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SHERIFFDOM OF LOTHIAN AND BORDERS AT SELKIRK,

B124/09

DETERMINATION

by

SHERIFF PETER G. L. HAMMOND

in Inquiry into the circumstances of the death of

MRS. ROSEMARY GREY or THOMPSON

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

APPEARANCES:

For the Crown: Mr. Keane, Procurator Fiscal Depute.

For Scottish Ambulance Service ("SAS"): Ms. Davie, Counsel.

For NHS 24: Ms. Sargent, Solicitor.

For Borders Health Board ("BHB"): Mrs. Coull, Solicitor.

Selkirk, 12 January 2010

The Sheriff, having considered all the evidence adduced and the submissions made thereon, determines in terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 as follows:

Section 6 (1) (a)

1. Rosemary Thompson, born 13 January 1946, died between about 15.30 and about 19.30 hours on 5 August 2007 at **********, Newtown St. Boswells, Roxburghshire.

Section 6 (1) (b)

2. The cause of her death was (a) acute pulmonary oedema as a consequence of (b) acute myocardial ischaemia, with underlying (c) coronary arterial atheroma.

Section 6 (1) (c)

3. There were no reasonable precautions whereby her death might have been avoided.

Section 6 (1) (d)

4. There were no defects in any system of working which contributed to her death.

Section 6 (1) (e)

5. Other facts which are relevant to the circumstances of her death are set out in the following Note.

Sheriff

NOTE:

Introduction

[1] Section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that where it appears to the Lord Advocate to be expedient in the public interest that an inquiry should be held into the circumstances of a death, the Procurator Fiscal shall investigate and apply to the Sheriff for the holding of an inquiry under the Act into those circumstances.

[2] This inquiry was held following an application by the Procurator Fiscal for the District of Selkirk in respect of the death of Rosemary Thompson. Mrs. Thompson was a 61 year old lady who had serious physical and mental health problems, and lived with a housemate who also had mental health problems. A matter of days before her death, Mrs. Thompson had been discharged from hospital, where she had been recuperating after an operation to amputate the

toes of her left foot. She was found to be dead when ambulance paramedics attended at her home on the evening of Sunday 5 August 2007 in response to a call following the involvement of "out of hours" social and health care services earlier in the day.

[3] The inquiry in this case was heard over six days: 14, 15, 16, 17, 18 and 30 September 2009. The Procurator Fiscal called the following witnesses:

a. Mrs. Diane Scott, daughter of Mrs. Thompson.

b. Dr. Geoff Wilson, Mrs. Thompson's General Practitioner.

c. Arthur Cross, Mental Health Support Worker, Scottish Association for Mental Health (SAMH).

d. Chris Yapp, Social Worker, Scottish Borders Council (SBC) Mental Health Team.

e. Justin McBride, Senior Psychiatric Charge Nurse, Galavale Hospital, Galashiels.

f. Thomas McCaskie, Home Carer, SBC.

g. Dr. Carolyn Young, GP, Borders Emerency Care Service (BECS), NHS Borders.

h. Ian Lowes, ambulance paramedic, Scottish Ambulance Service (SAS)

i. Mairi Jamieson, Advanced Medical Priority Dispatch System (AMPDS) auditor, SAS.

j. Dr. William Cameron, Medical Director, NHS Borders.

k. Janice Whiteford, District Nurse, NHS Borders.

l. Elaine Torrance, Head of Service for Social Care, SBC.

m. Anne Gibney, Clinical Services Manager, NHS 24.

n. Dr. Malcolm Alexander, Associate Medical Director, NHS 24.

o. Karen Brogan, Interim Head of Control, SAS.

p. Darren Scurfield, ambulance paramedic.

q. Professor Gerhard Kernbach-Wighton, consultant pathologist in Forensic Medicine.

r. Mrs. C.S., Mrs. Thompson's housemate.

s. P.C. Duncan Begg, Lothian and Borders Police.

In addition, I was referred to a number of documentary productions including parts of Mrs. Thompson's medical records, post mortem and toxicology reports, transcriptions of telephone calls, and event logs and protocols relating to the activities of the responding agencies concerned .

Background

[4] The deceased, Rosemary Thompson, was aged 61 at the date of her death. She resided at **********, Newtown St. Boswells. This was a house which was provided by the Scottish Association for Mental Health (SAMH), and which she shared with a housemate, C.S. Mrs. Thompson and C.S. had lived together at that address for many years and provided mutual support and companionship for each other. They got on well. Both had mental health difficulties. In 2004, Welfare Guardianship Orders were put in place to protect both Mrs. Thompson and C.S. in respect of unwanted visits by C.S.'s adult son.

[5] Mrs. Thompson had suffered health problems for many years. She had very bad circulation in her legs following an injury sustained in 1984. According to the medical records, she jumped from a balcony and sustained a fractured thoracic vertebra. This in turn had left her with kidney problems and she was prone to recurring urinary infections. She had hypothyroidism. Her mobility was severely restricted. She had walking sticks and a zimmer frame to aid her walking, but latterly she had become more dependant on her wheelchair to get

about. In terms of her mental health, she suffered from Bi-Polar Affective Disorder (formerly known as manic depression) and was on the Severe Mental Illness Register. She was prescribed tablets for blood pressure, thyroid replacement, major tranquillisers and long-term antibiotics.

Surgery, recuperation and discharge from hospital

[6] By the early summer of 2007, the nerve supply to Mrs. Thompson's legs had deteriorated, and circulation in her legs was poor. Her legs and feet were prone to infection. She was suffering substantial pain and discomfort as the toes of her left foot were becoming dead and thus a danger to her health. It was decided that the toes required to be amputated. This was carried out at Borders General Hospital (BGH) on 2 July 2007.

[7] Prior to her operation, Mrs Thompson was admitted to Galavale Hospital on 8 June 2007 to help ensure she was in the best physical and mental condition to undergo surgery. After her operation at BGH, she was returned to Galavale on 16 July 2007 for recuperation, and to allow the healing of her surgical wound to be monitored by nursing staff.

[8] There was no set timeframe for her returning home. Multi-disciplinary discussions took place between doctors, nurses, social work and Rosemary Thompson herself. Consideration was given to her anticipated needs on discharge, and how she could best be supported. On 23 July 2007, she was taken on a home visit by a physiotherapist to assess her functional ability to manage at home. Justin McBride, senior psychiatric charge nurse, stated in evidence that by the beginning of August, Rosemary Thompson was keen to go home. Her wounds had healed remarkably well, and there was no reason why she could not go home with appropriate support. He believed that sufficient support had been put in place for her. He stated that he would have made the same decision today based on the available evidence.

[9] Chris Yapp was Rosemary Thompson's social worker. He had responsibility for her post-discharge care arrangements. He described meeting with Rosemary Thompson, the Physiotherapist and ward staff to discuss her needs on discharge. He explained that the package put in place comprised three visits

per week from SAMH, a weekly visit from a Home Help to assist her with showering, and visits from the District Nurse in relation to her wound dressings and continence issues. The Emergency Duty Team could be contacted by telephone in the event of any health or well-being matters arising over the weekend which could not wait until Monday morning. He was satisfied with the care package in place at the time of Rosemary Thompson's discharge from Galavale Hospital on 1st August 2007. He did not have concerns about her ability to look after herself after discharge with these elements of support in place.

[10] Mr Yapp was asked about Mrs. Thompson's ability to cope in an emergency. He explained that he would have expected Mrs Thompson to use her Borders Emergency Alarm. This would either be around her neck or on her telephone, or she could ring Borders Council directly. C.S.'s evidence on this point was that both she and Mrs Thompson had emergency alarms. According to her, she had used her alarm but Mrs. Thompson was reluctant to use hers. He was confident that Mrs Thompson or C.S. could cope in an emergency.

Post-Discharge

[11] Mrs. Thompson was discharged home from Galavale Hospital on Wednesday 1 August 2007.

[12] On Thursday 2 August 2007, Neil Cross, Community Psychiatric Nurse, Galavale Hospital, visited Mrs. Thompson at home. His progress note referring to that meeting forms part of the medical records. The note refers to Mrs Thompson *"doing exceptionally well with regards to her mobility and she was keen to show me her walking up and down the sitting room, which she is doing fantastically at".* It also comments that *"She is still not very keen on having any kind of homecare or/support to help with the shower, although she does recognise that she may need this in the first instance"*.

[13] On Friday 3rd August, the District Nurse attended in the morning to change Mrs Thompson's dressing. Arthur Cross, Support Worker with SAMH, also visited Mrs Thompson in the morning. He walked her by wheelchair into the town centre where she did some shopping, and then brought her home. He left

her at home at about 11 a.m. Mr Cross found her to be less positive than she had been in hospital. He stated that she was not "100% her mental state". He did not have any concerns about leaving Mrs Thompson at home on the Friday. He was satisfied that Mrs Thompson or C.S. could have telephoned to obtain help if required. He was aware that Mrs. Thompson could have become incontinent of urine or faeces, but he did not have any concerns about her physical health that day. Also on Friday, Chris Yapp telephoned to arrange a visit to see Mrs. Thompson later that day. However, C.S. answered the call and told him that Mrs. Thompson had diarrhoea and it would not be appropriate for him to come. It was arranged that he would visit the following Monday instead.

[14] On Saturday 4th August Mrs Thompson received no visitors from health or care services. The only evidence of what took place during the time between Mr. Cross leaving Mrs. Thompson on Friday morning, and C.S.'s telephone calls on the Sunday morning, came from C.S. She stated on that on the Saturday Rosemary Thompson was *"just sitting quietly on the couch. She was not very happy."* She stated that Mrs. Thompson was not managing to get up off the couch to go to the toilet, and was soiling herself as she sat on the couch. It is not clear from C.S.'s evidence how long Mrs. Thompson had been immobile on the couch. However from Tom McCaskie's description of her lower garments being packed with a large quantity of impacted faeces, it is likely that she had been unable to move for some time.

Sunday 5 August

[15] On the morning of Sunday 5 August, Rosemary Thompson was feeling unwell. She asked C.S. to telephone the doctor.

[16] At approximately 11 a.m. C.S. telephoned Galavale Hospital and spoke to Justin McBride, Senior psychiatric charge nurse. She was concerned because Rosemary Thompson was on the floor. She had been incontinent and could not, or would not, get up from the floor.

[17] At approximately midday, Justin McBride telephoned the SBC Social Work Department Emergency Duty Team, and relayed C.S.'s concerns. He pointed

out that Rosemary Thompson had been discharged from hospital the previous Wednesday, and she had been incontinent for three days according to C.S. He was given the impression by the Duty Social Worker that someone would be sent round soon to investigate the situation.

[18] According to the notes of the Emergency Duty Team, the Duty Social Worker telephoned back shortly thereafter. She spoke to C.S., who stated that Rosemary Thompson had not been able to get of the couch for the previous three days and had been sleeping on it. She was very messy as she had not been getting up to go to the toilet. She was on diuretics, and these were making her need the toilet so often that she had not been bothering to get up and shower on the basis that she would be wet again soon anyway. C.S. told the Social Worker that Rosemary Thompson had been off her food and had not been eating since she got back from hospital. It was agreed that a carer would be sent round, and C.S. agreed to help with getting her to the toilet and shower and thereafter cleaning her up.

[19] At 11.39 a.m., C.S. telephoned NHS 24 seeking assistance. She explained to the call taker that Rosemary Thompson had just come out of hospital after having her toes amputated. She narrated that Mrs Thompson had not been to the toilet for three days and had been soiling and wetting herself because she was unable to get up from the couch. NHS 24 told her that someone would call her back as soon an adviser became available. She was advised that if there were any changes or concerns then she should call back to NHS 24.

[20] In response to Justin McBride's call, the Social Work Emergency Duty Team sent Thomas McCaskie, an experienced Home Care Worker, to **********. He arrived at approximately 12.15 p.m. He found Mrs. Thompson sitting on the couch. There was a strong smell of urine and faeces. Her lower half clothing and her feet were stained. He spoke to Mrs. Thompson and C.S. They told him that they had contacted NHS 24 earlier. Mrs. Thompson was very uncomfortable, and agreed to let him help her to clean herself up. He managed to get her onto her feet and helped her to the shower in the bathroom. With the assistance of C.S. he showered Mrs Thompson.

[21] At 13.17, Mr McCaskie phoned NHS 24 for assistance. They confirmed that C.S.'s earlier call had been logged and was in the queue for call back by an adviser. He described Mrs Thompson as having been in a terrible state with her clothes soaked in urine and bulging with faeces, but explained that he had managed to shower her. He was told that the advisers were very busy because it was the weekend. He was assured that an adviser would call back as soon one became available, but a timescale could not be given. He confirmed that her condition had not changed since C.S. had placed the earlier call. He was advised that if anything changed he should not hesitate to call them back.

[22] Mr. McCaskie managed to get Mrs. Thompson cleaned up and dressed, with new protective pads on. As Mr. McCaskie was helping Mrs Thompson back to the living room, she said that she felt very weak, and her legs gave way just before the living room door. Mr McCaskie was unable to prevent her collapse, and gently lowered her to the floor in the hallway.

[23] Mr McCaskie ensured Mrs Thompson was comfortable and telephoned NHS 24 again at 13.56 to advise of the change in circumstances. He explained that Mrs. Thompson was now on the floor. On this occasion he was put through to a nurse adviser and repeated the circumstances as he understood them. He listed the medications that she was prescribed. He confirmed that she had learning difficulties. The nurse said they would arrange for a doctor to attend because Mrs. Thompson was obviously not coping and might have to go back into hospital.

[24] At 14.19, NHS 24 sent a message to Borders Emergency Care Service (BECS) at Borders General Hospital, Melrose, following up the earlier calls. This was received at BECS at 14.23. The message passes on the information that Mrs. Thompson was unable to mobilise and was sitting on the floor, having been discharged from hospital the previous Wednesday. She had been *"off her legs since"* and had been found that day soiled with excrement. She had been cleaned up by the Duty Social Work team and left on the floor. The outcome was a request for a home visit within 4 hours.

[25] Dr Young, a doctor with BECS, gave evidence of being contacted at about 15.00 by NHS 24. She noted that the patient was on the floor and a carer had been unable to move her. It had been triaged by NHS 24 as a response within four hours. Dr Young explained that the four hour period started from when the call was passed to the Emergency Service. An official car and driver were not available to her in the area at that time, and she thought the patient could be seen more quickly if visited by the District Nurse, at least in the first instance. Dr Young contacted the District Nurse, Janice Whiteford. She asked her to look in on Mrs. Thompson to help her to get off the floor. The District Nurse said that she would do so and telephone Dr Young back. In addition, Dr Young telephoned the Out of Hours Social Work Service and Galavale Hospital to obtain more information about Rosemary Thompson. She wanted to be able to fully brief the admitting ward.

[26] Janice Whiteford is a very experienced District Nurse. She is a qualified Psychiatric Nurse, Registered General Nurse and a registered Midwife. She was contacted by Dr. Young at approximately 14.42. She confirmed that she was told by Dr Young that a patient had fallen, and that a carer had found her on the floor, attended to her and left her there. She was asked to assess the patient for injury, see how she was and report back. She attended at Rosemary Thompson's house some 5 minutes after receiving the call.

[27] On arrival, she met C.S., who was agitated and not very communicative. On examination of Mrs. Thompson, she found no bony injuries. Mrs Thompson seemed slightly sleepy. Her breathing seemed alright. She was not talking a great deal. With the assistance of C.S., she moved Mrs Thompson from the floor into a wheelchair. She wheeled her into the sitting room. She asked if she was sore and checked her over. Her mouth was dry so she gave her a drink. Nurse Whiteford recognised that, whatever was wrong with Mrs. Thompson, she was unable to function independently and needed to be admitted to hospital to be properly cared for. She could not stand, so she could not go to the toilet. She could not eat or drink independently, and needed help for all her personal care.

[28] Nurse Whiteford thought that Dr. Young had told her that the ambulance would arrive within one hour, and she was happy with that arrangement. According to her evidence, she was unaware that a four hour timescale was involved. If she had been told it could be as long as four hours, she would have recommended that the ambulance come sooner, and would have gone back to see Mrs. Thompson. However her concerns for Mrs Thompson were in relation to her ability to look after herself, rather than any immediate medical crisis. Mrs. Thompson did not appear to have had a stroke. There was no sign of that facially, and she was able to grip Nurse Whiteford's hand without any apparent weakness. There was no alteration in her skin colour. She was not in distress. She had a slight temperature. There was nothing else which gave Nurse Whiteford cause for concern about her condition. She would have noticed if there was anything obviously wrong with Mrs. Thompson. Her priority was her patient's comfort. Her concern about a four hour wait would have been because this is a long time to leave someone in these circumstances. Mrs. Thompson would have needed to go to the toilet and take food within that time. She needed fuller assessment and care in hospital.

[29] On her appraisal of the situation, Nurse Whiteford was satisfied that she could leave the patient on her own with C.S. She did not consider that it was necessary to remain with Mrs. Thompson to await the arrival of the ambulance, as she had other official visits to make and the ambulance was expected within a reasonably short time. The patient had a friend with her, and Nurse Whiteford considered that all she could do was make her comfortable to await the ambulance. Before leaving, she ensured that Mrs. Thompson was comfortable in her wheelchair with her legs elevated on the coffee table and propped up on a pillow. The patient was not in distress at that time. It is not possible to be certain about the exact time Nurse Whiteford left Mrs. Thompson. She thought that she had been there for approximately 45 minutes to one hour.

[30] Dr. Young confirmed that Nurse Whiteford telephoned her back. She could not recall the exact time, but thought that it would have been sometime between 15.00 and 15.30pm. Nurse Whiteford reported to her in that call that

she had found the patient sitting on the floor. The patient was responsive, although Nurse Whiteford was unable to get meaningful information from either her or the flatmate. She was a bit flushed and dry. Nurse Whiteford gave her a drink By the time Nurse Whiteford called back, she had left Mrs. Thompson's house.

[31] The decision to request an ambulance is a medical decision. At 15.20, after speaking to Nurse Whiteford, Dr Young contacted the Scottish Ambulance Service to request an ambulance to collect Mrs. Thompson and take her to Borders General Hospital. She also telephoned the BGH medical ward to arrange admission. Dr. Young asked for the ambulance with "Level 2" priority. This means that the ambulance should come within four hours.

[32] At 15.39 ambulance GAL20 was allocated to respond to the call. This ambulance was however diverted while en route to Mrs. Thompson's address because of a higher priority call.

[33] At 18.07 ambulance GAL455 was allocated to the task. This ambulance was also diverted while en route to Mrs. Thompson's address because of a higher priority call.

[34] At 19.11 the Out of Hours Service (BECS) called the Ambulance Service to ask for an estimated time of arrival of the ambulance. They were told that an ambulance would be with the patient as soon as they had a crew available.

[35] At 19.45 C.S. again phoned NHS 24 to report that they were still waiting for the GP to come out. The NHS 24 call handler told her that the GP had conferred with the District Nurse and it had been decided that Mrs. Thompson would have to go into Borders General Hospital that evening, and that they had arranged for an ambulance to attend.

[36] At 19.46 NHS 24 phoned the Ambulance Service asking for an estimated time of arrival of the ambulance. The advice was that they could not give an ETA, but would be with the patient as soon as they could.

[37] At 20.00 ambulance HAW480, crewed by paramedics Ian Lowes and Darren Scurfield, received a message from the ambulance control centre to attend Mrs. Thompson's address.

[38] At 20.23 the ambulance arrived at **********, and paramedics spoke to C.S.. They found Mrs. Thompson sitting on the sofa in the lounge. She was obviously dead. They checked and confirmed that there were no vital signs. At 20.35 they requested the police to attend. The police attended shortly thereafter and the paramedics completed a "Declaration of the Fact of Death" form.

Cause of Death

[39] Evidence of the cause of death was given by Professor Kernbach-Wighton. Professor Busuttil had carried out a post mortem examination, and his report was produced as Crown Production 4.

[40] Professor Busuttil's report records the medical cause of death as

– I (a) Acute pulmonary oedema

(b) Acute myocardial ischaemia

(c) Coronary arterial atheroma

II severe generalised atheratomous disease

Psychosis

Hypothyroidism

[41] On examination, Professor Busuttil noted evidence of pallor over the subendocardial surface consistent with acute ischaemia. Some interstitial fibrosis was also noted; also consistent with ischaemic damage. All three main coronary trunks showed very gross atheromatous changes, with marked narrowing to about 80% of normal in places. Both lungs were found to be acutely oedematous.

[42] Professor Kernbach-Wighton's opinion was that death was due to an acute ischaemic event to the heart, following upon severe underlying ischaemic heart disease. Cardiac failure caused by ischaemia to the heart leads to an imbalance, and fluid accumulating in the lungs. In layman's terms the mechanism of death was an increase of fluid on the lungs (oedema), leading to problems with respiration. The acute event referred to in the opinion section of Professor Busuttil's report might have been the early stages of acute myocardial infarct, produced by atheratomous disease. Artery disease develops over years. At some point it reaches the stage where the system is no longer able to compensate for certain effects. At this point necrosis of the toes can develop, or infarcts, which leave scars, can occur. The acute pallor is indicative of an acute ischaemic event to the heart because it demonstrates an acute lack of blood to the heart. The fibrosis refers to scarring of the heart muscle, which is a reaction showing that there had been previous episodes.

[43] Professor Kernbach-Wighton was of the opinion that the onset of the event immediately causing death could have been very quick, perhaps within 5 to 10 minutes. One cannot predict in advance when these events are going to happen. The heart did not stop immediately, otherwise there would have been no oedema of the lungs. It takes a couple of minutes for oedema in the lungs to develop, but once the function of the heart is disturbed it is a cascade. If this had taken place in hospital, rather than at home, Mrs. Thompson's chances of survival would not have increased. It would make no difference to the result.

[44] He also considered Crown production number 5, the toxicology report, and Crown production number 6, a supplementary report by Professor Busuttil which indicated that the drugs found in her system were in therapeutic levels, and did not materially contribute to her death. He also referred to Crown Production number 28, a letter from him to the Procurator Fiscal, wherein he stated that it was now impossible to give an exact time of death, but the whole pattern of findings was consistent with a fatal heart attack being the mechanism of death. He stated that there is no indication that other factors contributed to this, and it could not be said that the deceased could have survived if she had been found earlier, due to the severity of the morphological

changes. Her condition was such that she might have died at any time given the advanced changes within her heart.

[45] Dr Cameron also gave evidence in relation to the mechanism of death. He described how Mrs. Thompson would have suffered acute cardiac failure which led to her lungs filling with fluid. The underlying cause was generalised arterial disease. He explained that Pulmonary oedema can cause death within a short time. It is like water running into a bath, which is being pumped out again; but if it is not pumped out fast enough the bath fills up. In this case he likened the lungs to the bath in his example. The patient would be *in extremis*, distressed and breathing rapidly. There is often frothing spit being coughed up. The patient will turn a dusky blue colour as the fluid fills the lungs and there is an increasing lack of oxygen transfer from the blood (cyanosing). The colour is most significant around the lips, mouth, tongue, nose, ear lobes, hands and feet. As the condition progresses it becomes more generalised.

[46] Professor Kernbach-Wighton's evidence was that "Psychosis" and "Hypothyroidism" were not factors in causing the death. I accept that evidence.

Time of Death

[47] Professor Kernbach-Wighton stated that it was very difficult to estimate a time of death from the physical findings alone. However there was evidence from the paramedics and from C.S..

[48] On attending the house at 20.23, the paramedics discovered Mrs. Thompson in the lounge. It was immediately obvious to them that she was dead. They noted that she was a deathly grey pallor, and drained of all colour. They found no signs compatible with life.

[49] Ian Lowes checked for post mortem staining. He described this as the effect of gravity causing the blood to pool when the heart has stopped pumping blood through the body. The blood breaks down and affects the tissues, going from red to a more vivid deep dark maroon colour. He found staining on the lower side of her arms and hands, where they were resting on her lap. There was a

reddish purple discolouration of the skin on the underside. The paramedics attached cardiac monitoring to Rosemary Thompson's arms and upper legs to ensure that there was no cardiac output. In doing so, post mortem staining was noted on the thighs and edge of the buttocks. He spoke to having dealt with deceased people on a regular basis. He stated that post mortem staining can be influenced by a number of factors and can start 20 minutes after death and peak somewhere between 6-10 hours after death. He described the post mortem staining as affecting the outside section of the hand. He was not sure if it was on both hands. He couldn't confirm how far up the arm the post mortem staining extended but thought it was under both forearms about ¾ of the way up. He was only working from the right side of Rosemary Thompson to attach the cardiac monitoring pads but saw post mortem staining on the thigh at that side on the outside edge. He didn't move her to see more underneath. He described the colour as purple like a reddy bruising, not a deep colour.

[50] Mr. Lowes asked C.S. for more information. She told him that she had last spoken to Rosemary Thompson around 15.30 that afternoon. She had told her that she wasn't feeling very well. When he asked C.S. if Rosemary Thompson had said anything else, she told him that she hadn't spoken since then but that she had made funny noises. He thought that the noises imitated by C.S. suggested some type of respiratory distress. She had tried to speak to her but had received no response. The impression that he had from C.S. was that Rosemary Thompson had stopped speaking very soon after 15.30. From the description given by C.S., and the post mortem staining, he was concerned that death had occurred quite some time before the ambulance had arrived. As a minimum he thought Rosemary Thompson had been dead for a couple of hours.

[51] On arrival with his colleague, Darren Scurfield carried out a visual assessment of Rosemary Thompson. Her grey pallor, complete slackness of muscle tone and post mortem staining on her hands, which were by her sides, all indicated that she was dead. Along with Ian Lowe, he checked for pulse activity and respiratory effort. He found none. She was also cool to touch. All of there things indicated that she was dead. He carried out cardiac tracing, which

confirmed there was no electrical activity in the heart. There was post mortem staining on her hands, arms up to the elbow, on her hips to lower portion of thigh. The staining was a deep purple in colour. In his assessment she had been dead for at least an hour.

[52] Mr. Scurfield also spoke to C.S.. His recollection was that she told him that she had last spoken to Rosemary Thompson at around 3pm when she said she was not feeling well. Shortly after that, the patient had some breathing difficulty. He had the impression that had happened in the subsequent half hour or so He accepted that he might be wrong about the time she reported, and it might have been later.

[53] C.S.'s evidence to the inquiry about the timings differed somewhat. She said that she gave Mrs. Thompson a tap on the shoulder to get her to come to, which did not do any good. This was between about 17.30 and 18.00. According to her, Mrs. Thompson was then shouting for about 15 to 20 minutes, then her breathing became more difficult. She seemed to be breathing in gasps. Eventually, she realised that her chest was not moving. *"It just went quiet".*

[54] In my view, the picture which emerges from the evidence is one of an acute attack taking place some time between 15.30 (after the visit from Janet Whiteford) and 19.30 (based on Darren Scurfield's estimate that Mrs. Thompson had been dead for at least an hour before his examination at around 20.30). It is not possible to be any more precise than that.

CROWN SUBMISSIONS

[55] The Procurator Fiscal Depute submitted that the death had occurred between 15.30 and 20.30, and that the causes of death were as stated in the Post Mortem report. Death could have occurred at any time, and according to the evidence, the state of the disease was so advanced that Mrs. Thompson would not have survived even in hospital. There were no reasonable precautions by which the death might have been avoided. He did not suggest that I should make findings any under section 6 (1) (c) or (d)

[56] He raised two matters for comment; (i) communications issues between Dr. Young and Nurse Whiteford, and (ii) whether a higher acuity level for ambulance attendance should be considered where a patient has a recent history of hospitalisation. I propose to deal with these matters later in this Note, in considering the submissions of the agencies concerned.

SUBMISSIONS ON BEHALF OF SCOTTISH AMBULANCE SERVICE

Time of Death

[57] Ms. Davie submitted that whereas C.S. had attempted to outline the facts to the best of her recollection, her timings were suspect. Her recollection had clearly been affected by information she had obtained subsequently. She was confused as to whom she called on Sunday 5 August 2007, when she called them and what the outcome was. She thought the initial call was at 0800 or was 0900 Sunday morning, whereas the NHS 24 log shows that the call was at 11.39. She thought that Tom McCaskie attended at 15.00, when the evidence suggests that he arrived around 12.00. She thought that she was waiting during the afternoon for a doctor to arrive, rather than the ambulance service. She thought she had called back to NHS 24 around 16.30 – 17.00, whereas the log shows it is at 19.45. She said in evidence that they advised her to call back if the ambulance didn't arrive before bed-time, but that is not reflected in the recording of her telephone call. She appeared to have difficulty identifying her own voice on the taped conversations, and difficulty accepting that they represented what she had in fact said. Ms Davie invited me to find that the death had occurred between 15.30 and 18.50 (the mid-way point between estimates of the time-lapse since death of 2 hours (Ian Lowes) and 1 hour (Darren Scurfield).

Reasonable precautions, if any, whereby the death might have been avoided

[58] The evidence of both Dr Cameron and Professor Kernbach-Wighton suggest that the death could not have been avoided, no matter what precautions were taken.

Analysis of evidence on behalf of SAS

General System

[59] The Scottish Ambulance Service in the Borders covers the area from the Borders up to the coast at Berwickshire, and up to the Lothians as far as Linlithgow; or even Edinburgh if needed for an emergency there. The ambulance control try to spread the vehicles to different geographical locations to try to meet time standards for responding to calls. There are 4 stations at Hawick, Kelso, Galashields and Peebles. The first three have two vehicles and the latter station has one. There is also a station at Chirnside with two ambulances. Each station has a different shift cover pattern.

[60] Calls come in to the SAS Control Room. An emergency call handler takes the address and nature of the call. The details are then electronically sent to a dispatcher. The dispatcher has an electronic mapping system, which flags up the closest ambulance. Each ambulance is electronically tracked. There are strategic standby points for ambulances to be stationed, which are decided upon by dispatch. Emergency calls are priority. If an emergency call comes through then an ambulance can be diverted from an urgent call. Evidence on these procedures was given by Karen Brogan, and by Mairi Jamieson, Advanced Medical Priority Dispatch System auditor, SAS.

Acuity Level

[61] SAS were contacted by BECS, and a 'level 2' ambulance was requested at 15.20 hours. This meant that an ambulance would be expected to arrive within 4 hours. An urgent call is usually requested by a doctor or hospital, and can be contrasted with an emergency "999" call, applicable when there is an immediately life threatening situation. The appropriate acuity level is decided by a doctor, and not SAS staff. An example of a lower priority category would be a planned patient transfer. In that situation, no treatment is required en route. The ambulance would simply transport the patient for admission to hospital. It is not uncommon for an ambulance on an urgent call to be redeployed to another call in the event of an emergency.

[62] Dr Young made the decision that this ambulance should be acuity level 2, arriving within 4 hours. On the basis of the information available to her she

was satisfied that this was an appropriate disposal. Given the information available to the nurse and doctor at the time, it appeared that the situation had arisen over a day or two, the patient was stable and comfortable and it was not an emergency. A four hour timescale for the ambulance was appropriate in the circumstances, particularly against the background of an initial suggested disposal of a visit within 4 hours. I was referred to the evidence of Dr Cameron.

Information available to SAS

[63] The ambulance service logged the reason for the transfer as the patient being "off her legs". According to Dr. Young, that expression usually refers to elderly patients where they are unable to self-care or mobilise. It is a cover-all expression, but means "not coping". As far as the ambulance service is concerned, the use of this term suggests a transport issue, rather than any expectation that the patient might require treatment in the ambulance. Darren Scurfield thought "off her legs" was a catch-all term for general debilitation, meaning that a patient is perhaps not coping so well at home.

Response to call

[64] I was reminded that on two earlier occasions, ambulances had been dispatched to the call and then diverted by more urgent instructions. HAW480 was initially operating out of Hawick station but during the course of the shift the ambulance was requested to move to cover the Kelso area, which was busy and required cover. En route to Kelso, an urgent call was received at 20.00 to attend Mrs. Thompson's address in Newton St Boswells. The ambulance duly arrived at the scene at 20.23.

[65] The SAS log, Crown Production 19, details the history of the call from the initial request at 15.20 until the call was answered and the crew stood down. Karen Brogan pointed out how the dispatcher is shown continuously going in and out of the call log looking for available resources which could be sent to this job without depleting emergency cover in other areas. There are different initials against the 'call retrieved' entries in the log, which indicates that the area was very busy, and a dispatcher from another area was keeping check on

the jobs waiting. Over the five hour period of the log, the call was constantly being monitored by dispatch.

[66] Karen Brogan's subsequent investigation of the incident ascertained that from 15.20 onwards the service was busy, with very little availability of ambulances without depleting emergency cover elsewhere.

Adherence to Protocol

[67] Dr. Young and Mairi Jamieson confirmed that the ambulance service will alert the instructing authority if they are unable to make it within the expected time, and an opportunity will be given for the acuity level to be altered at that stage.

[68] At 19.11 hours the Out-of-Hours service (BECS) telephoned SAS to check what was happening with the ambulance. At 19.46 NHS 24 called looking for an ETA for the ambulance .

[69] The call at 19.11 hours from BECS was the point when the ambulance service advised them that they were not going to arrive within the estimated 4 hour period. Similarly the NHS 24 call at 19.46 hours was a further point at which an outside agency was informed that the ambulance would not arrive within the estimated time. Although the protocol envisages that the ambulance service should initiate the call to the requesting agency, Mairi Jamieson and Dr Cameron stated that an incoming call from a requesting agency to NHS 24 would serve the same function. The 19.11 call was within the 4 hour timescale. The purpose of the call is good practice, which enables reassessment if the agreed response time cannot be met.

Home Care package

[70] Counsel submitted that the evidence raised the issue of the adequacy of home care which had been put in place by the Social Work Department. She took me through the relevant evidence of Arthur Cross, Chris Yapp, Elaine Torrance , Thomas McCaskie, Nurse Whiteford, the ambulance paramedics, and C.S. herself. She submitted that there appeared to be reliance placed on the ability

of C.S. to respond appropriately in an emergency, and that reliance was misplaced. I will deal with this issue later in this Note.

SUBMISSIONS ON BEHALF OF NHS 24

[71] Ms. Sargent invited me to make formal findings in relation to the time and place of death. On behalf of NHS 24, she invited to make no findings in respect of section 6 (1) (c), (d) or (e); there being no evidence in support of such findings.

Reasonable precautions in terms of s 6(1) (c)?

[72] Ms. Sargent suggested that the most obvious precaution would have been to arrange urgent transfer to hospital. However the question was whether such a response was reasonable in the circumstances, and whether it might have resulted in the death being avoided.

Should NHS 24 have arranged an urgent home visit or transfer to hospital?

[73] The court heard evidence from Anne Gibney, a Clinical Services Manager with NHS 24, on how calls to the service are handled. When a call comes in, it is picked up by a call handler who then takes certain information from the caller, including personal details and symptoms. The call handler then triages the call with reference to the Routing Tool (Crown Production No 24). The call is then passed to an adviser if one is available, or placed in a queue for a call back within a certain specified period of time.

[74] The first call to the service was made by C.S., Mrs Thompson's housemate, at 11.39. The information given was that Mrs Thompson had not been to the toilet for 3 days. She was soiling and wetting herself. She was not able to get up from the couch, and she had "had her toes off". On the basis of these symptoms, having regard to the Routing Tool (Crown Production No. 24) the call was placed in a queue with a priority of 3, meaning that a call back should take place within 3 hours (i.e. by 14.39). There was nothing to indicate to the NHS 24 call-handler that the call was a serious or urgent one; or that Mrs Thompson displayed life-threatening symptoms requiring that the call should

immediately have been passed to a nurse adviser. It was appropriate to have placed the call in the queue.

[75] There is no evidence to suggest that a three hour call back time was anything other than appropriate. The symptoms described by Mrs Simpson were not such as to warrant a more rapid response. Dr Malcolm Alexander, the Associate Medical Director of NHS 24, was asked if he had any concerns that a 3 hour call back time had been placed on the original call. He was confident that the clinical presentation merited a 3 hour call back time.

[76] The call back to C.S. was due to take place by 14.39. In fact, Tom McCaskie, phoned NHS 24 back at 13.17, which was within 2 hours of the original call. He offered no new symptoms at that time and the call was returned to the queue. When Tom McCaskie phoned NHS 24 back at 13.56, the situation had changed because Mrs. Thompson was on the floor. The call was therefore put through to a nurse adviser who, after consulting with a manager, made the decision to refer Mrs Thompson to the out of hours service (BECS), with a recommendation for a home visit within 4 hours. This is logged on the NHS 24 Clinical Referral Notes (Crown Production No. 23). That document contains the information passed to the out of hours service by electronic transfer at 14.20.

[77] Because a car was not available to her, Dr. Young arranged for the district nurse to attend. She did so sometime between 14.35 ,when she reported back to BECS after her previous appointment, and 14.59, when she reported back to BECS after visiting Mrs Thompson.

[78] Therefore, within 1 hour of Tom McCaskie's second call to NHS 24 advising of the change in circumstances, a face to face home visit had been arranged. Nurse Whiteford's evidence was that Mrs Thompson seemed in no distress, but she knew the patient required admission to hospital as she could not function independently. She did not consider that a 999 ambulance was required. She did not feel that death was imminent. The prime reason for admission was Mrs Thompson's inability to self care.

[79] Ms. Sargent submitted that the response from NHS 24, which was to arrange a home visit within 4 hours, was entirely appropriate. NHS 24 is based on telephone triage, and call handlers and nurse advisers are therefore reliant on the information relayed to them over the telephone. Dr Young and Dr Cameron agreed that the district nurse would have a clear benefit over NHS 24 in making an assessment of the patient. Nurse Whiteford's visual appraisal, and the decision based on that reached by Dr Young, was to arrange an ambulance within 4 hours. There was no evidence to suggest that NHS 24 should have arranged a more urgent ambulance transfer, either at the time of C.S.'s call or Tom McCaskie's first or second calls. Therefore, to arrange an ambulance at an earlier stage was not a reasonable precaution which NHS 24 ought to have taken.

[80] Mrs Gibney gave evidence of a new protocol called "advise and refer", which was not in existence at the time of these events. This protocol provides that, in certain circumstances, a call handler can make a referral to out of hours without first routing the call to a nurse adviser. There is no evidence to suggest that had the "advise and refer" protocol been rolled out across NHS 24 as at August 2007, and followed, the recommended action and outcome would be anything other than a home visit within 4 hours. This is a standard timescale for district nurse referral. This would have meant a home visit by 15.39, which is in fact what transpired.

[81] Ms. Sargent submitted that in these circumstances, NHS 24 had responded entirely appropriately to the information they had. It would not have been a reasonable precaution for NHS 24 to have arranged an urgent ambulance, or earlier home visit, in response to any of the 4 calls made to the service during the day. In any event, she referred me to the forensic medical evidence. This clearly showed that any delay in admitting Mrs Thompson to hospital on 5 August 2007 did not have a bearing on her death. She submitted that Mrs Thompson would have passed away on 5 August 2007 whether she had been in hospital or not.

Any defects in the system of working at NHS 24 which contributed to the death, in terms of Section 6(1)(d)?

Call Handling - routing and prioritisation

[82] The decisions to place the call in a queue after C.S.'s first call at 11.39, and to return to the call to the queue after Tom McCaskie's first call at 13.17, were based on the symptoms being relayed by the caller. This is what a system based on telephone triage entails. A team leader would decide on the prioritisation of the call based on the symptoms and the Queue Prioritisation Tool (Crown Production No. 20). The prioritisation was checked by a queue safety manager, and we can see this was done by a Roseanne McGowan between 11.56 and 11.58 (Crown Production No. 22). Both would have been senior clinicians using their own clinical judgment and training. The system within NHS 24 for handling calls of this type, as explained by Anne Gibney in evidence, was adhered to. No defects in that system have been identified, far less any which contributed to the death of Mrs. Thompson.

"Worsening Statements"

[83] Both C.S. and Tom McCaskie were provided with what are referred to by NHS 24 as "worsening statements", when callers are advised that should anything change in the condition of the patient, they should phone back. That is exactly what Tom McCaskie did. The taped calls show the call handler providing the worsening statements to Mrs Simpson and to Tom McCaskie.

[84] It was Mrs Simpson's evidence, however, that she did not understand that she should call back if Mrs. Thompson's condition deteriorated. Ms. Sargent submitted that this did not expose any defect in the systems of NHS 24. She pointed out that the nature of telephone triage makes it very difficult to assess the capabilities of the person calling. There is nothing in the telephone call to suggest that Mrs Simpson did not understand. I was reminded that Tom McCaskie was confident that, because she had phoned previously, she could do so again.

[85] Even if it did amount to a defect in the system that the caller's understanding of that worsening statement is not in some way checked by NHS 24, it could not be said that this contributed to the death of Mrs Thompson. There was nothing in Mrs Simpson's evidence to suggest that there was a deterioration in

Mrs Thompson's condition until the point when she began shouting, and then experienced breathing difficulties. Mrs Simpson's evidence was that this was after her second call to NHS 24. In any event, even if Mrs Thompson's deterioration had prompted a call to NHS 24, or even direct to 999, the clear medical evidence was that the onset was very sudden and quickly proved fatal. It is therefore unlikely that the ambulance would have arrived in time to save Mrs Thompson.

Hospitalisation as a flag for upgrading urgency of response?

[86] Dr Alexander carried out an investigation reviewing NHS 24's handling of the calls. He gave consideration to whether recent hospitalisation was a flag which NHS 24 should use to upgrade the urgency or priority of a call. Should this have been highlighted more in the case of Mrs Thompson? Hospitalisation was, as at August 2007, and still is, a potential marker and will be reacted to by the Team Leader in prioritising calls where appropriate. The reason for hospitalisation will be considered in each individual case. However it would be relevant to take into account whether and to what extent the patient has recovered. Dr Alexander's conclusion was that as Rosemary Thompson had been discharged after a period of rehabilitation, flagging up her recent hospitalisation would not have changed the prioritisation given to the original call. The fact that recent hospitalisation was not flagged up as a prompt for more urgent care could not therefore be said to be a defect in the system which contributed to her death. Recent hospitalisation was identified in the second call by Tom McCaskie, in which the Nurse Adviser was given to understand that Mrs. Thompson was not coping as well as before she went into hospital.

SUBMISSIONS ON BEHALF OF BORDERS HEALTH BOARD

[87] Mrs.Coull, opened her submissions with a helpful review of the statutory basis of the Fatal Accident Inquiry procedure, and the sheriff's powers and duties. The lapse of time between the death and the commencement of the inquiry had caused some difficulties for witnesses. Mrs Thompson died on 5th August 2007 and the inquiry commenced on 14th September 2009. C.S., the only witness present at the time of death, commented in the witness box that it was

very difficult to remember exactly what had happened given the passage of time. Nurse Whiteford also felt disadvantaged by the delay when trying to remember timings.

[88] Mrs. Coull set out in detail her understanding of the circumstances and timetable of events according to the evidence led. Her submissions on these matters are largely accepted by me, to the extent that they are summarised and incorporated in my own findings earlier in this Note. For these reasons I do not intend to repeat all of her submissions on the evidence here.

Dr. Cameron's review and evidence

[89] Dr Cameron, Medical Director of BHB, has overall managerial responsibility for BECS. Dr Cameron explained the background to the provision of Emergency GP care, and how the Out of Service is a relatively recent innovation. He became aware of Rosemary Thompson's death on Monday 6th August. He asked for a review to be carried out. Dr Cameron stated in evidence that *"The initial review was fairly routine and did not throw up any issues. There was nothing standing out in terms of our own role."* His own findings were that *"Unfortunately it was a tragic outcome, but our staff had acted promptly and appropriately. Following a report from the Clinical Lead, a timeline and detailed assessment was prepared and at every point there was a prompt and adequate response from the team at the time."*

[90] He gave the opinion that it was appropriate for Dr Young to ask the District Nurse to see the patient. He said it was the "meat and drink" of a District Nurse's job. Dr. Cameron was also asked his views about Nurse Whiteford leaving the patient. He responded that there are circumstances when it is appropriate to stay; for example, where the patient's condition is so serious or unstable it could deteriorate rapidly. In that situation you would expect a 999 response. Another example would be where one had administered a significant dose of a drug, such as morphine, where the condition could change. That would raise the response level to a "blue light" one. In the vast majority of cases, a nurse would not be expected to wait for the arrival of an ambulance

because routinely ambulances could take anything between two to four hours to answer a non-emergency call.

[91] In response to questioning about the timescale of four hours, Dr Cameron gave the opinion that it was an appropriate timeframe given the information available to the Nurse and Doctor at the time. Dr Cameron was confused about where Rosemary Thompson had been at the time the ambulance was requested, but when clarified by the Fiscal he responded by stating that *"it does not change the fundamental point that the patient's condition was not an emergency"*.

Cause of death

[92] Mrs. Coull also commended to me Dr Cameron's evidence about the cause of Rosemary Thompson's death. According to him, it would have been a very rapid death, with obvious signs such as breathlessness, frothing at the mouth and cyanosis (blueness) around the mouth. His opinion was that it could have had a rapid onset, leading to death within minutes.

[93] The post-mortem examination was carried out by Professor Busuttil. He included psychosis and hypothyroidism as secondary causes of death. Professor Kernbach-Wighton stated in evidence that he did not share Professor Busuttil's opinion that these were secondary causes. If he had been preparing the report, he would not have included them. Professor Busuttil had commented in his report that Rosemary Thompson was not receiving medication for her psycho-affective disorder at the time of death. From evidence of Rosemary Thompson's General Practitioner, Dr Wilson, this was clearly inaccurate.

[94] Professor Kernbach-Wighton described Mrs Thompson being in an advanced stage of coronary arterial disease, which had damaged her kidneys. He explained that arterial disease develops over years. At some point the system is no longer able to compensate. In his opinion, death would have occurred rather quickly; but not instantaneously like with, for example, a cerebral haemorrhage. It would have been within five to ten minutes, or possibly even shorter. Although a rapid and final fatal collapse was consistent with her

underlying health problems, it would have been impossible for doctors to predict when this was going to take place. It could have happened at any time, and she would have been unlikely to survive even if she had been in hospital at the time.

Suggested S6 findings:

Where and when the death took place

[95] Mrs. Coull submitted that I should find that the death occurred on 5th August 2007 at **********, Newton, St Boswells, Roxburghshire. It was impossible to make a finding as to the time of death, because of the insufficiency of evidence.

The cause or causes of such death

[96] Mrs.Coull submitted that the secondary findings proposed by Professor Busuttil should be excluded, and this is reflected in my determination under section 6 (1)(b).

Reasonable Precautions whereby the death might have been avoided?

[97] As far as BHB and its employees are concerned, there were no reasonable precautions which they could have taken whereby the death might have been avoided. It was, in medical terms, an unavoidable death. BECS acted appropriately in response to the referral made by NHS 24. Mrs. Coull relied on evidence of Dr Young, Nurse Whiteford and Dr Cameron..

Defects in any system of working which contributed to the death?

[98] There were no defects in any system of working from Borders Health Board's point of view which contributed to the death.

[99] The precaution had been taken to admit Mrs Thompson to Galavale Hospital prior to surgery. She was then re-admitted to Galavale Hospital for care and recuperation before being discharged home. She was assessed rigorously prior to discharge. The assessment included a home visit with a physiotherapist. From evidence led at the inquiry it was clear Mrs Thompson was resistant to

help, and her social worker struggled to have her agree to a minimum level of support in the home. The Social Work Department was satisfied with the care package. Mrs Thompson was visited by her Community Psychiatric Nurse on 2nd August and the District Nurse on 3rd August, both employees of Borders Health Board.

[100] When NHS 24 referred Rosemary Thompson's case to BECS, Dr Young assessed the situation and arranged for Nurse Whiteford to visit the patient. The call had been assessed by NHS 24 as requiring a response within four hours. The District Nurse had visited Mrs Thompson, reported to Dr Young and an ambulance had been requested within an hour of the referral being made.

[101] In the light of his initial review, Dr Cameron was satisfied that there were no defects in the Service. He is a very experienced Clinician in the context of emergency care. He had worked as a General Practitioner in a practice providing out of hours care. He had been a member of the Working Party responsible for establishing Health Board out of hours services. He currently acts as an assessor of Out of Care Services. BECS has recently been successfully accredited by Quality Standards organisations.

[102] Although Dr. Cameron did not accept that there had been any lack of clarity in communications, he had overseen a review of the systems in place at that time which led to one improvement being introduced. He recommendation that the SBAR protocol be introduced in the Emergency Service, and this tool was introduced within Borders General Hospital in 2008. Dr Cameron identified it as being useful in the Emergency Service, where a lot of communication is done by telephone. Dr Cameron wished to ensure that there was clarity at the end of all telephone communications..

[103] Another improvement was the introduction of a nursing checklist for all calls from BECS. Nurse Whiteford explained that prior to this case, nurses would simply make a note in their diaries relating to telephone calls. The new form ensures a formal structure recording the patient's name, address, contact, reason for call, the assessment, all recordings and findings from the visit, and

the outcome. The nurses felt it was important to have more notes, and not just to rely on memories. It was good practice to review systems and procedures in the light of experience, and strengthen these when appropriate. When asked whether having more information would have helped in this case, Nurse Whiteford did not think that the outcome would have been any different.

SECTION 6(1) (c) (d) and (e) - DISCUSSION AND CONCLUSIONS

Principal conclusions

[104] I found all the witnesses credible. I also found all the witnesses generally reliable, with the exception of C.S. She was undoubtedly doing her best to assist the inquiry. However there are discrepancies in her evidence, particularly in relation to timings. I have only relied on her evidence to the extent of contemporaneous information given by her, or where corroboration is available from other sources (for example the timed tape recordings of telephone calls). Differences in recollection among other witnesses can be attributed to the passage of time between the events taking place and the date of the inquiry.

[105] There was no dispute over the cause of Mrs. Thompson's death. I have no hestitation in accepting the evidence of Professor Kernbach-Wighton and Dr. Cameron. Their evidence was that Mrs. Thompson was in a very parlous state of health. She had severe underlying ischaemic heart disease, and an acute event, namely a heart attack, appears to have caused death within a few minutes by causing pulmonary oedema. Her condition was such that she might have collapsed and died at any time. Her chances of survival would not have increased if the sudden event causing her death had taken place in hospital rather than at home. In any event, the health, social care and ambulance services contacted about Mrs. Thompson on 5 August 2007 were not dealing with the situation which brought about her rapid death. They had become involved because concerns about her ability to look after herself at home had been communicated to them. The only information the services had related to her comfort and care needs rather than any medical emergency. I am therefore satisfied that there were no reasonable precautions which might have been

taken by the agencies concerned which might have prevented Mrs. Thompson's death. I am also satisfied that there were no defects in any system of working which contributed to her death. So far as the relevant agencies are concerned, my specific comments are as follows:

Scottish Ambulance Service issues

[106] SAS maintain an ambulance fleet which provides cover throughout the Borders. Ambulances are stationed at standby points to enable them to respond as rapidly as possible to emergency calls from any particular area. Calls are responded to according to priority. If an ambulance is called to a routine job, or even an urgent one, that ambulance may be diverted by the Control Room if required to cover an emergency call elsewhere. This is obviously entirely appropriate and one would expect nothing else.

[107] Urgent calls to the ambulance service are usually initiated by a doctor, who decides the appropriate acuity level. In this case, Dr. Young decided that the ambulance call to attend to Mrs. Thompson should be acuity level 2, which envisages arrival within 4 hours. SAS had no input into this decision.

[108] SAS logged the reason for the call as a patient transfer; the patient being "off her legs". This term is also found in the NHS 24 Event Log report (production 24). There was some evidence about what this expression meant, but it is not clear in relation to this call who first used the expression. In any event, that was the information made available to SAS, and it is obvious that they can only act on the basis of information they are given. I accept Dr. Young's evidence that the expression "off her legs" could describe a number of different presentations of general debilitation, and would typically apply to an elderly person who was unable to self-care or mobilise. This would signify a transport issue, rather than a medical emergency such as would involve paramedic treatment en route.

[109] The Inquiry heard detailed evidence about the response by SAS to the call, and the reasons why there was a gap of 5 hours or so between the initial request for an ambulance at 15.20 and its arrival at 20.23. Outstanding calls are monitored. The evidence shows a procedure in place for constantly reviewing

their status. Computer print outs of the case history record the dispatcher regularly checking to see if an ambulance could be made available for the call without depleting emergency cover elsewhere. I accept Karen Brogan's evidence that the service was busy that afternoon and evening, and resources were at a premium. An ambulance was despatched at 15.39, and another one at 18.07, but these were both diverted en route by the need to answer higher priority calls. I accept that this was reasonable and necessary to enable SAS to fulfil it's responsibilities elsewhere.

[110] The ambulance service protocol requires that they alert the instructing authority if the ambulance will be unable to attend within the requested time. This gives an opportunity for the acuity level to be reviewed, and upgraded if there has been a change of circumstances. Although SAS did not in fact call back, there were inward calls enquiring as to the position. At 19.11 BECS telephoned, and NHS 24 did at 19.46. I accept the evidence of Dr. Cameron and Mairi Jamieson that the call from BECS at 19.11 was within the 4 hour timeframe, and would serve the same purpose as any call made by SAS. There was no reason for the acuity level to upgraded at that stage because there was no information to change the position.

NHS 24 issues

[111] I have carefully considered the evidence and submissions in relation to the call handling protocols and action taken by NHS 24 in response to this call. C.S.'s first call at 11.39 was placed in a queue for call back within 3 hours. The information imparted to NHS 24 was that Mrs. Thompson was soiling and wetting herself and was not getting up from the couch. They were aware that she had had her toes amputated. In my view the routing tool protocol was followed, and a call-back time of 3 hours was appropriate having regard to the evidence of Dr. Alexander. I am satisfied that there were systems in place to pick up any indications that the call was more serious and merited an urgent or emergency response, and to process it appropriately once that that had been ascertained. However, I accept the submission that there was no indication given to NHS 24 that there was any urgent or life threatening situation in this

case. The call was placed in a queue by an experienced team leader, and the prioritisation was checked by a queue safety manager.

[112] When Tom McCaskie telephoned NHS 24 on the first occasion, at 13.17, this was within the 3 hour response time for C.S.'s call. The information from him did not give rise to any concerns which ought to have upgraded the priority assessment because the position had not changed since the original call. When he phoned back at 13.56, the position had changed, because by that time Mrs. Thompson was on the floor. That call set in motion the recommendation for a home visit within 4 hours. After consultation with a manager, that recommendation was electronically passed to BECS at 14.20.

[113] NHS 24 are reliant on the information they are given by telephone. A health professional seeing a patient in person would have a clear advantage. When Nurse Whiteford visited Mrs. Thompson, her face-to-face assessment supported the NHS 24 triage decision. For these reasons, I am satisfied that there was no information available to NHS 24 which justified upgrading the urgency of the call and arranging an ambulance at an earlier stage.

[114] Neither does the evidence show that it would have been a reasonable precaution which might have avoided the death for NHS 24 to have arranged a home visit after C.S.'s call at 11.39. 4 hours is a standard timescale for a district nurse referral. The outcome would not have been any different had the "advise and refer" protocol been in place at that time.

[115] When C.S. and Tom McCaskie phoned NHS 24, they were both advised that they should phone back if there was any change in the condition of the patient. Although C.S. stated that she did not understand this, I accept from the tape of the call that there was nothing to suggest that to the NHS 24 staff. I do not consider that it can be said to be a defect in the system that steps were not taken to check the caller's understanding. It is difficult to see what further steps they could have reasonably taken. This did not contribute to the death.

[116] The Procurator Fiscal Depute invited me to consider whether recent hospitalisation of a patient should be a flag for more urgent prioritisation of a call. Dr. Alexander reviewed the handling of the calls by NHS 24. His

evidence was that hospitalisation was at the time a potential marker and would be taken into account in prioritising a call. He pointed out that Mrs. Thompson's discharge was after a period of rehabilitation. C.S. mentioned this in her first call, and Tom McCaskie did so in his second call. However, the concern at that time was that she was not coping as well as before she went into hospital. The issues focused on her mobility and inability to care for herself. Dr. Alexander's conclusion was that flagging up hospitalisation for special consideration in this case would not have changed the original prioritisation given to the call.

Borders Health Board issues

[117] Mrs. Coull founded strongly on Dr. Cameron's evidence as Medical Director of BHB. He had asked for a review to be carried out into the circumstances of this case, and the involvement of BHB employees, Dr. Young, Nurse Whiteford and Nurse McBride. His conclusion was that BHB staff had acted promptly and appropriately throughout. In my view, having regard to Dr. Cameron's evidence, it was entirely appropriate for Dr. Young to ask Nurse Whiteford to carry out the initial visit to the patient. This is part of the job of the District Nurse, and I note that she was a very experienced nurse. An ambulance could take between 2 and 4 hours to attend, and the District Nurse would have other calls to make. I accept that, having made her patient comfortable and reported back to Dr. Young, it would not have been reasonable to expect Nurse Whiteford to remain with her until the arrival of the ambulance.

[118] The evidence shows that Mrs. Thompson was discharged from Galavale Hospital at an appropriate time, her wounds having healed well, and she was anxious to return home. I am satisfied that BECS, Dr. Young and Nurse Whiteford dealt with the events of 5 August 2007 timeously and appropriately. In particular, within an hour of the referral from NHS 24, Dr. Young had sent Nurse Whiteford to investigate, and on receiving her report had requested an ambulance with an appropriate priority of 4 hours.

[119] In relation to communications between Dr. Young and Nurse Whiteford, the Procurator Fiscal Depute invited me to consider whether there was a misunderstanding between them, and whether communications issues required to be addressed. According to my notes of Nurse Whiteford's evidence in chief, she thought Dr. Young had said to her that the ambulance would be there within the hour, and she was happy with that. She was not advised it could be later. If she had been told it could have been as long as 4 hours, she would have gone back to see her and recommended an ambulance sooner, because she would have needed the toilet and food within 4 hours. In response to cross-examination by Mrs. Coull, she stated that she thought Dr. Young had said the ambulance would attend within 1 hour, but agreed that it is possible that time limits were not mentioned. She explained that the ambulance would usually be there within the hour, and accepted it was possible that her general understanding in this regard had informed her recollection of what had actually been said. However it arose, there did appear to be an element of misunderstanding between Dr. Young and Nurse Whiteford, although this is not relevant to whether or not the death could have been avoided.

[120] As part of a routine review of systems after Mrs. Thompson's death, Dr. Cameron recommended the introduction of a new communications tool to regulate telephone communications between team members. This was introduced in May 2008. It is known as "Situation, Background, Assessment Response" (SBAR). SBAR is a structural model for a phone call, which is designed to achieve clarity of understanding between parties as to what problem is being reported, what options have been considered and what response has been agreed. "Situation" calls for a concise statement of the problem, including name and role of caller, location and time of call. "Background" refers to the caller giving information about whom the call is being made, and the background is discussed. "Assessment" is a consideration of the options, when the condition of the patient is looked at in more detail. "Response" is the course of action which is agreed between the parties to the call. This will clearly reflect what action has been asked for and agreed to. All of these matters will be timed and documented. This is a commendable

introduction, and it seems to me that it will reduce the scope for any potential misunderstandings in future.

[121] For the reasons I have referred to earlier, I am satisfied that, as far as BHB and its employees are concerned, there were no reasonable precautions whereby the death might have been avoided. Nor were there any defects in any system of working which contributed to the death.

Other issues - Adequacy of Home Care Plan

[122] While the outcome for Rosemary Thompson may not have been altered, the evidence did raise the issue of the adequacy of home care arrangements after Mrs. Thompson's discharge from hospital. There appeared to be reliance placed on the ability of C.S. to respond appropriately in the event of an emergency. Counsel submitted that this reliance may have been misplaced, and I agree.

[123] Arthur Cross thought that C.S. was capable of making a phone call if required, but he was not her support worker and couldn't speak from direct knowledge.

[124] Chris Yapp gave evidence regarding the welfare guardianship order. This was applied for because neither C.S. or Rosemary Thompson appearing capable of making decisions regarding their own contact with I.S., C.S.'s son. Although they would sometimes be able to pick up the 'phone to an external agency, they would find it difficult to do so on a regular basis. In response to a question regarding whether he found it surprising that C.S. should leave it such a long time before contacting someone to help Rosemary, he responded that C.S. finds it difficult to deal with stressful situations. In case of emergency he considered that a Border Care Alarm would be used. This is an alarm system that operates through a pendant worn by occupiers or a red button on the telephone. It provides a direct "24/7" line to a social work employee at the press of a button. Mr Yapp was "fairly confident" that the bungalow was equipped with such an alarm. He assumed that C.S. had basic knowledge of how the alarm worked. He did not carry out a specific assessment for whether C.S. would be capable of coping with an emergency.

[125] Elaine Torrance gave evidence that she considered that the home care provisions which had been put in place were adequate. She referred to the situation being monitored, but could not explain how the situation would be monitored over the weekend, other than by reference to the Border Care Alarm and a list of telephone numbers provided to the two ladies. She acknowledged that, if this was part of the care package, it would be important to know if the alarm system was there and if the occupants knew how it worked. She was not aware whether it was in the flat nor whether the occupants could use the alarm.

[126] Tom McCaskie stated that C.S. appeared very vague when he attended Rosemary Thompson. She appeared confused. It was difficult to understand what she was communicating. She was obviously very concerned and quite stressed about the situation, but seemed detached. He relayed to C.S. that if there were any concerns she was to call back to NHS 24. As she had phoned NHS 24 previously, he was confident that she could do so again if need be.

[127] Nurse Whiteford spoke about meeting C.S. on entering the house, at which time she assessed her as perhaps suffering from some mental health problems. She appeared a little agitated. She was chain-smoking and uncommunicative. She was not willing to engage in conversation and only answered the questions put to her by the district nurse. She gave very monosyllabic answers.

[128] The paramedics formed the impression that the housemate, C.S., didn't understand the severity of the situation. In light of it being a sudden death, they attempted to get as much information as they could from her, but she appeared detached and not comprehending the situation. She couldn't really articulate what had happened, and seemed bewildered. She did not appear to have realised that Mrs. Thompson was dead.

[129] C.S. herself described Rosemary Thompson as lying on the sofa, unable to get up to go to the toilet from Friday, after Arthur Cross had left. If that is correct, Mrs. Thompson must have spent Friday afternoon, Friday evening, overnight on Friday, all day Saturday, overnight on Saturday, and most of Sunday morning - potentially up to 48 hours - sitting in her own waste without moving. Although her evidence of timings is suspect, in my view the degree of

soiling and the large amount of impacted faeces in her undergarments support the view that she was in that position for a significant period of time. C.S. stated that she only 'phoned for help at Rosemary Thompson's suggestion. She had taken no initiative herself. She forgot to tell Tom McCaskie about the existence of the wheelchair until after Rosemary Thompson had fallen on the floor. She doesn't appear to have given her any assistance by way of a drink of water prior to the district nurse attending. Finally, she witnessed what appear to have been the death throes of her flatmate and it didn't occur to her to dial 999 or seek help in any way.

[130] From all of this evidence, I agree with counsel that C.S.'s abilities fell short of being able to cope with an emergency situation. That is, by admission, something which the Social Work Department had not assessed or factored into their plans. The result was that there was a gap over the weekend when no arrangements were in place to monitor how Rosemary Thompson was coping. Chris Yapp was not sure whether the Border Care Alarm was in the flat, or whether either of the ladies knew how to use it. Therefore it clearly did not form part of any planned home care package.

[131] Whilst any additional safeguards incorporated into the home care plan would not, on the evidence, have avoided Rosemary Thompson's death, I consider that there is weight in counsel's submission that they may have allowed her a little more dignity and comfort in her last days. This is because help would have been forthcoming earlier. Although not in any way causally linked to Mrs. Thompson's death, these facts are an appropriate matter for comment in respect that they are relevant to the circumstances of that death.

Concluding Remarks

[132] My responsibility is to make a determination on this matter pursuant to section 6 of the 1976 Act, which I have done. It is not the function of an Inquiry to make any findings of fault or to apportion blame. Questions of what might or might not have been reasonably foreseeable are for consideration elsewhere and are not appropriate to this forum. The statutory provisions are

widely drawn and are intended to permit retrospective consideration of matters with the benefit of hindsight. Although causation has a role in determining what findings can be made under section 6 (1)(c) or (d), section 6(1)(e) permits consideration of any other facts which are relevant to the circumstances of the death, even though a causal link has not been established.

[133] This was a death which was inevitable given Mrs. Thompson's underlying state of health. Although there was a lengthy delay between the initial calls and the eventual arrival of the ambulance, the delay has been explained. In any event, earlier home visits or earlier hospitalisation would not have avoided the death. A full examination of the systems of work of the agencies involved has shown no defect which contributed to the death. However it is unfortunate that Mrs. Thompson was left over her final weekend in a soiled and undignified state, without the intervention of any planned outside help, and with only her housemate for support. Despite C.S.'s undoubted best intentions, and perhaps with the benefit of hindsight, she was unable to properly look after Mrs. Thompson, or reliably recognise and appropriately respond to her needs in her last days and hours.

[134] I wish to express my thanks to the Procurator Fiscal Depute, and to counsel and agents appearing at the Inquiry for their assistance in taking the evidence, and for their clear, careful and helpful submissions.

Sheriff Peter G. L. Hammond