded upon Dr Willox's evidence and submitted that Dr MacPherson had acted reasonably.

In my view both Dr MacPherson and Carolann Rogers presented as credible witnesses. They were each clearly doing their best to assist the Inquiry. Carolann Rogers, in particular,

cannot have found the experience easy. It is to her credit that she gave her evidence as concisely and clearly as she did.

The evidence of a credible witness, such as Carolann Rogers, may, nevertheless, be unreliable because her recollection is mistaken whether by reason of an error, the effect of the events, the passing of her partner, the passage of time since or otherwise. In my view the reliability of Carolann Rogers falls to be tested by reference to issues which are beyond dispute. As Mr Stewart observed, in adhering rigidly to the opinion that Dr MacPherson visited Mr Willock at approximately 1:00pm on 29 December 2009 Ms Rogers was clearly incorrect. The un-contradicted evidence I heard disclosed that Dr MacPherson recorded back in his surgery his entry in Mr Willock's notes between 13:09 and 13:11, rendering Ms Rogers' evidence of the timing of his visit to be unreliable.

Ms Rogers' account of Dr MacPherson's examination is also not supported by the doctor's notes in Mr Willock's medical records. I bear in mind that at the time he made these notes Dr MacPherson did not think Mr Willock needed to go to hospital or was so significantly or critically unwell that he required to be admitted to hospital. He entered the notes upon his return to the surgery following his examination, not following Mr Willock's death. There was, therefore, at the time of making the entries no requirement for Dr MacPherson to embellish or fail to record his findings and his actions during the visit. While, in my view, Dr MacPherson can be criticised for failing to record all his findings (whether normal or not) such that he has since altered his practice, that he recorded Mr Willock's abdomen was soft

and that his bowel sounded ok discloses he did undertake certain examinations of Mr Willock which Carolann Rogers was adamant had not taken place.

On balance, having carefully considered and analysed the competing testimonies of Carolann Rogers and Dr MacPherson, I prefer the evidence of the doctor where it conflicts with that of Ms Rogers. I find that, entirely understandably and unsurprisingly, Ms Rogers' recollection has been affected by the events surrounding the death of her loved one and the passage of time. That being so, in reliance upon the testimony of Dr Willox, I find, while there are some aspects of his assessment which can be criticised, e.g. his failure to enquire of Mr Willock about his aversion to light and his complaint of a sore neck, Dr MacPherson's visit to and examination of Mr Willock to be a reasonable assessment of his patient. As Dr Willox opined, his diagnosis of gastroenteritis was a probable diagnosis and his treatment to halt the vomiting and prescriptions to resolve the gastroenteritis in a non-vomiting patient was both reasonable and appropriate. It follows that I do not find established that it would have been a "reasonable precaution" for Dr MacPherson to arrange for Mr Willock to have gone to hospital.

Section 6(1)(d) of the Act – the defects, if any, in any system of working which contributed to Mr Willock's death

The Crown submitted with regard to a finding in terms of Section 6(1)(d) of the Act that while it would be sufficient to establish a defect in any system of working which "might have contributed" to Mr Willock's death, a defect need not be the principal cause of death. It would suffice, the Depute argued, if on the balance of probabilities, the Court found that

the defect “helped cause or bring about the death”. The Depute categorised this as a “lower level of causation” than actually causing the death.

In his submission, Mr Ross submitted that in considering a finding in terms of this sub-section the Court requires to address two questions:-

- 1) does the evidence establish there was a defect in the system of working? and
- 2) does the evidence establish on the balance of probabilities that any such defect contributed to the death?

He argued that a “lively possibility” of avoiding death is insufficient for a finding under this sub-section.

As I have already stated in my analysis of the legal framework there does, in my opinion, require to be a clear causal connection between the defect and the death. I must be satisfied that the defect in question did in fact cause or contribute to the death. The test is the balance of probabilities and that applies to both the defect and the contribution to the death.

The Depute submitted that there was a defect in a system of work with regard to the system of training and supervision of Call Handlers and Nurse Advisors. In support of that submission the Depute said that it could be inferred from the “numerous mistakes” which occurred that “on balance the system of training and supervision of Call Handlers and Nurse Advisors contributed to these failings”. The Depute highlighted that two Call Handlers and two Nurse Advisors failed in their performance and submitted it would be an

unlikely coincidence for such failings to have occurred without there being any defect in the system of training, coaching and supervision.

Mrs Ceresa aligned herself with this submission stating that NHS 24 training and supervision of staff and the system of work re the application of Process 18 were both defective. She also submitted that it was a defect that it was not mandatory for Nurse Advisors to check the call history of every caller.

The evidence which I heard clearly established a number of errors and shortcomings in the handling of Mr Willock's calls by the Call Handlers and Nurse Advisors. However, none of the Call Handlers and Nurse Advisors attributed their failings to a failure of training, coaching or supervision. Mrs McDermid stated she had been trained and should have followed her training. Her explanation for not doing so was her anxiety to put Mr Willock through to a nurse. Miss Fergie accepted that her verbal handover to Nurse Advisor Pamela Scally was not in accordance with the NHS 24 guidance in which she had been trained. She explained she was tired and rushed the telephone call as she was concerned about Mr Willock's breathing and wished to pass the call to a Nurse Advisor as quickly as possible. Nurse Scally had no explanation for not following the normal practice. With hindsight she accepted she should have followed Process 18 and arranged for Mr Willock to have a face-to-face consultation with a doctor.

The Crown led no evidence from those involved in the training and coaching of Call Handlers and/or Nurse Advisors despite, I understand, having included on their list of

witnesses individuals who may have been in a position to speak to same. The limited evidence which the Call Handlers and Nurse Advisors gave about training and supervision was not contradicted. In such circumstances, particularly as it was Mrs Houston's evidence that as far as NHS 24 was concerned no organisational causes of poor documentation by the Nurse Advisors was identified, the root causes being identified as the focus upon Mr Willock's individual symptoms without a holistic view of his overall health and the incorrect application of Process 18, Mr Ross submitted the Court could not simply infer from the fact that certain mistakes were made that "there was a defect in a system" with regard to the system of training and supervision of Call Handlers and Nurse Advisors which contributed to Mr Willock's death. I agree with this submission: the evidence I heard fell far short of establishing to my satisfaction that any such defect existed and did not establish any causal connection with Mr Willock's death.

Mrs Houston testified that, while part of the NHS 24 core induction training, in December 2009 a requirement for Nurse Advisors to access the call history was not part of Process 18. The Depute and Mrs Ceresa moved me to find it established that, contrary to the finding of the Investigation Team, this was a systemic failure. Mr Ross submitted I should not make any such finding.

I am however satisfied that the evidence led has established that the omission of a requirement in Process 18 for Nurse Advisors to access the call history was a failing. I find it was a defect in the system of working. That being the case, I require to consider whether in terms of the sub-section that defect in the system of working "contributed to" Mr Willock'

death. In support of her submission I should make such a finding, the Depute referred me to the evidence of Drs Shepherd and Laing. In so doing, however, the Depute invited me to apply the “realistic and lively possibility test” in Section 6 (1)(c) to the circumstances in Section 6(1)(d). I reject this submission. A “lively possibility” of avoiding death is insufficient for a finding in terms of Section 6(1)(d). The “lively possibility test” applicable in Section 6(1)(c) cannot be read across to Section 6(1)(d).

Applying the test of the balance of probabilities, which in my view is the appropriate test, having regard to the evidence of Drs Shepherd and Laing and their comments with regard to “speculation” when discussing the possibility of Mr Willock’s admission to hospital at different times “avoiding his death”, I have come to the view that the evidence does not meet the standard required to make any finding in terms of Section 6(1)(d). The causal connection between the said failure in the system of working I have found established and Mr Willock’s death has not been made out to my satisfaction.

Mrs Ceresa submitted it was a defect in the system of working which contributed to Mr Willock’s death that Nurse Advisors working in NHS 24 could not access the records of GPs working for OOHS. She suggested there was a defect in a system which expected Nurse Advisors to access a caller’s previous call history within NHS 24 but prevented the Nurse Advisors accessing information within the GP records of OOHS.

While this submission appeared at first glance superficially attractive, closer examination and analysis of the evidence does not support any such finding. Nurse Advisor Scally

testified that she could not access the information of Dr Branchfield's consultation through the computer system. Although she was aware of the opportunity of making a telephone call to "the hub" to enquire about the consultation with the GP from OOHS, she considered it would be of great benefit if the (content of the) OOHS consultation was more readily available to Nurse Advisors working for NHS 24. She said it would have been helpful in her role as a Nurse Advisor speaking to Mr Willock if she had known what Dr Branchfield had written following his telephone conversation with Mr Willock the previous evening.

Mrs Houston agreed with Nurse Scally it would have been helpful for Nurses McCulloch and Scally to have seen what Dr Branchfield had written. It was, she said, very difficult technically to achieve this and there were no plans within NHS 24 to afford nurses the facility to access the doctor's notes.

These views were challenged by Dr Gaw who was firmly of the belief that if a Nurse Advisor was able to access the doctor's clinical notes it could influence the Nurse Advisor in how she dealt with the call. He did not think there would be "some value" for a Nurse Advisor in a subsequent triage in being able to access an OOHS' doctor's note. He was concerned that a nurse was not trained to interpret a doctor's findings and any such findings could provide the nurse with false reassurance. This concern over "false reassurance" was also spoken to by Mrs Houston during her testimony. Mrs Houston further explained that if a Nurse Advisor wished to find out about a consultation with a doctor from OOHS, she could ask her Line Manager who then had authority to contact the OOHS for the information.

While I have some sympathy for the view expressed by Mrs Ceresa I do not consider from the evidence I heard I can find that the Nurse Advisor could not (and still cannot) access the OOHs' doctor's note on her computer screen amounts to a defect in a system of working. Furthermore, there was no evidence before me that in any way established to my satisfaction that even if that was a defect in a system of working, it contributed to Mr Willock's death. No causal connection has been established.

Section 6(1)(e) of the Act – any other facts which are relevant to the circumstances of the death

Any facts which I find established in terms of this subsection must be relevant to the circumstances of Mr Willock's death, that is the circumstances of the death as they may affect the public interest. I do not consider it is appropriate merely to reiterate as findings in terms of this subsection matters in relation to Mr Willock's death which I have already set out as established to my satisfaction. I specifically refrain from doing so.

The Depute submitted that the guidance from NHS 24 to Nurse Advisors is unduly restrictive and detrimentally influenced the Nurse Advisors in conducting their triage. I did not however hear sufficient evidence on the guidance given by NHS 24 to Nurse Advisors to establish to my satisfaction whether or not it is unduly restrictive and/or detrimentally influenced the Nurse Advisors in conducting their triage of Mr Willock.

The Depute suggested that Nurse Advisors should ask open questions at the commencement of talking to the patient to enable them to establish for themselves the main

reason for the call. She further submitted that, while a caller may reasonably assume that the information he imparted to the Call Handler is passed on to the Nurse Advisor, there was evidence before the Inquiry that only a limited amount of the information provided by Mr Willock had in fact been transmitted by the Call Handler to the Nurse Advisor.

There was more than sufficient evidence, which I accepted, to enable me to conclude that the Call Handlers and Nurse Advisors should have followed their training and asked open questions of Mr Willock. Mrs Houston informed me that the conclusions of the NHS 24 Investigation Team as set out in the Patient Safety Incident Report were based upon a “holistic view” of Mr Willock’s overall health. I consider such a view might have been formed had the Nurse Advisors, in particular, in accordance with good practice and their training, asked open questions of him during their triage.

The Inquiry heard that Process 18 is subject to review and has been altered by NHS 24 as a consequence of their investigation into the circumstances of Mr Willock’s death. Whereas in December 2009 it was only “good practice” for Nurse Advisors to check the call history when taking a call from a “return caller”, the amended version of Process 18, dated 23 November 2011, presently in force provides that it is mandatory for Nurse Advisors to do so.

Mrs Houston additionally explained that following the procurement of a new application (to be uploaded this year) Process 18 callers will be electronically identified and Nurse Advisors

will be unable to proceed through Process 18 without having reviewed the patient's past medical history and call history.

She also testified that the Call Handler process, as part of Process 18, has been improved. It is now provided that in every case where a Call Handler is aware a patient has called NHS 24 before and, following a new and improved definition of "same episode of care", the Call Handler determines the call falls within "the same episode of care", the Call Handler must discuss the call with their Team Leader. This amendment, Mrs Houston stated, will mitigate against the possibility of the mistakes made in relation to Mr Willock.

These are undoubted improvements to Process 18 and are to be welcomed. So too is Recommendation (3) of the Investigation Team set out on page 9 of the Patient Safety Incident Report. The evidence of Mrs Houston was to the effect that the National Patient Safety Meeting has agreed that recommendation, that if a patient has called before, an automatic alert will come up on an Advisor's screen advising the patient is a return caller. The alert, as I understand it, will be "self-generating" and not reliant upon input from a Call Handler. I was told NHS 24 are currently going through the "proof of concept" phase.

Mrs Houston advised that Recommendation (2) in the said Report to update Process 18 whereby a patient re-contacting the service with additional, worsening or changing symptoms on more than two occasions should be unable to receive self-care without a second clinical opinion had been reconsidered and is now accepted and due for implementation.

I trust that these two Recommendations will be fully implemented and that the consequential amendments to Process 18 become operational in the near future.

The Depute and Mrs Ceresa both observed that it is still not mandatory for Nurse Advisors to check the call history of every caller (as distinct from every return caller within the same episode of care, falling within Process 18). While it is good practice to do so, Mrs Houston confirmed that it is not a mandatory requirement. She advised that consideration had not been given to making it mandatory for a Nurse Advisor to check the call history of every caller, although without such a check she agreed that “potentially the same situation” as with Mr Willock could recur.

While I acknowledge that human error cannot be excluded, based on the evidence I heard, it seems to me that such a mandatory requirement would mitigate against the possibility of such error. In my view Nurse Advisors should check the call history of every patient put through to them.

I have already dealt with Mr Ceresa’s submission about the inability of Nurse Advisors to access the OOHS’ GP’s records in the context of Section 6(1)(d). On the effect of their inability to do so, there was a clear difference of view in the evidence from Nurse Scally, Mrs Houston and Dr Gaw. Nurse Scally said it would have been helpful for her and Nurse McCulloch to have had sight of what Dr Branchfield had written. Mrs Houston agreed but said it would be very difficult technically to put a system in place. Currently, she stated, there are no plans within NHS 24 to provide Nurse Advisors with the facility to access such

records. Dr Gaw was firmly against any such suggestion, emphasising what he considered would be the “false reassurance” sight of such records may give Nurse Advisors when conducting their own triage. He explained that, at present, a Nurse Advisor could contact a GP advisor who could then access the GP’s note.

I find it surprising that the operational system requires Nurse Advisors to check the call history of return callers (within Process 18) but does not provide them with the opportunity of viewing the OOHS’ GP’s records. While I have been unable to reach a concluded view, given the divergent opinions expressed before me, I consider it is an issue which warrants review by NHS 24.

DETERMINATION

1. In terms of Section 6(1)(a) of the Act, John Willock, who was born on 2nd August 1966 and resided latterly at 6 Parkhill, Erskine, died at home within 6 Parkhill, Erskine at 18:20hrs on 29th December 2009.
2. In terms of Section 6(1)(b) of the Act, the cause of his death was septicaemia, source uncertain.
3. In terms of Section 6(1)(c) of the Act, there were no reasonable precautions whereby the death of Mr John Willock might have been avoided.
4. In terms of Section 6(1)(d) of the Act, there were no defects in any system of working which contributed to the death of Mr John Willock.
5. In terms of Section 6(1)(e) of the Act:-
 - (i) Call Handlers and Nurse Advisors within NHS 24 should ask open questions of a caller with a view to forming a “holistic view” of the patient’s overall health and wellbeing;
 - (ii) Nurse Advisors within NHS 24 should check the call history of every caller; and
 - (iii) NHS 24 should undertake a review of whether or not it is in the best interests of patients that Nurse Advisors cannot directly access the OOHS’ GP’s records.

FINALLY

At the conclusion of the evidential part of the Inquiry and on the day of the oral hearing on submissions (in their absence) I expressed on behalf of the Court and all those appearing at

the Inquiry condolences to Ms Rogers and the other members of Mr Willock's family. I was most impressed and moved by the dignified and attentive manner in which they, and in particular Ms Rogers, conducted themselves throughout this complex and lengthy Inquiry. Their interest in and demeanour throughout the Inquiry, during what at times must have been a very trying experience for them, is to be commended.

Sheriff Colin W. Pettigrew
Sheriff of North Strathclyde at Paisley

7 October, 2013

ERRATUM

Since signing the Determination it has come to my attention that there is a typographical error on page 34 at paragraph 56(iii).

That paragraph should read:

“Nurse Scally on the afternoon of 28 December 2009 incorrectly advised Mr Willock to take Ibuprofen and failed to arrange for him to be visited by a doctor, which Dr Willox considered should have been undertaken at that time”.

Sheriff Colin W. Pettigrew
Sheriff of North Strathclyde at Paisley

8 October, 2013