INQUIRY UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 INTO THE SUDDEN DEATH OF RODERICK McINTOSH DONNET

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY

(SCOTLAND) ACT, 1976.

Fatal Accident Inquiry into the death of Roderick McIntosh Donnet, born 15th. September, 1952.

For the Crown : Miss Nadia Stewart, PFD, Dundee

For the Deceased's Family : Mr. R.G. Milligan, Advocate: Messrs Balfour & Manson, Solicitors, Edinburgh.

For Tayside NHS Trust : Mr. M.J. Fitzpatrick, Advocate: Central Legal Office of the

Scottish Health Service.

Dundee, 4th. July, 2007.

The sheriff, having resumed consideration of the evidence adduced and the submissions made in relation to the death of the late Roderick McIntosh Donnet, makes the following determination in terms of Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act, 1976, *videlicet:-*

1. In respect of Section 6(1)(a) of the Act, Roderick McIntosh Donnet (hereinafter referred to as "Roddy") died at Maryfield House, Mains Loan, Dundee DD4 7AA, on 29th. May, 2003 at 06.10.

2. In respect of Section 6(1)(b) of the Act, the immediate cause of death was broncho-pneumonia. The broncho-pneumonia occurred substantially as a result of the presence of a severe untreated outbreak of ulcerative colitis.

3. Under section 6(1)(c), reasonable precautions which might have avoided his

death would have been:-

(a) if his general practitioners had responded to the letter from Ninewells Hospital reporting Roddy's failure to attend at an inflammatory bowel disease out-patient review clinic in 1999, when they knew of his mother's death, that he was a chronic sufferer from ulcerative colitis and that he was resident in a local authority residential care home, and re-established a pattern of regular out-patient review of him by gastro-enterologists which would have had the result that he was known to the

service and his difficulties might have been better understood by those at Ninewells providing that service when he did require to be admitted on 16th. April, 2003;

(b) if his general practitioners had recognised the need

(i) to inform his relatives about the onset of dementia;

(ii) to determine formally whether he had the capacity to consent to treatment; and

(iii) in the likely event of it being determined that he had no such capacity, by advising his relatives of the prudence of appointing a welfare guardian to be responsible for decisions pertaining to his welfare and medical care.

(c) if Dr. Quinn of the Learning Disability Service had recognised the same needs as are set out in (b)

(d) if proper and urgent consideration had been given following Roddy's discharge from Ninewells Hospital on 17th. April, 2003, by Dundee City Council Social Work Department, by the gastro-enterologists, Drs. Hill and Barron who discharged him from Ninewells or by his general practitioners to his admission to a nursing home;

(e) if active and effective steps had been taken to persuade, failing which, compel Roddy to return to hospital as an in-patient either on 20th. April by Dr Ward of D.D.O.C. or 15th. May by Dr. Hollins for treatment for ulcerative colitis invoking, if necessary, section 24 of the Mental Health (Scotland) Act, 1984, then the likelihood is that with the intravenous treatments available in hopsital, the outcome would not have been death from ulcerative colitis;

(f) if Drs. Hill and Barron had (a) paid proper attention to the terms of the admissions referral from Dr. Badenhorst and given proper consideration to the management problems of Roddy in the community, especially getting him to take medication on a consistent basis, (b) had informed the general practitioners of the availability of mesalamine in soluble granule form and (c) arranged early out-patient follow up, as opposed to returning him to the community on the same medication as they had been told he was not co-operating with taking, then the prognosis would have been significantly better;

(g) it being appreciated by officers of Dundee City Council Social Work Department that, both as a matter of law and a matter of need, the appointment of a welfare guardian, who would have been a central repository of the necessary range of knowledge to take proper account of all of Roddy's welfare and health care needs, with power to take decisions for him to consent or refuse consent to medical treatment and who, being fully informed about the various conditions, would have had the information necessary to take proper informed decisions about treatment, which would have been likely to lead to a more positive outcome in relation to treatment for ulcerative colitis, than Roddy dying in extreme pain because of misunderstanding about both the facts and the law which got in the way of the continuation of effective treatment, was required;

(h) if section 47(4) of the Adults With Incapacity (Scotland) Act, 2000 was amended, in relation to the definition of "medical treatment," so as to provide that, included in that definition was, "any reasonable period of assessment required to ascertain whether a person is suffering from a mental or physical health disorder, including all investigative processes reasonable necessary and appropriate to any such assessment process;" and also to include, "such process or processes as may be reasonably necessary to enforce the patient's attendance at hospital or other place of treatment as may be justified in the circumstances."

4 In terms of Section 6(1)(d), there were the following failures in the systems of working that may have contributed to Roddy's death, namely:-

(a) The lack of proper training in the operation of the CentralVision computer system with particular regard to the retrieval of results posted thereon by the various laboratories at Ninewells being given to all doctors in post at Ninewells Hospital, but in particular Dr. Jane Wallace, prior to such doctors being ascribed an access code to the system; in particular, that training should have emphasised the importance of checking that the entry sought actually related, in terms of the date and the person submitting the request for a result, to that date and person and should have ensured that the critcical importance of submitting the correct patient identification number (the CHI number) had been fully understood and appreciated;

(b) The failure of the management of Ninewells Hospital to respond effectively to requests from Dr. Jones to make a sufficient number of beds available to accommodate the average daily intake of Ward 15, the acute medical admissions ward, so that patients arriving for admission would not require to suffer the indignity of being left on a trolley in a corridor for hours before properly being admitted;

(c) The failure of the management of Dundee City Council Social Work Department to appreciate the need for a system whereby residents in residential homes were accompanied on admission to hospital for in or out-patient treatment or assessment either by a relative or a carer and that in either event, to asssist with the presentation of a proper history for the patient, the care home notes should have accompanied the resident; and that no patient should be discharged from being an in-patient in hospital unless a relative or carer is present to accompany the resident back to the residential care home, where the particular resident's incapacity is of such a degree, as was Roddy's, that the resident would not have the capacity to consent to the medical treatment in contemplation;

(d) The failure on the part of Dr. Jones in particular, and the management of Ninewells Hospital, more generally, to appreciate the need to eliminate human error so far as possible, in persisting in instructing or permitting the manual transposition of blood test results from the CentralVision computerised records system to the patient's file, when a screen and printer were available to facilitate a print out of the results; and a failure by Drs. Jones, Barron and Hill, and the management of Ninewells Hospital generally, to appreciate and to train doctors to appreciate the value of using the computer system available to consider comparative results rather than the single latest results when considering blood test results, so that trends and changes could be observed and used as an aid to diagnosis;

(e) The failure on the part of Drs. Hill and Barron to complete and transmit to the general practitioners and the care home manager a proper and informative discharge note explaining the proper basis for Roddy's discharge on 17th. April, 2003, the investigations undertaken and the treatment given, the diagnosis, the prognosis, details of any planned further in or out patient treatment or review at the hospital and advice on treatment, medication or checking for symptoms which the general practitioners should carry out.

(f) The failure of the management of Ninewells Hospital to have in place a reasonable system for the preparation and issue of discharge letters; whether a discharge letter is actually necessary if an effective discharge note is properly communicated to the general practitioner is debatable, but if it is then arrangements must be established so that the letter is in the hands of the general practitioner no later than seven days from the date of discharge, and must be prepared by a member of the medical staff who was actually involved in the treatment of the patient;

(g) The failure by Dundee City Council Social Work Department in the preparation of care plans for residents of residential care homes to include in all cases a formal assessment of the resident's capacity to consent to (a) residing in a residential care home and (b) medical treatment, and to take appropriate action to promote the provision of a welfare guardian to all residents lacking either of these capacities;

(h) The failure of Dundee City Council Social Work Department to recognise as a matter of law that where a person does not have the capacity to consent to residing in a residential care or nursing home that in the absence of consent from a welfare attorney or welfare guardian with appropriate powers to sanction residence in such an establishment, or an order from a court sanctioning residence in such an establishment, that the detention of such a person in such a setting constitutes a breach of Art. 5(1) and (4) of the European Convention on Human Rights in the absence of any legal basis for the detention there of an incapacitated person and the absence of any legal process by which such detention can be regulated, reviewed and terminated and that, accordingly, there is a need to secure the appointment of a welfare guardian to such a person.

5. In terms of Section 6(1)(e), the following facts are relevant to the circumstances of the death, namely:-

(a) the unacceptable circumstances in which Roddy was kept on a trolley in a corridor near Ward 15 following admission, and the disinclination of nursing staff to render assistance to him, his carer or his sister when they complained about the situation, exacerbating a situation in which Roddy was already anxious and disturbed about where he was and what was happening to him, adding to his unwillingness to co-operate with staff;

(b) the failure of nursing staff to enlist the aid of and obtain information from Roddy's relatives for the purpose of assisting in his comfort and reassurance all with a view to enhancing the prospects of a satisfactory outcome to his admission;

(c) had Roddy been prepared to tolerate a flexible sigmoidoscopy while in hospital, under sedation if necessary, there would have been a definitive determination of whether he was suffering from an outbreak of ulcerative colitis;

(d) that with an acute outbreak of ulcerative colitis the classic symptom is a significant increase in the number of stools, usually in the form of diarrhoea, commonly with the passage of fresh blood, but in Roddy's case, he only passed one stool during the twenty four hour period of his admission;

(e) that death from ulcerative colitis, as opposed to one of its complications, is almost unheard of on account of the availability of various forms of medical and surgical intervention and there is therefore a likelihood that had medical intervention continued when it should have, the outcome would have been successful;

(f) that Ms. Mackie, the manager of Maryfield House, took decisions no doubt in good faith about Roddy's health treatment on her view that he was suffering from a terminal illness when she should instead have been encouraging his relatives to discuss the options with the general medical practitioners so that they could have taken an informed decision about whether or not treatment should continue;

(g) that Dr. Anderson from D.D.O.C. on being advised by Ms. Mackie that Roddy had been diagnosed as terminally ill a week previously did not check either with a next of kin or with one of Roddy's general practitioners prior to determining whether to abandon active treatment and confine treatment to palliative pain relief, albeit the dosage of morphine which she initiated did not of itself enhance the onset of death;

(h) that both the law and practice are in an unacceptable state of doubt as to whether a social care assistant has the authority to administer medication to a residential care home resident with incapacity; that Dundee City Council take the view that social care officers are neither trained nor authorised under the Adults With Incapacity (Scotland) Act, 2000 to administer medication and they have no responsibility if an incapacitated resident declines to take medication; that this is not clear to medical practitioners or district nursing staff who in terms of Section 47 of said Act may be so authorised, but do not regard it as part of their function; and that there is therefore potentially a serious gap in provisions for adults with incapacity resident in residential care homes over the effective process of the administration of medication;

(i) that hospitals in Edinburgh have appointed a liaison nurse in learning disability to be present for use in general hospitals to assist nursing staff there in dealing with incapacitated patients with physical ailments and that it may be worth introducing a similar scheme at Ninewells Hospital;

(j) that when dealing with incapacitated patients with ailments in the community, general practitioners should be able to obtain advice and assistance from hospital based doctors by telephone or other form of electronic communication or by domiciliary visit particularly where the latter would permit consideration of the merit of treatment and the likelihood of the patient being able to tolerate and comply with the treatment;

(k) that CentralVision does not appear to flag up when results are outstanding;

(l) that shortages of beds causes inappropriate pressure on hospital based doctors that may lead them to discharge patients who are not acutely ill but would nonetheless benefit, as Roddy would have, from a longer period of assessment and treatment in a hospital setting;

(m) that there is currently no system in Dundee for regular review of the mental and physical health of all adult Down's Syndrome sufferers notwithstanding the range of physical illnesses known to be associated with Down's syndrome; and

(n) that the process of applying for the appointment of a welfare guardian is unnecessarily expensive and cumbersome.

NOTE

Introduction:

[1] It is a matter of considerable regret on my part that more than four years have now elapsed since Roddy's death and his family are only now receiving this Determination and Note. The principal agency to blame for this state of affairs is the Crown who appear consistently not to give appropriate priority to investigating, preparing and conducting inquiries of this nature. I regret I feel obliged to say that the experience in this court at least has been such that it is legitimate to pose the question for the consideration of the new Scottish Parliament whether, given their apparent lack of interest in the conduct of inquiries of this nature, responsibility for the conduct of an Inquiry should remain with the Crown as opposed to some alternative agency dedicated to the investigation of sudden deaths where these have not patently been the result of the commission of a crime. Logically, such a separation would be wrong as it has historically for sound and proper reasons been the responsibility of the Crown to investigate all sudden deaths, but unless they are prepared to devote more resources to the preparation for and conduct of Fatal Accident Inquiries, perhaps by the establishment of a national specialised unit to do so, or the use on an *ad hoc* basis of advocates of the quality and experience of Mr. Milligan and Mr. Fitzpatrick for their conduct, then it is hard to see how the present unacceptable situation can change and responsibility for the conduct of inquiries would have to be transferred to a different agency. Mr. Milligan in his submissions starkly but correctly made the point that this Inquiry was bedevilled by the fact that the Crown failed properly to assess its importance, and failed to make a reasonable assessment of its anticpated length, compounding the delay in its commencement. As he properly observes, a number of important witnesses had understandably poor recollection of the cirucmstances thus reducing the utility of the whole exercise.

[2] In this particular Inquiry, I heard evidence commencing on 12th. September, 2005 and thereafter on 13th., 14th., 15th. and 16th. September, 2005, the Crown having asked the court administration to set aside one week for the conduct of this Inquiry. It should have been patently obvious that one week was never going to suffice. It did not help progress that the Inquiry had not properly been intimated to all interested parties in accordance with the provisions of the Procurator Fiscal Service's Book of Regulations so that NHS Tayside, for example, were not aware of its

commencement and were obliged to persuade me after this first week of evidence that they should be allowed to enter the process. Dundee City Council never did enter the process though in my opinion they ought to have. In fairness to the Crown, I am bound to express surprise that neither the health service at local level nor the local authority appeared to have a system to make themselves aware of newspaper intimation of Fatal Accident Inquiries nor did the local authority appear to have any appreciation of the potential significance for them of this one. One of my concerns in relation to aspect of the Inquiry which may have a profound effect on their operations was that there was no contradictor. However, in terms of the legislation, intimation was properly given and their failure to be represented is their problem. Following the intial week of evidence, it was not then possible to resume hearing evidence until 20th. March, 2006 and I then heard evidence on 21st., 22nd., 23rd and 24th. March. Once again that proved insufficient time to hear all the evidence relevant to the Inquiry. Evidence was next heard on the 26th. and 27th. June, 2006 and then on 1st. August, 2006. In addition to the oral evidence, a report apparently written and signed by Dr. Jason Hill, now of Waikato Hospital, Hamilton, New Zealand, dated 28th. February, 2006, was allowed to be lodged as a production for Tayside NHS Trust, and the Crown at the outset of the Inquiry had lodged a large number of productions, including medical records for Roddy, extending to some 691 pages. It should have been evident to the Crown that this was an Inquiry of some general importance. That responsibility for its conduct should have been delegated to a relatively inexperienced depute indicates either or both a lack of appreciation of or interest in the conduct of such an inquiry and/or a lack of adequately experienced deputes in the office of the Procurator Fiscal Service, in Dundee. As Mr. Milligan again correctly observes, nor did it help when one of the most important witness, David McCaw, a senior employee of Dundee City Council Social Work Department, produced in the course of his giving evidence, a series of lengthy and potentially significant documents which had to be hurriedly absorbed. This is not a criticism of Mr. McCaw, but of the local authority for failing to appreciate the importance of the Inquiry and the contribution which they could have made to it.

[3] In the course of the Inquiry, I heard evidence from Edith Donnet, Roddy's sister, James Donnet, Roddy's brother, Melanie Taylor, an employee of the Scottish Ambulance Service, Stewart Clark, also from the Scottish Ambulance Service, Dr. Abigail Patterson, a general medical practitioner, Dr. Thomas Pullar, a Consultant Physician at Ninewells Hospital, Dundee, Dr. Beren Hollins, a general medical practitioner, Dr. Kate Quinn, an associate specialist in learning disability at Strathmartine Hospital, Dundee, Dr. John Starr, a Consultant Physician at the Royal Victoria Hospital, Edinburgh, Dr. David Clarke, Consultant Physician, Stirling Royal Infirmary, Dr. Margherita Badenhorst, general medical practitioner, Thomas Campbell, care manager, Dundee City Council Social Work Department, Jacqueline Mackie, retired care home manager, Dundee City Council Social Work Department, Dr. Paul Rafferty, Consultant Physician, Dumfries & Galloway Royal Infirmary, Dr. David Sadler, Consultant Pathologist, University of Dundee, Dr. Michael Jones, Consultant Physician, Ninewells Hospital, Dundee, Euan Donnachie, Scottish Ambulance Service, P.C. Andrew McNutt, Tayside Police, Det Cons. Marcus Lorente, Tayside Police, Dr. Morag Barron, medical practitioner, York Hospital, Gordon Watt, Service Manager, Dundee City Council Social Work Department, David McCaw, Senior Social Worker, Dundee City Council Social Work Department, Diane Carter, Laboratory IT Systems Manager, Ninewells Hospital, Dundee and Dr.

Katharine Morrison, general medical practitioner, Mauchline, Ayrshire. I was particularly impressed by Dr. Pullar, Dr. Starr, Dr. Clarke, Dr. Jones, David McCaw and Diane Carter. The evidence of Dr. Patterson, Constable McNutt and Det. Cons. Lorente was largely formal and largely uncontroversial. I have reservations and concerns to varying degrees about the evidence of James Donnet, Dr. Beren Hollins, Dr. Kate Quinn, Dr. Margherita Badenhorst, Thomas Campbell, Jacqueline Mackie, Dr. Paul Rafferty, Dr. Morag Barron and Dr. Katharine Morrison, as I shall explain.

[4] Having heard all that evidence over a total of thirteen days, separated by nine months from beginning to end, it was not until 31st. October, 2006 that I was able to hear final submissions in both written and oral form and I regret that, on account of the other business of this court, and despite the best efforts of the sheriff clerk to make time available to deal with the preparation of this Determination and Note, it has taken me until now to be in a position finally to issue this. Unfortunately, I find that, despite all of the foregoing, there are a number of significant questions in my opinion pertinent to the circumstances of Roddy's death, to which I do not have any answers. This is, at least in part, on account of the Crown's failure to lead any evidence from Dr. Jaqueline Wallace, who, on the evidence I have heard, must be held to have made two critical administrative errors relating to blood test results. Had these errors not been made either Roddy would not have been discharged when he was or should have been the subject of more urgent out-patient follow-up than he was. Nor did the Crown lead evidence from a Dr. Anderson from D-DOC who, at the material time, were providing the out of hours GP service for Dundee, who was called to see Roddy on 22nd. May at Maryfield House and decided to initiate a syringe driver (a morphine pump), the doctor having recorded in his note that he had been told that Roddy had been diagnosed as terminally ill one week earlier when there is no evidence of any such diagnosis. Nor was there any exploration why Roddy, having suffered in about 1997 from ulcerative colitis, was not, as is the usual practice, subject to regular review thereafter. Nor was evidence led from Dr. Gardiner, one of the GPs at Roddy's practice, who saw him after his discharge from Ninewells to ascertain whether he may have been misled by the discharge note, if he saw one, from Ninewells in relation to the diagnosis and treatment of Roddy by him. Nor were witnesses being asked whether recommendations made by my former colleague, Sheriff Ian Dunbar, in the Fatal Accident Inquiry into the death of James Mauchland, some of the aspects of which bore a worrying resemblance to the present case, had been implemented. Nor was evidence led from Dr. Wood of D-DOC about her efforts to persuade Roddy to allow himself to be re-admitted to hospital. Nor was a full report commissioned from the forensic pathologist whose report appears to have been based to a degree on imprecise information from Tayside Police. Nor was there any evidence from any of the nursing staff responsible for Roddy's care or lack of it during his brief admission to Ninewells or in relation to his care in the community.

[5] In the James Mauchland Fatal Accident Inquiry, Sheriff Dunbar expressed concern about the way in which that Inquiry had been conducted, expressing particular anxiety about the length of time between the start and conclusion of the Inquiry and he also asked the question whether there should have been an Inquiry at all. He expressed reservations about the suitability of the provisions of the 1976 Act as a vehicle for the conduct of an inquiry into a death arising out of medical issues. He was concerned that that Inquiry had suffered from a lack of focus and raised the

question whether issues should have been identified prior to the commencement of evidence. He was also concerned about the lack of representation of professionals who might be the subject of criticism, whether justified or not, at such an Inquiry. He expressed the view that there should in all such Inquiries be what he described as a "management meeting" prior to the commencement of evidence so that proper evaluation could be given to the time allocated to the Inquiry and whether proper intimation had been made to all who might be the subject of criticism. All these observations, regrettably, appear to have been ignored in connection with the present Inquiry. While I understand his reservations about the provisions of the legislation and its propriety for a medical case where the concept of "accident" is not particularly apt and where expressions such as "reasonable precautions" and "defects in any system of working" present their own difficulties of interpretation, with the benefit of hindsight I can say that this Inquiry is one which required to take place and that the system under the 1976 Act is better than none at all, but it may be that a separate system with somewhat different rules and aims may be appropriate for medical cases in the future. Otherwise, I would associate myself with Sheriff Dunbar's concerns about the conduct of these Inquiries generally and add my concern that the Crown appear impervious to criticism as to how they are conducted.

The Circumstances relevant to Roddy's death:

[6] Roddy was born on 15th. September, 1952 suffering from Down's Syndrome which is a congenital disorder. Despite that, until the six month period prior to his death, he led a full and active life. His mother devoted her attention to his care and upbringing until she was in her 80s and suffering from poor health with sadly led to her death shortly after Roddy had been admitted to Maryfield House, Mains Loan, Dundee. He had been in there for respite care prior to his mother's death and, as I understood the evidence, had, in fact, been admitted on a permanent basis prior to her death, his date of admission being 2nd. November, 1998. He had a sister, Edith, who was older than him and a younger brother, James, both of whom resided in Dundee, and both of whom he saw on a regular basis.

[7] Roddy had a long history of complications with his health and with some behavioural difficulties with unrealistic aspirations. Dr. Kate Quinn initially raised the subject of his being admitted to residential care in about 1990 but it appear Roddy's mother was unenthusiastic about that at that time. So far as concerns his mental health, the general practitioner file discloses regular assessments by Dr. Quinn over many years with her making considerable efforts to ensure appropriate arrangements were made for his accommodation and daily activity. As early as 1993, he was enrolled in a "Down's Syndrome/Dementia Research Study" and as early as May, 1993, there were indications of dementia developing but no definite signs of Alzheimers Disease were found on neurological examination. There was also a question raised at that time about Roddy's visual acuity. He also appears to have had long term difficulties with his digestive tract. In May, 1996, he had a mild attack of a pneumococcal type viral disorder which responded to antibiotics. From about the same time there were increasing indications of liver malfunction. Biochemical tests revealed that he had a raised alkaline phosphate level for which there was no apparent explanation. His mother told Dr. Quinn in 1996 that he appeared to be becoming more forgetful and confused and Dr. Quinn arranged further assessment at that time including a CT scan. The scan was normal. In early

1997, he was the subject of investigation into what appeared to be an obstruction of his gastro-intestinal tract. It was in October, 1997 that he underwent a flexible sigmoidoscopy. He was diagnosed as then suffering from ulcerative colitis and probable scelerosing cholangitis. The recommendation at that point from Ninewells was that Roddy should be prescribed Asacol tablets 800mg 3 x a day plus Asacol foam enemas. He was reviewed in March, 1998 when it was reported and noted that he was unwilling to take Asacol tablets and very reluctant to consider treatment by way of enemas, but appeared to be in good health despite passing 3 or 4 bowel movements daily. He did not attend for review in 1999, by which time his mother would have died, and it is not obvious that his general practice did anything in response to being notified of his non-attendance. By that date, Roddy was a permanent resident at Maryfield House but it is not apparent that anyone told Ninewells about that. He was seen by Dr. Quinn at Maryfield in about June, 1999, who reported that he was described as being more confused, unable to focus and unable to respond to questions. There appeared to be a degree of paranoia and at times he was said to be weepy and depressed. However, she saw him again on 23rd. August, 1999 when his mood appeared to have improved and there was no evidence of a formal depressive illness. A review by Dr. Quinn in November, 1999, found him still in reasonable mental health. The position appeared to have deteriorated by February, 2000 with increased episodes of confusion and Dr. Quinn describing Roddy as having difficulty remembering his own name. He was assessed at Dr. Quinn's request, by the Department of Clinical Psychology at Ninewells, over the early part of 2000 for a dementia baseline assessment. They did not conclude that his cognitive ability had significantly reduced though he was only able to complete simple tasks. He was re-assessed by an occupational therapist in December, 2000, who reported a clear deterioration in his motor skills. He was also re-assessed by the clinical psychologist who found the results inconclusive of early signs of a dementing condition, with improvement in some social skills areas and deterioration in other aspects such as capacity to learn new tasks. By March, 2001, Dr. Quinn was saying in terms that there were clinical signs of dementia though even in September, 2001, the clinical psychologist was less convinced though accepting that there did appear to be a deteriorating process occurring. By January, 2002, she was accepting that he was probably suffering from dementia. This was made clear to care home staff at Maryfield, who were given training in relation to Roddy's increased care needs and to his general practitioner but no one appears to have communicated the probable onset of the dementia to his brother or sister. Dr. Quinn saw him in March, 2002 and described deterioration with increased confusion and disorientation, but still manageable in the care home setting. In October, 2002, there is a first reference to a possible epileptic seizure. In January, 2003, Dr. Shah reported from the Department of Neurology at Ninewells to his general practice, that Roddy was suffering from Alzheimers or vascular dementia or both and that the deterioration process would continue. It was suggested that he needed a "planned change of care for the future such as a residential home rather than a sudden change." It was unclear and not explored in evidence whether the Department of Neurology appreciated that he was residing in a care home or whether they meant that a nursing home should now be considered. The CT scan showed a degree of atrophy beyond the norm for his age.

[8] The foregoing medical history demonstrates that it certainly cannot be said that prior to the commencement of 2003 there was any lack of medical care either on the part of his general practitioners, who saw him regularly and who responded, in

medical terms, appropriately to the information they were given about his condition, or on the part of the various departments at Ninewells Hospital who played parts in his care. Equally, he was regularly assessed both by Dr. Quinn, the psychiatrist, and by clinical psychology and occupational therapists. The only criticisms which can properly be made of the medical and psychological specialists involved in his care up to this point is their failure to inform his relatives about his chronic conditions and, in particular, about his ulcerative colitis and the onset of dementia. His relatives should have been informed about both of these chronic conditions and the implications for Roddy's future care. There is also scope for concern about how well the medical and psychological specialists communicated with each other. Dr. Quinn, for example, was unaware that Roddy had a diagnosis of ulcerative colitis.

[9] It is also worth observing that, until 2001, there is no indication in any of the medical reports of any difficulty in securing Roddy's co-operation, at least for the purposes of examination, though there were always some concerns about his compliance with medication, especially enemas.

[10] While Roddy had years of discomfort with his abdominal tract, including complaints of abdominal pain, diarrhoea and constipation, these conditions appeared to respond to medication. However, on 24th. February, 2003, he was suffering from diarrhoea. On 10th. April, 2003, he was said to have had recurring diarrhoea for two to three weeks. He was visited by Dr. Margarhita Badenhorst from his general practice who was aware of the diagnosis of ulcerative colitis from 1997 and noted that he was passing 4-8 motions per day. She found the abdomen soft with normal bowel sounds but prescribed Asacol tablets, which are anti-inflammatory, and Asacol foam enemas. He was seen by a doctor from D.D.O.C. on 13th. April who found his abdomen to be soft and pain free but generally found him difficult to examine and wondered whether he might have a chest infection. He also wrote "diarrhoea all week ? Staff not quite sure what's what with medication." The same doctor, who appears to have been a Dr. Green, seems to have seen him later the same day and noted that he could get no history from the patient and that he was not co-operative. He then noted, "Staff not nursing - therefore limited knowledge." This was an insightful observation. On the limited information available, which included a reference to diarrhoea plus discomfort, Dr. Green provisionally concluded that he might be suffering from a chest infection and prescribed anti-biotics. We shall never know whether anyone told Dr. Green that Roddy suffered from ulcerative colitis or that he had been prescribed Asacol tablets and enemas.

[11] Dr. Badenhorst saw Roddy again on 14th. April when he appeared to be improved, having had three enemas and only one bowel motion that day. She noted that he was "not very keen" on the enemas. She prescribed ointment for his "raw perianal area."

[12] The notes maintained by the care home staff at Maryfield House from the beginning of 2003 portray a picture of inconsistent behaviour on Roddy's part and of increased confusion. There are references to episodes of incontinence of urine and to increased need for assistance in connection with washing and dressing. He had been noticed as suffering from involuntary jerky movements especially of his arms diagnosed as being myoclonus which is associated with epilepsy. The staff recorded in some detail a discussion with Dr. Quinn on 9th. January at which she explained

that Roddy had been dementing for three years and would deteriorate progressively. She explained that he did not need to be moved to a nursing home at that date but he would require to be reviewed shortly and would need to be moved to a nursing home in the near future. It was noted, " The main problem is staffing levels to meet his needs." His care plan had been reviewed in December, 2002 with it being noted that he required maximum supervision with all tasks, personal hygiene being highlighted. It was noted that his eyesight appeared to be deteriorating. However, there were other days when he was noted to be "fine," wanting to go to daycare or anticipating a visit from his brother and sister. 28th. January, 2003 is the first indication of faecal incontinence, apparently while at daycare. On 30th. January, there is reference to him having a bout of diarrhoea. There is then a gap in the records until 28th. March, 2003. Again, after that date, the presentation is variable, there being days when he attends at daycare and others when he is recorded as being incontinent of urine. From 7th. April onwards there are frequent references to his bowels being "very loose." On 9th. April there is a reference to "a few bowel movements." On 10th. April, there is an instructive entry by someone called "Eve Thornton" recording the visit that day from Dr. Badenhorst and noting, "Dr. asked if I knew Rod had severe ulcerative colitis. I said no. It was apparently diagnosed a long time ago." She also recorded the anti inflammatory medication prescribed and that a nurse would come in, presumably to carry out the enemas. The notes record that the first enema was administered on 11th. April but it is also noted that on that day he had very bad diarrhoea. On 12th. April he is noted as refusing to eat and refusing to take his medication and as having further diarrhoea, in bed, and refusing to co-operate with staff who were trying to clean him. He is recorded as having a second enema on 13th. April in the course of which he became distressed and appeared frightened. Four episodes of diarrhoea between 08.30 and 13.45 were noted on 13th. April. There appeared to be a fifth motion at 19.40. On 14th. April he was unco-operative and refused to take any medication until evening. He was given a third enema on 15th. April and was said to be "not as reluctant as before." Three episodes of diarrhoea appear to have been recorded.

[13] Dr. Badenhorst attended to see Roddy at the request of Maryfield House staff, on 16th. April. She decided that he should be admitted to hospital. In her admissions note, she recorded "Few weeks of increased stool frequency. Started Asacol tabs + enemas 5/7 ago - initially improved but now refusing all fluids/solids/medication. Dehydrated/flat/cold. Diarrhoea 6-10 bouts/day. Diagnosed U.C. 1997. Down's;

Dementia: Epilepsy." She then listed his current medication and under the heading, "Provisional diagnosis" wrote, "Flare-up ulcerative colitis/dehydration." Apart from the number of bouts of diarrhoea, everything else she noted about Roddy's history has documentary support. I have no reason to doubt that she was told by care home staff that he was experiencing 6-10 bouts a day of diarrhoea. How accurate that is over a period of time is not clear and is not supported by any written record. Dr. Badenhorst clearly appreciated the importance of informing the hospital on the history of the number of bowel movements. There is no evidence that care home staff had the same appreciation of the importance of accurately reporting the number of movements and there has to be a question mark about how accurate the information in that respect which Dr. Badenhorst was given and communicated to the hospital was.

[14] Ward 15 is the acute medical receiving ward at Ninewells Hospital. Dr. Badenhorst telephoned them requesting Roddy's admission but gave no evidence about the content of that telephone call and I cannot trace any record of it. Dr. Badenhorst called for an ambulance to take Roddy to hospital. Bill Taylor, an experienced social care officer on the staff at Maryfield House, noted, "When the ambulance came Roddy refused to go. But after some persuasion he went into Ward 15 Ninewells Hospital. I accompanied him into hospital but as his sister came to the ward I returned to Maryfield." Unfortunately no part of that entry is timed.

[15] NHS Tayside, as they now are, operate a computerised system across their health region, Tayside, comprising the districts of Angus, Dundee and Perth and Kinross, and North Fife, whereby all general practices in the area and all hospitals can have computerised access to laboratory results for haematology, bacteriology, biochemistry and radiology. This is known as CentralVision. Each patient has a unique reference number. Roddy's is 1509520015. The laboratories at Ninewells will not issue any result unless they are satisfied that the name and the unique reference number, now known as the CHI number, match to avoid any risk of the wrong results being attributed to anyone. In 2003 if the name and CHI number did not match, then the results would not be issued and would be retained until a doctor recognised by the system gave the system a matching name and CHI number. Now the system will not accept the sample for examination - will not print out a label to be attached to the sample without which the lab will not undertake the analysis - unless the doctor requesting the sample inserts the correct name and CHI number. That is an important improvement, for reasons which will become obvious, over the position as at 16th. April, 2003.

[16] Roddy was admitted to the medical admissions unit at Ward 15 at 12.00 noon on 16th. April, 2003. He was first seen by Dr. Jane Wallace, a pre-registration house officer (i.e. in her first year of post graduate employment), who plainly had the admissions note from Dr. Badenhorst and who obtained some information from Bill Taylor for she wrote "H x from Carer/GP letter/Patient." She then wrote, "Few weeks of increased stool frequency, 6-10 a day; 0 blood, possibly some maleana a week or two ago. Started Asacol + enemas 5/7 ago - helped initially - now refusing all food/liquid/medication. C/o abdominal pain. Carer doesn't know whose clinic he attends." She noted a history of epilepsy, Down's syndrome and dementia and also noted that he had been prescribed sodium valproate. She noted all other medications he was prescribed. She noted that she was unable to complete a systemic enquiry and that Roddy lived at Maryfield House and that he "manages to wash and dress with encouragement." She noted his temperature, pulse and blood pressure, the last mentioned being raised at 164/107. She noted his respiration was 100% on air which is slightly unusual and may suggest a degree of hyperventilation. Otherwise, where there should be results for chest and abdominal examinations she has noted "Patient refused examination." Her provisional diagnosis was "Exacerbation of colitis" and she noted under the heading, "Management Plan," "AXR (abdominal X-ray), routine bloods, IV fluids." All the medical experts who gave evidence described this as a good clerking note containing all the essential information they would expect to see at this stage especially given Roddy's presentational difficulties. In particular, it seems to me that she took the point that Roddy was as much a management problem as anything else, noting that the medication prescribed by the general practitioner had helped the condition initially

but that he was now refusing to take it. The way she has recorded contiguously the period over which there has been in increase in stool frequency and what that increase was, while understandable, does not in my opinion coincide with Dr. Badenhorst's admission note in that Dr. Badenhorst did not say he had been having 6-10 bouts of diarrhoea for a few weeks. The only significant thing that Dr. Wallace got wrong was Roddy's CHI number. On admission, Roddy should have had a band applied to his wrist with the CHI number written on it. It should also have been on the external cover of his file and it was correctly noted on Dr. Badenhorst's admissions request. For reasons we shall never know, Dr. Wallace wrote the CHI number as 1509520130 instead of 1509520015. It is a reasonable inference that the blood sample which was taken by Dr. Wallace or by a nurse on her instructions was submitted to the laboratory bearing the wrong CHI number. Computer screendumps lodged as part of a report prepared by Diane Carter, the Ninewells Laboratories IT manager, demonstrate that a request was entered for Roderick Donnet, date of birth 15-9-52 at 14.09 on 16th. April and that the results were available at 15.18 but were "held for review - results held for verification of patient ID."

[17] Roddy appears to have spent some considerable time following admission, and it appears that Dr. Wallace had completed her examination by 12.30, prior to his being admitted to the ward, being nursed on a trolley. It appears that while he was being so nursed he passed a motion in the toilet. No stool culture was obtained. It is not clear whether having a stool culture to examine bacteriologically would have made any significant difference to the outcome. There is no evidence to suggest it would have.

[18] There is a nursing entry of 14.30 on 16th. April which reads, "Attended for abdo X-ray but refused to go on table. Therefore X-ray not done."

[19] There is an interesting but unresolved divergence between the nursing notes and the medical notes as to the time of Dr. Pullar's examination of Roddy. The nursing notes state that this happened at 19.00. The medical notes which Dr. Pullar when he gave evidence said were in his hand say 16.41. I think the latter is more likely but the question is begged why there should be such a divergence. Dr. Thomas Pullar, who is a Consultant Physician, saw Roddy and noted that he declined to be X-rayed, complaining of pain. Dr Pullar wrote, "Please try again." He noted that the abdomen was soft and non-tender and that bowel sounds were present. He noted, "Needs bloods, stool culture, abdominal XR.....IV fluids, IV methyl prednisolone as per protocol. Gastric opinion...phone @ could they take. NB He is frightened of hospital. His niece is staff nurse ward 4. If possible could he go to Ward 4 but be looked after by GI team."

[20] In the absence of any evidence from any nurse I have no clear information when he was admitted to a bed in the ward but the ward he was admitted to was Ward 15. Dr. Michael Jones, a consultant in acute medicine, explained in his evidence that Ward 15, which he was responsible for, was the medical equivalent of an Accident and Emergency Unit with all the same difficulties as such a unit in that admissions ranged from the immediately life threatening to the trivial. Nursing staff were used to triage the incoming patients in the same way as they were used in an Accident & Emergency Unit. In fact the two main sources for patients arriving at Ward 15 came either via a GP admission or from the Accident & Emergency Unit. Dr. Jones

explained that Ward 15 comprised a 31 bed unit and that the average daily admissions rate was 36 so that he and the nursing staff were extremely busy and were faced with a continuous exercise in bed juggling, an exercise which was entirely unsatisfactory and not conducive to the process of determining who required urgent admission on the one hand and who could go home on the other and that, regrettably, persons being nursed on trolleys in corridors was a frequent event. He made it pretty clear that this was a source of constant dissatisfaction and frustration to him but that the authorities responsible for the administration of the hospital had failed to offer any practical solution to the problem. It was clear to me that Dr. Jones was a highly intelligent, capable and dedicated doctor occupying a very stressful position, who deserved support which was not forthcoming. He was supported in the operation of Ward 15, where he tended to be in attendance from early morning until mid afternoon - the peak admissions period - by a team of consultants from a variety of specialties - Dr. Pullar, for example, was a rheumatologist by specialty - who along with squads of registrars and house officers at various levels - undertook the assessment of new patients arriving when he was not on duty. I recognise that consultant acute physician is a relatively newly created post following on the success of A & E consultants but if the current system at Ward 15 is to be maintained, it is obvious that at least one additional acute medical consultant is urgently required as is an arrangement whereby acutely ill patients are not managed in corridors. No explanation was offered as to why Roddy was not transferred to Ward 4.

[21] Ulcerative colitis is a chronic condition i.e. once you have the condition it is likely to recur from time to time. Its cause is not known though there is some evidence that it is associated with immuno-deficiency. There is no known cure for the disorder. It affects the large bowel (as opposed to Crohn's disease which affects the small bowel and in terms of its definition can affect any part of the gastro-intestinal tract) and causes ulcers in the lining of the bowel sufficient to permit the contents of the bowel to leak from the bowel into the abdominal cavity and, vice versa, fluids to leak from the abdominal cavity to leak into the bowel, it being that latter state of affairs which causes recurring diarrhoea, often containing fresh blood, that combination being a classic symptom of inflammatory bowel disorder, the generic name for ulcerative colitis and Crohn's disease, and, in particular, of ulcerative colitis. Inflammatory bowel disease is incurable but is normally relieved and the symptoms are normally well controlled by anti-inflammatory medication, known as mesalamine, trade name Asacol, which can be administered in tablet form orally or by means of foam enema via the rectal passage. It was also discovered belatedly by the general practitioners, not at the suggestion of the gastro-enterologists but by a pharamacist at Boots the Chemist plc, that it was also available in liquid form. If that treatment is not successful, or for a moderate to severe outbreak of the disorder, the hospital based treatment involved the insertion of intravenous fluids and intravenous methyl prednisolone, a steroid, which is generally very effective in controlling outbreaks and would normally produce a significant improvement in a patient suffering from a moderate to severe outbreak within three or four days. Should that form of treatment be unsuccessful there is the ultimate surgical option of an ileostomy. There is always concern about any case of inflammatory bowel disorder leading to distension and performation of the bowel, the latter constituting a surgical emergency to prevent death from septicaemia. For this reason it is standard procedure to request an abdominal X-ray as a matter of urgency in order to ascertain whether there is any risk of perforation of the bowel. An abdominal X-ray itself, however, will not confirm

the presence of either inflammatory bowel disorder. The existence of such a disorder can only be definitively determined by some form of colonoscopy of which the better and more thorough procedure is a flexible sigmoidoscopy with which the entire bowel can be explored. It was agreed by all the experts that that was an uncomfortable procedure which could cause significant pain in relation to inflamed areas of the bowel, though it would normally be done without anaesthetic, possibly with the administration of a sedative. It was said that it would be difficult to perform this procedure without the co-operation of the patient, though if the patient is sedated I am not clear how much co-operation he would be capable of giving. Normally, with ulcerative colitis, the abdomen will be tender and that should be observable on clinical examination but there was a difference of opinion as to how reliable such clinical examination was. Some of the blood test results, particularly that for C-reactive protein, if raised, are indicative of inflammation though generally are non specific indicators of the location of that inflammation. The increase in bowel activity, especially in a person who has already been diagnosed as suffering from one of the inflammatory bowel diseases, is generally regarded as a reliable marker of an occurrence or recurrence of the disorder.

[23] A fall in the water content of the body, dehydration, is a common recognised incident of persistent diarrhoea. The proper proportion of fluid in the body requires to be maintained within quite narrow limits to ensure proper functioning of body tissues. Body fluids contain a number of mineral salts. These too must be fairly rigorously maintained. With severe dehydration, rehydration by means of intravenous fluids is essential, normally commencing with a saline drip to replace lost salts and then with a dextrose drip, alternating. Intravenous treatment is universally administered in a hospital setting.

[24] It was for the reasons set out in the last two paragraphs that Dr. Badenhorst wished Roddy to be admitted to hospital as he was dehydrated partly as a loss of body fluids into the bowel on account of the ulcerative colitis, partly because of the loss of fluids caused by diarrhoea, partly because Roddy was not eating or drinking and thus not replacing the fluids that he was losing and partly because he would not recover from his inflammatory bowel disorder unless he was medicated. It was important for diagnosis and treatment for the hospital staff to be informed of the frequency of bowel movements. Dr. Wallace in her clerking notes does not observe any finding that Roddy was dehydrated but she had that information in Dr. Badenhorst's admission request and noted, amongst other things, that Roddy was not eating or drinking and she would doubtless appreciate that that would inevitably lead to dehydration. In any event, we know from her notes that one of the first things she requested was "IV fluids" which was entirely appropriate. Quite properly she wanted an abdominal X-ray to exclude any possibility that Roddy had a perforated bowel or that the bowel was distending with a serious risk of perforation, which would have meant that consideration of the surgical option would have had to be urgently undertaken. She also wanted blood test results to see what these would indicate about Roddy's condition - an entirely appropriate course to follow. As we have seen, when Dr. Pullar saw Roddy, he was concerned that Roddy had refused abdominal X-ray, though in his evidence he did not consider that the bowel was distended on examination given that it appeared not to be tender and normal bowel sounds were present. He was also concerned that there were no blood test results though it is not obvious, other than requesting blood results, that he sought to find out why there

were no blood test results, though he would be able to see that the patient was admitted at 12.00 noon, and that he should have known that the taking of blood at admission would be routine and that haematological and biochemical results should have been available within two hours. He also noted the need for intravenous fluids and it appears from the fluids chart that this process with saline commenced at 17.00, five hours after his admission, though no one commented on the significance of this delay. Dr. Pullar also instructed the commencement of intravenous methyl prednisolone, a steroid, which is known to be a highly effective agent for countering inflammatory disorders. In his note he made reference to "as per protocol." By that, he was referring to an NHS Tayside document (Production F1) headed, "Acute Services Division - Medicine and Cardiovascular Group: Inflammatory Bowel Disorder (IBD) : Ward 15 Guidelines." He explained that this document had been produced to assist consultants working in Ward 15 to initiate treatment for persons suffering from inflammatory bowel disorder until their management could be taken on by gastro-enterologists who apparently only work normal office hours and who also undertake out patient clinics. I note that initial assessment should include a "stool for microscopy and culture." There is no evidence that that was ever obtained prior to discharge but no one made any observations on the consequences of this failure. Dr. Pullar said that, on the basis of the information he had, he considered he should proceed on the basis that he was dealing with a severe outbreak and it was for that reason he selected methyl prednisolone to be administered intravenously. There was no unfavourable comment from any of the witnesses about this document or Dr. Pullar's decision about treatment. On the contrary, Dr. Pullar was praised for his insight in observing Roddy's frightened state and what might be done to alleviate it and for taking the safe course of treating the outbreak as serious and proceeding accordingly in accordance with the guidelines. The guidelines too were generally regarded as apt and the document as extremely useful to have available in an acute medical ward. Dr. Rafferty told me that there were similar guidelines at Dumfries & Galloway Royal Infirmary and that he had always found them helpful, for example. I cannot find any documentation to tell me when methyl prednisolone was administered but I do note that instructions for it to be stopped were given by Drs. Hill and Barron, the gastro-enterologists, the following day.

[25] The evidence from Dr. Kate Quinn, Psychiatrist, who had been involved in Roddy's care for a considerable period of time, supported by Roddy's brother and sister, James and Edith Donnet, was to the effect that, even prior to the onset of his dementia, Roddy would not have had the mental capacity to comprehend and implement important decisions of any complexity. Their evidence, which I accept, was to the effect that he would not at the material time, April 2003, have had the capacity to understand and make decisions about his health and, in particular, to give informed consent to any invasive medical procedure. He would not have the capacity to grant power of attorney. It is unlikely that he would ever have had the capacity to do so.

[26] There was also a considerable body of evidence to the effect that Roddy would not have been able to make himself understood to anyone who was not familiar to him and would be likely to have been frightened in what to him would be the strange environment of the hospital. This is illustrated by Dr. Pullar's note and by Roddy's behaviour in being unco-operative with examination and refusal to co-operate with X-ray procedures as well as being unco-operative with ambulance personnel. It was a

matter of good fortune and common sense that he was accompanied to hospital by the carer, Bill Taylor, but as Dr. Wallace's notes suggest, there were limitations to the information he could convey. I was disappointed to learn from Thomas Campbell and Gordon Watt that there were no instructions, guidelines or protocols about accompanying a resident of Maryfield House or any other local authority care or nursing home into hospital, about taking the resident's file, which might have been of assistance to the medical and nursing staff, or about supporting the resident through at least the process of admission. Bill Taylor is to be commended for having remained with Roddy until Edith Donnet arrived but Dundee City Council Social Work Department must look urgently at the establishment of procedures for the accompaniment and assistance of persons of reduced intellectual capacity for whom they have a responsibility, particularly residents of care and nursing homes, who are necessarily admitted to hospital for treatment of a physical ailment or condition. The Care Commission may also wish to give some consideration as to what is appropriate for care homes generally in relation to this difficult issue. It was Mr. Watt who conceded to me that you would not leave a child on his own to admit himself to hospital and that it was equally inappropriate for someone who had the intellect of a child.

[27] Edith Donnet, Roddy's sister, had spoken with staff at Maryfield House on 15th. April, as had James Donnet, Roddy's brother. Both had been told that Roddy was unwell, not eating or drinking, appeared to be in a lot of pain and was tearful. Edith Donnet was telephoned about 11.00 on 16th. April by staff at Maryfield House to the effect that Roddy was to be admitted to hospital and they were having difficulty persuading him to enter the ambulance. Unfortunately, she was not able to attend but said that she would go shortly to Ninewells Hospital and meet Roddy there. She met Roddy and Bill Taylor at Ninewells Hospital at Ward 15. She described Roddy needing to go to the toilet. She told one of the nurses there who handed a urine bottle to Bill Taylor and told him to get on with it. Roddy had in fact soiled himself and after some time, Bill Taylor was assisted by nursing staff to clean him up. He was on a trolley in the corridor and that is where he was assessed and examined by Dr. Wallace. After a two hour wait, she accompanied Roddy to the X-ray department where she said Roddy started to get "spasms in his tongue." He would not co-operate with the staff there and he was then returned to the corridor outside Ward 15 where he was left for another two hours until Edith Donnet became angry with nursing staff as she saw other more recent arrivals being admitted to beds ahead of Roddy who was becoming increasingly agitated and upset. Eventually, he was admitted to a bed where he was seen by Dr. Pullar. It was Edith Donnet who had told Dr. Pullar about the family member who was a staff nurse on Ward 4 and he told her that Roddy would be admitted to that ward, though he never was. Beyond the general evidence of Dr. Jones about the difficulties surrounding the functioning of Ward 15, which he recognised were unacceptable but about which he had striven in vain to get meaningful action from management, I was offered no evidence disputing this disgraceful and distressing state of affairs and accordingly have no reason to doubt the accuracy of Miss Donnet's testimony. To what extent this poor quality of treatment may have affected the outcome could only be a question of speculation but the treatment meted out to Roddy in the circumstances was inhumane and completely unacceptable. It is instructive to observe that Miss Donnet's evidence was that once he was in a bed he settled and became calm and she felt able to leave him and go home.

[28] James Donnet visited Roddy in Ward 15 about 19.00 on 16th. April. He did not think that Roddy knew who he was, something which had never happened before. He, Roddy, was sitting up in bed. A nurse told James that they had been trying, without success, to persuade Roddy to have an X-ray but he was not asked to help, he was not told of the importance of the X-ray and he was not told about the provisional diagnosis of ulcerative colitis. It was obvious to him that Roddy was frightened and he considered that to be largely attributable to the unfamiliar surroundings and Roddy's inability to understand what was happening to him. He observed that there was a meal on Roddy's bedside table which was untouched. James described his brother as being incoherent and unresponsive. Given that most people who did not know him would have difficulty in understanding him when he was at his best, James's description of his state makes it all the more important that anything which could be done to provide him with comfort, support and someone who knew him was done. James told me that he had never seen his brother in this state before and had never known him to be frightened of new places when he had taken him to new places and was there to support him. It can only be speculation as to whether some of his fear and distress would have been alleviated if he had been admitted to Ward 4. I observe that there is an entry in the nursing notes as part of the entry relative to the examination by Dr. Pullar which reads "? for transfer to Ward 4 if possible because niece works there + he may be more co-operative when she is there." For all I know there may have been no space in Ward 4 or the niece may not have been on duty, though that was not the evidence of Edith Donnet.

[29] The next timed entry is in the nursing notes for 21.30 on 16th. April which reads "AXR unsuccessful. Venflon fell out..medical staff aware." No evidence was led which in any way elaborated on this entry.

[30] The next timed entry is in the nursing notes and reads, "23.00 Venflon re-sited. Patient refusing tablets at present. BP dropped from admission." Again, no evidence was led elaborating on this entry.

[31] The next timed entry involves Dr. Jane Wallace and emerges from the evidence given by Diane Carter about the operation of CentralVision. It demonstrates that a person using the unique identity code allocated to Dr. Jane Wallace accessed CentralVision five times between 00.19.22 and 00.21.06 on 17th. April. It is reasonable to assume that the person effecting access was indeed Dr. Wallace. It is unknown whether she had been at work continuously since 12.00 noon on 16th. April or whether she had been off and had now returned to work. Dr. Jones explained that it was the task of the junior doctors to enter the blood test results from the initial blood sample on the clerking sheet and these entries can be seen on the back sheet of the clerking notes. It appeared to witnesses giving evidence at the Inquiry that these entries were in a different hand to the hand which completed the clerking notes otherwise but whoever may have written down the results, it appears the results were accessed by Dr. Wallace. It was Dr. Jones, in the course of making a statement to Detective Constable Lorente of Tayside Police, who first noticed that these were the wrong results, a fact which appeared to have escaped the Crown until Dr. Jones raised the subject again in the course of the Inquiry, following which the Crown at my insistence made further inquiry as to how this may have occurred, leading to the evidence at a later date from Diane Carter, who was an extremely helpful and capable witness. It will be recalled that Dr. Wallace submitted the blood sample

using the wrong CHI number and that the lab had held the results for verification of the patient's identity. Ms Carter was able to produce copies of the screen pictures visited by Dr. Wallace and these form part of the productions associated with her report, NHS 3, 4 and 5. The first document examined by Dr. Wallace bore a specific document identity number which it would be inappropriate to reproduce. It is production NHS 3(4). It demonstrates that it relates to a request entered on 17th. December, 2002 by Dr. K White of Neurology Outpatients. It demonstrates a raised level of alkaline phosphate which is an indicator of abnormal liver function and was something for which Roddy had earlier undergone investigations. It would appear that this entry related to a blood sample taken when Roddy attended at neurological out-patients in connection with his CT scan in December, 2002. Ms. Carter explained that to get this entry to appear on the screen Dr. Wallace had to click on (1) "Biochemical medicine" and (2) a date box for 17th. December, 2002. When she did that on 17th. April, 2003, there would have been no entry for 16th. April, 2003 as the results were still being held for patient identification verification and continued to be held for that purpose until 26th. April when they found their way on to the CentralVision system. So the entry written down on the clerking sheet for the sample of 16th. April 2003 comprised the results obtained for the blood sample taken by Dr. White at Neurology Outpatients on 17th. December, 2002. In the absence of evidence from Dr. Wallace it is hard to see how anyone else could have made this potentially lethal mistake and apart from gross human error it is hard to see any alternative explanation for it. She had to click first of all on the wrong date to get access to this wrong entry. The entry itself states the date "17th. December, 2002" at three separate locations. The entry says it relates to a request by Dr. White at Neurology Outpatients whereas, as can be seen from other examples, it should say that it relates to a request from Dr. T Pullar at Ward 15. Dr. Wallace therefore compounded her erroneous noting of the CHI number by transcribing the wrong set of results on to the clerking sheet. Dr. Jones and Drs. Hill and Barron thereafter made reference to these entries and proceeded upon the basis that these were correct.

[32] My only criticism of Dr. Jones stems from this. It was, according to his own evidence, at his insistence that junior doctors transcribed the results from the computer screen to the clerking sheets rather than printing out a copy of these results. There was no question of a printer not being available for there was one on Ward 15. He said in evidence that they had tried printing out the results but that that had generated a lot of paperwork making it harder to find these results whereas the clerking sheet did not often go missing. He also maintained that it was in any event a useful training exercise for the young doctors to undergo as it made them think about the significance of the results. With the greatest of respect to Dr. Jones, and without prejudice to his concerns about the amount of paperwork generated, his position is open to two criticisms, firstly, as this case demonstrates, that no one beyond the junior doctor will know that the junior doctor has transcribed the wrong set of results with all the potentially horrendous consequences that that might have, and, secondly, that it removes any prospect of comparing current blood sample results with previous ones which comparative exercise is universally acknowledged to be useful as a means of detecting change, particularly where the patient is, as here, a poor historian. As a matter of urgency, a system which permits a print-out of the blood results from the computer to be attached to the clerking sheet, with any relevant comparative material and which thus obviates scope for human error in transcription, must be introduced.

[33] There was, unfortunately in the evidence a difference of medical opinion about the significance of this error as I shall narrate in due course. It is instructive that Dr. Jones himself noted at the time of his examination of Roddy on 17th. April two figures from the erroneous results one of which was elevated from the norm and the other of which was lower. Presumably he considered these results to be of some significance.

[34] The next timed entry is in the nursing notes at 00.25 on 17th. April. It is there noted that "IV fluids recommenced." Roddy was noted as being asleep. The nursing staff noted that "Medical staff aware that patient has refused medication."

[35] At 03.30 Roddy was observed by nursing staff to be "sound asleep."

[36] At 07.30 he was noted to have "slept all night," and to be "settled at present." It was noted that "IV fluids continue as charted. Venflon intact. No bowel movement overnight." There was no further evidence to eleborate upon these entries but I observe at page 156 of Crown production 1 (Daily IV Fluid Prescription and Fluid Balance Chart) that at 07.00 on 17th. April Roddy refused to take fluids by mouth and there was apparently no urine output - I assume that is what is signified by the word "dry."

[37] Roddy was seen by Dr. Jones on his ward round. There is no time for this entry in the medical notes but the nursing notes imply that it was at about 07.45. Dr. Jones told us that the notes were made by Dr. Suzanne Shepherd who was then a specialist registrar and who is now a consultant physician in her own right. She has noted that the diagnosis was ulcerative colitis. She also noted that Roddy had Down's Syndrome. She noted that he was said to have been passing 6-10 stools per day with the question of the presence of blood being inconclusive. A raised alkaline phosphate level was noted along with a reduced MCV level. The next part of the note appears to suggest that there should be a study of whether Roddy was suffering from an iron deficiency and needed Ferritin. He was said to be apyrexial on examination with a normal pulse and blood pressure. The upper right quadrant of the abdomen was said to be "dull to percussion," but normal bowel sounds were detected. The management plan was "AXR; Adults with Incapacity Form; GI team. If AXR OK, discharge ?" Dr. Jones, in evidence, accepted the proposition put to him that in cases of inflammatory bowel disorder, clinical examination had to give way to radiological examination, but he explained that that was specifically related to the risk of the development of toxic megacolon. He further explained that with ulcerative colitis in a severe outbreak, the patient's condition could deteriorate quite rapidly. He instructed the reference to Adults with Incapacity form to alert colleagues of the need to consider the completion of an AWI Act form in terms of Section 47 of that Act if it were determined that Roddy required to undergo any significant procedure, for example, a flexible sigmoidoscopy. It was part of his function to ensure that patients were seen by the specialist team germane to their particular condition - hence his reference to assessment by the gastro-enterologists. He agreed that he had noted that if they considered there was no reason for his remaining in hospital then he could be discharged. He said in evidence that the investigation of Roddy to date had proved negative for any major complication of the condition and that he had had little in the way of bowel activity which limited activity was inconsistent with a severe outbreak of inflammatory bowel disorder. He also took into account that Roddy was

abhorrent of hospitals and considered that he would therefore be more comfortable in his home setting. He accepted that there was "a big drive" to deal with anything that could be dealt with outside hospital in the community ascribing this to the proposition that "hospitals are dangerous places in terms of infection." So far as he was concerned, however, the final decision would lie with the gastro-enterologists.

[38] When Dr. Jones saw Roddy, he had with him, insofar as they had been completed by that date and time, Roddy's medical records. These contained the wrong blood test results as recorded and written up by Dr. Wallace. Dr. Jones demonstrated in the course of his evidence his own very clear understanding of the Ninewells based computerised "CentralVision" system and how to get information accurately from it, though he did not do so i.e. he did not personally consult with the computer screen to obtain results on Roddy. Given his pivotal role at Ward 15, I make absolutely no criticism of him for not having done that. He was entitled to assume that he could delegate that task to a junior doctor such as Dr. Wallace and to assume that she would have been adequately trained in the system and have an adequate appreciation of the need to extract accurate information from it. Where I do criticise him, and I do so with some diffidence given both his own expertise in the operation of the system and his contribution to its robustness, and his need to concentrate on the process of assessing and treating a large number of seriously ill patients, is in his continuing support for the system of junior doctors writing up the results in the patient's medical records, rather than printing out the results and attaching these to the medical records and I do so for two reasons, firstly, that his system perpetuates the risk of importing human error in the transcription of the results, where there is no need for human intervention beyond selecting the appropriate "screen dump" and pressing the printer button, and secondly because his system eliminates what appears to me to be one of the most significant benefits of the "CentralVision" system, that is the immediate ability to contrast a current set of test results with previous ones so that changes or trends in such a series of results can be decerned.

[39] It is evident from NHS Prod. 3 that a request emanated from Ward 15 for biochemical and haematological results on a blood sample taken that morning from Roddy. It is not clear who instructed that that should be done and no clinician is named on the request. This demonstrates raised levels of ALT, albumin and C-reactive protein. It is the last of these factors with its raised level of 34 which is interesting. It would appear that this sample reached the laboratory at about 10.10 in the morning of 17th. April and it looks as though the results were available for biochemistry at 10:41:40 and for haematology at 10:23:24. What is clear is that no one looked at these results notwithstanding that there was a body of evidence to the effect that with cases of inflammatory bowel disorder blood samples would be taken daily while the infection appeared to be persisting. I am bound to ask what the point is of submitting a blood sample to a laboratory for testing if no one looks at the result. I accept that the laboratory will look at the result and inform of any immediate cause for alarm but the fact is that had any doctor compared the information from this second blood test with what was believed to be the result from the first blood test, they would have wondered why there had been a significant rise in the C-reactive protein level, which is an indicator of an active inflammation, when all the clinical signs were pointing in the opposite direction. It might then have been recognised that they were working from the wrong results in the first place and the correct results,

still held by the laboratory, might have been identified and considered, and these would have demonstrated on admission a raised C-reactive protein level of 59. Both Dr. Clarke and Dr. Starr were of the opinion that, had they been treating Roddy and aware of that figure, they would have kept him in hospital for further observation. What is clear is that these results would have been available for Drs. Hill and Barron, the gastro-enterologists, to consider at 13.00 when they agreed to discharge Roddy and I am at a loss to understand why they did not consider them. They recorded the C-reactive protein figure as being 4, which was, of course, part of Dr. Wallace's inept transcription, so they clearly considered that the C-reactive protein measure was one of some importance to proper diagnosis. They may have had pause for thought about discharging Roddy if they had bothered to check the results and see the significant change in its level. Dr. Jones conceded properly that there was a training issue for medical staff about undertaking comparative studies of test results to look for changes of this very nature.

[40] The next curiosity came from the evidence of Jaqueline Mackie, the manager of Maryfield Hostel, who had noted these matters in the hostel's records with some care, at Crown Production 6, page 600, and whose evidence was confirmed by Edith Donnet. Miss Mackie had had a call from Miss Donnet at 10.00 on 17th. April to the effect that the hospital was discharging Roddy and enquiring whether her daughter-in-law, the staff nurse on Ward 4, could collect him. Whoever made the call did not appear to appreciate that Roddy resided at Maryfield House, but seemed to be aware of Roddy's next-of-kin and relative working in Ward 4. How such a call could be made at 10.00 on 17th. April when Roddy had not yet been seen by the gastro-intestinal team is a mystery. The caller was not identified and the Crown, in another error, appeared to have made no effort to do so. Miss Mackie then received a further telephone call, this time from Ninewells Pharmacy at 12.40, still prior to the assessment, apparently, by the gastro-intestinal team, to the effect that Roddy's oral medication was to remain the same but that enemas were to be stopped, and that Roddy was being discharged. At 13.00, Miss Mackie noted a call from staff on Ward 15 that Roddy was to be discharged by ambulance back to Maryfield House, that his X-ray and blood tests were normal (his X-rays were but his blood tests were not) and that he was eating. Given that he is recorded as having been seen by Drs. Hill and Barron at 13.00, according to the nursing notes, these doctors having carelessly failed to time their entry, the decision to discharge appears to have been instant. It is a matter of considerable regret and dissatisfaction that the Crown made no attempt to lead any evidence to explain this series of oddities and, in particular, made no attempt to lead evidence from any member of the nursing staff involved in the process of caring for and discharging Roddy on 17th. April, for the limited evidence available is susceptible to the construction that Roddy was regarded as a nuisance who should be got rid of from the ward at the earliest opportunity. Given that the evidence is that he did not eat either before his admission to Ward 15, nor after his discharge, the assertion that he was eating normally is also suspect.

[41] Miss Mackie accepted in cross-examination by Mr. Fitzpatrick that she must have agreed to Roddy's return to Maryfield House by ambulance without a carer first going to the hospital to accompany him. She should not, with the benefit of hindsight, have agreed to Roddy's discharge from Ward 15 without the presence of either a carer he would know and recognise or a member of his family. However, much time was devoted in the course of the inquiry to the unsatisfactory nature of his discharge

when, in the greater scheme of things, this was of no great consequence. As Mr. Fitzpatrick pointed out, while it is clearly accepted that Roddy was upset by his ambulance journey, within a short period of his return to Maryfield House he was chatting with staff and other residents and appeared settled. I should say for the avoidance of doubt that in relation both to his admission to and discharge from Ninewells Hospital I have absolutely no criticism whatsoever to make of the ambulance personnel involved. On the contrary, they appear to have done all that they could to minimise the upset and trauma to Roddy.

[42] It is instructive to note that Dr. Badenhorst had telephoned Miss Mackie at 08.30 on 17th. April to enquire about Roddy, to be told that he remained at Ninewells Hospital. Her obvious interest and concern in her patient's welfare contrasts starkly with that of the gastro-intestinal team.

[43] After the initial distress from the ambulance journey, Roddy settled well back at Maryfield House and is reported to have calmed down, to have gone through to the lounge and, later, to have been "chatting away." It is also recorded that he had a loose bowel movement. He went early to bed but awoke crying at 03.30. He was plainly upset and said that he was frightened. After being reassured by a staff member, he settled but declined to take any fluids. Later on 18th. April, he is recorded as seeming tired and refusing food and medication. At about 18.00 he is recorded as "yelling out." This continued intermittently through the night. He was unco-operative with staff trying to bath him on the morning of 19th. April - it took four of them to do it - and he was screaming and shouting. He was incontinent of urine and it required three staff members to clean and change him as he remained unco-operative. He grabbed a staff member by the stomach and squeezed, causing her pain, behaviour in which he had not previously engaged. Later in the day, he settled, had some food and two glasses of water. In the evening, 20.30, he was again incontinent of urine, and struggled with staff who were trying to help him. He appeared to be frightened and distressed. The general practitioner was telephoned and district nurses were sent to see if they could assist. By 04.30, the following morning, he was once more screaming and had been incontinent of urine. He appeared very frightened. With great persistence, the staff managed to reassure him and got him to drink some milk. By 08.00 he had been incontinent of faeces and urine and once more was resistant to the efforts of staff to clean and change him and his bed. He appeared to be pointing to something he seemed to be seeing on the other side of the room. By lunch time he appeared to be complaining about stomach pain and was distressed and tremulous. An emergency GP was called. A Dr. Ward visited who thought Roddy had a urinary tract infection.

[44] In Crown production 2 at page 286, there is an instructive note apparently written by Dr. MacGregor of the D.D.O.C. service in relation to a call on 19th. April, 2003 at 20.50 when it is noted that Roddy had been incontinent of urine and appeared to be suffering from abdominal discomfort. It is then recorded, under "history," "He's been investigated at N/Wells for abdo pain, which has not shown anything up." At page 281 of Crown production 2 is the D.D.O.C. sheet pertaining to Dr. Ward's visit on 20th. April. There was a further complaint about abdominal pain and whether now

Roddy was retaining urine despite having taken fluids quite well. She recorded that Roddy had been in hospital but since his discharge "he has taken to his bed, urinary incontinence, not eating." She then recorded, "Eventually agreed to admission to hospital on basis of staff not coping - declined further DNS (District Nursing Service) involvement or susp. antibiotics." Since Dr. Ward was not called to give evidence, I do not know who eventually agreed to the hospital admission - whether it was Roddy, the staff of Maryfield House or Ninewells Hospital, but insofar as the note records "staff not coping" that is a clear reference to the staff at Maryfield House and is insightful. That the staff there were not coping should have been evident to the management of Dundee City Council Social Work Department and, in particular, to Miss Mackie, the manager of Maryfield House.

[45] Another significantly unsatisfactory aspect of the inquiry related to the so-called discharge note. This is Crown Production 1/5 but it is essential to be aware of what that production actually is. On the face of it it tells you that it is the "Case Records" copy of the discharge note because it is yellow and not pink, white or blue. The white copy, which would be the principal and not a copy at all, is supposed to go to the general practitioner. The evidence suggested that normally the principal discharge note is given to the patient and there was no evidence that any different course was followed on this occasion. However, there is no evidence of that discharge note ever reaching any general practitioner or of any general practitioner looking for it, interpreting it or misinterpreting it, so I cannot reach any conclusion about any general practitioner being misled by its terms. There is, however, a reference in the nursing notes for 15.00 on 17th. April, recording Roddy's discharge and noting "GP letter taken with belongings." One cannot help but be appalled at the lack of wisdom in entrusting this important document to Roddy's care. Nor was the pink or blue copy produced. All the medical witnesses agreed that the words "No evidence of active IBD" was an inappropriate way to describe Roddy's diagnosis and a number of the experts felt that a general practitioner might well be misled by such a description had it reached them, and that the addition of the two exclamation marks was deprecatory and offensive - the implication being that Roddy should not have been the subject of an admission in the first place - but it is quite plain that these words have been written on to the yellow copy at a different time from the initial completion of the discharge form. Dr. Barron identified the writing as that of Dr. Jason Hill, who is now in New Zealand. We have the benefit, if that is the right word in the circumstances, of what purports to be a report from him, in the form of a copy of a letter to the Central Legal Office of the Scottish Health Service. Dr. Hill acknowledges having seen Roddy on 17th. April, 2003, with Dr. Barron. He notes that Roddy was first diagnosed as having ulcerative colitis in 1997 but that there appeared to have been no significant problems with it between then and 2003. He makes no mention of any lack of regular review during that period. He makes no mention of the entry in the yellow copy of the Discharge Form but I have no reason to think that he was asked about it. It would be wrong, therefore, to speculate about when and why he felt it appropriate to amend the Discharge Form, beyond observing that that is not a normal thing to do. He makes reference to the drug prescriptions sheet. No one else did. So far as I can determine, he is referring to Crown Production 1, page 152 which appears to show the administration of Asacol at 18.00 and 22.00 on 16th. April and 08.00 and 14.00 on 17th. April. He also observes that Roddy remained under the care of Dr. Pullar, but I am quite clear from the evidence of Dr. Jones that the position was that the final decision on discharge rested with the gastro-enterologists. He also

refers to the raised CRP level and other biochemical markers as being consistent with an outbreak of ulcerative colitis but he did not have the correct blood test results to refer to from 16th. April and failed to consider the results from the blood taken on 17th. April. I do not understand from the evidence that Roddy had been "for years" on sodium valproate; on the contrary, this had been a relatively recent change in his medication. Having said all that, it was generally accepted that the most sensitive clinical marker of an active outbreak of the disease would be increased stool frequency and that there was no continuing high level of activity. He makes no reference to having given any consideration to the obvious patient management difficulties which Roddy would present when in the community and no mention about whether any fear of being in hospital was present or played any part in Roddy's discharge taking place at the time which it did, but there is no indication that he was asked about any of these issues. The real issues about the discharge form are why it was considered appropriate to give this to Roddy to deliver given his intellectual defects, why no one telephoned the general practitioner to discuss the case when Roddy patently presented management difficulties and, most of all, why it takes five weeks for a discharge letter written by a doctor who may not even have seen Roddy, to reach the general practitioner. The management at Ninewells require to apply their minds to how better issues can be communicated to general practitioners than committing a form to the care of any patient without any thought about that patient's appreciation of the importance of the form and why it takes so long for a formal letter to be written and issued. Both these practices are unacceptable. In the case of the former, the use of facsimile transmission or e-mail to the general practitioner should be utilised. In the case of the latter, there should be no more than three days elapse before the formal discharge letter is sent to the general practitioner. Five weeks of a delay is completely abysmal and utterly unacceptable. Nor is it acceptable that these letters are written by some junior doctor who may not even have seen the patient, thus introducing scope for confusion and misunderstanding. In this respect both the medical profession and those responsible for its administration require to join the rest of us in the 21st. century. The importance of all this is that the evidence from the general practitioners, from the care home manager, from Roddy's relatives and from the D.D.O.C documentation all suggests that they were left with the impression in relation to Roddy that "Ninewells couldn't find anything wrong with him," an impression which, with the benefit of hindsight is clearly a wrong impression, and, worse, it led further to the impression that staff at Ninewells perceived Roddy to be a nuisance, leading to allegations that he had not been treated properly, allegations which have no material foundation, the reality being that he has been the victim of an appallingly inept communications system.

[46] There is no indication that either of Drs. Hill or Barron took any opportunity to discuss their findings with any relative of Roddy or with anyone from Maryfield House or Dundee City Council Social Work Department. It should have been obvious to them, and, frankly, to the other medical staff involved in his post-admission treatment, and to the general practitioners, that it was no longer appropriate that Roddy should be cared for in a residential home setting and that he needed to be admitted to a nursing home. His discharge from hospital would have been the ideal occasion on which to effect that change. This reflects the failure on the part of all the medical staff to consider the patient management difficulties which Roddy presented.

[47] At Crown Production 6, page 607, the Maryfield House notes, it is recorded that Roddy suffered diarrhoea and was thus incontinent of faeces. His brother is noted as having tried to persuade him, without success, to go to the toilet. He is recorded as "screaming" during the night and of having again been incontinent of both faeces and urine and of being unco-operative with staff. In the course of 21st. April, he is recorded as not eating and of only taking minimal fluids. Dr. Gardiner from the GP practice visited, noted that Roddy had been crying out intermittently in the course of the night, had been doubly incontinent and had had diarrhoea for three weeks. He noted that he was resistant to assistance from staff and that he was not eating. He noted that on examination he was "peaceful" but resistant to simple things like taking his pulse.

[48] On 21st. April, Roddy was also seen by Dr. Quinn and Tom Campbell, his care manager. They agreed that Roddy should be admitted to Camperdown Nursing Home but subject to the proviso, which strikes me as somewhat odd, that "the GPs must get Roddy's physical well-being sorted out first." Again, hindsight is a wonderful thing but quality nursing care was what Roddy most needed at that time to ensure that he was eating, drinking and taking his medication, as well as dealing effectively with the consequences of his incontinence and recognising that he was continuing to suffer from ulcerative colitis. In any event, they should both have realised that Maryfield House staff were not coping with Roddy.

[49] The Maryfield House notes for 22nd. April continue to reflect good spells and bad spells, continuing incontinence and resistance to help in that context, sometimes eating and sometimes declining to eat and of often appearing to be frightened and in need of reassurance. The position was similar on 23rd. April, ending with an entry that indicated that, after he went to bed, he was "roaring loudly," was saying that he was frightened and was pointing at the mirror, saying there was something there. Jackie Mackie in her evidence spoke of him "seeing" his mother in a corner of his room, though that does not appear to have been recorded. He is recorded as reciting the words of the Lord's Prayer. He then seemed to have two good days on 24th. and 25th. April when he took some food, quite a lot of fluids and his medication. On the evening of 26th. April and apparently in the course of a visit from his brother, James, he became distressed and appeared to be hallucinating, pointing to the other side of the room. It was noted that his ankles were swollen and that he was short of breath and wheezing. On 27th. April, there was a period when he held on to two staff members in his room and was reluctant to allow them to leave, being apparently frightened. The double incontinence continued throughout, but otherwise he seemed more settled.

[50] The Maryfield House records, Crown Production 6, page 618, show that on 28th. April, Tom Campbell and Jackie Mackie took Edith and James Donnet to Camperdown House Nursing Home and that it was agreed that Roddy should move there within the next week. He seemed to have been reasonably well over 28th. and 29th. April though incontinence continued. He was seen on 30th. April by the "incontinence nurse" who made various suggestions about more appropriate pads and pants to accommodate them and said that these would be delivered that day. One wonders why it took so long for her assistance to be sought.

[51] 1st. May signalled a return to Roddy being unco-operative and appearing to suffer pain on passing urine. On 2nd. May he is recorded as appearing to be "holding in" urine. However, 3rd. and 4th. May appear to have been good days where he ate and drank well and co-operated with staff and was a bit more lively than he had been. 5th. May was, again, a peaceful and uncomplicated day. On 6th. May, it would appear that staff from Camperdown Nursing Home came to assess him. He seems to have been all right on 6th. and 7th. May. It is recorded that on 8th. May staff telephoned Wallacetown Medical Centre for more incontinence pads and were told these would not be available until 21st. May, which is appalling. On 9th. May, staff thought that he was in pain but were unclear about the source of the pain. There is no further record about this but on 10th. May he is recorded as being unco-operative. On 9th. May it is recorded that "Roddy's family" had requested that his church be informed of his "health situation" and his imminent move to Camperdown Nursing Home, which they did. There is nothing adverse other than incontinence from 11th. May and staff are recorded as helping him to pack on 12th. May and then he is recorded as having become very obstinate. He is recorded as having refused to eat or drink on 13th. May. He is also recorded as having slept all night but to be looking "an awful colour - very pale." Dr. Badenhorst seems to have had a discussion with Edith Donnet on 13th. May about which she recorded that Roddy was to be moved to Camperdown "on Saturday." She noted that she had discussed with Edith Donnet "his Alzheimers, epilepsy, ulcerative colitis," and that she had "explained medication." Edith Donnet did not recall the full detail of this discussion but did recall being told about ulcerative colitis.

[51] On 14th. May, Maryfield House staff record that Roddy seemed "more alert and content" but that he had some "stomach pains." He was seen by Dr. Gardiner, presumably with a view to his transfer to Camperdown, who records that Roddy seemed "very tremulous" and that his speech seemed much worse and that he was agitated. He wondered if Roddy had been "feverish." He recorded loss of weight. He noted that his bowels were loose and that he had been doubly incontinent. He also noted "L UL crackle" which I take to mean that there was some unusual sound from his left upper lung. He recorded for a second time "speech very indistinct" suggesting that this was particularly notable.

[52] The night staff at Maryfield House noted that Roddy had "soiled" at 04.00 and 06.00, on the latter occasion there being blood present. The doctor was called and Dr. Hollins visited at 10.00. It is noted that, "After examination, Doctor said Roddy was very poorly and his chest infection had worsened. Doctor questioned whether Roddy should be admitted to Ninewells or remain here. Doctor said to continue with anti-biotics and paracetemol to lower temperature.....Doctor said he was going to discuss Roddy's colitis and chest infection with other doctors in his practice to establish whether steroids should be prescribed. Dr. Hollins said a doctor would call to-morrow." Dr. Hollins himself recorded, "Asleep to-day - has had bloody diarrhoea overnight. Very hot. Hasn't taken any tabs to-day. Hot to touch." However, he also recorded that his abdomen was soft and non-tender and that his chest was "clear." He also recorded, "Carers don't think he would cope with hospital admission - review to-morrow." He later recorded that he had discussed Roddy with "Dr. B at surgery" and had noted that it might be worth trying oral prednisolone for his "U.C." which indicates that they remained of the opinion that ulcerative colitis remained the principal medical problem to be tackled.

[53] At 12.20 on 15th. May, according to the Maryfield House notes, ascribed to one "M.Ritchie" another important witness not called by anyone, "The priest (also not called) visited from St. Vincents to give Roddy his Last Rites. Roddy's brother and sister were present, also staff." Jackie Mackie explained that the priest had explained to her about the Last Rites having been changed to be "The Sacrament of the Sick," which he said it was appropriate to administer to someone who was seriously ill and did not necessarily mean that the individual was dying. Edith Donnet said in her evidence (p94/95) "I am aware that the priest visited....I wasn't aware that he got the Last Rites, no. He said a prayer and stuff when the priest was there but I didn't recall the Last Rites." She agreed that there might have been a misunderstanding but made it clear that she had not requested the administration of the sacrament and that as far as she was concerned it was only on 28th. May that Dr. Hollins told her that Roddy was dying. She did seem confused about what had happened on 15th. May. James Donnet said that he knew Roddy was dying when he was not responding to treatment. He recalled the priest calling and administering what, so far as he was concerned, was The Last Rites. Asked why that was done, he said, "Because they felt that he was dying and that was a good couple of weeks before he actually died. He felt that he went downhill quite a bit and that he was dying." Asked who organised the administration of the sacrament, he said, "It would have been Jackie, the care manager. I think it was her that actually suggested it knowing that he was involved with the church, something like that." As I have already indicated, the whole circumstances leading up to Roddy's death are full of occasions when there was either no communication when there should have been or inept communication and this appears, with the dubious benefit of hindsight, to have been the worst example of this. James Donnet had made up his mind that Roddy was dying. Jackie Mackie, as I interpret her evidence about how people behave before they die, had come to a similar conclusion. Yet not two hours prior to the administration of the final sacrament by the priest, Dr. Hollins had seen Roddy and, while he may have considered him to be "poorly" (a word often used by doctors in Scotland when they are trying to tell relatives that death is imminent), he was continuing to look for a positive way of trying to treat the active outbreak of ulcerative colitis and was not at this stage contemplating merely palliative care. But the significance of this misunderstanding is to be found in the D.D.O.C. record - Crown Production 2 page 273 - when the emergency doctor called out by Maryfield House staff started his note with "diagnosed terminally ill 7/52 ago." He may have been so "diagnosed" by his brother and the manager of the care home but he had not been so diagnosed by any member of the medical profession.

[54] In fact the Maryfield House records suggest that later on on 15th. May, Roddy's breathing was easier, he took medication he had earlier refused and he took fluids.

[55] Dr. Badenhorst visited on 16th. May and it is recorded that she made it very clear to the staff that Roddy had to have his Asacol administered, which raises in my mind the question what had been happening up to that point. She suggested crushing the tablets if necessary to get him to take them. He also took some food and drink and did take all his medication that day. Dr. Badenhorst noted that he was still very unresponsive but was resistant to abdominal examination. His abdomen however remained soft. She seemed to question whether he had had the prescribed prednisolone. She emphasised the need to maintain fluid intake.

[56] On 17th. May, Roddy had had something of a disturbed night but he was recorded as having a better colour and not feeling so clammy and hot. He was taking fluids and took his medication except for the prednisolone. He seemed to be retaining urine again. He ate very little.

[57] 18th. May seems to have been a mixed day. There was double incontinence. For a while he sat in his chair and was observed to be digging his nails into the flesh of his arm. A district nurse visited and was concerned that Roddy was becoming dehydrated and urged the staff to ensure he drank more. However, at tea time he appeared to have a decent meal and to have taken his medication. On 19th. May, again the records show something of a mixture between Roddy sitting up in his chair while a new mattress was fitted to his bed and his continuing to retain urine to the extent of needing to be catheterised.

[58] On 19th. May he was seen by Dr. Hollins. He noted that Roddy "looked a bit better." He was taking more fluids and less blood was being seen in his faeces. His temperature had reduced. He was noted to complain of pain from time to time. His abdomen was soft and not tender. His bowel sounds were active. His pulse was regular and his chest was clear. He was, however, not passing urine. He had very little to eat or drink that day and there seemed to be ongoing problems about administering his medication.

[59] He is recorded as having had a comfortable night on 20th. May but to be very hot and flushed at 06.30. The doctor sent Pentasa Granula, a crystallised form of Asacol, which it was hoped would be easier to administer in a drink than the tablets had been. No one asked why this had not been thought of sooner. However, Roddy spat it out. James Donnet visited and was noted to be "very concerned" about his brother's condition.

[60] The records for 21st. May disclose the usual problems with incontinence and that Roddy appeared to be very hot and flushed, but that he drank water and took some medication.

[61] The Maryfield House staff records state that a nurse visited Roddy on 22nd. May and that there seems to have been some discussion about whether a capsule could be changed to liquid but exactly which capsule is not clear. Roddy was noted to have "cried out when turned" but to be drinking well. He was noted later in the day to have again cried out when turned and to have taken little in the way of fluids. That prompted a call to D.D.O.C. and the arrival of Dr. Anderson. Care home staff recorded, "Doctor from NewDoc visited. Roddy was crying out while she was there. He was also very hot. Has prescribed a medication to be given via syringe driver." They also noted, "District Nurse asked us to please only clean Roddy's mouth with the swabs. Do not try to give him fluids. Do not turn Roddy unless he appears to be uncomfortable." Further, they noted, "Roddy's brother has been informed." Dr. Anderson appears to have been the doctor who attended and I have already made observations about the Crown's failure to call her as a witness. Apart from the opening observation, "Diagnosed terminally ill 7/52 ago," nothing else she has noted of itself would lead to a change to a diagnosis of "palliative care," and the commencement of a diamorphine syringe driver. It is quite clear that Roddy was crying out in pain while the doctor was present but the call-out service had noted a

history of ulcerative colitis. It would be understandable if the doctor had been faced with a patient in obvious pain said to have been diagnosed as having been terminally ill that palliative care to relieve pain would have been initiated. However, no one admits to having diagnosed Roddy as having been terminally ill on 15th. May, or at any other time prior to Dr. Anderson's arrival, notwithstanding that that is the day on which the Last Rites were administered. It is not clear that the district nurse was present when the doctor attended or whether she came later to fit the syringe driver but the instructions to stop administering fluids is consistent also with only administering palliative care. I am left not knowing the source of information which led the doctor to write that Roddy had been diagnosed a week earlier as being terminally ill and I am therefore unable to reach a conclusion as to whether anyone made a mistake or whether it had been agreed in advance and if so by whom that active treatment be terminated, but I cannot help but observe that the relative informed was James Donnet who appears to have done nothing to intervene to promote a return to active treatment.

[62] The Maryfield House records for 23rd. May disclose that Roddy was " settled" but hot, requiring regular sponging. The doctor and district nurse are recorded as having visited. The doctor was Dr. Hollins who noted, "Seems to be failing over the last couple of days. Ongoing fever. Refuses anything orally. Has seemed to be in pain on being moved so DDOC started syringe driver last night. Seems peaceful. Briefly woke up. Very hot to touch. Pulse 80. Chest clear. Abdo soft - no pain. BS active. No masses. Still having watery diarrhoea. Underlying diagnosis uncertain but everybody wants him kept at home. Continue supportive care." And he continued the administration of the morphine via the syringe driver. It is not clear from his note who he is referring to when he uses the word "everybody." He talked, in general terms, in his evidence about Roddy's treatment arising out of a "consensus from the doctors and his carers and his family," but it is hard, frankly, to see objective evidence about the establishment of that consensus and at times people appear to have been pulling in different directions. It was not clear, for example, that he consulted with any member of Roddy's family before taking major decisions about his care and treatment, though Roddy's inability to give proper consent to treatment should have been obvious to him. He did not in Roddy's case contemplate the completion of a certificate in terms of Section 47 of the Adults With Incapacity (Scotland) Act, 2000. He recognised generally the potential benefit from the point of view of a medical practitioner wishing to determine what treatment option to follow with someone who had reduced intellectual capacity the merit of having a legal guardian who could take these decisions but had not suggested that that might be appropriate in Roddy's case. He indicated that in his practice, much of the workload of the practice was dealing with sufferers from dementia and, again, in that context acknowledged the benefits of the patient having a legal guardian or attorney who could take decisions on the patient's behalf but accepted that general practitioners as a body were not doing anything to encourage people to make deeds granting power of attorney nor encouraging friends or relatives to seek appointments to be a person's welfare guardian where that person either never had or had lost the mental capacity to take health decisions for him or herself. He thought there was beginning to be some encouragement from professional bodies. He did say that it was important to involve Roddy's family in the last few weeks of his life, but apart from meeting with Edith and James Donnet the day before Roddy died, there is no evidence of his having involved them and I am in no doubt that one of the doctors at the practice, and he

was the one first on the scene, should have told family members about the fitting of the diamorphine syringe driver and the change from active treatment to palliative care. His evidence suggested, as he put it himself, a drift into that situation rather than it being a logical result arrived at after careful consideration, as one would have hoped it always would be. His evidence suggested that, so far as how things operated in practice went, doctors would discuss matters with relatives relating to the care of a person with reduced intellectual capacity if relatives initiated that discussion. It was not a discussion that doctors would normally initiate. His evidence was that they would discuss the case with whoever had called them and that tended to be care home staff. It was also to the effect that because of a doctor's duty to respect patient confidentiality, in the absence of a legal appointment there was a reticence to speak to any single relative. It was his understanding on 15th. May, 2003, that care home staff had discussed with Roddy's family the possibility of re-admission to hospital and that the family did not wish that to happen. I have considerable difficulty in understanding how that decision can be treated with respect in a vacuum. If the family members had been told by a doctor that Roddy was terminally ill as at 15th. May and had concluded that they did not wish his final days to be in Ninewells having regard to the recent unhappy experience he had had there and that the care home staff were willing and able to continue to support him through his final illness, then I can well understand that they would have decided against his removal to hospital. On the other hand, had they been told that the underlying cause of his condition appeared to be ulcerative colitis, that it was making him dehydrated and generally very unwell but that it would be likely to respond to a routine form of treatment with anti-inflammatories, either steroidal or non-steroidal depending upon the severity of the outbreak, along with the administration of fluids intravenously, that without such treatment he would die painfully and that the only place in which he could be effectively treated was hospital, then they might have reached a different conclusion. Why they were not given that information at a point where Dr. Hollins and Dr. Badenhorst were continuing a course of active treatment for ulcerative colitis but which now patently required hospital management of Roddy, I am at a complete loss to understand. It is clear from the post mortem report that ulcerative colitis was the primary cause of death. He need not have died from ulcerative colitis. Not to encourage its hospital treatment was a mistake, arguably a profound mistake. It was also a mistake to accept from Jackie Mackie, the care home manager, as he did, what she claimed were the views of Roddy's family. He should have obtained these views directly.

[63] Dr. Hollins' position was that on 19th. May, Roddy looked better and so he assumed that the prescribed oral prednisolone was having the desired effect of combating the ulcerative colitis. However, by 23rd. May, he looked as if he was dying. I must say I have some concern about decisions being taken on the basis of how people look. However, it was not Dr. Hollins who made the diagnosis that Roddy was terminally ill and he said in terms that he would never do so without writing something in the notes. He wrote nothing in the notes, however, about the decision implemented by an emergency doctor; nor did he do anything inconsistent with the conclusion of the emergency doctor, so I am afraid I do not understand his position in relation to this aspect of Roddy's treatment either. Nor could he explain the conflict between his recording of Roddy's condition on 15th. May, that his chest was clear, with the Maryfield House notes in which he was recorded as having said that Roddy was very poorly and that his chest infection had worsened. Nor could he explain why

Roddy's condition had deteriorated rapidly from looking better on 19th. May to looking like he was dying on 23rd. May. He might of course well look like he was dying if another doctor had initiated a course of purely palliative care and had stopped the process of administering fluids but Dr. Hollins does not seem to have asked himself what happened to his patient who appeared to be improving on 19th. May but who was now deemed to be in a terminal phase of an illness which, because of the medical interventions available, does not normally cause death. Nor do I understand his doubt about whether the condition was truly ulcerative colitis when the condition appeared to respond to active treatment for ulcerative colitis and the real problems appear to have been associated with poor management of his condition in an inappropriate location - the residential home - when he really needed to be managed in hospital. However, when he was asked the direct question whether there was any discussion about making a decision to stop treatment, he denied that there was any such discussion though he agreed that there had been discussion about his re-admission to hospital the result of which had been that he should not be re-admitted and he further accepted that Roddy's prospects of survival would have been much better had he been being actively treated in hospital that being cared for by untrained staff - untrained in the nursing sense - in a room in a residential hostel. Dr. Hollins also did not explain why he had not sought advice from any specialist at Ninewells.

[64] Over the night of 23rd and into 24th. May, Roddy was in a poor condition. He was hot to touch. He was given increasing doses of diamorphine for pain relief. He appeared to be continuing to suffer severe pain and was crying out frequently. He appeared to move very little throughout 25th. May and generally to be comfortable though incontinence continued. He was clearly in pain when moved but was otherwise peaceful. He was in greater distress throughout 26th. and 27th. May with shaking and crying out and he was given increasing doses of morphine. On 27th. May his breathing was noted to have become laboured and there is a note to the effect that James Donnet was to be called in the event of any change to his condition. On 28th. May other residents appear to have been told that Roddy was very poorly and not expected to survive. Dr. Hollins had seen him on 26th. May and had noted that the supportive treatment was to continue and that Roddy was taking "hardly anything" orally. Dr. Hollins revisited on 28th. May and found Roddy to be very peaceful. He noted having a discussion with Edith Donnet and Jackie Mackie and telling them that Roddy would die within the next few days and that he suspected that Roddy had cancer of the bowel - though I regret that Dr. Hollins was unable to offer any objective basis for this provisional diagnosis. He noted, "The family are concerned that Roddy's symptoms weren't taken seriously when he was in hospital."

[65] The final entries for 29th. May, 2003 record Roddy's passing at 05.50 and the family's request that a post mortem examination be undertaken.

[66] My only other observation on the background is the cynical one that Roddy's blood test results appear to have attracted significantly greater interest on the part of the medical profession after his death than they did before. The CentralVision records demonstrate that they were viewed by Dr. Pullar on 28th. August, 2003 and on 5th. September, 2003, by Dr. Jones on 9th. November, 2004 and by Dr. Hill on 10th. November, 2004.

Post Mortem Examination:

[65] I cannot avoid repeating my earlier observation that it makes no sense for the Crown to invest in a substantial and expensive inquiry as this one was without the benefit of a full and not merely summary post mortem report.

[66] Post mortem examination was carried out on Roddy by Dr. David Sadler, a senior lecturer in forensic medicine and pathology at Dundee University, on 2nd. June, 2006. His report set out that Roddy died at 06.10 on 29th. May, 2003 with the causes of death being said to be ulcerative colitis and bronchopneumonia, as the main cause of death and Down's Syndrome, as a factor. The family had some difficulty with the inclusion of Down's Syndrome as part of the cause of death and I have some difficulty with that too. Roddy did not die because he suffered from Down's Syndrome, though I accept Dr. Sadler's evidence that there is a connection between having Down's Syndrome and being susceptible to infections and inflammatory disorders. It is also true that if he had not been suffering from early onset senile dementia which is directly related to his Down's Syndrome, he would have had better insight into his condition, been a better historian and is likely to have been a more co-operative patient, but none of these factors seem to me to justify the inclusion of Down's Syndrome as part of the cause of death and its inclusion seems to me to carry the unfortunate implication that death from ulcerative colitis and bronchopneumonia may be more likely to be unavoidable if you also suffer from Down's Syndrome. I accept his evidence that bronchopneumonia is a common terminal event for sufferers from Down's Syndrome but his evidence was that there was no known association between Down's Syndrome and ulcerative colitis.

[66] Autopsy revealed severe ulceration of the lining of the large intestine - ulcerative

colitis. In addition there was severe bronchopneumonia affecting the entire right lung. Death was attributed to the combined effects of ulcerative colitis and bronchopneumonia with Down's Syndrome being "viewed as a significant contributory factor."

[67] Dr. Sadler explained that Down's Syndrome is associated with many other medical conditions including congenital heart disease and leukemia. The average life expectancy for a sufferer from Down's Syndrome was approximately 30 with about one quarter of sufferers living up to about 50. With increased longevity, new associations were coming to light, including Alzheimer's Disease. It was also recognised that serious infections, particularly of the respiratory tract, are an important cause of morbidity and mortality for Down's Syndrome sufferers. In his opinion, therefore Down's Syndrome may have contributed to the onset of broncho-pneumonia. He was unaware of any recognised link between ulcerative colitis and Down's Syndrome. He considered that, while Down's Syndrome was not a strong contributory factor, it was worthy of recognition in the cause of death for statistical purposes.

[68] It was Dr. Sadler's evidence that ulcerative colitis was a serious condition which had even more serious complications if untreated. Sometimes ulcerative colitis was a cause of death but death was much more commonly attributable to one of the complications, most significantly, perforation of the bowel. The effect of ulcerative colitis was to reduce a person's mobility and generally to be debilitating thus

increasing the risk of a pneumococcal infection. In his opinion, therefore Down's Syndrome may have contributed to the onset of broncho-pneumonia.

[69] It was Dr. Sadler's evidence that ulcerative colitis was a serious condition which had even more serious complications if untreated. Sometimes ulcerative colitis was a cause of death but death was much more commonly attributable to one of the complications, most significantly, perforation of the bowel. The effect of ulcerative colitis was to permit the absorption of toxins from the bowel into the abdominal cavity leading to metabolic and biochemical disturbances. As a condition itself, it was rarely a primary cause of death. In Roddy's case, however, the wall of the bowel was intact and there was no perforation.

[70] The immediate cause of death was broncho-pneumonia. However, Roddy was suffering from an acute episode of ulcerative colitis. That latter condition would lead to increasing immobility and that would in turn lead to pneumonia. The mechanism of death is that the pneumococcal infection spreads, filling the lung, increasingly reducing its capacity to take in oxygen for absorption into the bloodstream. In this case, that situation was being compounded by bacteria from the ulcerative colitis being absorbed by the bloodstream which would have led to septicaemia. Because of the blockage of the lung, the body also could not expel carbon dioxide.

[71] Dr. Sadler accepted that his summary report made no mention of any examination of the brain but he had examined the brain and found this to be small, which was typical of what would be expected in a 50 year old Down's Syndrome sufferer. It was his evidence that, in the absence of any other intervening cause, Roddy would have died as a consequence of the process of brain atrophy caused by Alzheimers Disease, but that in the present case broncho-pneumonia consequent upon ulcerative colitis was such an intervening cause. It was his opinion that, in the absence of any further intervening cause, Roddy would have died from the brain disorder within a short period of time. He explained that when the brain fails, breathing movements could be diminished and that too commonly led to pneumonia as the terminal event, particularly when the coughing reflex was diminished. There were a multitude of factors associated with dementia in its various forms which could contribute to the development of pneumonia as the brain loses its ability to control and regulate bodily functions. However, he did not consider that that stage had been arrived at here but instead regarded the ulcerative colitis as the disease which led the occurrence of death via broncho-pneumonia.

Other Expert Evidence:

[72] For the avoidance of doubt, I use the word "other" to signify my regard for Dr. Sadler as an expert notwithstanding my reservation about the propriety of including Down's Syndrome as a factor in the cause of death.

[73] The first other expert, and in this sense I am using the word "expert" to signify a witness who was not a witness to any of the facts relevant to this case and whose evidence was opinion evidence in its entirety, by contrast with witnesses such as Dr. Pullar, Dr. Jones, Dr. Badenhorst or Diane Carter, who are all experts in their own right but whose evidence was a mixture of fact and opinion, was Dr. John Michael Starr, who was led by Roddy's family. He was a 45 year old consultant physician

practising principally at the Royal Victoria Hospital in Edinburgh but also at the Western General Hospital there. His professional qualifications were MB, ChB., BS., FRCP, Edinburgh. He worked principally for Lothian Universities Hospital Division but he also held a post as consultant physician to the Lothian Memory Treatment Service for the treatment of adults with learning disability and with dementia. He was on the specialist register for both general and geriatric medicine. He was a part time reader at Edinburgh University in geriatric medicine. His particular specialty was in the assessment of sufferers from Down's Syndrome as to whether they were developing dementia. This was a special and unique post which Lothians Health Board had been persuaded to create in about 2001. Dr. Starr had been a consultant for just over ten years. He said that his particular interest was in the subject of cognitive decline, both normative as a consequence of the ageing process and non-normative as for example the process experienced by sufferers from dementia. He had published over 100 papers and currently held research funding in excess of £12,000,000 in this field. He had won an award two years ago for a specific project looking at new ways of assessing the physical health of older adults with learning difficulties and for the last two years he had spent half his working time with the Down's Syndrome Scotland Society with a focus group of adults with a learning disability to determine what sort of assessment of their health is worthwhile and then putting the results of that assessment into operation in terms of care and treatment. He was accordingly very familiar with working with adults with incapacity in the context of their physical health problems, particularly with Down's Syndrome sufferers, and he was familiar with the provisions of the Adults With Incapacity (Scotland) Act, 2000. If I may respectfully say so, those representing Roddy's family demonstrated considerable acuity in finding and employing Dr. Starr who was in a unique position to assist me in coming to conclusions about the present circumstances and I am obliged to him and those who presented him to the Inquiry for the huge assistance I thus derived.

[74] Dr. Starr had produced a report, production F2, in which he made it clear that his sources of information were the GP and Ninewells Hospital records for Roddy and the Maryfield House care home notes, a copy of the post mortem report and copies of the opinions of Drs. Clarke and Morrison, who were called as expert witnesses by the Crown.

[75] He had no comment on the content of the post mortem report. He considered that the admission note prepared by Dr. Badenhorst was of excellent quality and I have no difficulty in agreeing with that assessment. He explained that ulcerative colitis is an inflammation of the colon. Its appearance, if one could see inside the sufferer's rectal passage, would be a series of ulcers presenting as a reddening of the skin. It was believed to be an auto-immune condition i.e. a condition generated when a person's immune system attacks part of their own body but the precise mechanism remains unknown and there was no medicinal cure for the disorder. The consequences could be very severe. Death could result through loss of proteins and fluids from the body leaking into the colon through the ulcerations. Vice versa, toxins in the bowel can travel in the opposite direction. If the inflammation progresses, the bowel may distend and both the process of distention and untreated developing ulceration can cause bowel perforation so that bacteria and other toxic substances can get into the peritoneal cavity within the abdomen and can cause peritonitis and death. The sufferer's ability to eat and drink is affected and there is a risk of

developing other infections such as pneumonia. Because of immobility and debilitation such other infections are harder to overcome than normal. Ulcerative colitis can therefore be of itself a life threatening disease but it is the risk of the complications associated with distention and perforation of the bowel which requires hospitalisation in cases which are not responding to anti-inflammatory treatment. There is a surgical option but that would involve the removal of the colon in its entirety.

[76] He noted that in Roddy's case there was no reference in the post mortem report to any perforation of the colon. Dr. Sadler had already confirmed that that was the position. Dr. Starr's assessment therefore was that the mechanisms leading to death were the debilitation caused by ulcerative colitis, a loss of protein and immuno-globins that would assist naturally in resisting infection and the development of pneumonia.

[77] In relation to the administration of methyl prednisolone at Ninewells and in particular by Dr. Pullar, he observed that this was a steroidal anti-inflammatory treatment applied intravenously. It was a very effective drug in the combat of inflammatory conditions. He further commented that the Ward 15 protocol, Production F1, set out a helpful scheme to approach treatment for a patient suspected of having an inflammatory bowel disorder placing particular emphasis, as it did, on the restoration of fluids to the body. He agreed with the proposition that six to ten bowel movements daily would indicate a severe attack of inflammatory bowel disorder and he considered that, on the information available to him, Dr. Pullar had commenced the appropriate treatment by way of methyl prednisolone and fluids both to be administered intravenously. Intravenous administration was more rapidly effective and overcame any disinclination on the part of the patient to take the medication orally.

[78] The ultimate treatment option in a severe case was the surgical removal of the bowel. This he described as a life saving option. The patient would end up with an ileostomy, with a stoma in the abdominal wall and an ileostomy bag. That, as a permanent process, would be a matter of some difficulty for a patient with Down's Syndrome and dementia, but it would not be impossible. He had, for example, a patient with Down's Syndrome and dementia for whom renal dyalisis was being contemplated.

[79] In the normal severe inflammatory bowel disorder episode, several days would elapse before recovery would begin as the steroidal anti-inflammatory drug began to work and as fluids were restored. Saline would be the normal first fluid to introduce and in the Ninewells paperwork there was a plan to alternate between saline and dextrose which was also normal practice. The fluid lost from the body would contain salt which required replacement. Other minerals would also be lost. For these reasons there is a need during the acute phase to carry out daily blood tests so that it can be seen that the treatment is having the effect of replacing what is being lost through the leakage to the bowel. The starting fluid was saline. Thereafter the doctor should be guided by the blood test results as to what is required.

[80] In due course there would be a need to deal with nutrient loss and the nutritionists would be the experts to deal with that.

[81] He was mildly critical of the record of the admission assessment by Dr. Wallace acknowledging however that she was a pre-registration house officer only in her first year of being a doctor. In his opinion, Roddy could have been to some extent examined simply by looking at him. Dr. Pullar had appreciated and had recorded that Roddy was frightened. In Dr. Starr's opinion, it was as important to record the patient's mental condition as his physical condition. More experienced doctors should have recorded factors which they could see simply by looking at the patient.

[82] Maelena, to which reference was made, is altered blood. It looks black and has a tarry consistency. Generally it means that the blood has come through the small bowel and has been digested there. Generally this means that the source of bleeding is further up the system than the small bowel. It is not an indicator for ulcerative colitis.

[83] On admission, Roddy's pulse rate was normal and his temperature was normal. The former suggests no acute pain or increased heart work rate. The latter suggests a lack of infection. The blood pressure was high. That may reflect acute illness but it is unwise to read too much into a single blood pressure result. By 23.00 on 16th. April his blood pressure had significantly reduced and that may represent a reduction in anxiety level but it may also reflect a loss of fluid. In his opinion, a patient suffering from a severe outbreak of ulcerative colitis should have his blood pressure checked on a four hourly basis. In Edinburgh, most patients with severe ulcerative colitis would be subject to continuous blood pressure monitoring.

[84] Dr. Starr had become aware of the use of the wrong blood test results. He

assumed, and it is a reasonable assumption in the light of standard procedure and given the recording of the arrival at the laboratory for analysis of a blood sample from Roddy at 14.09 on 16th. April, that Dr. Wallace had taken a blood sample from Roddy in the course of the clerking in process, though she does not actually record doing so. Dr. Starr noted that Dr. Pullar had written, "needs bloods, stool culture, abdominal X-ray," which suggests that no blood test results were available at the time of his examination. It would appear that a separate hand from that of Dr. Wallace noted the blood test results on to the admission clerking notes but it is clear from the CentralVision computer records that it was Dr. Wallace or someone using her access code who retrieved the information shortly after midnight on 17th. April, the information retrieved being the wrong information. According to Dr. Starr, the noteable difference between the two sets of results, the correct ones and the wrong ones written on the admission clerking notes, are the figures for C-reactive protein. The readings show its entirely normal level of 4 in December, 2002 but significantly elevated at 59 from the blood sample taken on admission on 16th. April, 2003. C-reactive protein is a protein produced by the liver in response to the body suffering from some form of inflammation. It is, said Dr. Starr, a reaction to the presence in the body of tumonecrosis factor alpha which is released where there is inflammation due either to an auto-immune condition such as ulcerative colitis or due to an infection or neoplasia, a form of cancer which can have associated inflammatory effects. When tumonecrosis factor alpha is produced it acts upon the liver which responds by producing C-reactive protein. C-reactive protein is described as an acute phase marker

i.e. it is very sensitive to changes in the level of inflammation in the body and so an increase in its level informs that there is an ongoing incidence of inflammation. It does not define the cause of that inflammation but is clear evidence of the existence of an inflammatory process. Also relevant in this context are the results for platelets. The correct result should have been 494. The actual result was 335. Platelets within the blood are a further indicator of acute inflammation and reference is often made to them as a marker to measure activity where there is an outbreak of inflammatory bowel disease, but, again, the result will vary where there is any form of inflammation and it is not specific to inflammatory bowel disease. Of some relevance is the lymphocite result but there are known difficulties in interpreting the lymphocite count for sufferers from Down's Syndrome and the count can be lowered by the ingestion of steroids, which Roddy began ingesting intravenously on 16th. April as prescribed by Dr. Pullar. The final marker of some consequence is the albumin level which was recorded as being 36 which is at the bottom of normal whereas it was in fact 27 and had gone down to 25 by 17th. April. Albumin is another protein produced by the liver and its lowered count is an indication of nutritional problems or liver or kidney dysfunction. Albumin can be lost through the bowel when ulcerative colitis is active. A reduced level suggests that the illness has been present for more than just a day or two and is a strong marker for a poor prognosis.

[85] Dr. Starr was impressed by the note made by Dr. Pullar, in the course of his examination late on the afternoon of 16th. April, relating to Roddy's mental health, his experience being that normally such notes exclusively concerned themselves with physical conditions. Dr. Pullar clearly appreciated the benefit to Roddy in having the opportunity to be nursed in a ward where a relative who knew him was a staff nurse. No evidence was led as to why that did not occur. Dr. Starr commented on the concern a normal person would have about a hospital admission. He said that for a person with Down's Syndrome it would be like being removed from familiar surroundings with a bag over his head and subject to pain and an inability to fathom what was happening or why. It would be a very frightening experience. He stated that,

in Edinburgh, there was a liaison nurse for people with learning disability who were admitted to general hospital. That nurse would have a good understanding of the condition from which the patient was suffering. It might also be of assistance to involve a speech therapist to aid understanding and communication though he did not know if this would have been of any assistance in Roddy's case. The liaison nurse would be able to assist other staff, particularly nursing staff, with some insight into the mental condition and its effect on the patient's perception and understanding of what was taking place. She would be aware of the resources available to assist a frightened and unco-operative patient. This service had been available in Edinburgh since about 2002 and Dr. Starr had made frequent use of the service and had found it of considerable value.

[86] It was a matter of some concern that Roddy was seen on 17th. April by yet another strange face, Dr. Jones, and not by Dr. Pullar. This was not consistent with the concept of continuity of care which was of particular importance for patients with learning difficulties. Dr. Pullar may have been able to say whether Roddy was or was not improved in his health by a comparison with his presentation the previous afternoon. While I recognise the inherent merit in this observation, I cannot regard it

as a fair criticism of Dr. Pullar, Dr. Jones or the system where, in reality, the concept of continuity must take second place the efficient operation of the ward. Dr. Starr's comments do give rise to the larger question, too large I think for this inquiry, whether it would be better and more efficient and "patient-friendly" to take people with learning disability out the normal system altogether and nurse them in their own separate facilty when they have a physical illness. It strikes me, for what it may be worth, that Ward 15 is a sifting process where acute conditions are initially addressed and then the patient is diverted to the relevant specialist. In theory at least, a similar smaller unit could be established either in a general hospital or at a psychiatric unit catering exclusively for patients with mental health issues currently suffering, as so many do, from some physical illness or injury, with a combined staff which would include psychiatrically trained nurses, psychiatrists and other appropriate therapists working alongside general nursing staff and medical specialists. I recognise, however, that that is a very simplistic view and, as I say, a proposition that would require examination in an enquiry much wider than the scope of the present one.

[87] Dr. Starr was also critical of Dr. Jones for apparently ignoring the raised alkaline phosphate level from the blood test results. Dr. Jones appears to have seen Roddy at 07.45 on 17th. April in the course of his ward round. It would seem at that point that Roddy had still not been X-rayed and Dr. Jones noted the need for an abdominal X-ray. He also wished Roddy to be reviewed by the gastro-intestinal team, which was entirely approriate. But he then wrote "Home ?" Dr. Jones had noted a history of ulcerative colitis with a recent history of 6-10 bowel movements daily, with blood, a raised alkaline phosphate level and a lowered MCV level. Dr. Starr observed that the raised alkaline level was an indicator of abnormal liver function and he would have wanted to know whether this was a new event or a problem of long standing so he would have checked historical blood test results to see the comparative figures. Had Dr. Jones done that, the probability is that he would have recognised that he was working from a wrong set of blood test results. I have to say I think there is some merit in this criticism. The information about previous blood test results was readily accessible - either by viewing a computer screen or a print out and there was both a screen and a printer on Ward 15 - but that obvious step was not taken. Dr. Starr made the point that this was all the more correct as a way to proceed when dealing with a patient who was patently a poor historian. We know now with the benefit of hindsight that Roddy did have a long standing liver dysfunction but it is not clear if that could have been known to the doctors who saw him on 17th. April, 2003, though there may have been some reference to it in his medical file.

[88] Dr. Starr also noted that Dr. Jones had recorded the need for an "AWI Act form." There was no sign of any such form having been completed. Given Roddy's discharge there was no particular significance in the non-completion but the note serves to confirm that Dr. Jones knew he was dealing with a person with mental difficulties and that, had he required to be detained in hospital for treatment, a treatment plan would have been required and relevant persons would have had to be contacted. It is not clear if this was a factor in determining Roddy's discharge and no one was asked whether the practical difficulties that this would give rise to were an encouragement to discharge.

[89] Dr. Starr had had an opportunity to view the abdominal X-ray ultimately obtained and was able to confirm that there was no distention of the bowel to be seen. That meant there was no acute condition requiring surgical intervention at that point. If he had been responsible for the patient, he would, given the history of abdominal pain, also have requested a chest X-ray to see if there was evidence of gas escaping from the bowel and lodging under the diaphragm, which could have been the cause of the pain.

[90] A general physician would be authorised and be able to use a rigid sigmoidoscope. This was a rigid tube with a lamp at the end which would permit viewing of about the first 15 centimetres of the anal passage. Alternatively and more definitively, a flexible sigmoidoscopy could have been carried out by the gastro-intestinal specialist. This uses fibre optic technology and would permit examination of about 60 centimetres of the bowel permitting a view of the entire bowel. If the patient was suffering from an outbreak of ulcerative colitis then ulceration would be seen, normally all over the bowel. Roddy had undergone flexible sigmoidoscopy in 1997, when he was originally diagnosed as suffering from ulcerative colitis, apparently without difficulty, though it is perhaps noteworthy that his mother would have been alive then. It was noted that his presentation was unusual with most of the anal passage having been spared. Dr. Starr made the point that compliance with the procedure is important. There are risks in using sigmoidoscopes. With rigid ones there is a risk of poking through the bowel lining and thus making matters much worse. Roddy may not have been compliant and whether on the day he would have been able to undergo the procedure is something only the doctor about to undertake the procedure could properly gauge. The result of a flexible sigmoidoscopy would, however, have been determinative and in Dr. Starr's opinion, should have been considered for Roddy. Some sedation or general anaesthetic could have been considered but either of these steps also gives rise to complications which would have had to be considered. It would have been unlawful to proceed without the completion of a form in terms of Section 47 of the Adults With Incapacity (Scotland) Act, 2000.

[91] Dr. Starr commented that Drs. Hill and Barron had noted that Roddy was eating and drinking normally. There is no technical meaning to that. It simply means that Roddy had been observed to eat and drink. However, a fluid chart (Crown Prod.1 page 156) suggests he refused to take fluids orally and records his lack of output of urine. It suggests a degree of dehydration, which had been noted on admission. There is no information in the nursing notes as to what he ate and drank - by contrast with the careful notes kept at Maryfield House and by contrast with the evidence of James Donnet that Roddy's dinner was at his bedside untouched and that he could not get him to eat or drink.

[92] Dr. Starr also noted that the gastro-enterologists recorded, of Roddy, "poor compliance with medication," but apart from enemas, which would have involved administration by community nurses, they sent him home on the same medication. Dr. Starr was rightly critical of the lack of consideration given to the observations from Dr. Badenhorst in her admission note about compliance issues and appeared not to consider what would be done to assist the patient's management in the community. He was also critical of their failure to arrange, if they were discharging

him from hospital, prompt out-patient follow up. I think in all the circumstances that that is also a justified criticism, given the history they had.

[93] Dr. Starr noted that the real figure for C-reactive protein was not 4 as noted by the gastro-intestinal team but 59 on admission and 34 on 17th. April. Like Dr. Jones, neither member of the gastro-intestinal team appears to have bothered to check CentralVision to obtain either or both of current information or historical comparative information about these results. Had they done so, they might have appreciated that they were working from the wrong set of results and that their assumption that his C-reactive protein level was normal at 4, a factor they plainly considered important for they noted it, was in fact at one or other of 59 or 34. Dr. Starr was unsure what the effect of Down's Syndrome on C-reactive protein might be but the actual reduction from 59 to 34 might demonstrate that the medication was working - either that prescribed by Dr. Badenhorst prior to admission, the Asacol anti-inflammatory, or the methyl prednisolone steroid based medication intravenously administered since admission.

[94] It should have been one of the gastro-enterologists who completed the discharge form - whoever authorised the discharge. It should be signed. Dr. Starr considered it to be confused as to whether Asacol was to continue in tablet or enema form or both.

[95] The actual discharge letter was dictated by a Dr. Williamson. This doctor does not ever appear to have examined Roddy nor been involved in his treatment. The letter says it was dictated on 28th. April, was typed on 15th. May and reached the general practitioner on 19th. May, 32 days after Roddy was discharged. This is completely and utterly unacceptable at a time when the facility for instant communication exists. It is unacceptable that the discharge letter is written by a doctor other than the doctor who determined that the patient should be discharged, as this merely gives rise to further opportunity for error. It is unacceptable that it takes more than 24 hours for information to reach the patient's general practitioner where there is essential ongoing treatment as there was here. This attitude amongst doctors which permits and appears to promote inappropriate delegation and inordinately slow transmission of important information about patient care must change immediately. They must also be provided with adequate secretarial facilities.

[96] The letter dated 15th. May indicates that the gastro-enterologists found no evidence of active inflammatory bowel disease and so they stopped treatment with methyl prednisolone but, as the letter says, "he was advised" to continue with his Asacol product. Roddy would not understand this advice. In any event, the advice in the letter continues the confusion as to which of the Asacol products Roddy was supposed to use. Again it does nothing to address the patient management difficulties. Oral Asacol is normally prescribed, said Dr. Starr, as a maintenance treatment to inhibit the return of an inflammatory bowel disorder and can assist in the treatment of a mild to moderate outbreak. It is not as effective as oral steroids which in turn are less effective than intravenous steroids. Dr. Starr expressed the hope that doctors would consider with care the need to administer an enema to a person with Down's Syndrome and dementia.

[97] Dr. Starr speculated that Roddy's symptoms had settled briefly on 17th. April. He accepted that there was no significant abdominal tenderness, no distension of the bowel and no rigidity, no altered bowel sounds and no indication of acute inflammation from the wrong blood results from which the doctors were working. There was also a clear abdominal X-ray and no bowel movements other than shortly after admission. Dr. Starr accepted that all the foregoing tended to indicate that Roddy was not acutely ill with ulcerative colitis. But the gastro-enterologists offer no differential diagnosis for the recently recorded symptomatology and by discharging him on the same medication they appear to accept that he was suffering from ulcerative colitis. They do not, for example, appear to have given any consideration as to whether his condition may have been caused by any of the forms of medication which he was required to take, a common cause of bowel dysfunction. In particular, sodium valproate, which Roddy had been put on relatively recently, is known to cause diarrhoea in some patients. It can be supplied with enteric coating but it does not appear to have been in Roddy's case.

[98] Had the discharge note been issued with the words on it "no evidence of active IBD," Dr. Starr considered that would have been misleading as a diagnosis. The original words which had been scored out "exacerbation of ulcerative colitis" would at least have let the general practitioner know, had the discharge form reached the general practice, which it appears not to have done, that at least the gastro-enterologists had reached the same diagnosis as the general practitioner. In Dr. Starr's view it would be understandable, faced with a discharge note in these terms, if a general practitioner had concluded that inflammatory bowel disorder had been excluded as the aetiology. A general practitioner is not obliged to accept the diagnosis in the discharge note but it flies in the face of sending a patient into hospital for specialist treatment then to act contrary to the information issued by the specialists.

[99] Dr. Starr was in no doubt, patently with the benefit of hindsight, that Roddy continued to suffer from ulcerative colitis until it caused his death. It was therefore, he considered, a reasonable inference to draw that if he had not been discharged when he was that he would have continued to respond to treatment for ulcerative colitis. Had he not continued to respond to treatment an alternative diagnosis would have been considered. In any event, he could have continued to be monitored and further investigation could have been undertaken by the gastro-enterologists as they considered appropriate. On the other hand there was perceived to be a benefit in getting Roddy back to Maryfield House as soon as possible and that would have had to have been weighed against the severity of the disease. Dr. Starr accepted that that was not an easy balance but to make the correct decision required accurate information which the gastro-enterologists did not seek.

[100] It was unfortunate and not conducive to a good outcome that Roddy spent a considerable amount of his time after admission to Ninewells being nursed on a trolley in a corridor. It would have helped him settle if he had had someone familiar with him present to assist to relieve his anxiety. Communication with relatives, one of the guiding principles of the Adults With Incapacity (Scotland) Act, 2000, was also highly relevant and important.

[101] Dr. Starr had some criticism to make about reliance on physical abdominal examination generally. He considered this was especially true when the patient suffers from Down's Syndrome and dementia. The current methods for abdominal examination had been developed in Victorian times but the value of these methods had not been subjected to rigorous research. Such research as there was tended to suggest that such examination produced results of limited accuracy. In the present case there was a difference about the assessment of the liver among doctors. He suggested that it would be wrong to place much reliance on abdominal examination.

Dr. Jones had, of course, accepted that physical examination of the abdomen was secondary, in terms of its diagnostic value, to radiological examination.

[102] Dr. Starr further observed that it was unusual for a patient on admission only to be examined in relation to one part of the body but it may be that Roddy would not co-operate with a chest examination. He seems, however, (Crown production 1 p 72) to have tolerated an ECG examination. That would be more of an interference than an ordinary chest examination. Such an examination would exclude pneumonia which could cause abdominal pain. Dr. Starr did not consider that Roddy had pneumonia at this stage but a chest examination would have excluded it.

[103] Pneumonia was, however, the ultimate cause of death. Had Roddy remained in hospital and had his dehydration and nutrition attended to and his ulcerative colitis treated, it is unlikely that he would have died from pneumonia. The low albumin level suggests an illness of several weeks duration, which would be consistent with the history noted by Dr. Badenhorst and to be seen on an examination of the Maryfield House notes, of diarrhoea over several weeks and poor eating and drinking over the same period.

[104] The assessment of the gastro-enterologists is in stark contrast to the assessment of the pathologist, and he is the final arbiter, observed Dr. Starr.

[105] Dr. Starr considered that it was disappointing that there was no follow up after admission with the carers. For all the hospital staff knew, the person who accompanied Roddy into hospital may only have had minimal knowledge of him and enquiries should have been made of the care home manager or Roddy's keyworker.

[106] It was also his opinion that discharge had occurred " by default." For this he was critical of the gastro-enterologists for having discharged Roddy without obtaining an independent history, without considering that morning's blood test results and without considering alternative causes for the reported symptoms. This caused circumstances in his opinion in which the general practitioners may have been confused as to whether ulcerative colitis was the correct diagnosis. Had they been clear that it was, they may have been more focused in their efforts to get Roddy back into hospital.

[107] One of the caring agencies with whom Dr. Starr frequently came into contact with in Midlothian had adopted a policy of taking out welfare powers of attorney for all people in their care who were fit to instruct such a deed almost as a matter of course. He considered this to be a good practice against the contingency of being unable to make decisions for yourself so that there was a legally responsible adult

who could readily be identified who could take these decisions for you. He thought there was a "mixture of understanding" among his colleagues about the provisions of the Adults With Incapacity (Scotland) Act, 2000 depending largely on the proportion of the particular doctor's workload suffering from incapacity. He was involved in the training of specialist registrars in south east Scotland about the law on adults with incapacity but considered it was less clear what training was being given more generally and to consultants in particular. He was aware of a number of patients who had welfare guardians but understood that having one appointed was "quite burdensome," an assessment with which I would agree. He considered it better to have a proxy than not as from his perspective it eased decision making.

[108] He regarded it as part of his duty as a doctor to discuss legal issues with people who were suffering from reduced mental capacity for example as to whether they should continue to drive or should be surrendering their licence, about making a will if their time was limited and they had not done so and about considering granting powers of attorney, particularly welfare powers. He would do this in his field once he had got to know the patient and he accepted that this would not be appropriate at a first meeting. He accepted that, logically, this type of issue should be dealt with better by general practitioners who knew their patients better than any hospital consultant normally would. He was surprised to learn that the general practice of which Roddy was a patient had not advised relatives or carers about the merits of an application under the Adults With Incapacity (Scotland) Act, 2000. He was surprised to learn that Dr. Quinn considered that it got in the way of her working relationship with her patients. So was I.

[109] The appointment of welfare attorneys or guardians was a good thing, he considered, for the reasons already advanced but in the circumstances that pertained here, the question was whether the provisions of the Mental Health (Scotland)Act, 1984, which has since been replaced by the Mental Health (Care and Treatment)(Scotland) Act, 2003 should have been utilised to get Roddy back into hospital when the general practitioners considered that otherwise it would have been apt to do so following the original discharge on 17th. April. That could have been initiated by a general practitioner on an emergency basis to get an emergency condition attended do. A mental health officer should have been able to advise on appropriate courses of action if the general practitioners themselves were unfamiliar with the procedures. A sheriff could still authorise admission under the otherwise defunct provisions of the National Insurance Act, 1947. However, Dr. Starr considered that the power of persuasion still remains the best course and he would have undertaken a domiciliary visit had he been asked to do so. He said that it was common for people to be afraid to go into hospital and if a link could be provided between home and hospital than can reduce anxiety.

[110] A consultant physician dealing with a person with a learning disability with a known history of mental disorder should liaise with learning disability or psychiatric services. With particular regard to Down's syndrome sufferers, the average lifespan has increased significantly in recent years but disability learning services were still geared largely to teaching life skills to young people with disability and they had yet to recognise a need to deal with older disabled persons now experiencing the early onset of diseases of old age. In Tayside and South East Scotland a managed clinical network had been established for people with learning disability and it was his hope

and aspiration that assessment of their physical health would become an integral part of this management process and that patients would increasingly be directed to specialists like him who could help in addressing the range of problems and not just one specialty. This process was in its infancy. It was a response to the recognised and growing problem more generally associated with elderly patients but also now being seen with ageing sufferers with learning disability that one specialist treats a condition without considering what another health specialist may be doing with the particular patient which had resulted from time to time in conflicting prescribing. Here, Dr. Quinn from the Learning Disability Service did not know Roddy had ulcerative colitis and might easily have prescribed medication which could have exacerbated that physical problem, though in fact she did not. The general practice had prescribed sodium valproate which is known to cause diarrhoea in some patients apparently without considering whether it should be prescribed with an enteric coating, which was available, something which ought to have occurred to them as being appropriate with a patient they knew had a history not only of ulcerative colitis but digestive disorders more generally.

[111] In Dr. Starr's opinion, had Roddy been re-admitted to Ninewells Hospital and had the diagnosis of severe ulcerative colitis been made, as it almost certainly would have been, it may well have been that treatment would have proved effective and he would not have died when he did and in the manner in which he did as a consequence of ulcerative colitis. Had he been in hospital and had he been treated for ulcerative colitis the chances are that he would not have died at that time from that disorder.

[112] A patient admitted with severe ulcerative colitis would be introduced to intravenous steroids which would normally produce an improvement in the patient's condition within two to three days. Dehydration would normally also have to be addressed. Normally the extent of the disease would then be explored. Most people with inflammatory bowel disease are likely to be in hospital for more than a week.

[113] In relation to the use of Section 47 AWI Act forms, Dr. Starr was of the opinion that these were "condition-specific" and should be used only for the treatment of the specified condition. If a new condition develops the form can be amended or a new form completed. Prior to the issue of any certificate or amended certificate there should be a discussion with the patient's next-of-kin and carers to ascertain whether a patient would have wanted a particular form of treatment.

[114] Dr. David Norman Clarke was a 58 year old retired consultant physician with interest in general medicine and gastro-enterology who was led by the Crown as an expert witness. He was an expert witness and along with Dr. Starr was one of the two most impressive witnesses to given evidence to this inquiry. Though recently retired, he was continuing to work on a part time basis at both Stirling Royal Infirmary and Falkirk and District Royal Infirmary. He had qualified as a medical practitioner in 1970 and had been based at Stirling Royal Infirmary for the past 26 years. He held the fellowships of both FRCS and FRCP, Glasgow. Dr. Clarke had provided a report, Crown production 10 and a supplementary report, Crown production 11.

[115] Dr. Clarke told the inquiry that throughout his career he had encountered on an almost daily basis someone suffering from ulcerative colitis. He was the only witness

to the inquiry in a position to offer this degree of knowledge and experience in the diagnosis and treatment of inflammatory bowel disease generally and ulcerative colitis in particular. This included dealing with acute admissions to hospital. He had only rarely had to treat persons suffering from Downs' Syndrome but had regularly treated patients suffering from dementia.

[116] From the records he had ascertained that Roddy had suffered from inflammatory bowel disease since 1996 there being some uncertainty whether he had ulcerative colitis or Crohn's disease initially. These were the two forms of inflammatory bowel disease, the former affecting the large bowel and the latter the small bowel. Ulcerative colitis is confined to the colon and normally involves ulceration normally at its most severe in the rectal passage. Roddy did not present with visible ulceration of the rectal passage. His 1997 outbreak appeared to have been relatively mild. The hospital records showed that he was seen for review in December, 1997 and March, 1998 but not thereafter and that may coincide with his mother becoming too unwell to be responsible for his care. Dr. Clarke explained that regular follow up was the norm for sufferers of inflammatory bowel disorder and he was very keen on regular review. If someone failed to attend he would offer a further appointment and if they still did not attend he would write to the patient warning of the consequences of not having regular reviews. Sometimes he would copy that letter to the patient's general practitioner. There was no evidence one way or the other of a similar practice at Ninewells Hospital.

[117] Dr. Clarke explained that, while it might appear paradoxical, a sufferer from ulcerative colitis could become constipated and require a laxative or bulking agent to ensure that motions flowed smoothly. Roddy had been prescribed Fybogel and this was unlikely to have been a factor of any materiality in relation to his diarrhoea.

[118] Dr. Clarke agreed with the provisional diagnosis of Dr. Badenhorst, Roddy's general practitioner, who was aware of a history of ulcerative colitis, and who noted with care the history of recent symptoms given by the carers at Maryfield House and who reached the correct conclusion on the basis of that and her own clinical examination.

[119] Similarly, the provisional diagnosis on admission to Ninewells, Ward 15, was of ulcerative colitis and he took no issue with that, subject only to the observation that there appeared to be no reference to rectal bleeding, which he would normally expect to have been observed. The absence of fresh blood would indicate Crohn's disease rather than ulcerative colitis. Ulcerative colitis always starts in the rectum and bleeding is one of the hallmarks of the condition.

[120] Dr. Clarke agreed that a significant increase in the number of bowel movements was a factor to be taken into account in reaching a diagnosis of ulcerative colitis but he would also expect an increase in body temperature, and for there to be markers in the blood tests. There might also be some dilation of the bowel to be seen on abdominal X-ray. The presence of maelena, altered blood, would not indicate ulcerative colitis but would be more likely to indicate a digestive tract disorder.

[121] If Roddy was not eating, drinking or taking his medication then he would become dehydrated and his ulcerative colitis would develop. Generally, Asacol, a non steroidal anti-inflammatory medication keeps inflammatory bowel disease at bay. There is no cure.

[122] Dr. Clarke also considered that Roddy should have undergone a chest examination on admission. While hindsight suggested it would not have added to the stock of knowledge it was a sensible and standard thing to do. He agreed with Dr. Starr that there were some chest conditions that presented with the patient complaining of pain in the abdomen and so, if the patient had been co-operative, a chest examination should have been performed.

[123] Dr. Clarke did not think there were material differences between the right set and wrong set of haemotology results but the position was different in relation to the biochemistry results. There were material differences in the figures for albumin and C-reactive protein. The erroneously incorporated figure for C-reactive protein from December, 2002 was entirely normal. The correct figure for 16th. April, 2003 is elevated. It remained a relatively low reading. Typical levels in a severe outbreak ranged from 100-170 but 59 and the subsequent 34 from the blood taken on 17th. April are abnormal and would indicate the presence of some inflammation or infection. The low level of albumin could be associated with lack of protein through not eating properly but albumin is also lost into the bowel if it is ulcerated so that is a second indicator of inflammation in the bowel. These results are consistent with a mild outbreak of ulcerative colitis. The wrong results were, therefore, misleading. The overnight reduction from 59 to 34 might reflect the efficacy of Roddy's introduction to the intravenous steroids.

[124] Dr. Clarke approved of Roddy being commenced on intravenous fluids and steriods by Dr. Pullar on 16th. April on the basis of the symptomatology then known to him, and of the other investigations which he initiated.

[124] Dr. Clarke expressed the opinion that it was most unusual for a person said to be experiencing six to ten motions daily for a period of time to have only one during the twenty six hours or so that he appears to have spent in hospital. Most people admitted to hospital would continue to have diarrhoea as it is a direct response to the inflammation. It is hard to explain that position in a manner consistent with a significant outbreak of ulcerative colitis, even if he had not been eating. Also, he did not appear to have a fever. His temperature was normal. His blood pressure became normal. If he had had severe dehydration and ongoing diarrhoea, neither of these would be expected to be normal. The X-rays eventually obtained were normal. Accordingly, he considered that, in the light of all these foregoing factors, a discharge back to Maryfield House was reasonable and that it was also reasonable to discontinue intravenous fluids and steroids. However, he accepted that one of the factors affecting this decision was the "normality" of the wrong blood. The condition to discharge would have been more difficult to justify had the correct blood test results been available. He thought that these might have suggested investigation by flexible sigmoidoscopy. The alternative would have been discharge with an early out-patient follow up and in deciding which he accepted that it would be relevant to consider Roddy's attitude to being in hospital.

[126] Dr. Clarke agreed that there might be some scope for criticism of the discharge note, the terms of which were "slightly misleading." He would have made the diagnosis mild to moderate inflammatory bowel disease. He thought at least in general terms that the decision by the gastro-enterologists to discharge was a reasonable decision, subject to the maintenace of Asacol and to out-patient follow up. The Asacol dosage was what was normally used to maintain remission or for treating a mild relapse.

[127] Dr. Clarke considered that it would have been difficult to carry out a domiciliary visit because of time and pressure in the hospital setting. Few consultants now do domiciliary visits. He did not see what a consultant could have contributed to the process of encouraging Roddy to return to hospital. The question whether the use of force would be appropriate would then apply. On the other hand, he would have been receptive to a telephone call for advice from the general practitioner and would have been encouraging the re-admission of Roddy on a report of fresh blood being observed in his stools. That encouragement would have been enhanced on being told that Roddy was crying out in pain and that he was continuing to suffer from diarrhoea. Dr. Clarke said he had regularly had telephone calls from general practitioners.

seeking advice on treatment of a particular patient.

[127] It would not be appropriate for ambulance service personnel to force anyone into an ambulance. They would be at risk of being charged with assault. The same applies to the use of force by medical or nursing personnel in the absence of consent or other authorisation. In Roddy's case, there is a documented history of disinclination to take medication or to co-operate with medical procedures and this creates a very difficult situation for those attempting to treat. Dr. Clarke would have suggested that an adults with incapacity assessment should be carried out. If that had determined that the adult could not make decisions for himself about treatment, there would be real practical difficulties in an ordinary hospital setting in investigation and treatment. Even the administration of an enema requires co-operation and without that it is a distressing experience for both the administrator and the recipient. The use of sedation might have some merit for a one-of task but ulcerative colitis is a chronic condition and if the resistance to treatment is also chronic then treatment becomes very difficult. Where resistance could not readily be overcome, Dr. Clarke would have consulted with relatives and carers to determine a course of action, spelling out the real, practical difficulties surrounding treatment, and inviting their input as to how to proceed. Sedation would almost certainly have been required and that gives rise to concerns about the operation of the respiratory system. Dr. Clarke accepted that the consequences of non-treatment would also have to be spelled out. This would have included making the point that on account of the onset of dementia in particular Roddy's lifespan was limited and he might not want to continue to suffer. He felt account had to be taken of that as a matter of morality. It was Dr. Clarke's position that, whatever the patient's mental condition might be, if physical resistance to treatment continued, then doctors were faced with a difficult moral dilemma about whether it was right to continue to treat.

[129] It was clear that by 15th. May, 2003 the ulcerative colitis had progressed to a stage at which it was life threatening. Efforts should have been made then or before

to re-admit Roddy to hospital. Most general practitioners would have known, whether they were members of the practice or an out of hours service, that Asacol was a medication for inflammatory bowel disorder. Dr. Clarke considered that by 21st. April, Roddy's family should have been being told that Roddy was suffering from ulcerative colitis and that he would die if he were not admitted to hospital for treatment.

[130] In his opinion Roddy died from ulcerative colitis, with broncho-pneumonia merely being a terminal event.

[131] Roddy might not have died at this time and from ulcerative colitis had he continued to take his medication as prescribed to him. He would have required to take Asacol for the rest of his life but he was not unfamiliar with taking tablets.

[132] Dr. Clarke found it hard to understand what the general practitioners were doing in the period up to 22nd. May if they had not determined that Roddy was terminally ill. If that were not their view, then they should have been making determined efforts to get him re-admitted to hospital.

[133] Dr. Clarke considered that Dr. Badenhorst's admissions note was of high quality. He further considered that both the examination and course of action adopted by Dr. Pullar were entirely appropriate, though he would have preferred there to be a chest examination. Dr. Pullar had noted a disinclination to be examined on Roddy's part.

[134] Given the history but the lack of motions currently, Dr. Clarke would have wanted to carry out a flexible sigmoidoscopy, which would have been determinative for the presence of ulcerative colitis. Such an investigation would have required sedation or restraint. About 50% of patients who have to undergo flexible sigmoidoscopy prefer to be sedated. The presence or otherwise of ulcerative colitis does not appear to render the process any more or less comfortable.

[135] The process of sedation would require the issue of a section 47 certificate after discussion with relatives and carers and the holding down of the patient's arm so that an injection of the sedative could take place intravenously. In the absence of agreement from the relatives he would have involved a psychiatrist as he had had to do from time to time. It was his opinion that since Roddy suffered from dementia the surgeons would have been unenthusiastic about carrying out an ileostomy on account of the likely difficulty of Roddy complying with a bag, but such an operation would have been a last choice solution.

[136] On reflection, Dr. Clarke accepted that, in a case of this nature, he might have agreed to undertake a domiciliary visit which would have allowed him to meet with and talk to carers. There would then have been an opportunity for physical examination and, if appropriate, opportunity for a discussion about the management of the patient including, again where appropriate, a dignified ending to his life.

[137] With regard to blood tests, there should be some form of indication in the patient's records that a result is outstanding. He would expect a phone call from a lab technician to alert him to anything really unusual and there was nothing to stop the doctor from phoning the laboratory. More commonly now results were held on

computer, with a monitor available on every ward and each doctor having an access code.

[138] It would be normal practice for a gastro-enterologist to consider X-rays without the need for assistance from a radiologist.

[139] In a patient with ulcerative colitis, diarrhoea would continue until the inflammation was reduced because the effect of the inflammation is to cause body fluids to leak into the bowel from which they would be discharged in the form of diarrhoea. That would continue even if the patient was neither eating nor drinking.

[140] The apparent change in the C-reactive protein reading does not appear to have been observed by anyone. If the reading had gone from 4 to 34 in 24 hours, Dr. Clarke would have wished to establish the cause of that and the change would suggest an ongoing inflammation. Anyone with a C-reactive protein level who is to be discharged requires close monitoring and should certainly be seen by a gastro-enterologist within three weeks. The low albumin level would have caused Dr. Clarke further concern. In fact, having been made to think about it, Dr. Clarke ultimately came to the conclusion that if the proper results had been available then discharge at the time at which it occurred would not have been appropriate and further investigation would have been indicated. There should have been a flexible sigmoidoscopy in normal circumstances so there should at least have been a discussion with relatives and carers as to the undertaking of such an investigative process. A return to the care home on an aggressive anti-colitic therapy might have worked but that would require review by the gastro-intestinal team as a matter of priority. If that had not worked, then urgent re-admission would have been indicated. Dr. Clarke thought that, with sedation, it would have been possible to undertake the flexible sigmoidoscopy on Roddy. That would also have shown up the presence of any tumour in the bowel which would not be revealed by an abdominal X-ray. A general practitioner should know that. Cancer of the bowel associated with ulcerative colitis does not usually occur within ten years of first diagnosis of ulcerative colitis.

[141] There is tremendous pressure on acute medical beds in almost every hospital. If a patient's condition appears to have resolved and there are no worrying features, then there is a pressure to discharge the patient as quickly as possible and that pressure may well be reflected in what occurred here. The discharge note issued with the patient was poor. A system of the issue of discharge notes without review by the consultant in charge of the case is poor.

[142] The third expert called was Dr. Paul Rafferty, aged 52, a consultant physician at Dumfries & Galloway Royal Infirmary, with special interest in respiratory medicine. He was called by Tayside Health Board and, with all due respect to them and him, he was a rather odd choice of expert being neither involved with persons with incapacity or with inflammatory bowel disease other than in the passing. He had been a consultant since 1991 and throughout the time since then he had worked at Dumfries & Galloway Royal Infirmary, a small general hospital with 450 beds, another contrast with Ninewells which is one of the largest teaching hospitals in Europe. Dr. Rafferty was one of a group of nine physicians at his hospital, all doing general medicine but each also having a particular specialty.

[143] In preparing for the inquiry, Dr. Rafferty had had access to the Crown productions and to Dr. Starr's report. He had then written his own report which was production NHS 1.

[144] He had noted from the Ninewells medical records for Roddy that he had been the subject of investigations there in 1996 one of the conclusions from which was that he had abnormal liver function. Investigations to ascertain the cause of that discovered mild ulcerative colitis. That was discovered by means of a lower gastro-intestinal endoscopy. Roddy was then started on Asacol tablets and enemas and remained well for about five years thereafter. I think there is a question as to how frequently he had enemas as it is clear that he was resistant to them at all times accepting as I do the evidence about this from his sister. He further noted that in January, 2003, Roddy had been referred by his general practitioner to Ninewells's Department of Neurology after a number of falls and increased episodes of agitation and some seizure activity. These symptoms were said to relate to the early onset of dementia.

[145] Dr. Rafferty agreed with Dr. Clarke that ulcerative colitis was a disorder which could cause inflammation throughout the bowel, but predominantly the large bowel, which was episodic in nature and which, while incurable, normally responded to treatment for its alleviation. Asacol enemas could alleviate the condition and when it was at its most active could be administered up to twice daily. When the condition was in remission, taking Asacol tablets daily helped to maintain the remission.

[146] Dr. Rafferty further made reference to work carried out with Roddy by Professor McDermott relating to abnormal liver function in 2002. The professor had suggested regular monitoring of Roddy's blood and watching for biochemical changes. Tests for this purpose appear to have been carried out in September and December 2001 and in February, 2002. He thought there had been a further such test in December 2002 but that test was carried out at the request of the Department of Neurology. In any event, the results of all these tests were on the CentralVision system and could be accessed by date. It would appear that on 16th. April, 2003, the junior doctor who inserted the blood test results into the admissions file inserted the results for December, 2002 rather than for the blood she had taken that day.

[147] Dr. Rafferty considered that C-reactive protein, which changed rapidly, was not a good indicator for consideration of change in relation to a recurring illness but he appeared to agree that it was a protein which reacted quickly to change in the condition of the body, particularly caused by infection. He did not consider, and in this he was out of line with Dr. Starr and Dr. Clarke, both of whose evidence on this subject I have preferred, that the results from December, 2002 on the one hand and 16th. April, 2003 on the other, were materially different. He did say that what was important was to observe change, something the doctors at Ninewells simply did not do. He considered the results demonstrated a relatively stable situation and, again, that seems somewhat at odds with Drs. Starr and Clarke.

[148] On a consideration of the Maryfield House notes, the first reference to loose stools was to be found on 7th. April. When that persisted, Roddy was seen by Dr. Badenhorst on 10th. April when she diagnosed a flare up of his ulcerative colitis. She prescribed Asacol, both in tablet form and by enema. It is noted that Roddy did not

like the enema procedure. Dr. Badenhorst re-visited on 14th. April, when Roddy appeared to have improved. By 16th. April, however, he was reported to be flat, dehydrated, and refusing both solids and medication. There was reference to his crying out in pain. Dr. Rafferty observed that it was easy for a person with diarrhoea to become dehydrated and thus run the risk of triggering renal failure. Dehydration was a good reason for getting a patient into hospital.

[149] Dr. Rafferty noted that there was nothing in Dr. Badenhorst's admission note about observing blood in the stools and without being critical of her it was hard to find objective evidence of a record of six to ten bowel movements a day.

[150] Dr. Rafferty considered that Dr. Wallace ought to have been able to expect to get a good history about Roddy's condition from the carer. I observe that Dr. Starr was significantly more circumspect about that, and that may reflect his greater experience in dealing with care homes, some of whose staff would be better, as historians, than others. I accept as a matter of practicality that the carer present should in general terms have understood why Roddy was being admitted to hospital but it should be obvious to any doctor that any carer will only be in contact with the patient and other patients for a part of any given day and part of any given week and will not necessarily know the whole picture. Doctors should seek out either a keyworker or written records where precise information is significant.

[151] It appeared to him that Dr. Wallace had done all the right things and initiated all the correct processes albeit there is no reference in her notes to a requirement for a stool culture. Dr Rafferty expected that nursing staff would obtain a stool sample "as a matter of routine." Dr. Pullar had applied the Ward 15 protocol for inflammatory bowel disorder appropriately by commencing fluids and methyl prednisolone intravenously. Normally, that procedure would continue until improvement in the patient's condition was observed. The improvements to look for would be a reduction in temperature or a settling of pulse rate or if the patient was eating or drinking normally. Then you would change to oral steroids which should continue so long as the patient remained toxic.

[152] Dr. Rafferty also noted that Roddy was apparently frightened of hospital and that Dr. Pullar had noted that his niece worked in one of the wards and there might be merit in transferring him to her ward so that there would be a familiar presence which might improve his level of co-operation. That did not happen. Why it did not happen was not explored in evidence.

[153] Dr. Rafferty then dealt with the morning of 17th. April and the examination by Dr. Jones. He noted that Dr. Jones had recorded the abnormal results (albeit taken from the wrong set of results), for alkaline phosphotase and mean cell value. He also noted that Dr. Jones had recorded bowel sounds as being normal and that Roddy was apyrexial with normal blood pressure. He requested that efforts persist to obtain an abdominal X-ray and that an AWI Act form should be completed, though none ever was. The alkaline phosphotase had been raised for several years and on a comparison with earlier blood tests there was no significant change, but it is not obvious that Dr. Jones undertook that comparison. Having said that, he may have been aware from the notes of Roddy's earlier investigation for "? liver malfunction." The low mean cell value figure indicates an iron deficiency and can be a marker,

said Dr. Rafferty, for almost any disease. Patients with ulcerative colitis are commonly anaemic and that would explain the low haemoglobin figure. The reduction in this case was modest and of no immediate concern. Dr. Rafferty wondered if the AWI form was for the purpose of forcing an X-ray on the basis that Dr. Jones would want to exclude any distension and especially perforation of the bowel before discharge. As he explained, "Sometimes telling people that a test had to be done whether they consent or not is sufficient to dissuade resistance." If Roddy was maintaining physical resistance, that could be overcome by a mild sedative being injected intravenously.

[154] By the time of Dr. Jones's examination, Roddy had been in hospital for about 20 hours and had been seen by three doctors all of whom had found his abdomen soft and had noted the presence of normal bowel sounds. He had had one loose stool. There was no evidence of abdominal tenderness, no abnormal bowel sounds and no diarrhoea. His temperature, pulse and blood pressure were all normal. All these indicators are inconsistent with an acute and severe episode of inflammatory bowel disorder. It was therefore appropriate, in Dr. Rafferty's opinion, to consider discharge home, subject to assessment by gastro-enterologists and confirmation that nothing unusual was discovered on X-ray. The element missing from the foregoing list is the blood test results. Of course, Dr. Jones thought he had blood test results but, as we know, he had the wrong results and I am afraid I favour the opinion of Dr. Clarke with his experience as a gastro-enterologist, when he tells me that faced with the correct set of results he would have wished to carry out a flexible sigmoidoscopy, though I am bound to accept that there is a strong body of evidence to the effect that all these other signs are inconsistent with the presence of a severe episode of ulcerative colitis.

[155] On the materiality of the difference between the wrong results which were used and the correct results which were not, Dr. Rafferty commented that the haemoglobin result was not significantly different. Those where the difference was arguably significant were C-reactive protein which was elevated at 59 and the platelets level similarly elevated at 494. The platelets result was a reactive change. The C-reactive protein indicated inflammation so that does indicate some current inflammatory condition. Both elevations, he said, were relatively modest and not indicative of any specific inflammation. The reduced albumin level indicates a loss of protein consistent with ulcerative colitis. These markers, taken together, are indicative of the presence of some significant inflammatory condition but are not indicative of a severe attack. The markers would have to be regarded in the light of the other clinical findings, said Dr. Rafferty. I have two problems with that approach. Firstly, it is clear that there is a divergence of view between Dr. Clarke and Dr. Rafferty about the significance of the correct blood test results. Secondly, it is an approach which pays no regard to the clear indication from Dr. Badenhorst in her admission request to the effect that Roddy was a management problem in the community - "initially improved but now refusing all fluids/solids/medication." The approach, apparently meeting with Dr. Rafferty's approval, is "This man is not acutely ill and therefore does not need to be in hospital - so send him home;" as opposed to "This man is ill, probably with ulcerative colitis - though by undertaking a flexible sigmoidoscopy we could resolve that definitively and his general practitioner is telling us that those responsible for his care in the community cannot get him to co-operate with his care; what can we do to make him well before we discharge him

and how can we improve his management in the community ?" To my mind, the latter approach, the approach which Dr. Clarke would have been likely to adopt, is more consistent with the type and quality of care I would have expected Roddy to receive than the former. What was absolutely clear from the evidence of Dr. Clarke was that there was no way Roddy should have been discharged back into the community without the community i.e. both the carers and the general practitioners being made aware that the diagnosis remained ulcerative colitis, that there was an argument that that could be managed better in the care home setting provided he was co-operative, that there was no current need for intravenous treatment which could only be carried out in hospital but that Roddy's condition should be reviewed urgently by a gastro-enterologist. None of these things was done.

[156] While the position is not conclusive, a consideration of the actual blood test results for 16th. and 17th. April demonstrates a reduction in the C-reactive figure from 59 to 34. I appreciate from the evidence that C-reactive protein is a somewhat volatile marker but that information suggests a reduction in the inflammation which may in turn suggest that Roddy was benefiting from the treatment he was receiving. Logic suggests that there would have been merit in his remaining in hospital until his C-reactive protein figure was back to close to normal. But this improvement in the results went undiscovered because no doctor looked at the results for 17th. April. Dr. Rafferty accepted that these correct results appeared to demonstrate that the condition that was causing the inflammation appeared to have settled a little. We know, with the dubious benefit of hindsight, that that condition was undoubtedly ulcerative colitis and that is the condition for which he was being treated.

[157] Much of the foregoing is also relevant to the examination by the gastric team though it was all the more important that they get it right as they were the final arbiters on the subject of discharge. They did not check the blood test results. They did not apparently consider the general practitioner's admissions request. They did not appear to appreciate that Roddy had presented a management problem in the community. They did not consider how well the staff of a residential care home would be able to cope with him. They did not recognise that his condition had improved since his admission to and treatment in hospital. They simply saw, in their terms, someone who was not acutely ill, as at that point he was not, and therefore someone who did not need to be in hospital, irrespective of what the difficulties in caring for him in the community might be. They did not think about these difficulties, even when they noted "poor compliance with medication" as one of the factors which had caused him to be admitted. They decided to discharge him on the same medication with which they had noted he had not been compliant. One might reasonably ask what did they expect to happen. It is true that they made a referral to the inflammatory bowel disease clinic but the reality is that Roddy was dead from ulcerative colitis and still no appointment for the clinic had been issued.

[158] One of the factors taken into account by Drs. Hill and Barron was that Roddy was said to be eating and drinking normally. There is no evidence that Roddy was eating and drinking normally. Unfortunately the Crown chose not to lead any evidence from any nurse who had been involved in Roddy's care during his admission, though nursing staff might have been able to explain the period of difficulties with intravenous medication, as there are otherwise unexplained delays in the commencement and resumption of the administration of both fluids and steroids

if one considers the relevant charts, and as to why it was being maintained that he was eating and drinking normally when James Donnet reported Roddy's untouched dinner at his bedside and the fluid charts demonstrate that he was neither taking liquid in nor passing urine. It is quite clear from the Maryfield House records that both before and after his hospital admission Roddy was not eating or drinking normally and had to be encouraged todo both. This is why Jackie Mackie started recording quite specifically both his food and liquid intake. On the balance of probability, I do not believe that Roddy was eating and drinking normally during his in-patient stay at Ninewells and that the nursing staff could properly have said that he was. In any event the fluids chart was available to Drs. Hill and Barron and it would have demonstrated cause for doubt about the accuracy of that assessment.

[159] Dr. Rafferty agreed with me that if Drs. Hill and Barron had checked the results for the blood sample taken on 17th. April, prior to discharge, and it appears to me from the information from CentralVision that that information was imported to the system to be seen at 10.41, so it would have been there to be checked, they would have seen a change in the C-reactive protein figure from 4, which they wrongly believed was the result from 16th. April, to 34 and so they might have deduced from that information that there was an active inflammatory process taking place. They might even have recognised that the results they were working from were the wrong results. However, they did not bother to check prior to discharging Roddy. Dr. Rafferty agreed that such a change in the C-reactive protein figure would be a cause for concern. However, he would not concede that the gastric team should have sought out these results for comparative purposes. I regret that in this respect I disagree profoundly with him and regard his position as untenable.

[160] Dr. Rafferty accepted that there was scope for a difference of opinion on the value of carrying out a flexible sigmoidoscopy, especially on an unco-operative patient. He agreed that such an investigation would have produced a determinative result. While I accept that the level of co-operation to be expected would have been an issue, I do not think it can properly be said that there is scope for a difference of opinion about its value. With a poor historian, it seems to me blindingly obvious to attempt a test which will determine definitively what the cause of an illness is, particularly when there is reason to believe that the illness is a potentially life threatening one if not treated. I accept that AWI Act procedures would require to be complied with and that physical resistance by Roddy might have rendered the process incapable of being performed though I suspect with the administration of an appropriate sedative he would have slept through it. So, again, I cannot agree with Dr. Rafferty's position.

[161] Dr. Rafferty did agree with the suggestion that on discharge an appointment with the inflammatory bowel disease clinic should have been fixed. He contented himself, however, with the observation that Roddy was being discharged to a nursing home and would not therefore be on his own. This, in my opinion, is a critical error both in the way that Roddy was treated and in Dr. Rafferty's expression of opinion about the quality of that treatment. The fact is that Roddy was not being discharged to a nursing home. In my opinion, he should have been discharged, when the time for discharge was right, to a nursing home and not back to a care home where he could not be managed. Responsibility for his discharge to an inappropriate setting to some extent rests with these doctors who ignored the general practitioner's

reference to management problems but the main responsibility for this must rest with Dundee City Council Social Work Department. Hindsight is a wonderful thing but if there was ever an appropriate time to move Roddy from Maryfield House to a nursing home then the time was on his discharge from Ninewells Hospital.

[162] Moving on to the period after discharge, Dr. Rafferty regarded it as significant that those responsible for his care did not consider that Roddy would cope with a further admission to hospital but I regret he offered no explanation as to why that was significant. It may be that in his own mind he was maintaining his earlier error in thinking that Roddy was in a home where there were qualified nurses responsible for his care. He was not. And with all due respect to those who were responsible for his care, leaving the general practitioners aside for the moment, none of them were qualified to form a view about what Roddy could cope with medically. It is instructive that at least two of the general practitioners who did see him attempted to have him re-admitted to hospital so patently they did not think that Roddy could not cope with another such admission and they were better qualified to reach that conclusion than those to whom this qualitative assessment appears to be being attributed. I regret that I can find no evidential support for Dr. Rafferty's conclusion and it is a matter of considerable concern to me that no greater effort was made to get Roddy back into hospital.

[163] Dr. Rafferty made a number of criticisms of the report by Dr. Starr. He considered that Dr. Starr placed too much emphasis on the misinformation deriving from the mistranscription of the blood test results. Standing in particular the evidence of Dr. Clarke on this topic, I do not agree. I entirely accept that Dr. Jones and the gastric team had no reason to suspect that there had been an error in transcription but I am at a loss to understand why the gastric team did not check the current blood test results prior to discharge and transcription was done, in general terms, in accordance with the instructions of Dr. Jones. It follows that I do not agree that the discharge from hospital at the time it occurred was appropriate. Nor do I fully agree with the submission that forcing him back into hospital would have been inappropriate. The general practitioners, with the exception of Dr. Badenhorst who properly stuck to her original diagnosis, were now in some doubt as to what was wrong with Roddy but they had no particular reason to think that he was suffering from something which was terminally incurable. They just could not persuade him to get back into an ambulance. Inherent in the assumption that Roddy could not be forced back into the ambulance is the assumption that he was in a position to make a choice in the matter. Patently, he was not. This was evident from the evidence of his sister and brother and most particularly from Dr. Quinn. So I reject as nonsense the suggestion that Roddy was exercising any kind of informed choice when he put up resistance either to removal from his familiar surroundings or to examination. He was merely reacting instinctively no doubt conditioned by pain to people whom he did not know trying to do things to him which he did not understand. What was required here, and what never happened at a time when it might have made a material difference, was someone from the medical profession with sufficient knowledge sitting down with Edith and James Donnet and informing them properly about what was wrong with Roddy, including his dementia and its outcome, explaining what the options were in relation to the suspected ulcerative colitis and obtaining their informed consent to an appropriate course of action. Alternatively, the general practitioners could have sought direction from the court. In the short term,

the provisions of the Mental Health (Care and Treatment)(Scotland) Act, 2003, particularly S.36, could have been invoked had there been both a need and agreement to proceed with active treatment. This task should have been initiated by the gastric team, possibly in conjunction with a psychiatrist - and Dr. Quinn who had known Roddy for some time would have been the obvious choice for that - or with a better informed general practitioner, and by that I mean someone who was clear that ulcerative colitis, and not something other than ulcerative colitis, was the continuing diagnosis from the Ninewells specialist team. I do not accept Dr. Rafferty's conclusion that a decision not to re-admit not at least without further discussion among professionals and with the family was appropriate.

[164] Dr. Rafferty observed, I thought with some concern, that it was hard to understand the sudden move to solely palliative care. I share that concern. It was a Dr. Anderson from D.D.O.C. who were at that time providing the out of hours cover for Dundee who decided on 22nd. May, 2003 to introduce a morphine syringe driver and to change the diagnosis to palliative care. Dr. Anderson unfortunately was not called to give evidence - and this was a critical error on the part of the Crown - and so I can only speculate about the circumstances in which the doctor wrote "diagnosed terminally ill 7/52 ago," but it is clear that that piece of information coloured the doctor's approach to treatment. In my opinion, assuming that the doctor proceeded on the basis of information given by carers, then the doctor should not have done so without at least checking with the patient's general practitioner or next-of-kin. Again, I do not intend to be disparaging to the carers but they should, quite simply, not be involved in a decision of this nature. It is not their decision to make. It must be made by a relative, by a doctor or by someone with legal authority to do so. I have no reason to think that Dr. Anderson had any knowledge of Roddy prior to 22nd. May and therefore I have no reason to think that the doctor had any proper basis upon which to take the course of action adopted. I accept that the evidence is that the dosage of morphine prescribed would not itself have been fatal nor of itself create an irreversible state of affairs but Roddy's immobilisation which would be the result of the strong sedative effect of the morphine would inevitably lead to a terminal event. Dr. Rafferty explained that a syringe driver is designed to give continuous pain relief and so there is a tendency for coughing to be suppressed. Patients therefore tend to retain secretions in their chest leading to infection and pneumonia. In fairness to Dr. Anderson who had no opportunity to offer any explanation for these events, Dr. Hollins saw Roddy the following morning and continued the palliative treatment. He was unable to offer me any sound basis for having done so given that hitherto he had apparently been continuing to address active treatment. I regret that I have to say that I have concerns about the conduct of Dr. Hollins.

[165] Dr. Rafferty said in his report that a number of factors would have been considered by the general practitioners in deciding whether or not Roddy should be returned to hospital. The first, he said, was his refusal to be admitted, and I have already explained why I do not consider this to be a valid approach. The second, he said, was their "understanding of the need that he would require very significant sedation to undergo treatment with enemas and intravenous drug therapy and that this would pose a major risk of chest problems." I am afraid that this is entirely speculation on the part of Dr. Rafferty. There is no evidence that the general practitioners considered any such thing. Dr. Badenhorst continued to believe that Roddy was suffering from ulcerative colitis and continue to try to treat him in the

community for that illness. She may have thought it was counter-productive to force Roddy back into hospital but I do not recall her saying so. Dr. Hollins, whose evidence at times was unsatisfactory, was not clear what he was treating Roddy for though he seemed at least in treatment terms to be adhering to the diagnosis of ulcerative colitis while saying at other times that he thought Roddy might have been suffering from bowel cancer. He did not raise the problems of sedation as a consideration against re-admission. I am not to be understood as saying that there would have been no cause for concern about Roddy's ability to co-operate with treatment, though it was Dr. Rafferty who seemed to suggest that a small intravenous injection with a benzo-diazepine would have allowed Roddy to sleep through a flexible sigmoidoscopy, nor am I suggesting that there would be no cause for proper concern about the value in the longer term of treatment that could only be effected by using sedatives on a continuing basis. This is the sort of thing, however, which should have been discussed with Roddy's relatives. But there was no evidence of it being a factor in any consideration the general practitioners might have engaged in over attempting to get Roddy back into hospital. So again I do not agree with Dr. Rafferty's assertion that this was a factor. His third factor is the distress caused to Roddy by his removal from a familiar environment. I accept that there would have been a huge issue in circumstances in which everyone was properly informed as to whether there was merit in continuing or discontinuing active treatment and one of the considerations relevant to that discussion would have been the evidence of Roddy's distress on the previous occasion. The problem is that it is not clear what was the cause of that distress. While there is some evidence of a lack of co-operation from Roddy while in hospital, there is no evidence of him clinging on to items of equipment to prevent movement, there is no evidence of throwing food about, there is no evidence of struggling with nurses, there is no evidence of resistance to ECG examination, an X-ray was ultimately achieved and there is no evidence of continuous removal of either intravenous drip, so evidence to support the conclusion that Roddy was frightened in and intolerant of hospital is somewhat thin. Maybe he was frightened of ambulances; maybe he was just frightened by people in green uniforms taking him away from his home. Again, I accept that the progress of Roddy's dementia is a major factor which ought to have been considered and fully explained to his relatives as should the consequences of his continuing to deteriorate mentally. Had they decided to instruct the termination of active treatment and instead instruct palliative care in the knowledge that he would die from the progress of the ulcerative colitis, on the hypothesis that they were first properly informed about the position had active treatment been successful, then no one could fairly have criticised the family members had they elected to stop active treatment. On the evidence, one could be forgiven for coming to the conclusion, in fact, that James Donnet, Dr. Hollins and Miss Mackie had in fact come to such a decision, and I will say more about this later. But insofar as there was a decision not to have Roddy re-admitted to hospital, and in my opinion that happened by default rather than because there was a decision taken, none of the factors advanced by Dr. Rafferty was the subject of any proper discussion to form the basis for such a decision.

[166] I do not consider that it was Dr. Starr's position that Roddy had pneumonia at the time of his admission to hospital on 16th. April. His point was that he might have had and that might have been an explanation for his apparent abdominal pain. A chest examination would have excluded pneumonia as a cause of the pain if one

had been carried out. It was not and that was a matter for criticism. Dr. Rafferty accepted that a fuller examination would have been preferable but he made the point that with an unco-operative patient you would concentrate on the area which appeared to be painful.

[167] Dr. Rafferty expressed the opinion that, almost universally, patients with inflammatory bowel disease would have some abdominal tenderness. Dr. Jones was unconvinced as was Dr. Starr about the value of this kind of physical assessment, Dr. Starr making the particular point that in his experience sufferers from Down's syndrome did not react normally i.e. in a manner typical of a non-sufferer and only limited reliance could be placed on any such reaction or lack of reaction.

[168] Dr. Rafferty accepted that human error was the only explanation for the erroneous transcription of the results but did not consider the consequences of the error to be significant or to have been likely to lead to a different course of treatment. In this he is as odds with Drs. Starr and Clarke whose opinions on this I prefer.

[169] Dr. Rafferty agreed with Dr. Starr that there would have been merit in doing a comparative exercise with blood test results. He said that there was not the time in the course of a busy hospital day to go to the computer and check the records. The records, of course, could be printed off and put in the patient's file. It could be, modern technology now having progressed as it has, that some form of hand held technology could now hold these results but I heard no evidence of that and it is not for me to speculate. I do not understand, however, how it can properly be said that there is no time to consider information which is critical to the welfare of the patient. The information from blood tests, particularly comparative material demonstrating change, will commonly be more important than the results of at least some forms of physical examination. It strikes me as absurd that a doctor does not make time to be aware of blood test results, even if they are normal, for that tells the doctor quite a lot about the patient.

[170] If it was not unreasonable for the gastric team to assume, as Dr. Rafferty suggests, that if Roddy's condition deteriorated he would be re-admitted, why did they not indicate that on the discharge note ?

[171] Dr. Rafferty suggested that keeping Roddy for observation over the next few days would, demonstrably, have achieved nothing for he did not start suffering from diarrhoea again until some time later. He based this comment on his reading of the care home notes, he said. However, on the hypothesis that Roddy's behaviour in hospital would have been the same as in Maryfield House, which does not necessarily follow, then shortly before his return to Maryfield House, he was screaming in distress in an ambulance and took some time to settle. He had a loose bowel movement on 17th. April about 19.30. He was crying at 03.30 on 18th. April. He was very tired in the morning of 18th. April and refused lunch. Later he refused medication. He did not have tea. He was yelling out in the course of the evening. He refused to permit the application of cream to his sores. He was yelling out during the early hours of 19th. April. He was unco-operative with staff who were trying to give him a bath. Later on the same day he was fighting with staff, shouting and screaming. He was incontinent of urine. He assaulted a member of staff. He was in the early evening screaming and trembling. He was again incontinent of urine and

fought with staff trying to assist him. He appeared to be frightened and distressed. At 04.30 on 20th. April he was heard screaming. He had been incontinent of urine. At 12.50 he was complaining of pain in his stomach. The staff called the out of hours GP service and the doctor who visited wanted to admit him to hospital. The GP was told that Roddy was not taking his medication. Efforts to get him into the ambulance were unsuccessful. He was incontinent of faeces, diarrhoea, in the evening of 20th. April and again in the course of the night. I am not sure that I understand what Dr. Rafferty means when he says "nothing much happened over the next few days."

[172] Dr. Rafferty conceded to counsel for the family that he was not familiar with the *Hunter v Hanley* test, and that only 2 - 3% of his patients had bowel disorders. Only about 2% of his patients were adults with learning difficulties. About 5% of his patients suffered from dementia. He had never treated a person suffering from dementia in relation to a bowel disorder. I regret that I could not put much store in Dr. Rafferty's evidence. He did not seem to have the necessary background to support some of the opinions he ventured and a number of his opinions had little or no basis in fact when subjected to analysis. He also engaged in speculation which was unhelpful for example suggesting that Dr. Pullar might have decided on intravenous treatment as an easier way to get medication into Roddy rather than because he thought he was dealing with a severe outbreak of inflammatory bowel disorder when Dr. Pullar had told the court straightforwardly that, on the basis of the history given, he assumed he was dealing with a severe outbreak and followed the protocol accordingly. Dr. Rafferty was also inconsistent. He suggested that abdominal tenderness would be found in any patient suffering from inflammatory bowel disease and there would be a reluctance to permit examination, when the evidence in this case was that at least initially Roddy resisted abdominal examination by Dr. Wallace. He did however agree with every other doctor who gave evidence that the terms of the discharge note, if issued in the same form as the copy left on file, were appalling and limited and potentially misleading. He also considered that the double exclamation marks were dismissive in their intent, or so he would have assumed, and could be regarded as "a bit of a slap down for the GP." He said it would not be practical for discharge notes to be seen by consultants, never mind prepared by consultants, prior to their issue but did not explain what the impracticalities comprised. He would have expected a junior doctor to "inform the nursing home" about the basis of the discharge. He accepted that it would be preferable for a patient with learning difficulties to be examined in a quiet place and not in a hospital corridor.

[173] Dr. Rafferty accepted that it was possible that Roddy would not have died from ulcerative colitis when he did had active treatment been effectively continued. He agreed that that would almost certainly have required intravenous fluid and steroids which could only be administered under nursing supervision in hospital.

[174] Dr. Rafferty could not see any point in a domiciliary visit as nothing could be done in a home setting.

[175] Dr. Rafferty's specialty was the respiratory system and he made frequent use of a bronchoscope. When he did so with an adult with limited intellectual capacity he would always invoke S.47 of the Adults With Incapacity (Scotland) Act, 2003, procedure. He had no experience of dealing with a welfare guardian and did not

know what a welfare guardian's powers would be. He would deal with next-of-kin where he considered the patient was not able to take a decision about treatment. He could see merit in the concept of a welfare attorney or guardian, the basic concept having been outlined to him, having had experience of family disputes about what should happen next, as "ideally, you would like one person to be in charge."

[176] In relation to the use of sedation, a doctor would be unenthusiastic in using it simply to get a patient admitted because it is difficult to get a history or a reaction to the presence of pain from a person who is unconscious. He accepted however that there would be occasions when there was no alternative. Had he been contemplating Roddy's admission on 15th. May he would have discussed with family members the possible use of sedation to get Roddy into hospital.

[177] He accepted that there was scope for improved communication between the hospital medical staff and the general practitioner about the practitioner's patients and that the present case demonstrated deficiencies particularly when the patient had reduced intellectual capacity. Telephone contact about the discharge and the diagnosis and about the problems of management in the community would have been helpful. It would also have been helpful to have someone with whom the patient was able to communicate present.

[178] I want to be clear, given the criticisms that I have made, that I have no reservations whatsoever about Dr. Rafferty's general ability as a doctor nor about his credibility. He came to this court and made an honest attempt to contribute to what by any standard is a difficult set of circumstances. I have the misfortune to disagree with him about a number of aspects of his evidence, in some aspects profoundly, but it remains the case that he is an experienced consultant committed to the care of his patients and none of my criticisms should be regarded as in any way detracting from that position or from his capabilities as an experienced consultant physician.

The Performance of the General Practitioners:

[179] It is very clear that Roddy's mother was a shining example to all of us, devoting her life to the care of her congenitally disabled son, ensuring that he had the best quality of life that he could and that all the opportunities available for him to learn skills and to socialise were taken. In this context, her importance was as the central respository of knowledge about his health, both physical and mental, and the treatment for it and the sources of that treatment. It is no criticism of either Edith or James Donnet that they could not replicate the level of involvement of their mother but it is a crucial fact in understanding this case, in my opinion, and one of general importance to all people who take on the role of carer for relatives or friends who are either born with reduced intellect or come to suffer from reduced intellect from a wide variety of causes in the course of their lives. This is most starkly demonstrated in the particular context of this case where the evidence demonstrates that, until very close to the time of Roddy's death, neither his brother nor sister knew that he suffered from ulcerative colitis and only had a limited understanding of what ulcerative colitis was and what its consequences for Roddy were likely to be. There are a number of pieces of evidence, most particularly from Dr. Clarke, but also, for example in the admissions form completed by Dr. Wallace - "Carer doesn't know whose clinic he attends" - which demonstrate that the expectation is that once a person is diagnosed

as suffering from inflammatory bowel disorder they should be regularly reviewed by gastro-enterologists. It is clear from the medical records that after the condition was diagnosed Roddy attended in December, 1997 and March 1998 for such reviews, but not thereafter. Roddy's mother died in the course of 1998, as I understand it, and he was permanently admitted to Maryfield House on 2nd. November, 1998.

[180] Since neither Edith nor James Donnet knew Roddy had ulcerative colitis or what it was, neither could be expected to make inquiries as to what treatment, if any, he should be receiving for it. Since there is no reason to assume or expect that the gastro-enterologists at Ninewells Hospital would have been aware of Roddy's mother's death, they would simply assume, when Roddy did not attend for appointments, that he was defaulting. However, his general practice knew that he had ulcerative colitis as can be seen from the GP records, for, from 31st. October, 1997, they were prescribing Asacol tablets and enemas for him. I cannot find any record of Maryfield House being informed on admission of the medication regime to which Roddy was subject but it was clear from her evidence that Jackie Mackie, the care home manager, was also aware that Roddy had ulcerative colitis. She was not asked about regular reviews and I cannot draw any adverse inference as I do not know whether she would be aware of the merits of such reviews, but that begs the question as to why staff in the care home were not made fully aware of this medical condition and the need for reviews. It is the general practitioners, the so-called primary care provision, who knew he had ulcerative colitis and who ought to have known that he should be subject to regular review. Had they ensured that he was, the likelihood is that those who needed to know would have had an awareness of the condition and perhaps a better understanding of its consequences and potential consequences for Roddy. All the evidence is, however, that the performance of the general practitioners was reactive and not proactive, and that they liaised solely with the care home staff and not with any relatives. If for no other reason than to ensure there is a central repository of information about the health and healthcare needs of an individual with reduced intellectual capacity, this lack of interest from the general practitioners demonstrates the need for a person such as Roddy to have a welfare guardian appointed.

[181] In fact the level of contact between Roddy and his general practitioners between 1997 and 2001 was pretty limited and it can be assumed that Roddy was in reasonable physical health, though Ninewells Hospital confirmed the diagnosis of ulcerative colitis in March, 1998. There is a letter, Crown prod. 2, p. 365 from Ninewells Department of Digestive Diseases to Dr. Montgomery at Tay Court Surgery, dated 31st. March, 1999 informing that Roddy failed to attend at a review clinic on 22nd. March, and Dr. Dillon said to Dr. Montgomery that he had been aware of poor compliance with therapy in the past and he assumed that the non-attendance for review meant that Roddy was well. He said in terms that he was not offering a further review but that he would be "happy to discuss his case with you, should he have problems in the future." Responsibility for monitoring ulcerative colitis was therefore firmly placed in the hands of the general practitioners.

[182] Dr. Kate Quinn, an associate specialist in learning disability, normally based at the Craigowl Centre at Strathmartine Hospital, Dundee, had known Roddy for more than 10 years prior to his admission to Maryfield House. He had not really been her patient until latterly but she had regularly encountered him at the Dudhope Adult

Resource Centre and she would meet with him there from time to time if staff at the Centre considered there was a problem which required to be addressed. She explained that whether a person with Down's Syndrome would have contact with Adult Learning Disability Services was needs led and there was no process of regular review. Once again, in other words, responsibility fell upon carers or the general practitioners to request assessment reactively. It is to her credit that Dr. Quinn routinely reviewed Roddy at the Adult Resource Centre but it is not clear to me whether that was part of any formal process or just a combination of luck and good practice by Dr. Quinn and, again, it strikes me that for Down's Syndrome sufferers, there should be a regular formal review process given all the medical risks to which they are susceptible. Be that as it may, Dr. Quinn saw Roddy in June, 1999 and wrote to Dr. Montgomery advising of additional levels of confusion on Roddy's part and of some indications of paranoid behaviour. She informed that she had initiated checks for hypothyroidism as well as blood checks and she considered that she might be seeing the onset of dementia. Neither she nor the general practitioners brought this to the attention of Roddy's relatives and no one seems to have considered the legal position about consenting to treatment, albeit this would be prior to the introduction of the Adults With Incapacity (Scotland) Act, 2000. The investigations do not appear at this time to have produced results causing any additional concern and Dr. Quinn seems to have initiated herself a process of three monthly review of Roddy. She also arranged assessment at clinical psychology and for a CT scan. It was into the early part of 2000 before further signs of deterioration were noted. In June, 2000 Dr. Quinn informed the general practitioners that Roddy was showing clinical signs of a dementing illness. In January, 2001 the clinical psychologist, while noting a deteriorating situation was still uncertain whether Roddy was suffering from dementia, though in March, 2001 Dr. Quinn was saying in terms that Roddy was "beginning to show signs of dementia." By September, 2001 that diagnosis was being formally supported by the clinical psychologist. By letter dated 10th. January, 2002, Dr. Quinn wrote to Jackie Mackie at Maryfield Hostel confirming that Roddy may be suffering from " a deteriorating condition such as dementia" and she confirmed having given some training to staff at the hostel on how to deal with his management. Again there is nothing to indicate that any of this was discussed with Roddy's relatives. The process of deterioration continues throughout 2002 and by October, 2002 Dr. Quinn was reporting to the general practitioners in terms that "He suffers from dementia which is clinically progressing."

[183] In her evidence, Dr. Quinn said that there was a time when Roddy would have been able to understand simple medical issues, such as, if you had a headache, then you would take an aspirin or, if you had toothache, you went to the dentist but he would not have understood, for example, a reference to neurology. She was, however, not surprised that his general practitioners had not utilised the provisions of Section 47 of the Adults With Incapacity (Scotland) Act, 2000 as the "uptake" of the Act had been "very patchy."

[184] Taking the foregoing evidence along with that of Edith and James Donnet, I am quite clear that, by the very latest in the middle of 2002, Roddy's intellectual capacity was reduced to a state when he could not competently consent to medical treatment. Dr. Jones, however, on 17th. April, 2003, appears to have been the first medical practitioner to recognise that state of affairs. It should have been obvious to the general practitioners.

[185] By letter dated 8th. January, 2003, Dr. Shah from the Department of Neurology at Ninewells wrote to Dr. Badenhorst following a neurological examination of Roddy, though the CT scan results were unknown at the time he wrote the letter. He expressed the opinion that the cause of various neurological defects may be "Alzheimers as is often seen with young Down's syndrome patients with cognitive impairment. This may also be vascular dementia.....Mr. Donnet is likely to deteriorate progressively over time and it would be kinder to him to arrange a planned and phased change of care for the future such as a residential home rather than a sudden change." By letter dated 7th. February, 2003, the Department of Neurology reported that "this man's CT scan does show a degree of atrophy which is probably more than would be expected for his age." There is no evidence that any of this information was conveyed to Roddy's relatives, nor to Dr. Quinn, who said in evidence that she was not aware of it, nor to anyone at an appropriate level at Dundee City Council Social Work Department. This is a further clear indication of the need for a central repository of health information, such as a welfare guardian. Patently the information was of profound significance to Roddy's care management.

[186] Unaware of the foregoing, Dr. Quinn and Mr. Thomas Campbell, Dundee City Council Social Work Department, who was Roddy's care manager, met in January, 2003 in response to concerns being expressed by staff at Maryfield House about their ability to cope with Roddy, and decided that, following a change to sodium valproate, Roddy had appeared a little more settled and could continue to reside at Maryfield House, though a move to a nursing home would have to be considered soon. They did not consult with the general practitioners or with any of Roddy's relatives about this decision.

[187] At the very least, the foregoing chapter of evidence demonstrates very poor communications among professionals involved in Roddy's care and, most particularly, with his relatives. Arguably, it demonstrates a failure to comply with the law.

[188] Moving to 10th. April, 2003, there is no doubt that Dr. Badenhorst made herself aware of Roddy having had ulcerative colitis in 1997 and quickly diagnosed that her patient was suffering from an outbreak of ulcerative colitis. She prescribed Asacol tablets and enemas. This was entirely appropriate. It is instructive to note that "Eve Thornton," a social care officer, made an entry for that day in the Maryfield House contact notes (Crown prod. 5, p.588) relating to Dr. Badenhorst's examination which reads, " Dr. asked if I knew Rod had severe ulcerative colitis. I said no. It was apparently diagnosed some time ago." The note makes reference to enemas which were to be administered by the "nurse." It is not clear what information this or any other social care officer had or was given about ulcerative colitis or the critical importance of ensuring adherence to the prescribed medication. The question is begged whether a social care officer, with all due respect to their abilities, should be administering medication and should be responsible for administering medication.

[189] The process of administering enemas commenced on 11th. April and was undertaken by the district nurse. The Maryfield House note records that "Roddy was distressed due to pain in his rear....for approx ten minutes and then very calm." There is then a further note dated 12th. April, by a different social care officer to the effect that when the district nurse came that day to administer the enema, Roddy

"refused" and became quite distressed. The district nurse said she would try again later but telephoned later saying that, having discussed the situation with her colleagues, she would leave it until the following day. It was clear from the evidence of Dr. Clarke and Dr. Starr that Asacol enemas were more effective than Asacol tablets in attacking a current outbreak and it was accordingly obvious that their administration should take place regularly. It is not clear whether the decision of this district nurse was drawn to the attention of the general practitioners. However, after some difficulty and persuasion, an enema was successfully administered on 13th. April. There is no record of him having an enema on 14th. April. However, he was seen by Dr. Badenhorst who noted that he was looking better and that he had had three enemas and there had been a reduction in his bowel movement to only one. Later in the day, however, he had diarrhoea and was noted to be trembling and crying. He refused to take medication. He did however relent in the evening and did take medication. The Home notes record the administration of a further enema on 15th. April and that Roddy was "in obvious pain." He had two noted episodes of diarrhoea on 15th. April. It was the district nurse who called in Dr. Badenhorst on 16th. April, noting that Roddy was "v.flat - refusing solids, liquids and medication." On examination, Dr. Badenhorst noted that he was crying and might be dehydrated. She then arranged for his admission to Ward 15 at Ninewells and wrote her admissions note, which all the medical witnesses described as a good, informative note. It is not clear exactly how well Dr. Badenhorst had been informed of the difficulties in administering medication but clearly she had some information on the subject. While it was entirely correct that she reported this information in her admissions note, it does not appear to have occurred to her that there had been a degree of improvement she had noted on 14th. April and then this dramatic change, possibly on account of Roddy's lack of co-operation, by 16th. April. It might be a counsel of perfection and I accept that at that stage she had no reason to anticipate that Roddy would not make a full recovery with effective treatment in hospital, but hindsight suggests that it might have been a good idea, particularly with the information about his advancing dementia, to consider a move on discharge to a nursing home where qualified nursing staff would have better understood his condition and would have been better trained to ensure the administration of appropriate medication. I do not want in any way to denigrate the efforts of the social care officers at Maryfield House in their care of Roddy for it is quite clear from a large body of evidence that they went far beyond the call of duty in looking after Roddy in all sorts of ways, both physical and emotional, but I regret that it should have been obvious to their management and to the general practitioners, at worst shortly after Roddy's discharge from hospital, that they simply could not cope with Roddy's multiple difficulties and he should either have been in hospital or a nursing home.

[190] It is instructive that, following Roddy's discharge from hopsital on 17th. April, between that date and his date of death on 29th May, 2003, he was seen and examined by eight different general practitioners and that his death was certified by a ninth who had never met him in life and who did not appreciate that he was a Down's Syndrome sufferer. This is hardly consistent with the concept of continuity of care in which concept Dr. Starr placed much emphasis. Three of the practitioners were from Roddy's general practice, Dr. Badenhorst, Dr. Gardiner and Dr. Hollins. The other six were from D.D.O.C.

[191] The first of these, on 19th. April, was a Dr. MacGregor from D.D.O.C. who saw him at 21.00. It is instructive that the note taken by the service's nurse receptionist includes "Has been investigated at N/Wells for abdo pain, which has not shown anything up." That information can only have come from Maryfield House staff. The diagnosis was "urinary incontinence." There then seems to have been some discussion by telephone about the fitting of a catheter in which Edith Donnet appears to have become involved, expressing concern about the fitting of a catheter causing distress to Roddy. That seems to have dominated the treatment plan irrespective of whether it was a good or bad thing from Roddy's perspective. It also illustrates how easy it must have been for a relative to become involved if he or she chose to do so.

[192] On 20th. April at 13.40, he was seen by a Dr. Ward from D.D.O.C. against a background of continuing lower abdominal pain and a query about whether he was retaining urine. Dr. Ward noted that Roddy "apparently has dementia" and had also noted some history of the recent brief in-patient period at Ninewells. Dr. Ward noted, "Eventually agreed to hospital admission on basis of staff not coping - declined further DNS involvement or susp. antibiotics." There is a later note on the same day from Dr. Ward timed at 15.28 which reads, "Re-visit after refusal to go in ambulance. Sedation/forcing admission not deemed appropriate." There is then reference to the administration of anti-biotics and a request for help from the District Nursing Service. The diagnosis was "prob UTI." Maryfield House staff noted Roddy's refusal to enter the ambulance without further comment and that the doctor had returned and prescribed liquid anti-biotic.

[193] On 21st. April he was seen by Dr. Gardiner of the Tay Court Practice. He recorded a background of Roddy "intermittently crying out in pain and then being incontinent of both urine and stool. Diarrhoea for three weeks. Resists staff helping to change him. Not eating. Refluxing but no vomiting. Didn't sleep due to pain. Peaceful at the moment but apparently can be very unco-operative. On examination, peaceful; he is resisting simple things like taking a pulse. P100. Chest clear. Abdo soft non-tender (no reaction to exam anyway)." Otherwise the note suggests he tendered advice and no other form of treatment was initiated nor was there any further attempt to admit him to hospital. However, the Maryfield House note states that he presribed soluble paracetemol and advised staff to continue to push fluids and to record input of all food and drink, which they did.

[194] On 26th. April, Roddy was "assessed" by Dr. McIntosh from D.D.O.C. whose diagnosis was "odeamatous ankles." That was against a history of Roddy shouting out, refusing medication and only passing small amounts of urine. It would appear that Roddy's legs and ankles were swollen on examination and the advice given was to elevate them and to involve the general practitioners on Monday to check kidney function. This outcome is based on a nine minute assessment by telephone and the doctor did not carry out any physical examination.

[195] The next entry, notwithstanding that the last one suggested contact should take place with the general practitioners "on Monday" is for 13th. May, 2003 when Dr. Badenhorst had a discussion with Edith Donnet about Roddy's proposed move to Camperdown Nursing Home the following Saturday. Dr. Badenhorst noted that she "chatted re his Alzheimers, epilepsy, ulcerative colitis," and "explained medication."

[196] The next entry is for 14th. May and appears once more to involve Dr. Gardiner who noted that Roddy "seemed very tremulous. Speech seemed much worse though agitated. Been feverish. Wt. Loss. Bowels loose. Doubly incontinent." He noted pulse and blood pressure and then "L UL crackle" which Dr. Badenhorst explained meant that Dr. Gardiner was hearing unusual sounds in Roddy's left upper lung. He prescribed co-amoxycillin.

[197] Dr. Hollins saw him on 15th. May. Roddy was asleep when he called. He was given a history of "bloody diarrhoea" overnight. Roddy was very hot and had not taken any medication that day. He was hot to touch. His abdomen was soft and non tender and his chest was clear. Bowel sounds were active. Dr. Hollins decided to start administering paracetemol regularly. He then noted, " Carers don't think he would cope with hospital admission." He decided that he should review Roddy the following day. Later he noted, "Discussed with Dr. B at surgery. Might be worth trying oral prednisolone for his U.C." There is, unfortunately, no note of the time of this visit. However, the Maryfield House notes record the visit as having occurred at 10.00a.m. it is recorded that Dr. Hollins said that Roddy was "very poorly." It is recorded that Dr. Hollins said that Roddy's chest infection had worsened, though that is inconsistent with his own note. He said he wanted to discuss what should be prescribed with his colleagues and that someone would visit on the following day but meantime to continue with antibiotics and to give paracetemol regularly to keep his temperature down. There is a further note in Crown prod. 5 at p.633 which reads that "After examination doctor said that Roddy was very poorly and his chest infection had worsened. Doctor questioned whether Roddy should be admitted to Ninewells or remain here. I said I would contact Roddy's brother." The note goes on to record the instruction to continue with anti-biotics and paracetemol and that Dr. Hollins was to discuss with his colleagues the merit of trying a course of oral steroids but it would be open to inference that Dr. Hollins was pessimistic about the outcome. His own evidence, however, was that he did not consider at this point that Roddy was terminally ill but that he was concerned that he was developing a major illness. He also accepted that there were signs that Roddy was becoming dehydrated and he recognised that that could only properly be addressed in the hospital setting by the introduction of intravenous fluids. Several of the expert witnesses, most particularly Dr. Rafferty, had observed that it was hard to understand what the GPs thought they were doing at this point and were at a loss to understand why they did not push harder to get Roddy re-admitted to hospital. I do not understand Dr. Hollins' position either in this regard and I particularly do not understand why he did not make a point of discussing the situation directly with one of Roddy's next-of-kin.

[198] It was at 12.20 on 15th. May that the Last Rites were administered to Roddy. James and Edith Donnet were present. James had been told by Maryfield staff of Dr. Hollins' assessment and he said in evidence that he had come to the conclusion by this date that Roddy was dying. That conclusion, with due respect to James Donnet, who struck me as an entirely decent, caring man, was formed on the basis of inadequate information about what was wrong with Roddy and it is not clear to me what information, if any, that James had at that stage about the extent of his brother's dementia and how that condition was complicating treatment. I consider that I am entitled to conclude, on the balance of probability, that the message going out from James and from the Maryfield House staff was that Roddy was terminally ill

and I consider that impression was formed from the opinion conveyed by Dr. Hollins in the course of his examination on 15th. May.

[199] Dr. Badenhorst visited on 16th. May and noted that Roddy had started on a course of oral prednisolone which he was apparently tolerating, as well as anti-biotics. She also noted that there had been no bowel movements since 16.00 on the 15th.

However, Maryfield House staff have noted that she asked that "we make sure Roddy has Asacol 400mgs tabs are given 3 x 2 as it is essential that he receives them. Dr has said we should crush them as Roddy is reluctant to take them." She then goes on to describe having done so and being successful in getting Roddy to take them. There is some confusion therefore as to whether he is getting prednisolone or Asacol or both. There is reference in the care home notes for 17th April (Medication taken except prednisolone).

[200] Dr. Hollins visited Roddy on 19th. May and considered that he looked a little bit better and noted that he was taking oral fluids, that there was less blood in his diarrhoea and that his temperature was down. He still seemed to be suffering intermittent pain. His abdomen remained soft and non-tender with active bowel sounds though he did note that the bladder was not palpable. His pulse was regular and his chest was clear but again he was not passing urine. Once again it appeared that the successful administration of treatment for ulcerative colitis was having some positive effect on Roddy's presentation.

[201] On 20th. May, the general practice phoned Maryfield House to the effect that Roddy was now to be prescribed Pentasa Granules, Asacol in a soluble form. Why this was not thought of sooner is not clear.

[202] D.D.O.C were telephoned at 18.58 on 22nd. May because Roddy was crying out in pain when staff tried to turn him about 18.30. Dr. Anderson apparently arrived at 19.25 and left at 20.05. She has noted that Roddy was diagnosed terminally ill a week ago (15th. May) and that he was unable to take anything orally to-day. She noted that he was in pain on turning. On examination she considered that he was having "colicky pains" and was pyrexial. She prescribed analgesic and cooling measures and asked the District Nursing Service to start a syringe driver with diamorphine. Her diagnosis was "palliative care." I have considerable concern about what happened here. I do not know who told Dr. Anderson that Roddy had been diagnosed as terminally ill a week before but that takes us back to 15th. May, Dr. Hollins' assessment that Roddy was "poorly," the discounting of the merit of a re-admission to hospital and the administration of what most people understood was The Last Rites though Jackie Mackie did explain that the priest had said that he was administering the Sacrament of the Sick, which was appropriate where a person was seriously ill and not necessarily terminally ill. I cannot exclude the possibility that the information given to Dr. Anderson by care home staff was a misunderstanding of the position to which misunderstanding Dr. Hollins contributed. Dr. Anderson could see that Roddy was in pain and was being told that he was terminally ill. I have reservations about whether she should have accepted that information from care home staff without checking with the general practice or a next-of-kin but I also have some sympathy for her in the situation in which she found herself. While I do not

consider that it would be appropriate for me to be proscriptive, I would like the relevant authorities to consider whether an out of hours service doctor should be able to initiate a morphine syringe driver without authority either from the general practice whose patient is involved or from the next of kin.

[203] The real curiosity comes with the visit on 23rd. May of Dr. Hollins. He notes, "Seems to be failing over the last couple of days. Ongoing fever. Refluxes anything orally. Has seemed to be in pain on being moved so DDOC started syringe driver last night. Seems peaceful. Briefly woke up. Very hot to touch. Pulse 80. Chest clear. Abdo soft - no pain. BS active - no masses. Still having watery diarrhoea. Underlying diagnosis uncertain but everybody wants him kept at home. Continue supportive care." He then goes on to prescribe further palliative treatment. It is evident, with the benefit of hindsight, that Roddy's ulcerative colitis had now taken a firm hold, despite the medication prescribed to control it, and that active treatment is no longer under consideration. There is, however, no reason to suppose that if Roddy had been admitted to hospital on or about 15th. May and had tolerated treatment by intravenous fluids and steroids that he might have made a complete recovery from this outbreak of ulcerative colitis. There is, as I have already said, an issue about the value of doing that given the progress of his dementia. Dr. Clarke, it was, who said that as a matter of morality he would have discussed with the relatives the value of continuing with active treatment. There is no evidence of any such discussion having taken place with the relatives here and I regard that as inexcusable.

[204] Dr. Hollins saw Roddy again on both 26th and 27th. May when he was hardly eating anything and was substantially sedated though he continued to have "profuse diarrhoea." He visited again on 28th. May and had a discussion with Edith Donnet and Jackie Mackie informing them that Roddy would die within the next few days and informing them that he thought that Roddy had bowel cancer, which he did not have. He noted, "The family are concerned that Roddy's symptoms weren't taken seriously whilst he was in hospital." The final entry records Roddy's death at about 05.50 on 29th. May.

[205] There were mistakes made at Ninewells Hospital during the brief period of admission. These focus on the administrative failures of Dr. Wallace and the failure of all doctors other than Dr. Pullar to check blood test results. Had they done so, the preponderance of expert opinion is to the effect that if they had decided to discharge it would have been on the basis that Roddy had had an outbreak of ulcerative colitis that might be continuing, that it was relatively mild and should respond to non-steroidal anti-inflammatory treatment but that urgent review by gastro-enterologists should have been arranged. Dr. Clarke's final position was that he would have kept Roddy in hospital and tried to carried out a flexible sigmoidoscopy. He expected he would have been able to do that successfully. Had he done so, he would almost certainly have found an active outbreak of ulcerative colitis which could have been treated in hospital with out patient follow up. It is fair to say that the major curiosity for all the doctors examining him in hospital was the lack of bowel activity which everyone agreed was inconsistent with serious active inflammatory bowel disease but it seems likely that on account of the treatment initiated by Dr. Badenhorst and that initiated by Dr. Pullar, both of which forms of treatment were entirely appropriate, his bowel movements may have settled. So it would be wrong to conclude that his symptoms were not taken seriously while he was in hospital. What was disregarded,

apart from the need for care in relation to patient identification numbers and comparative blood tests, was how Roddy could properly be cared for in the community, as the post discharge events demonstrate, particularly in the absence of a clear care plan from the gastro-enterologists and I am particularly critical of them in this respect. It is clear that care home staff were misled about the basis of the discharge. It seems likely that they inadvertently misled at least one of the D.D.O.C. doctors as a consequence. However, what is hard to understand is what the general practitioners at the Tay Practice were up to during this period when they should have urged Roddy's return to hospital, and at the very least should have discussed with the next of kin, and not taken "instructions" from care home staff, whether or not it would be appropriate to try to force Roddy's re-admission to hospital. I accept the evidence from a number of doctors and, again, the clearest evidence was from Dr. Clarke, about the difficulties which would surround the administration of sedation and the long term difficulties about treating someone who was physically resistant to treatment, but the next-of-kin should have been told that the current problem was, almost certainly, one which was remediable in the short term and would be fatal of not remedied, and that hospital admission was essential if it were to be remedied and that trying to deal with the condition out of hospital was unlikely to be successful. Had the relatives taken the view that, on account of the advance of dementia there was no point in proceeding further, that would have been a decision which would have commanded respect and no doubt would have been followed but it is not clear that the next-of-kin understood that he had dementia, never mind what its consequences would be.

[206] The poor quality of communication among professionals also contributed to the circumstances. If the general practitioners did not understand the basis upon which their patient had been discharged from hospital then they should have pursued the gastro-enterologists and I heard no credible explanation for their failure to do so.

The performance of Dundee City Council Social Work Department

[207] There is no doubt that social care assistants at Maryfield House in the last few months of Roddy's life had a traumatic time with him and their devotion to his care and their high level of involvement is a testament to their caring natures and to the affection that Roddy was able to generate. They should take pride in the quality of care they gave him right up until last moment.

[208] Having said that, there is a very considerable question about whether he should have still been in Maryfield House. Responsibility for that rests, so far as I could get to the bottom of it, with his care manager, Tom Campbell, though I appreciate that it is not as simple as that, as funding arrangements required to be put in place. It would be Tom Campbell, with appropriate medical support, who should be making the case for a transfer. The medical support in fact came from Dr. Quinn but there is no reason that it could not also have come from the general practitioners. It will be recalled that Dr. Ward from D.D.O.C. tried to get Roddy re-admitted to hospital as the carers were not coping. The carers, who patently did their best, were not qualified nurses and I simply do not know how consistently medication was enforced. That Roddy appeared to get better and then relapse may have had

something to do with the consistency or inconsistency with which he was medicated. The evidence about that is unclear. What is clear is that in the middle of his deterioration, though at a time around the last two weeks in April, 2003 when Roddy was relatively stable, a decision was made to transfer him to Camperdown Nursing Home. It is fair to record that both Edith and James Donnet were involved in that decision but it is less clear, beyond themselves recognising that Roddy was difficult to manage at Maryfield House, how well they were informed why the move was necessary. Dr. Quinn had no recollection, unsurprising given the lapse of time, of being involved in a decision to transfer Roddy to the nursing home, but accepted from the notes that she had been. Thomas Campbell explained that in a sense "care manager" was a misdescription in that his function was not to engage in front line care for an individual but to arrange and get in place the care package that that particular individual required, arranging resources to meet needs. He had been Roddy's care manager since October, 2002 and was aware of his residence in Maryfield House. He relied on the care home manager and staff to draw his attention to any need for change and that was a perfectly reasonable approach for him to adopt. An assessment of needs was carried out in about October, 2002 involving care home staff and an occupational therapist. There was no consultation with his family or with the general practitioner. Dr. Quinn was consulted but this is another illustration of a band of professionals working away in their own silo without regard to what other professionals are doing for the same patient and it is absurd that family members are not involved in this kind of review.

[209] Mr. Campbell appeared to have a limited grasp of the Adults With Incapacity (Scotland) Act, 2000 or how its provisions might create obligations to be carried out by local authorities. He had had some training on the Act but considered its implementation to be the work of mental health officers. He was not a mental health officer. The outcome of the review appeared to be that for the moment Roddy should stay at Maryfield House but it was appreciated that if his dementia continued to cause deterioration as it would do in the absence of any supervening illness, then a time would come in the not too distant future when nursing home care would be required. Mr. Campbell accepted that Roddy could play no part in this decision making process but was unable to explain satisfactorily why his family had not been involved. He had not considered that there was any need for the appointment of a welfare guardian and considered that that would only be required if there was a dispute between the local authority and the relatives about what would happen to the incapacitated adult. He had not taken advice from his authority's legal department. He was unable to explain how he knew there was no disagreement with the family when they family had not been consulted. No further review was planned and it was left to care home staff to contact him should further consideration of the position be required.

[210] Matters relating to the accompaniment of residents in care homes to and from hospital were operational matters for the management of the care home. He talked about this being a "good practice" but he did not suggest that the local authority had a policy or had issued any guidelines on the subject or that the localo authority had any obligations in this respect.

[211] Dr. Quinn seemed to decide quickly after Roddy's discharge from Ninewells Hospital that it was time to move him to a nursing home and Tom Campbell, Miss

Mackie and Roddy's keyworker were all involved in this decision. The family were, in effect, told about the decision rather than being involved in it. They were taken to Camperdown Nursing Home and shown round and appeared to be content with the proposal to move Roddy there. A date was set for the move, finance having been put in place, but it did not happen because of his deteriorating health. Tom Campbell asked Dr. Quinn to meet with Edith and James Donnet as he thought they had reservations about the need for the move.

[212] He had been informed of the deterioration in Roddy's condition by staff at Maryfield House and was aware that Roddy had had The Last Rites administered. He played no part in that. He said he thought that Roddy would be moved to hospital but he had played no part in the decision that he should remain at Maryfield House until death. He did however produce a note he had retained of a telephone conversation he had had with a Margaret Graham, a social care officer at Maryfield House, on 21st. May, 2003 which read, "Roddy has improved very slightly but still gets very tired. Steroids are almost finished. Staff nurses are finding it difficult to get Roddy to take medication for ulcerative colitis. This is the source of his problems. If he takes this prognosis is quite good." It will be observed that there is an inconsistency between saying that the steroids are almost finished and that there is a problem getting Roddy to take his medication for ulcerative colitis but this reflects my own view that if greater effort had been made to get medication into Roddy, best achieved by hospitalisation, the prognosis would have been good.

[213] Mr. Campbell had never seen the letter from Dr. Shah at the Department of Neurology. With some diffidence he accepted that there was a problem if information relevant to Roddy's needs was being given to a general practitioner with whom his system had no contact. Mr. Campbell acknowledged that there was a difficulty about communications between medical and social work professionals. He thought "they" were working on that, about, for example, making computer systems compatible. He accepted that there might be merit in having a single individual legally responsible for the care of the patient. He accepted that the present arrangement was akin to management by committee with all the drawbacks inherent in such a system. He thought in the case of someone with Roddy's difficulties, the central person should be medically qualified and accepted that that might be a general practitioner.

[214] Mr. Campbell thought that care home staff would take the patient's care notes with them if the patient was being admitted to hospital but he was unaware of any general rule or practice. He thought there might be an issue of confidentiality. He was unaware of any current consideration being given in the light of the outcome of this case to a procedure whereby care home notes would routinely be made available to doctors but he acknowledged that this case illustrated the potential value of doing so.

[215] Jackie Mackie aged 58 was the recently retired manager of Maryfield House, having retired on 10th. January, 2005. She had been either acting manager or manager there for the preceding three years. She had an SVQ, level 3, in care and an HNC in care. She had worked with people with learning disabilities almost all her working life. She had been at Maryfield House when it opened in 1985. She had then spent five years working in another hostel operated by Dundee City Council and on its closure had returned to Maryfield. Before 1985, she had worked for Dundee City

Council Education Department, with disabled children, and before that as an auxiliary nurse in Strathmartine Hospital, Dundee, which provides services for persons with learning disability, in Ashludie Hospital, Monifieth, Angus, which is largely a geriatric unit and Glasgow Royal Infirmary. She impressed me as a person who cared about what she was doing and cared about the welfare of residents for whom she was responsible. It was clear that she was fond of Roddy and had found the circumstances of his death distressing.

[216] She had first got to know Roddy at the Dudhope Adult Resource Centre when she was working in the hostel annexed to it. She was able to describe how Roddy equated his attendance at the Resource Centre with "going to work." The Resource Centre was a day centre for adults with learning disabilities where efforts were made to enhance their skills. He had always been a very cheerful person. She knew that he particularly enjoyed the company of his brother, Jimmy, who was very close to him and who would take him out regularly to football matches, to the pub for a drink and a game of snooker and regularly took him away on holiday. Roddy took part in all of the activities at Maryfield and had a full and active life.

[217] For most of the time at Maryfield, the staff there had no difficulty in helping Roddy with his daily needs. Any more significant issues would be addressed by his care manager, latterly Tom Campbell. Health issues were dealt with by his general practitioners or by Dr. Kate Quinn who saw Roddy on a regular basis.

[218]Ms. Mackie's evidence was that care home staff would not consult with Roddy's relatives on a daily basis but they would be invited to six monthly reviews and would be consulted about medical problems. James would visit at least once a week and had regular informal contact with the staff during which any problems could be addressed.

I have reservations about how accurate that evidence is and I regret that I am critical of Ms. Mackie in that there were times when she and her staff took decisions about Roddy's health where the relatives ought to have taken the decisions instead, especially in relation to his re-admission to hospital after the discharge on 17th. April, 2003.

[219] She told the court that Roddy had had a couple of falls in the latter part of 2002. He was moved then to a downstairs bedroom. Tom Campbell had been consulted about that move but she was unsure if the family had been involved. Dr. Quinn and the general practitioners had been consulted about the cause of the falls and they were associated with a more general deterioration in Roddy's condition. She also recalled a discussion which had either involved Tom Campbell or his senior, Ron McIlquham, about moving Roddy to a nursing home. She could not recall if the family were involved in that discussion. She explained that the staff at Maryfield were carers, not qualified nurses. Maryfield House had been built to house patients during a process of transfer to the community from the old Strathmartine Hospital which had been an old fashioned long stay mental hospital. In Roddy's case, he was deteriorating to the stage where nursing care was required. She recalled Roddy being the subject of some kind of formal assessment by "two ladies," and then Dr. Quinn had told her that Roddy was suffering from dementia. She could not recall if she had discussed this with Roddy's family. She was aware, in general

terms, of a connection between Down's Syndrome and early onset dementia. She was not aware of any connection between epilepsy and either Down's Syndrome or dementia. There was an assessment early in 2003 as to whether he should be moved. She could not recall if the family had been involved in that. She accepted from the notes that a decision by Dr. Quinn had been recorded on 9th. January, 2003 that Roddy could remain at Maryfield House meantime but would need nursing care "in the near future." She said that there was a problem with staffing levels though that had improved following the involvement of the Care Commission.

[220] Dundee City Council had required the maintenance of what were known as contact sheets for each care home resident. There were three shifts of carers at Maryfield and these provided information for the next shift so that continuity of approach could be maintained. She had trained the staff as to the contents of the contact sheets and it was observed by a number of the medical experts who had referred to these sheets how useful and comprehensive they were in providing insight into Roddy's behaviour and treatment. All the staff had to have an SVQ level 2 in care prior to employment and part of their training for that qualification was the recording of relevant behaviour and events.

[221] Ms Mackie recalled that she had been told just prior to Roddy's admission to Ninewells Hospital on 16th. April, 2003 that Roddy had ulcerative colitis. She had not known previously and did not know if the family knew. She knew that he had had medication for his stomach but did not know what the precise diagnosis was. The keyworker would not necessarily know either. This evidence caused me some concern. I do not know for no one asked her how well she or any other member of staff at Maryfield House understood the condition, ulcerative colitis, or what medication was required for it or what the consequences would be if the medication were not taken. She told me it was not "policy" for the patient's keyworker to require to be familiar with the resident's medication. So who was ? In evidence I heard later from David McCaw, a senior mental health officer, who made the point that there was concern about what he referred to as the "interface" or perhaps lack of interface between social work and National Health Service services, and it appeared to me that on this critical issue of a patient's medication there was a gap in services with the social work department not really prepared to deal with medication and the health service not really being prepared to deal with residents in a care home. Roddy did not have the capacity to know about his illnesses, or the importance of taking the required medication and I have considerable doubts about the effort made to overcome his resistance to taking medication in whatever form it may have been presented. It is, frankly, unclear whether a failure to ensure compliance with medication for ulcerative colitis is a direct factor in Roddy's untimely death, but there is a body of evidence from which I consider it could be concluded that, when Roddy took or was made to take his medication, his condition improved and that, when he refused and was not compelled to take his medication, his condition deteriorated. It is unsatisfactory that a person who does not have the mental capacity to take required medication for a physical condition is left in a situation where whether or not the medication is administered depends on the persuasive ability of a given social care officer, especially if they are not trained in and do not consider it part of their function to understand the importance of the medication to the patient. There must either be a system where trained nurses in the community take on the role of administering medication to those who need it, since they will by virtue of their

training understand its importance, or a patient dependent upon medication, as most care home residents are likely to be, will have to be kept in a location where there is at least one qualified nurse always present to deal with the administration of medication, or social care assistants will have to accept that this is their responsibility and will have to receive such training as may be necessary to enable them to undertake such a responsibility. I respectfully suggest that this is an area which, if it does not already have their attention, should be considered by the Care Commission to determine what the best way forward is, but the present vagueness is not acceptable and may have contributed to Roddy's death from ulcerative colitis.

[222] I also consider it of importance to look at the circumstances of Roddy's admission to and discharge from hospital. We know that Roddy was resistant to going into an ambulance. However, twice he was persuaded to enter an ambulance, albeit with difficulty. I make absolutely no criticism of the ambulance crews nor of their management for adopting the straightforward approach which says that a person cannot be forced into an ambulance and if a person will not go, the appropriate thing to do is refer the problem back to the general practitioner. Dr. Starr observed that it is a matter of anxiety for most of us to be admitted to hospital. For a person with Down's Syndrome and dementia, it is like being removed from a familiar environment with a bag over one's head, he said. Roddy would not understand what an ambulance was nor what a hospital was and would not associate either of these things with trying to make his pain go away. It was undoubtedly useful that Bill Taylor was available to accompany Roddy into hospital. It was also helpful that Edith and James Donnet at different times also attended at the hospital but beyond these presences Roddy was in a strange place with limited support. Yet there is only fairly limited evidence about him being non-compliant. More thought requires to be given to addressing the fear of the unknown that a person like Roddy will suffer. A number of ideas emerged in the course of the inquiry but I do not consider that any one of them provided an all embracing solution and this is an issue which requires wider consideration. I do not know, for example, whether Roddy would have gone more comfortably in a vehicle with which he was familiar. I do not know if Roddy would have been more compliant and less anxious if a psychiatric nurse accustomed to dealing with persons with learning disabilities had been present. What I do know from the evidence in this case is that treating Roddy in the same way as a patient without learning disabilities was not a satisfactory way to proceed. But there is an urgent need to look at how this problem can be effectively addressed. It was unfortunate that Roddy was discharged by ambulance without a carer being present. Ms. Mackie ultimately accepted that that was her fault but the staff on Ward 15 should not have discharged Roddy in the absence of a responsible adult known to him who would have again helped to assist with his anxiety. Arrangements must be established between the local authority social work department and Ninewells Hospital to ensure that this does not happen again. Ms. Mackie told me that normally a patient would be kept on the ward at Ninewells until someone could come to collect them.

[223] If not on account of the experiences of 16th. and 17th. April, then certainly on account of the experiences of 20th. April, when Roddy resisted returning to Ninewells when Dr. Ward recorded that "staff" were "not coping," and there were clearly problems about the administration of medication, then Roddy should have been transferred to a nursing home as a matter of urgency. I am at a loss to understand

why that was not the subject of urgent consideration at that stage as it must have been obvious to Ms Mackie that Roddy could no longer be managed at Maryfield House. This should also have been obvious to the general practitioners who did not do anything about it either. It does not appear that Roddy's family were informed of his so-called refusal to return to hospital, which is another failure. They should have been involved and they should have taken the decision about what happened next, though to do that they would have required to have been fully informed.

[224] Ironically, it was the following day that Dr. Quinn and Tom Campbell concluded that Roddy should be transferred to a nursing home, when he was physically fit enough to be transferred. Ms Mackie thought that there had been some discussion with James Donnet.

[225] By the time the funding had been arranged and a place found at Camperdown Nursing Home and this had been approved by Edith and James Donnet, Roddy had become very ill. Ms. Mackie said in terms that he was not eating and was reluctant to take medication. Both these things would make him very ill. She thought that he was close to death. She thought that that had also been the opinion of the general practitioner but she could not recall which one. Ms. Mackie seemed to have formed her opinion on the basis of her experience in dealing with people close to death. She said that Roddy had been hallucinating and talking about seeing his mother. She did not appear to consider that this might be the effect of some of the medication he was taking and I am unsure whether this experience she described was before or after the commencement of the morphine syringe driver. She thought that the family knew "when the priest came" that the end was near too. She described being present when the syringe driver was fitted and there was a discussion about whether Roddy should be moved but she and her manager agreed that he should remain at Maryfield. It seems likely that she was the person who told Dr. Anderson that Roddy had been diagnosed as terminally ill the previous week. It would appear that she must have misunderstood what Dr. Hollins said. She had however gone on to organise some help and training for the staff to help them with the process of dealing with Roddy during his final days and had assistance which she had valued from the district nurses.

[226] Ms. Mackie recalled that the ambulance crew had handed in "a letter" when they returned Roddy. It is a reasonable inference that this would have been the missing discharge form. No explanation was offered as to what had become of that.

[227] Under reference to the Maryfield House records for the period leading up to Roddy's admission on 16th. April, she accepted that there was no evidence to support the assertion in the admissions letter that he was having six to ten bowel movements a day and that in that respect the information given to Dr. Badenhorst was inaccurate.

[228] Ms. Mackie told the court that she had had some training in the Adults With Incapacity (Scotland) Act, 2000. She thought that this had been in 2001. She said she asked Dr. Quinn whether Roddy should have a welfare guardian appointed and Dr. Quinn had said that it was unnecessary. Ms. Mackie had disagreed with that as she did not consider that Roddy understood the need to take medication and thought it would have been helpful to have a welfare guardian appointed. She had discussed

this with David McCaw and Dr. Fabian Haut of the Learning Disability Service at Strathmartine Hospital. Dr. Haut, she said, was sympathetic to the notion. She considered that a number of residents of the Home would have benefited from the appointment of welfare guardians. However, nothing was done.

[229] Gordon Watt, 57, was a service manager for older peoples' services with Dundee City Council. He had held that position for four years. He had been employed by Dundee City Council for twenty years. His present role was as one of three service managers responsible for providing services to older people, including the provision of home care services for the elderly. He also had certain responsibilities in relation to the phenomenon of "bed blocking." He had had no direct line responsibility for Roddy, though he had had in the past, and it appeared that those most recently responsible were no longer in the employment of the local authority. One of the people he had in mind in this respect was Ms. Mackie and he was not aware that she had given evidence to the Inquiry.

[230] Formerly he had had management responsibility for half of the Dundee City Council care homes. In his present job he had responsibility for funding care home placements and had links with local authority and private care home operators. He also had a link with the Care Commission in relation to standards for the operation of homes. He claimed to have a good working knowledge of the residential care sector in Dundee.

[231] There would be a care plan for every resident in a care home. Its preparation was subject to discussion with carers and relatives. It would relate essentially to practical issues or personal care and personal support. It would include details of health care professionals involved with the individual. In a care home plan he would expect to see details of bed care, for example, management of sores, ability to take medication, assistance with eating issues etc.

[232] He was of the opinion that carers in a care home did manage medication. They also had the ability to involve district nurses and community psychiatric nurses if there were difficulties. The guidelines provided that the social work department should not be administering medication without what he referred to as a "mandate" from a general practitioner or district nurse. He did not know whether there was such a mandate for Roddy.

[233] His bottom line position was that a person, even a person of limited intellectual capacity, could not be forced to take medication. It would be the general practitioner who would determine if the individual required hospital treatment.

[234] He recognised the importance of having a sufferer from Down's Syndrome and dementia kept so far as possible in familiar surroundings. He accepted that a hospital admission removed such a person from such surroundings. He accepted that in such a situation residents needed a lot of support. However, there was no protocol or standard plan for the management of admission to hospital. There could, of course, be recourse to the legal process having regard to the level of incapacity but generally effort would be made to manage the situation without unnecessary formality. There were good links, he considered, between medical and care home staff. It would be "expected" that with someone like Roddy being admitted to

hospital, then he would be accompanied by a member of staff from the care home. The basis of that expectation was not explained. The same applied to a person being discharged. There was, as he put it, a practical aspect in relation to staff availability and that there was a need to comply with Care Commission requirements about staff numbers in the home. Staff were, however, normally inventive and would get someone to come out. He did not seem impressed with the suggestion that providing care cover for hospital admission , appointments and discharge should be part of the responsibility of the local authority. I recognise that there are significant resource implications but these will have to be addressed. He accepted that, in the absence of a carer, a doctor would not be able to obtain a reliable history from the intellectually disabled patient. This would be particularly important in relation to the present medication a patient was taking (or not taking.) He accepted that there was no practice as such for care home notes to accompany a patient to hospital. He was aware that, because of pressure on beds, discharges from hospital could take place at short notice. He said that there had been some informal discussion generally about patient discharge for patients supported by the local authority. There had been no discussion about not discharging in the absence of a carer or relative. Things operated on an *ad hoc* basis. This does not strike me as being adequate, certainly not for someone as lacking in capacity as Roddy was at the material time. A formal system in which such a patience will only be discharged into the care of a carer must be established. You would not discharge a child without a carer being present. The same must follow for someone with the intellect of a child.

[235] He said that it would be atypical to provide support for a resident who was a hospital in-patient but he did not discount the possibility on a case by case basis of some level of support being provided. As a matter of generality, however, the resources did not exist to support those who were convalescing in hospital. There was an ongoing discussion with the National Health Service at local level - Tayside NHS Trust as it has now become - about the provision of what is known as "interim care" which would enable the discharge of a patient from hospital to another care setting on an interim basis to improve their health before they go home, but as presently envisaged that other care setting would be a nursing home. I cannot help but observe that while this is primarily for disabled people still well enough normally to live at home, such a system if it had been available at the time of Roddy's discharge, would have had the merit of taking him to a nursing home where the staff should have been more capable of managing him effectively and many of the problems which arose and are now under contemplation would not have materialised. Beyond that discussion, which remained current, Mr. Watt had no suggestions as to how a resident with limited intellect who had to be in hospital could be supported from admission to discharge by local authority staff.

[236] Mr. Watt told the court that the traditional approach in Dundee had been that general practitioners would continue to support their patients in care homes all over the city and so, in any particular care home, each resident might have a different general practitioner. There had been some discussion about designated general practitioners having a responsibility for residents of a particular care home to get continuity and consistency of medical input. Such an approach would have the support of Dr. Starr but I recognise that this is a potential minefield and simply welcome the fact that Dundee City Council officials have had the foresight to try to address the problem. Superficially, it appears to me that there would be merit in each

care home having a designated general practitioner but that is a matter requiring careful discussion among all the interested parties including the Care Commission.

[237] Mr. Watt told me there were no formal arrangements for liaising with relatives about the medical condition of any resident, nor any change in it. While I accept that there is a line to be drawn somewhere - and I tentatively suggest that the line should be where medication is prescribed or prescribed medication is withdrawn or changed - there must be an obligation to have a formal system of informing relatives about the health of their loved ones in care.

[238] Mr. Watt told me that there was a protocol of about three years standing whereby there should be co-ordination between hospital staff and "any other interested party" with a view to supporting a smooth and effective discharge from hospital. Patently this would be of the greatest significance where there is a need for ongoing community based care to ensure that all the necessary aspects of that care package are in place for the time of discharge. The opinion of a relative may be taken into account. Had such a protocol operated for Roddy, one would like to think that someone like his keyworker might have met with the gastro-enterologists and have received an explanation of the basis upon which he was being discharged, the medical regime on which he required to be maintained and the importance of out patient follow up. Had something like that happened, the need for re-admission would have been better understood. Mr. Watt conceded that the operation of the protocol had not been hugely successful. Nursing staff, in particular, seemed to be unaware of the protocol. He observed that there was a large turnover of staff at Ninewells Hospital. That serves to emphasise the need for a protocol. Certainly, whenever someone is being discharged into a nursing home or residential care home, their keyworker should be informed, preferably in writing, of the basis for the discharge, the need, if any, for out-patient follow up and the need, if any, for medication.

[239] Mr. Watt thought it would be unusual for care home staff to know something about the health of a resident that they would deliberately not communicate to relatives. That, with respect, is not good enough. A duty to communicate, unless there is some good reason not to, which should be approved at at least care manager level, should be recognised.

[240] There was again no standard recognised practice where the individual cannot communicate effectively, as here, and would be assisted by the presence of a carer familiar with his means of communication. I was told that this just depended on availability of resources which is just quite simply not good enough.

[241] It seemed to be his experience of Ninewells Hospital that if a person was presenting there as distressed, then they would be discharged as soon as possible.

[242] Mr. Watt said that, in relation to the use of welfare guardianship, the Scottish Executive have stressed that guardianship should be the ultimate sanction and that other appropriate actions should be taken instead, so far as possible. Dundee City Council worked in partnership with others to try to establish the wishes and views of persons with incapacity and in particular to work with their families. Where there was no conflict, the approach would be to try to assist with the implementation of

decisions. So far as guardianship is concerned, the local authority recognised that that was a question of degree, but best practice, he said, led them to prefer to work with individuals. A guardianship order, he thought, would not permit physical implementation of a decision to medicate. He was only willing to recognise limited situations in which a person who was incapable of taking decisions on his own behalf would benefit from the appointment of a welfare guardian. He did not say anything about the financial resource implications.

[243] David McCaw, aged 56, was a senior social worker with 32 years experience of working for Dundee City Council Social Work Department. He is a mental health officer. He currently has responsibility for the application of the Adults With Incapacity (Scotland) Act, 2000 to "service users." This made him a senior officer in strategy and performance planning.

[244] He explained that the attitude of Dundee City Council when the Act came into force was that they would confine intervention in pursuance of the Act to those cases where there would be a resultant benefit to the adult which could not otherwise be achieved. There was no suggestion that the provisions of the Act were mandatory. So an empirical exercise of discretion when a benefit might be achieved was to be the approach. A questionnaire had been framed to assist social work staff in considering whether there was a need to seek advice in any given case about the propriety of exercising any duty to act. This led to widespread training, including the staff of residential care homes. One illustration of where intervention under the Act might be appropriate would be where a resident of a residential home lacked capacity to consent to his or her care plan and there was disagreement from a relevant quarter about the details of the plan. Applications had been made to safeguard adults from unscrupulous relatives. He was unaware of any specific protocol concerning decisions pertaining to the health of an incapable adult, particularly where the health issue was a different health issue from the one giving rise to the incapability. Guidance suggested a case conference but that was not mandatory and he was aware that in the majority of cases informal discussion achieved the required outcome.

[245] The local authority had no specific guidance about what to do in a case where the individual had no residual capacity to consent.

[246] Mr. McCaw said that it would be fair to describe the approach of Dundee City Council as "needs driven." By that he meant that where a problem was drawn to the attention of the local authority whether by its own staff or otherwise then consideration would be given to the propriety of making some form of application under the Act.

[247] There were a number of ways in which the Act addressed the issue of consent to medical treatment and the giving of medical treatment in the absence of consent. A section 47 certificate issued by a medical practitioner could authorise the giving of medical treatment without consent. A welfare guardian with power to give or withhold consent for medical treatment could give consent in the absence of the patient having the capacity to do so, but only where the medical practitioner has a specific course of treatment in contemplation. An intervention order could not authorise the performance of a specific health care procedure. The difficulty arose where there

was continuing resistance from the patient in respect of which there were, he considered, specific provisions within the Act prohibiting the use of force and detention. There was the practical issue about overcoming physical resistance, no matter what the Act might say. He referred to section 47(7) of the Act, which provided that the authority conferred by Section 47(2) "shall not authorise (a) the use of force or detention, unless it is immediately necessary and only for so long as is necessary in the circumstances....." Determining what force would be necessary in accordance with the provision would be a matter for the medical practitioner and this is, he said, uncharted territory. He was unaware of any case in Scotland where the issue of what constituted reasonable force and for how long had been considered. He said that it would be within the power of a sheriff to make such an order on cause shown.

[248] With regard to the use of sedation to get someone with incapacity to enter hospital having regard to the provisions of the Act, if it was considered necessary in order to safeguard the patient's interests so far as concerns his health and it was the minimum intervention necessary in accordance with the principles of the Act and there was a benefit to the adult which could not otherwise be achieved, then the giving of such ancillary treatment as might be required to facilitate the main treatment could be authorised, in Mr. McCaw's opinion. For example, the giving of a general anaesthetic to facilitate a major operation would be covered by the section 47 certificate. Mr. McCaw was unaware of the issue of sedation ever having been tested in court.

[249] Another way of dealing with difficult issues such as the merit of performing an operation, such as an ileostomy, which might have had to happen in this case, would be by application to the court and the appointment of a *curator ad litem.*

[250] Mr. McCaw acknowledged that there would be a benefit for a medical practitioner faced with some of these difficult decisions to be dealing with a legally appointed guardian rather than having to convene a committee of relatives, who may have a range of views. It was, however, not the policy of the local authority to appoint a welfare guardian for that purpose at least in the absence of an overture from a medical practitioner in a particular case. There would, of course, be a range of persons to be consulted before an application could proceed.

[251] For the avoidance of doubt, Mr. McCaw told me that he had never met Roddy nor had he had any input to his care or well-being or any decision relating thereto.

[252] Mr. McCaw informed the court that there was a dichotomy of opinion among local authorities between what he described as the "universalist" view and the empirical view in relation to making applications for the appointment of welfare guardians. In the former, an application for at least an intervention order would be made in every case where a decision required to be made affecting an individual which decision was outwith his capacity to consent. A neighbouring authority, having obtained Counsel's Opinion, had adopted the universalist approach. He understood the advice they had received was to the effect that it was impossible to give precise interpretation as to when it would be necessary to seek an order under the Act and that therefore an approach which sought an order in every case would not be wrong. The Scottish Executive, on the other hand, in the light of what had become known as

the "Bourne Wood" case, have issued advice to the effect that a universalist approach is not necessary. In any event, local authorities are enjoined to use the principles of the Act, even although no application for either guardianship or intervention order is made. The law as it currently stands does not make it mandatory to make an application and have a guardian appointed even for an adult with no residual capacity whatsoever. This continues to be the subject of debate. Mr.McCaw, with more than thirty years' experience in caring for persons with mental disorders, believed that "horses for courses," essentially the empirical approach, was the proper approach. He believed that incapacity alone should not form the basis of the decision to make an application. It is with some diffidence given his experience that I respectfully suggest that even he needs some further training on the consequences of caring for a person with no or limited capacity to consent to medical treatment and to being looked after in a residential setting.

[253] Mr. McCaw observed that one of the difficulties about co-ordinating and informing on cases of this nature is that the local authority care manager does not have the authority to co-ordinate health care. Mr. McCaw did not think that a welfare guardian would have that authority either. Co-ordination, co-operation and communication among social work and health professionals is very much a matter of local custom and practice. Mr.McCaw said we were very much at the mercy of how well integrated health and social care were in the health area concerned.

[254] He agreed that it was not unusual for a residential care home resident to be seen by a variety of general practitioners both from his own practice and from out of hours GP services. He accepted that, given that background, it might not occur to any individual doctor to initiate an application. The person responsible for co-ordination in the residential care home setting was the manager of the home.

[255] He considered that generally getting someone to take medication would be the responsibility of the medical practitioners. There were practical difficulties about how far a social care officer could go in relation to the administration of medication. They cannot, in fact, administer medication but they can assist the resident to take medication. The approach had been a reversion to the general practitioner if the resident declined to take medication. It would then be for the doctor to determine how to surmount the problem. A visit from the district nurse was a possibility. Removal to a nursing home was another alternative.

[256] He accepted that Roddy's case appeared to demonstrate an absence of anyone prepared to take a lead or even be in an effective position to take the lead in making decisions and seeing that they were implemented. This, he said, was the consequence of managing health care and social care by two entirely separate routes of management and accountability so that the extent to which there was co-ordination between the two was left to the goodwill of the professionals concerned. If communication was poor then there would be a weakness heightened by no single person having an overarching responsibility for overseeing the effective provision of care and seeing that the various professionals did what they should be doing The overseer, in a perfect world, would have experience with both health care and social care. He accepted that until that perfect world materialised, there would be merit in having a welfare guardian if, as nothing else, a central repository of information. But he did not consider that a welfare guardian was in a position to insist that health care

procedures were carried out or that a particular treatment or approach to treatment is carried out. The provision of health care, he considered, remained with medical practitioners. The guardian's powers are limited to consenting to what is proposed by the medical practitioner and to imply that somehow there could be a more overarching role that ensures co-ordination actually takes place and the best decisions are thus made in this complex interface is stretching the point too far.

[257] In the present case, what became of the information transmitted to the general practitioner from the Department of Neurology was a useful example. The doctor at Neurology would have no obligation to convey that information to a welfare guardian. Mr. McCaw wondered if that might be a failing in the Act. The reality, as I see it, is that if there had been a welfare guardian, he would have had to consent to the referral to Neurology and would thus be aware of it and could pursue either Neurology or the general practitioner for information. Generally a welfare guardian would seek a power conferring access to the adult's medical records and would thus be entitled as a matter of law to the same right of access as the adult would have. In any event, it seems to me as presently instructed that a welfare guardian is in a position which is the equivalent of being *in loco parentis* and it is inconceivable to me that a doctor would decline to give a court appointed legal guardian relevant medical information. I have no doubt that, except in the mot exceptional circumstances, a court would order that information be disclosed to the guardian. I accept that a guardian cannot compel a doctor to act, but he can look for another doctor who will.

[258] Mr. McCaw said that his experience suggested that, where only a welfare guardian was to be appointed, especially if the welfare guardian was to be the chief social work officer of the local authority, then the appointment process could be simplified. I would wholeheartedly agree with him. There would, he said, be major resource implications if local authorities were forced to adopt the universalist approach. There would also be implications for court resources. There was a suggestion from Ms. Hilary Patrick who is a well known expert in this field, that the appointment of a proxy would be an acceptable alternative. He had reservations about that as any dilution of the system would reduce the safeguards protecting the adult concerned. There would need to be an appeal procedure. There would need to be some form of safeguard against collusion. But for the appointment of a welfare guardian the present system was unnecessarily bureaucratic and expensive.

[259] Mr. McCaw was good enough to produce to me a report from the Mental Welfare Commission about "significant interventions" and draft guidance from the Scottish Executive following the "Bourne Wood" judgment of the European Court of Human Rights. He felt that the latter "skirted round" some of the more difficult issues. It is fair to observe that both these documents and the decision were all written subsequent to Roddy's death, but they appeared to me all to be relevant to the current treatment of persons with reduced mental capacity. The report from the Mental Welfare Commission had been written by Hilary Patrick but had been endorsed by the Commission, who had said, "We hope her paper will assist family members, lawyers and practitioners in their decisions about the use of the Adults With Incapacity Act." Mr. McCaw had already explained the distinction between the universalist and selective approached discussed by Ms. Patrick in a way not markedly different from her. The majority of local authorities had adopted the selective approach. There were, said Mr. McCaw, between 60,000 and 70,000

people in Scotland suffering from dementia. If the universalist approach were to be adopted a huge undertaking for local authorities would arise. It would also present a significant new burden for the sheriff court, he ventured to suggest. He observed that Ms. Patrick favoured the selective approach and that she advocated simplification of the initial application for either intervention or guardianship orders. He retained concerns about the adequacy of the protection of the adults concerned.

[260] The paper written by Ms. Patrick owed its origins to the "Bourne Wood" decision which arose out of the interpretation of English legislation and is a decision having regard to the law of England. It was about the basis upon which a person without the capacity to consent can be moved into a care home having regard to the individual's right under Art. 5 of the European Convention on Human Rights. With due respect to the witness, the case was about the basis upon which a person without the capacity to consent can be detained within a mental hospital without any statutory order detaining him, and in my opinion, it is a decision highly relevant to the present circumstances for reasons which I will come to explain. The witness went on to observe that Ms. Patrick's report did not address the issues concerning the medical profession surrounding Section 47 - and almost every medical expert in this case did express concern about the provisions of Section 47 - that being the part of the Act which had caused the greatest controversy and debate during its passage through the Scottish Parliament. There were, he said, by way of example, current issues about whether dentists and nurses could undertake assessments of capacity which remained unresolved.

[261] Mr. McCaw was less complimentary about the guidance from the Scottish Executive. He described the observations at page 8 about the implications of the Bourne Wood case as "seriously garbled." He did not consider that the document offered any real guidance pertinent to the present circumstances.

[262] Finally, Mr. McCaw accepted that any system to provide an "interpreter" to try to explain Roddy's views, would be fraught with difficulty.

[263] It is instructive that in the document referred to by Mr. McCaw, produced by the Mental Welfare Commission, in the foreword the Director of the Commission writes, "Unfortunately, however, the Act does not make it clear when Welfare Guardianship or Intervention Orders should be sought. This uncertainty has led to widely different recommended practices. Some have argued that Guardianship or Intervention Orders should always be sought when a major action is to be taken on behalf of a person who does not have the capacity to consent to this. Others have argued for a more selective approach.....There can be no definitive decision about the use of Welfare Guardianship or Intervention Orders until this matter has been tested in the courts.....The Commission thought, however, that it would be helpful if the arguments supporting different interpretations of the Act could be clearly presented and carefully analysed to assist those who have to decide whether to apply for statutory orders to protect individual's welfare." Unfortunately and despite the best efforts of Mr. McCaw, the absence of representation for Dundee City Council meant that, other than Mr. McCaw from his position in the witness box, I did not have the benefit of clear presentation and careful analysis of this issue from the perspective of the local authority.

[264] It is also instructive that in paragraph 11 of the document issued by the Scottish Executive entitled, "Draft guidance for local authorities on when to invoke the Act," the Act being the Adults With Incapacity (Scotland) Act, 2000, the document being undated but apparently issued to local authorities in about May, 2006, it was recognised that "If the adult is being moved to a care home or other institutional setting, or is to receive a major care package in his/her own home, consideration should be given to the care plan, and in the case of an institution, to the care regime, to consider whether or not circumstances could amount to a 'deprivation of liberty' in terms of Article 5 ECHR. ...If so, and application for an order will be required, even if the adult appears to be in agreement or is compliant with the proposed change."

[265] There were two remaining witnesess of significance. The first of these was Diane Carter, aged 51, who is the laboratory IT systems manager for NHS Tayside based at Ninwells Hospital, Dundee. She had been in post for 29 years and had the professional qualification of B.Sc (Hons). She had been asked by the Crown to consider certain computer generated laboratory records relating to Roddy from 2002 and 2003 and to assist the court's understanding of the operation of the IT systems at Ninewells in the particular context of the issue of blood test results.

[266] She confirmed that Crown Prod.1 was the medical records of Roddy and that p118 consisted of certain biochemistry results and that page 98 comprised certain

haematology results. On the former (which in fact comprises a set of eight

biochemistry test results over a period) there is an indicator "PID" which stands

for "patient identity number." It is now known as the Community Health index

number ("CHI number")and is a unique identifier for any patient within Tayside - and

in fact now nationally. Ms Carter explained to the court how each individual number was derived. I shall not replicate this evidence lest that information might be capable of misuse but suffice it to say it appeared to me to be a well thought out and effective system. Every patient now in Tayside should have a unique CHI number more or less

from birth. That reference number was used in all medical contexts including reporting on samples.

[267] Shown NHS 3/1, she confirmed that this was a bundle of computer generated

sheets she had produced for the purposes of the inquiry. She explained that the

CentralVision system was an electronic health patient records system which

allowed clinicians throughout Tayside to view laboratory reports on patients.

It allows general practitioners and hospital clinicians access to the records and

results as soon as they are put into the system by the laboratory. The laboratory's electronic system sends the results to CentralVision as soon as they have been put in.

Roddy's CentralVision number was specified and there is a sheet containing a series of entries from 24th. February, 2003 to 10th. November, 2004 showing all accesses to reports by doctors over the period. The first doctor appears to be "A Hendry" and his code demonstrated to the witness that he was a general practitioner. By reference number the record also identifies the document accessed. The next five entries are all in the name of Dr. J. Wallace between 00.19.22 and 00.21.09 on 17th. April, 2003. No one else accessed the system in Roddy's lifetime so that it looks very much as

though Dr. Wallace or someone standing beside her noted the wrong results. The results were accessed after Roddy's death by Drs. Pullar, Jones and Hill. The witness could tell from the code that Dr. Wallace was hospital based. The abbreviation "tuht"

stood for Tayside Universities Hospitals Trust. One of the documents she looked at twice and she looked at three other documents once only. Page 3 of the production lists the four documents accessed by Dr. Wallace on 17th. April being four documents which were put into the system on 17th. December, 2002. Page 4 of the production is Dr. Wallace's entry in the systems directory so that it contains her e-mail address, pager number and department. This was from the Tayside NHS Intranet Directory. Page 5 was a printout of a sheet unique to Roddy showing all bacteriology, haematology and biochemistry results with sample date and time of collection, date and time sample received in lab and date and time report was issued to CentralVision. There is also a bacteriological sample entered as received at 00.01.01 but a haematological sample entered at 14.09.00 on 16th. April. The result for that became available at 10.53.13 on 17th. April. The bacteria result did not become available until 19th. April and the biochemical result apparently did not become available until 26th. April at 12.54.49. However the second biochemical result collected at 00.01.01 on 17th. April has a result at 10.41.40 on 17th. April, which would have been available

prior to discharge.

[632] A two day delay is normal for a normal bacteriological test. She thought that a

doctor looking at a screen connected to CentralVision would at about midnight be

able to see results of a blood test done at about 14.00 on that day. Routine biochemistry tests are available in about two hours.

[268] A particular identified document is the biochemistry results for 17th. December, 2002. This is what Dr. Wallace looked at twice and these are the results she wrote

down. When Dr. Wallace looked at this screen view the only results which would

have been available were those for 17th. December, 2002. She would input her

access code and obtain access to the system. She would be presented with a

search screen into which she would enter the patients CHI number or she could search by name instead but if she used the number the record would come up right away. The left hand tree would then come up offering her a number of options. If she wanted

"haematology" she would then click on "haematology" and might be offered a series of different dates. When the witness did it for "biochemistry" on 26th. June, 2006, she

was offered a series of dates, 5 in total, as well as "earlier" and "later" options. The user then has to click on the date i.e. to get the document viewed twice by Dr. Wallace she had clicked on the "biochemistry" box for 17/12/02. Once she had clicked on that, what appeared on the screen would be like document 3/4 p.(1). On that document/screen the date 17/12/02 appears in three separate places. It is the day the request was entered into the laboratory system - that is on the bottom left hand side of

the report. The bottom right hand figure is the date the report was printed in the laboratory and therefore made available to the system. Then at the very bottom right

hand side is "sample date time" - that is the time the sample is taken from the patient. To know when a result would be available on the screen you have to look at NHS

3/1/5 which tells you when the result was imported into the CentralVision

system. Apart from the patient's date of birth, there is no other date on the document viewed by Dr. Wallace twice at about midnight on 17th. April, 2003 apart from 17th. December, 2002. Because the system is dependent upon the user knowing the date of the material they are searching for, any user should understand the significance of the date for that is the last thing they click on before obtaining a result. The results page here for biochemistry on 17th. December, 2002 also makes it clear that the result has been requested by "N/W Neurology Outpatients," another indication that it is not the sample apparently taken on admission to Ward 15 by Dr. Wallace. The clinician who has made the request is also named, "Dr. K. White" who is not either Dr. Wallace or one of the Ward 15 consultants. That is a record of where the sample came from. On the request form that accompanies the sample there must be identification of the person making the request. The witness was unable to comprehend how Dr. Wallace could have made this series of errors in transcribing the wrong results on to the patient's records. The correct date is emblazoned all over the screen. So is the source of the request. The witness considered that it was the transcription process that was the problem. If a print out had been used it would at least have allowed others

perhaps more alert to look at it and realise that they were not looking at the correct set of results. Prod 3/4/p ii was an earlier version of the same results sheet into which only one result had been entered, for comparative purposes. What the witness looked at was the latest entry for that date. However, she also appears to have looked at two other documents on screen which are earlier incomplete reports of the

biochemistry tests again all dated 17th. December, 2002 and all requested by Dr. K. White for N/W Neurology Outpatients so she has considered three reports, all for the same wrong date and all requested by the same wrong source.

[269] Much the same applies to the haematology results. The print out with the

document identification is the complete set of haematology reports. It too has

three references to 17th. December, 2002 and says in terms that it was requested by Dr. K. White, N/W Neurology Outpatients.

[270] The witness had attempted to make enquiries about the apparent delay in

posting the biochemistry results. It is noted that the haematology results were

posted at 10.53.13 on 17th. April. The biochemistry results had not been posted on CentralVision until 26th. April, at 12.54.49. Apparently the request form accompanying the sample did not have the full CHI number for Roddy. It is now obvious that, although Dr. Badenhorst had written the correct CHI number

on the Admission Request form, Dr. Wallace managed to write down the

wrong number on the Admission sheet and presumably wrote the wrong

number on the sample request form. The information including the raised

C-Reactive Protein level was withheld by the lab pending validation of the CHI number. It was available at 15.18 on 16th. April, 2003. The witness concluded that no

request was made from the "requesting officer" for the biochemistry results

(which would follow as she thought she had them) but someone must have

requested the haematology results on 17th. April as they were then issued. The

17th. April samples results were made available, and thus must have had a correct CHI

number, prior to the 16th. April results. The computer audit trail says on it

"Results held for verification of patient ID." The paper request forms are only

held for about a month and then destroyed so the original is not there. Staff in

reception in the laboratory would query the identification. The CHI number should be entered by the requesting source on the request form which accompanies the sample. The CHI would be on the patient's wristband or case notes. The request would be purely manual and not done by computer.

[271] The system now has changed. It is based on CentralVision where the user logs

in with their own ID, identifies the patient by the 10 digit CHI number and there is then a menu which enables them to create an electronic request. In other words the request will not be permitted unless you have properly identified the patient. So the situation which arose in the present case is now unlikely to recur. The system is not quite yet at 100% but about 90% of the hospital terminals and 50% of GP terminals now operate on an electronic sampling request basis. The witness believed that samples would now be refused if they were not properly identified.

[272] In 2003, faced with a wrong CHI number, the laboratory would have processed the sample and held the information until they had confirmation of the patient's identification. This would normally come from the requesting doctor telephoning the laboratory because the results were not appearing on CentralVision. The doctor would then be asked to confirm the CHI number and any difficulty would be resolved. Alternatively, the laboratory would contact the requesting doctor if the results gave rise to cause for concern to query the patient's identification. No paper copy of the results would be issued either without the correct CHI. Had the doctor telephoned the laboratory the problem with CHI numbers could have been resolved. No one else would come looking for them as she had written the wrong results into the casenotes.

[273] It was the understanding of the witness that the junior doctors do the transcription from the screen on to some form in the case notes for the benefit of consultants because the paper report would not yet have reached the case notes. Now, there are printers in 90% of the wards and the results could simply be printed out. There is a printer on Ward 15. That printing facility has always been available. Whether printers have always been available she was less certain about. Using the print out would avoid any risk of mis-transcribing.

[274] She confirmed that Roddy's records had been accessed by Dr. Pullar on 28th.

August and 5th. September, 2003, and that Dr. Hill accessed the records on 10th. November, 2004

[275] In relation to 16th April biochemistry sample date and time of collection, the system default is 00.01.01 if no time is entered for the time of collection of the sample. The same applies to the biochemistry entry for 17th. April, 2003. She did not know why the biochemistry results had been inputted on 26th. April. There was no logic to that.

[276] It was the requesting officer who got the CHI number wrong. The top date on the "results" print out is the most recent results available at the time of request at about 00.20 on 17th. April. Presumably that is why she clicked on that box.

[277] Shown NHS 3/5 the Laboratory Management Information request audit enquiry this demonstrates that the results were available at 15.18 on 16th. April, but they were "held for review" by a biochemist because of the CCA result. That appears to have been "manually validated" but it appears that no further attempt was made to enter the results until 17th. April at 10.36 when again the results were held for verification of patient ID. "KENI" is the user identity in the laboratory system to identify who did the manual validation.

[278] Training in the computer system is available. All junior doctors are trained during their induction. New doctors coming in will be trained. Otherwise it is through "peer training." The system is fairly self-explanatory and they are "self-guided" through. Once they have identified the patient, they have access to a menu where they can choose what they want to see.

[279] To access the system there is a registration form which must be completed and countersigned by a lead clinician. That however is no indicator of having received any training in the system. The witness believed that the doctors

would also receive training in laboratory procedures. She could not say whether doctors were told that if they did not enter the correct CHI number, then they would not get laboratory results. She considered that it was for the laboratory staff to guide doctors on how to use the forms. A handbook was issued to each junior doctor telling them how, in 2003, to complete the manual request form. Now they are trained in the test requesting side. That is now undertaken by the IT Training Department. If a doctor were now to enter an inaccurate CHI number "Invalid chi details" would come up on the screen. They have to have the patient properly identified. It will be on the wristband attached to the patient's wrist and on the case notes for the patient. The wristband numbers are handwritten, which is not ideal, and they were looking at bar coding. Human error was being eliminated so far as possible.

[280] The final witness of significance was Dr. Katharine Mary Morrison, a general practitioner from Mauchline, Ayrshire whose qualifications were Mb.CHB, with post graduate qualifications in general practice, obstetrics and gyneacology, child health, complementary medicine, psychotherapy and medical jurisprudence. She had been in practice as a general practitioner for 19 years. She had been asked by the Crown to act as an expert witness and to consider in particular the conduct of the general practitioners. She explained that in her locality there were three residential nursing homes and three residential care homes as well as a GP run community hospital. She had, however, little experience in dealing with sufferers from Down's Syndrome and could not recall having encountered a person with Down's Syndrome living in residential care. She did, however, have many patients suffering from dementia both in the community and in residential and nursing homes.

[281] Having been a police surgeon for 19 years, she had extensive experience in preparing reports for the courts. She had also undertaken 11 commissions as an expert witness. She had provided reports in medical negligence cases, personal injuries cases and in other cases where the actions of general practitioners or police surgeons were being subjected to scrutiny.

[282] She had produced a report, Crown Prod. 13 together with a response to a request for additional information, Crown Prod. 14. I regret I have to say that in a number of respects, the report was based on information which was not consistent with the evidence I heard. For example, she states, " Due to his mental state he had been due to transfer to a nursing home but because his condition deteriorated

considerably at Maryfield House and his death was expected a decision was made to keep him at Maryfield House where he was familiar and comfortable with the staff and surroundings." What she says may well be the truth but the evidence I heard was to the effect that Dr. Quinn and Thomas Campbell decided that Roddy should not transfer to Camperdown Nursing Home "until the GPs had got his condition under control." She also states, "Back in the nursing home Roderick's sore stomach continued and he needed to have diamorphine injections. The doctor who attended wanted to admit Roderick again to hospital but in attempting to do this Roderick held on to his wheelchair tightly and also wrapped his legs round the chair and screamed whenever anyone tried to move him into an ambulance. After about half an hour of this the ambulance men said that they would not be able to transport him to hospital because it would constitute an assault if they did. The doctor considered his position and made the decision to look after Roderick in Maryfield House." I presume this is a reference to the events of 20th. April. If it is not, then I am not clear what the reference is to. On 20th. April, Dr. Ward, a lady doctor from D.D.O.C., attended twice, first at 13.40. The complaint was of lower abdominal pain. Her provisional diagnosis was a urinary tract infection as there was some history of retention of urine. Her main reason for hospital admission was that the staff were not coping with Roddy who was declining medication. He was not, however, at this point prescribed diamorphine. I do not know from what source she obtained her graphic description of Roddy's resistance to removal by ambulance. I am not aware from any other source that Roddy used a wheelchair. It was Dr. Ward who prescribed amoxycillin in suspension and she records getting Roddy to swallow this without difficulty. There was no history at that stage of him refusing anti-biotics as he had not been prescribed anti-biotics. So far as I am aware, no diamorphine was administered prior to the fitting of the syringe driver on 22nd. May. It was not Dr. Hollins who called the ambulance on 20th. April but Dr. Ward. I do not know the source of her evidence that Roddy was seeing his "dead parents in the mirror" unless she has been discussing the case with staff at Maryfield House, but they made no reference I know of to his father. She makes reference to Jacqueline-Ann Risbey. No one else has. I do not understand Dr. Hollins to have considered that Roddy had the capacity to consent to treatment so Dr. Morrison's answer about his refusal to be admitted appears to be based on an inaccurate premise. Her sole criticism of the general practitioners is their failure to request a domiciliary visit from a gastro-enterologist following Roddy's "refusal" to return to hospital. Presumably, again, this is a reference to the events of 20th. April, 2003.

[283] It was her conclusion that the care delivered by the general practitioners was of an appropriate and reasonable standard. She claimed that, in reaching this conclusion, she had applied the *Hunter v Hanley* test plus that from what she referred to as *The Litho* test, which she claimed was a decision of the House of Lords. She gave me no reference for this authority. She said that she had to put herself in the position of the average general practitioner of average knowledge and having done that she concluded that the general practitioner in the present case had not been negligent. Despite this, she appeared to accept that re-admission to hospital and, in particular, re-hydration would have substantially improved the prognosis. She maintained that Roddy's disinclination to re-enter the ambulance must be regarded as a refusal to consent to treatment and thus the doctor's hands were tied. The only way to get round that, she said, would have been to make an application under the "Mental Health Act," (the Mental Health (Scotland) Act, 1984

would still have been in force at that time) and the only way to get him into hospital would have been to pursue an application under the Act. His relatives, general practitioner and a consultant gastro-enterologist would all have been required to override Roddy's resistance to admission and a consultant psychiatrist would have had to assess him. Practical considerations, such as would he have tolerated an intravenous drip, would arise. He might have to be heavily sedated, which would have potentially given rise to other health problems, particularly the risk of chest infection. She understood his brother and sister were not keen on his re-admission to hospital so that would have prevented a Mental Health Act application. There would have to have been a definite management plan. A doctor has to think if a patient is to be admitted to hospital what is then going to be done with them. I regret I have to say that most of the foregoing does not stand up to close examination. It is nonsensical to assert that Roddy was in a position to exercise a rational decision. He was not. He had no idea what admission to hospital meant. He did not comprehend the need for life saving treatment. Had an application under the 1984 Act been necessary on an emergency basis, all that would have been required is certification from a medical practitioner that he was suffering from a mental disorder, namely mental impairment, and that he would benefit from treatment for his condition were he to be admitted to hospital and that if he were not so treated there would be a risk to his health or safety. That could be done under S. 24 of the Act and would have permitted hospital detention for a period of 72 hours. That period could then have been extended for up to 28 days with the consent of the managers of the hospital. That would have been plenty time to make an assessment and determine whether he would comply with treatment for ulcerative colitis and, hopefully, get on with that treatment. What his relatives would have considered appropriate would depend on the comprehensiveness and accuracy of the information they were given and neither of them was consulted at the material time by Dr. Hollins never mind given a full and proper explanation of the options. Roddy had intravenous drips in each arm, fluids and steroids, during his most recent short period of in-patient treatment, and, although there is evidence of one coming out, the evidence also is that it was re-fitted. It would have been obvious to a consultant psychiatrist that Roddy did not have the capacity to consent or withhold consent to medical treatment for ulcerative colitis. Doctors (and dentists) sedate people every day of the week to enable them to conduct a variety of treatments and there is no reason to think that a mild sedative would not have been sufficient to permit Roddy's admission. I accept that the gastro-enterologists would have to consider that a course of treatment was worthwhile, taking into account all the difficulties associated with Roddy's care, but the situation was one in which he would die a painful death, as he patently did, in the absence of intervention. In my opinion, Dr. Morrison has offered nothing more than a series of excuses for inaction on the part of the general practitioners, and it is not noble. Had they tried and failed, there would be no scope for criticism but they appear to have been fixated with this nonsense about Roddy's resistance to treatment and somehow unable to see that if a mental health intervention was required then they should have got on with it.

[284] She was another member of the medical profession who claimed that consultants were often unapproachable. I heard evidence from four consultants. I do not know how representative they are but none of them struck me as being unapproachable. I expect Dr. Jones would be unenthusiastic about being approached by a general practitioner on the simple basis that one of his primary

functions would be to identify the specialist who should deal with the particular patient's particular problem, and it would therefore be that specialist who should be approached, but Dr. Starr and Dr. Clarke both indicated that they regularly discussed patients with general practitioners. It may be that some consultants have an "image" problem which requires to be addressed but I do not accept that general practitioners should not seek guidance and help from consultants because they find them unapproachable.

[285] Dr. Morrison did not understand the concept of a welfare guardian. She considered that the doctor would still require to be satisfied that the patient was consenting to treatment, failing which she would have to resort to the provisions of Section 47. She considered that to treat a resistant patient would be an assault. In response to the suggestion that she might find herself in some difficulty in refusing to perform a procedure consented to by a welfare guardian, she said, "It is one of these marshy areas." It ought not to be but her evidence suggests that there is a steep learning curve in this area for general practitioners to navigate. To a lesser extent, this may also be true of hospital based doctors at whatever level, but the hospital consultants were at least all familiar with the requirements of Section 47 of the Adults With Incapacity (Scotland) Act, 2000. Dr. Morrison considered more generally that the provisions of the Act were not very clear, that there had been a lack of consultation with general practitioners about its contents and that general practitioners had a poor understanding of where they stood with regard to their rights and responsibilities towards patients. For good measure she added that the provisions of the Mental Health (Care and Treatment)(Scotland) Act, 2003 were also extremely confusing and she referred to a recent case where she had been called upon to act as a police surgeon where none of the agencies knew what they were supposed to do nor understood the rules. Simple clarification of the issues arising out of these two pieces of legislation would be welcomed by general practitioners particularly in relation to what she described as "difficult consent issues." I have some sympathy with her. It would appear from her evidence that doctors have hammered into them in the course of their training the need for their patients to consent to treatment and they have great difficulty with the concept that someone other than the patient can be authorised to give that consent instead. While the practical issues of compliance remain to be considered, the law is relatively clear and in terms of its broad principles relatively unchanged by the Adults With Incapacity (Scotland) Act, 2000. An appointee whether by the patient in a Deed of Attorney or by the court in a welfare guardianship or possibly in an intervention order for a particular purpose can give or refuse consent, if that power is conferred either by the deed of appointment or order of court, for medical treatment, as though he were the patient, provided the patient lacks the capacity to consent to the particular treatment.

[286] She accepted that, as a matter of practicality, there was no issue of confidentiality about discussing with relatives the condition and treatment needs of a resident in a residential home who was suffering from dementia. This happened regularly. She further accepted that it was not satisfactory that in the present case Roddy's sister and brother had not been made aware properly of the extent of his dementia nor that he had a diagnosis of ulcerative colitis until it was too late for that information to be of any practical value in the sense of it being too late for meaningful intervention to address his medical conditions. She recognised that there was no

mechanism for that. She agreed that the practice was to discuss care and treatment with carers and not to discuss with anyone other than carers. She agreed that general practitioners tended to be reactive and would discuss with relatives who approached them but they were unlikely to initiate such discussions. She seemed to accept that communicating health care issues via a third party i.e. leaving it to carers to tell relatives, was unsatisfactory, as it clearly is. She agreed with the suggestion that a nominated general practitioner should communicate with a nominated relative so that everyone is properly informed. That, she thought, would be a sensible approach and "would avoid a lot of misery." There was merit in having clear lines of communication.

[287] Dr. Morrison said that in her experience, an understanding of what is happening to them has a huge impact on the compliance with treatment of patients with impaired mental capacity, thus making the point for me of the need for external decision making where the patient does not understand what is happening to him. For example, and it is a common problem, she said, a patient with dementia admitted to a general medical ward in hospital will shout all night, getting no sleep and ensuring that no one else does either. They were inclined to pull out drips and catheters because they did not understand why they had been attached to them. In an ideal world, she said, they should be looked after in small units with a much higher degree of staff supervision, instead of being "lumped in" with everybody else. For such a unit, both general and psychiatrically trained nursing staff would work together. That would improve conditions in hospital for everyone but most particularly for those with dementia. I wholeheartedly agree.

[288] Dr. Morrison's evidence about the move from active treatment to palliative care was, I regret to have to say, about as vague as the actual evidence about the change of status of care. She seemed to accept that there had been a "drift" into palliative treatment but she seemed to think that this included trying to get Roddy to take medication and to eat and drink normally, which did not strike me as consistent with the concept of palliative care. She did not think that there was a definite point of change. Alarmingly, she said that there were times when you went to see a patient and "it hits you in the face" that the person is dying. This, she said, was often easier with a patient not known to the doctor. I have to confess that I am unaware of and distinctly unenthusiastic about this approach to diagnosis. It appeared to be on this basis that she considered that the commencement of the syringe driver was appropriate. She considered this to be "a merciful act, done in good faith." It would have been had it been accepted by those responsible for his treatment that Roddy was terminally ill, but that was not Dr. Hollins' position in evidence. She said it would have made a big difference to Roddy's level of comfort and I do not doubt that in terms of palliative care pain relief it was entirely appropriate. The syringe driver was started at a dosage which would have relieved pain but would not have hastened death. If a patient who is already ill stops eating and drinking, the patient will die quite quickly.

[289] Dr. Morrison appeared to accept that Dr. Hollins would be familiar with Roddy's mental state. She reached that conclusion without knowing what Dr. Hollins had told us about having a brother who suffered from Down's Syndrome, so he was acutely aware of and sympathetic to Roddy's condition. She seemed to think it would be possible to explain to Roddy in simple language the importance of his being admitted

to hospital but she was not clear on what basis she had formed this opinion. She said she had said to people of normal intelligence that they would die if they did not undertake a particular form of treatment, including the need for admission to hospital for treatment, but she did not think that that would be appropriate for Roddy. I am afraid I do not understand her position. If it would have been possible to explain in simple terms to Roddy that he would die if he did not go to hospital, that surely would have been the most effective and therefore the most appropriate action. I am satisfied that Roddy did not have the capacity to make the connection between pain and being terminally ill and the need for medical intervention to alleviate the pain and to avoid death. I reach that conclusion on the evidence from Edith and James Donnet and Dr. Quinn and Dr. Pullar and Dr. Jones all of whom were clear he did not understand the need for treatment. Dr. Morrison eventually accepted that in her own evidence.

[290] She accepted that there should have been a discussion with the relatives prior to the decision to change to palliative care only but she was unable to help me as to when in this case that should have taken place.

[291] In the course of her evidence, she appeared to become more positive that it was a failure on the part of the general practitioner to seek advice from a gastro-enterologist. There is no doubt that if Dr. Hollins was unclear about the basis upon which Roddy had been discharged from hospital that he should have contacted those responsible for his discharge, Drs Hill and Barron, to become clear about the basis for his discharge. But given that they had made no significant alteration to his medication, it should have been clear to Dr. Hollins, as it appeared to be toDr. Badenhorst, that the diagnosis remained ulcerative colitis. I accept that if any doubt about that had been cleared from Dr. Hollins' mind, he might well have focused better on what to do to get Roddy back into hospital and so in this respect I agree with Dr. Morrison. She was at least by inference critical of the more experienced doctors in the practice for not being of assistance to Dr. Hollins with his dilemma. I have some sympathy with that suggestion.

[292] She agreed that a classic symptom of inflammatory bowel disease was frequent passage of bloody stools, along with a systemic unwellness, and seemed to imply that this should be well known to the average general practitioner.

[293] Dr. Morrison expressed concern about what she described as "revolving door admissions" to hospital. I confess to having some trouble taking her seriously but if what she says has any basis in fact then there is a grave need for urgent examination of and improvement in the relationship between general practitioners and hospital based doctors. She gave the illustration of admitting a patient suffering from chest pains to be told on discharge, "This patient has chest pain - not a heart attack. This is a rubbish admission. Why are you wasting our time ?" It would be wrong to come to any conclusion about such observations without hearing the other side of the story but generally one would expect a cautious approach from general practitioners i.e. cautious viewed from the patient's perspective and to admit rather than not admit if in doubt. I would expect those based in hospital to understand that dilemma for the general practitioner and to be content to be discharging a patient who turns out not to be suffering from a major illness. Dr. Morrison said that she felt an element of that in the circumstances of this case i.e. that the gastro-enterologists

were implying that the admission was a waste of their time, and certainly there has been much criticism of the contents of the discharge form, if it was issued in the form we have seen with the copy available to the court. Perhaps there is a need for hospital based doctors to acquire a better understanding of the difficulties out in the community in terms of both diagnosis and treatment. Dr. Jones had told us in his evidence that for some time there had been a general practitioner working with the team of doctors on Ward 15 and he had found this of considerable value. I would have thought that it was obvious that there would be times, with the limited tools available outside hospital, that a general practitioner could not be sure about diagnosis and could not rule out a positive diagnosis that required urgent admission to hospital. There have been a number of inquiries over the years about the difficulties in recognising the onset of meningitis, for example. It would be a matter of grave public concern if general practitioners felt discouraged in cases where they were uncertain about diagnosis from sending a patient to hospital for fear they got a row from a consultant, and worse still, from hospital based doctors of lower standing, for wasting his time. She also sympathised with the view that Roddy should have been detained longer in hospital at least for observation, instead of the approaching apparently being, "he's not ill so we're sending him home." She felt that sometimes a degree of respite and a degree of time for other conditions to manifest themselves could be helpful.

[294] She considered that the suggestion that a patient was better off at home than in hospital was more driven by economics than sound medical practice. Again, I cannot accept that at face value and it was not my impression from the evidence from the consultants that they would discharge a patient who needed to be in hospital. I am inclined to think that the truth lies somewhere in the middle that hospital based doctors do have to make decisions about the most appropriate use of limited bed space available and therefore retain the most ill patients to whom they can render the greatest medical assistance perhaps sometimes at the expense of those, like Roddy, who are less seriously ill, especially if they present management problems. It is quite clear from Dr. Jones' evidence that there are insufficient beds available at Ninewells for acute medical admissions but I heard nothing to suggest that Roddy could not have been moved to the gastro-intestinal ward had admission been considered appropriate. In fact, it was Miss Donnet's evidence that there were beds available in that ward.

[295] She agreed that she had not seen any documentation setting out the alleged consensus among the doctors, carers and relatives about Roddy's treatment. She accepted that the decision to move him to a nursing home was itself indicative of a significant change in his mental health and his ability to care for himself.

[296]] With her patients aged 75 or over and in other cases where there was a mental

disorder likely to worsen, a protocol had been devised whereby such patients

were asked what they would like to happen to them in the event of their

condition requiring admission to hospital and these so-called statements of

intent were normally sent to and left with the patient's next of kin. She kept

certain statements of certain patients where, for example there was limited

external support for the patient, in medical files so that she could encourage

their invocation if the time came. I confess to being unclear about the status of such documents. She accepted that, with this type of patient, the problem came to a head when they stopped accepting help. In the setting in Ayrshire in which she was operating, word generally reached the GP fairly quickly if someone had gone off the rails because word would come from the postman or the local shopkeeper or other villagers. She recognised that the position would be different in the city and considered that that was when the medical and social work professions required to get together and determine whether to invoke rights under legislation to get access. There

would always be a degree of informal information about a person's mental health, for example, from district nurses involved in physical care, or from the dentist, but there was little in the way of formal review. She considered that a formal approach would only be appropriate after all else had failed in cases where the outcome would be death or a serious restriction if a condition was not subjected to treatment. It had to be recognised too that even when mental health legislation was invoked there were difficult issues about the consequences of non-co-operation and therefore about the merit in intervening. If, for example, a patient required long term medication, would they co-operate with taking it ? However, if there was an obvious benefit from treatment and the individual irrationally refused to co-operate, then sectioning under mental health legislation was the way to go. That should have been considered in this

case. There would have been considerable problems about how treatment might have been administered if he was, for instance, resistant to being on a drip but he would need to be in hospital to be on one and plainly he needed to be on a drip if he were to survive ulcerative colitis. She accepted my analogy of intervention with the teenage anorexic which would address both physical and mental health. The distinction, she thought, was that with anorexics, these tended to be young women with their lives ahead of them and who had family support, to be contrasted with dementia where increasing non co-operation was the order of the day and the condition did not respond to treatment so what was the point in treating a physical disorder. She saw with the benefit of hindsight what she described as a lack of motivation to treat Roddy. By that she meant that the doctors were not engaged in a philosophical process of working out what was the best thing to do to ensure that Roddy survived this particular attack; more what was the best thing to do having regard to the

wider picture for Roddy. This last passage in her evidence would imply a decision not to treat, a position that Dr. Hollins denied had been reached. I can understand why Dr. Morrison came to the conclusion that she did but my impression of the evidence remains that confusion reigned rather than that a deliberate decision had been taken not to treat. I have already said that had such a decision been taken by Edith or James Donnet in the full knowledge of the options I would have respect for

such a decision and would not find anything ethically, morally or legally wrong with it - but there is no evidence of such a decision having been taken as opposed to circumstantial evidence that it might have been. It is of some concern if doctors generally are making decisions about who it is more important to treat, particularly if they are being driven to these decisions by economic considerations. If economics are to dictate who gets treated and who does not, these are decisions for Parliament, not the medical profession.

[297] Dr. Morrison admitted that she did not know what possible benefits there were for any of her patients in the provisions of the Adults With Incapacity (Scotland) Act, 2000. Its provisions were not being widely invoked by medical practitioners who, similarly, saw no value in the provisions. She thought her profession had not had the benefit of explanation or education in these benefits. She knew about Section 47 but not a lot else. She considered that it would be of value to the medical profession generally if a person whose intellectual capacity was so reduced as to render them incapable of consenting to medical procedures if that person could have a single legally authorised representative who could give informed consent or refusal of consent to treatment. She had had no training on the Act. She had not seen any video presentation on its contents. She was not aware of the principles set out in the Act.

[298] She claimed, I have to say to my consternation, that as a result of abominable treatment in the press and media, and because they were not immune from prosecution, that a culture had grown up among doctors of proceeding on the basis of not doing harm rather than doing good. She described what she herself called an appalling situation of a person who had been admitted to a Glasgow hospital, who suffered from dementia, and was doubly incontinent, and who was left to lie for days in his own faeces because he would not "consent" to having a bed bath. She claimed that that level of fear was permeating the whole culture of medicine and while she understood the need to get away from medical paternalism, things had gone too far in the other direction. Doctors needed reassurance that they would be protected if they acted in reasonable good faith. I have to say I do not recognise this portrayal of the state of the medical profession and it was not how all the other members of the profession from whom I heard evidence presented themselves. I fear that any question of a review of immunity from prosecution has been irrevocably prejudiced by Dr. Harold Shipman.

[299] It was her firm view that there was a need for a greater level of co-operation and communication between general practitioners and hospital based practitioners. She said that this was exemplified by the discharge note in the present case and that it might not be appreciated how off-putting the receipt of such a discharge note would be to the average general practitioner. However, all the hospital based doctors, without exception, were unhappy to varying degrees with the terms of the discharge note and did not suggest there was a general policy of slapping general practitioners down for wasting their time. Nonetheless she regarded this as a "highly destructive culture," which had the capacity to get in the way of treatment for the patient.

[300] Dr. Morrison accepted that the length of a patient's stay in hospital was a matter for the clinical judgment of the hospital based doctor responsible there for the

care of the patient. She further accepted that a patient with a chronic condition may require a series of admissions to hospital to treat acute phases of the chronic condition. However, she said that she understood, from the perspective of the general practitioner and the care home staff, why they would think that the period of admission would appear to have been remarkably short. They would have thought that it would have been desirable for there to have been a longer period for assessment and consideration of the practical difficulties about treatment. It could be argued that hindsight has proved that their concerns were well founded. She accepted, however, that that type of assessment was not the function of an acute medical ward. Nor was respite care. That, of course, does not mean that it is not the function of the hospital. It should have been and hindsight suggest, in particular, that it should have been the function of the gastro-enterologists with Roddy on their ward. She considered that nurses should have drawn the attention of medical staff to Roddy's intellectual limitations and care difficulties. There was a need to assess how capable he was at self-care or at co-operating with the administration of care and whether he remained able to be cared for outwith a hospital or nursing home. She would not categorise all this as negligence in treatment, but as a missed opportunity.

[301] She was shown the result of the blood tests taken by the general practitioner on 14th. May, 2003 (Crown Prod. 2 pp 241 and 340. Curiously, to me, the biochemical tests do not appear to have a result for C-reactive protein but the alkaline phosphatase level is substantially raised. This information should have reinforced the need to consider re-admission.

[302] Dr. Morrison accepted that there was no evidence discovered while Roddy was in hospital consistent with him having an acute episode of ulcerative colitis. Shown the formal discharge letter, Crown prod. 1, p 4, she agreed that this was entirely professional in its terms.

[303] Dr. Morrison considered that in the unusual case of not being able to persuade a patient to be admitted to hospital, there was a place for a domiciliary visit by a consultant. She accepted that in the present case she would not have required the presence of a consultant to tell her that the patient was dehydrated and required to be admitted to hospital for fluids. But the presence of a consultant would have allowed a discussion with relatives out of which a fully informed decision would have emerged. However, she also seemed to accept that a general practitioner could have had a discussion with a consultant or specialist registrar about the background, the current symptoms and the problems caused by resistance to treatment and thus obtained advice. She accepted that, as a matter of practice she would have such a conversation about "once a fortnight" with a hospital based doctor about her own patients. She considered that such a discussion should have taken place here.

[304] She was not aware of any hospital in the United Kingdom which currently has a "specialist" unit for persons who suffered from mental disorder where they had a physical condition requiring hospital treatment. She was unaware of any research or literature on the topic. She accepted that a consultation exercise on the merit of such a proposal would be required. She did not say, but I will, that the commencement of such a process is long overdue.

[305] She further accepted that another way of dealing with this case was to introduce nursing care to the residential home. It is plain from the evidence that the District Nursing Service was utilised particularly in the latter stages, but also for the administration of enemas. Since we did not have evidence from any district nurse involved in Roddy's treatment, I do not know what difficulties they encountered or whether they recommended any action which was or was not followed. They should certainly have recognised that Roddy was dehydrated and that there was an urgent need to address that issue.

[306] She was only aware of one exceptional case where a specialist nurse had accompanied a patient into a general hospital and this had involved a child who was seriously disturbed and violent having to be nursed in a mental hospital but the specialist nurse who followed him there was a paediatric nurse. Her involvement had been resisted all the way up to medical director level. That might indicate a resistance because of the fear of creating precedents to any innovative idea.

[307] Dr. Morrison was a difficult witness. Some of her observations - a reference to the General Medical Council as a "bunch of old gits," for example - were somewhat ill considered but she was prepared to put her head above the parapet and express a view that there were significant problems between hospital based doctors and general practitioners about what might loosely be described as "communication." Much of what she said was based on an inaccurate absorption of the information in this case and at the end of the day I have no choice but to regard her evidence as being of limited value on account of its unreliability.

The Significance of Roddy's Mental Incapacity Status.

[308] All adults are presumed to have legal capacity, but that is a rebuttable presumption. Issues of capacity are specific to a particular adult in particular circumstances, for a particular purpose and at a particular time. A disease, injury or disorder may cause an impairment, resulting in an intellectual disability which may, in particular circumstances, at a particular time and for a particular purpose deprive the adult of legal capacity. An impairment of an adult's ability to communicate may have the same effect. Intellectual impairments have a range of causes and are almost infinitely variable in the range of their effects on capacity. The Scottish Executive in a consultation document published in 2000 (The Same As You ? A Review of Services for People With Learning Disabilities) has defined a learning disability as "a significant, lifelong condition which has three facets: reduced ability to understand new or complex information or to learn new skills; reduced ability to cope independently; and a condition that started before adulthood (before the age of 18) with a lasting effect on the individual's development." Down's Syndrome is recognised as a genetic condition which results in learning disability but the range of that disability is enormous from those who are profoundly handicapped to those who are virtually capable of independent living. Learning disabilities cannot be cured but can be minimised by a number of factors, the most significant of which is focused education, though the home environment is of almost equal importance. The presence of Down's Syndrome, on its own, does not reverse the onus in relation to capacity.

[309] When a person lacks capacity, for example to enter into a contract, the effect is that he cannot validly be a party to a contract and the contract is void *ab initio.* But the question of capacity or lack of it is particular to the nature of the contract and to the time of its formation. An individual with limited intellectual capacity may validly enter into a contract to buy a cake but not to enter into a hire purchase contract to acquire the use of a motor car. It depends upon an assessment of the individual's capacity at the material point in time.

[310] Where capacity is lacking either wholly or to a significant degree and there is no reasonable prospect of it being restored, it may be necessary to put in place a legal technique to allow one or more decisions to be taken, or acts or transactions be carried out, on behalf of the incapacitated adult. One of the issues in respect of which an adult may lack capacity is to take a decision concerning his health.

[311] The intimately personal and physical nature of the practice of health care professionals means that the acts essential to the actual delilvery of that care would be assaults in both civil and criminal law, unless the acts were justified. The Scottish Law Commission have stated that "The invasion of a person's bodily integrity by treatment that he or she has not consented to (or that has not otherwise been authorised) amounts to a criminal offence and a civil wrong {SLC Discussion paper No. 94}. The categorisation of authorisation other than the patient's own consent are patently of importance both to adults who are not competent to give valid consent and to members of the medical profession who are accustomed to the protection from assault charges being achieved by the process of obtaining consent. Apart from the competent consent by the patient, consent for the non-competent patient can be obtained from an appointee who, in relation to an adult, will now almost invariably be either a welfare attorney or a welfare guardian, the former being appointed by Deed of Attorney by the adult when he had capacity to do so and the latter being appointed as a result of an application to the sheriff under Section 57 of the Adults With Incapacity (Scotland) Act, 2000. There may, on rare occasions, be authorisation for a single procedure - perhaps the termination of a pregnancy for example - under an intervention order granted by a court. Otherwise a doctor may be authorised to act under the *parens patriae* jurisdiction of the court, where application may be made to the court for authority to carry out a particular act - see, for example, *Law Hospital NHS Trust v Lord Advocate* 1996 SLT 848. A doctor also remains entitled to act in terms of the doctrine of necessity for emergency treatment where the patient is unable to consent on account of being unconscious, drunk or otherwise incapable of giving consent. That doctrine has its limitations and has been affected by the provisions of Part 5 of the 2000 Act and to some extent also by the *Bourne Wood* decision - *HL v United Kingdom* (2005) 40 E.H.R.R. 32. Treatment for a mental disorder may also be sanctioned under mental health legislation but that is of limited relevance to the present circumstances, though may be of greater relevance to the issue of hospital admission for an incapacitated adult who cannot validly consent to admission, especially where he offers physical resistance. The medical practitioner primarily responsible for an adult's treatment, where he is of the opinion that the adult is incapable in relation to a decision about the medical treatment in question and has completed a certificate to that effect in terms of Section 47(5) of the 2000 Act, has authority to do what is "reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult." It should be observed that the foregoing provision is subject to

the provisions of sections 49 and 50 of the 2000 Act. S. 49 applies where there is an outstanding and unresolved application to the sheriff, the existence of which is known or made known to the medical practitioner, for the grant of an intervention order relating to the medical issue concerned or for the appointment of a welfare guardian with power to consent or refuse consent for medical treatment. The operation of Section 47(2) is in effect suspended pending the outcome of the application and the doctor cannot treat unless the treatment is "authorised by any other enactment or rule of law for the preservation of life of the adult or the prevention of serious deterioration in his medical condition." In an emergency, the doctor would have to fall back on the doctrine of necessity or get an order from a court to permit treatment. Section 50 applies where a welfare guardian or attorney has been appointed or a person has been appointed under an intervention order with powers in relation to medical treatment. Again S. 47(2) will not apply where the doctor is aware of the existence of the appointee and it would be reasonable or practicable to obtain the consent of the appointee to any proposed medical treatment. Where the doctor and the appointee are agreed on the proposed treatment then the treatment can proceed subject only to the right of "any person having an interest in the personal welfare of the adult" having a right of appeal to the Court of Session. Where the doctor and the appointee do not agree the doctor "shall request" the Mental Welfare Commission to nominate a medical practitioner from the list established and maintained by them to give an opinion as to the medical treatment proposed. Subject to a right of appeal to the Court of Session, that nominated medical practitioner's certificate is determinative.

[312] The immediately foregoing paragraph makes clear, in my opinion, the need for there to be a clear assessment of a patient's capacity to consent to a particular treatment at a particular point in time for any medical procedure but particularly prior to any invasive procedure. There may also be an issue as to whether admission to hospital for assessment could be regarded as medical treatment for the purposes of Part 5 of the 2000 Act. Detention for assessment is a familiar concept under mental health legislation and it seems to me at least arguable that hospital admission for assessment is medical treatment for the purposes of section 47. If the matter is in doubt, it should be resolved by amendment to the 2000 Act, so that doctors are clear that they may admit for assessment under a S. 47 certificate in appropriate circumstances.

[313] The question then arises as to what Roddy's capacity to consent was at the material times in the present case. There were a series of tests carried out on Roddy between 2000 and 2002 by clinical psychologists but they had a particular purpose in view and that was to try to determine whether Roddy was suffering from dementia. These psychologists were working in tandem with Dr. Quinn who is very clear that from 2002 at least Roddy was suffering from dementia. What is less clear is how the combination of his existing learning disability compounded by this neurological illness affected his capacity to consent to treatment.

[314] It was clear from the evidence of Edith Donnet that while Roddy lived at home with their mother he was able to participate in a range of activities and was extrovertly sociable. He took part in sport, dancing and drama. He enjoyed music and television. That began to diminish following his admission to Maryfield House. He seemed to have an understanding of his mother's death and was very sad. It was

the first time his sister had seen him cry. On the day he was admitted to Ninewells, when she attended there, he immediately recognised her but apparently he had not recognised his brother, James Donnet. She also said that he knew he was at the hospital because he had pains in his stomach. Staff on the ward would have had difficulty understanding what he was saying in the absence of someone familiar with the way he spoke. The staff at Maryfield House looked after his money i.e. they collected his benefits and used them for his welfare. They had not discussed with her what they recorded as being his increased state of confusion from autumn 2002 onwards and she did not think he had presented as suffering from increased confusion. She was unaware of any formal assessment of his mental capacity. However, it was her assessment that at the time of his admission to Ninewells in April, 2003, he would not have had the capacity to consent to medical treatment. His mother had always made these decisions for him. It was, she suggested, always a great struggle to get Roddy to understand things. He could only understand on a very simple level and there were times when she had difficulty in understanding his speech. He struggled to count up to ten. With a very great struggle he could write his name. He knew that if you died you went to Heaven and that you would not be here any more, but he would not understand that he might die if he did not take his tablets. He could not have lived independently. He would have left the gas on. He was never capable of dealing with money. He would not know if he had been given the correct change. He could boil an egg but he would then allow the pot to boil over or forget to turn off the gas, so he would require to be supervised. On her evidence it is easy to conclude that Roddy would not, as at April, 2003, have had the capacity to consent to medical treatment because he could not have understood the information it would be necessary for him to understand to be "informed."

[315] According to James Donnet, prior to Roddy's admission to Maryfield House, he would generally see him once a week and they often went to football matches together. He also took him to play snooker and went to see him perform in plays. Roddy never had any understanding of the scoring system at snooker however. He did not know in what order the balls should be potted. James thought Roddy had adapted well to his admission to Maryfield House but the level of contact between them reduced to about once a fortnight. Before he was admitted to Maryfield, their mother was essentially responsible for his care and for making decisions on his behalf. After his mother died, both he and his sister had "input" into making decisions for Roddy. That seemed to be restricted to yearly reviews of his care plan and informal contact with Maryfield staff. He met in the former situation with Tom Campbell but did not really understand what his role was. He did not in the normal course of things have meetings with any medical practitioner about Roddy's health and health treatment. He was not aware until near Roddy's death, for example, that Roddy suffered from ulcerative colitis. He said that by March 2003 he had observed that Roddy was unsteady on his feet and appeared to be "slowing down" quite a lot. James also said of Roddy, "To me, he had dementia all his life." I took that to mean that he was aware of the extent of his brother's intellectual limitations. He said that Roddy always had problems remembering things, but emphasised the change in his demeanour and ability from March, 2003. Roddy was not really ever able to make decisions for himself. James said that he was like a 7 or 8 year old intellectually. He thought Roddy would "find it hard to understand" that he could take medication and it would make him well. He did not think that Roddy had recognised him when he visisted him at Ninewells Hospital on the evening of 16th. April, 2003. That had not

happened before. Roddy was frightened and was unaware of where he was. His food lay on the table untouched. He was quite incoherent and not responding to anything. That was not the position historically. Roddy had always enjoyed going to new places and did so confidently. He confirmed the plan to move Roddy to a nursing home about three to four weeks prior to his death. James said that after the discharge from Ninewells, he had tried to encourage Roddy to take medication when he was refusing to do so but "he wasn't understanding things at that time." Again, from this body of evidence, which I accept, it is clear that at no time throughout his adult life would Roddy have had the capacity to be sufficiently informed to make a decision about consenting to medical treatment for ulcerative colitis.

[316] Dr. Hollins told the court that he would not expect to be able to get any information from Roddy about what had happened to him in hospital. He was aware of the assessment from the Department of Neurology of progressive brain deterioration. He knew that Roddy had Down's Syndrome and was suffering from the onset of dementia. He accepted that Roddy would not be able to communicate effectively with anyone at the hospital and that he was confused. While he was not, so far as I can see from the notes, specifically asked, I am in little doubt that he would not have considered that Roddy had the capacity to give informed consent to medical treatment for ulcerative colitis.

[317] Dr. Quinn knew that Roddy had Down's Syndrome and was aware of his attendance at an Adult Resource Centre from the late 1980s. She said that he had a vivid imagination and would fantasise. He was not the subject of regular assessments because he was receiving a good quality of care from his mother but his mother had expressed concern about what she perceived to be an increase in his confusion and forgetfulness in 1996. At that time there was no evidence of psychiatric illness as opposed to his congenital intellectual impairment. Over the years from then he had a series of tests carried out on him by clinical psychologists to try to determine whether he was suffering from dementia but the tests were inconclusive. As she put it, "Because of the intellectual impairment that precedes any dementive process, with a sufferer from Down's Syndrome it is very difficult to measure the degree of dementia and confirm whether or not dementia has taken place." Her observation generally when she had seen Roddy is that he would be "quite confused." There was a time when he would have understood basic things but nothing too complicated. He would not understand, for example, why he had been referred to the Department of Neurology for assessment when he was. She had observed by the beginning of 2003 that staff were having to cut up his food. There was the odd episode of urinary incontinence. He would not have been able to take a decision about a transfer to a nursing home. It would be plain to anyone with a medical qualification that Roddy had Down's Syndrome and had reduced intellectual capacity. Communication with him would be difficult. There would need to be a s. 47 certificate if he had to undergo any medical treatment which would otherwise require consent from the patient.

[318] For the sake of completeness I would simply add it that was plainly recognised by Dr. Jones when he examined Roddy in Ward 15 in the early morning of 17th. April, 2003 that any invasive procedure would require the completion of a section 47 certificate.

[319] It is accordingly quite plain on the foregoing body of evidence that at no time during the episode of ulcerative colitis first provisionally diagnosed by Dr. Badenhurst on 10th. April, 2003, did Roddy have the capacity to consent to medical treatment for it. All suggestions therefore that he had the capacity to refuse to consent to treatment are ill-founded. He was acting instinctively and not rationally and that should have been obvious to any medical practitioner. Accordingly, his disinclination to go to hospital should have led the medical practitioners concerned to consider what could be done to get round his lack of capacity to take a rational decision about his medical treatment. The first thing that they should have done but did not do was try to involve his family to encourage him to comply with admission, as once he was in hospital he could have received treatement in terms of the doctrine of necessity in the initial stages and then in terms of what is permitted under Part 5 of the Adults With Incapacity (Scotland) Act, 2000. If that was unsuccessful then, having discussed matters with his next of kin, consideration should have been given to an admission under s.24 of the Mental Health (Scotland) Act, 1984. If the situation were to be replicated to-day, the relevant provision would be Section 36 of the Mental Health (Care and Treatment)(Scotland) Act, 2003 which permits a medical practitioner - any medical practitioner - who considers that his patient has a mental disorder and that because of the mental disorder the patient's inability to make decisions about the provision of medical treatment is significantly impaired, and I observe the use of the expression "medical treatment" and not just treatment for his mental health, and who considers that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment requires to be provided to the patient, and that if the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person, and that making arrangements with a view to the grant of a short term detention certificate would involve undesirable delay, is able to grant an emergency detention certificate authorising the removal of a patient to hospital and his detention there for a period of 72 hours. I accept that considerations will still arise on an empirical basis about the value of utilising this provision but the suggestion that there would have been no proper legal basis for Roddy's admission to hospital is a suggestion based on ignorance. There is clearly a need to educate the medical profession and, in particular, general practitioners and those employed with out-of-hours services, in the law in relation to the admission of patients who on account of limited intellect do not have the capacity to understand the need for treatment for a particular condition.

[320] I also consider that there would be merit, so that any doubt in the minds of medical practitioners can be removed, in amending the definition of "medical treatment" as currently contained in Section 47(4) of the Adults With Incapacity (Scotland) Act, 2000 so that medical treatment includes "any reasonable period of assessment reasonably required to ascertain whether a person is suffering from a mental or physical health disorder including all investigative processes reasonably necessary and appropriate to any such assessment process." I believe that this would address some of the concerns addressed by the hospital based consultants about the vagueness of the present provisions and their concerns, which seemed to me to be justified concerns, about how properly they were operating having regard to the provisions of section 47. I do not think much can be done to address the concerns about the "condition specific" nature of the provisions so long as the legal philosophy is based on the proposition that capacity or a lack of it is based on

particular circumstances at a particular time and for a particular purpose, other than to stress the value, in cases where a person is subject to a permanent significant level of incapacity, of the appointment of a welfare attorney or welfare guardian with authority to consent to medical treatment. Notwithstanding the existing provisions of section 36 of the Mental Health (Care and Treatment)(Scotland) Act, 2003, it might well also simplify the process if the definition of medical treatment was also extended to include "such process or processes as may be reasonably necessary to enforce the patient's attendance at a hospital or other place of treatment."

[321] It follows logically from this that where a general practitioner is in any doubt about whether the circumstances set out in s.36 of the Mental Health (Care and Treatment)(Scotland) Act, 2003 apply, he should be entitled to insist on an appropriate specialist carrying out a domiciliary visit to assist in determining whether or not the criteria as hereinbefore set out are met. I express no view as to whether the "appropriate specialist" need be of consultant status, having heard only limited evidence on that particular issue. There may be a need to educate hospital based doctors on the need in this type of situation for them to undertake a domiciliary visit.

[322] I now turn to consider the law more generally about the protection of adults with incapacity who are residents in residential care, as distinct from living in their own homes or in a home environment with relatives or friends. The type of establishment I have in mind generally would be those providing a "care home service" as that expression is defined in Section 2(3) of the Regulation of Care (Scotland) Act, 2001. The basic question is on what legal basis is a person resident in such an establishment where the person concerned, like Roddy, either never has had or has lost the capacity to consent to his residence there.

[323] Once agains the starting point must be the legal rebuttable presumption in favour of capacity, but it is pretty clear that Roddy would never had have the capacity to determine whether he wished to reside at Maryfield House and, if he ever had, then he had certainly lost that capacity by the beginning of 2002. The evidence on precisely how he came to be there is not particularly clear but it appears to have arisen from a realisation on the part of his mother, Dr. Quinn and Dundee City Council Social Work Department, that on account of his mother's age and infirmity and Roddy's inability to care for himself that he required to be admitted to a residential care home. There does not appear to have been any further formality forming the basis for his admission. The admission was in November, 1998 by which time the Scotland Act 1998 was in force which, of course, required public bodies such as local authorities not to act in a manner incompatible with the European Convention on Human Rights. This was, of course, followed by the Human Rights Act 1998 which directly incorporated the Convention into Scots law. Article 5 of the Convention provides:-

"1. Everyone has the right to liberty and security of person. No one shall be deprived of their liberty save in the following cases and in accordance with a procedure prescribed by law." The only relevant case is the lawful detention of the somewhat unfortunate association of "persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants." That lawful detention requires a procedure prescribed by law. There is no definition in the Convention itself of the expression "persons of unsound mind."

[324] In *HL v United Kingdom* (2005) 40 E.H.R.R. 32, the European Court of Human Rights considered the circumstances in which a sufferer from autism was confined to a mental hospital in opposition to his carers' repeated requests that he be allowed to be treated in the community. The patient was unable to consent or object to medical treatment. He had been discharged on a trial basis to "paid carers." After an episode of agitated behaviour at a day care centre, he was re-admitted to hospital. Since he was compliant and did not resist admission nor try to leave the hospital, the medical officer decided that compulsory detention under the Mental Health Act 1983 was unnecessary. I should make it clear that the hospital concerned was in England and it was English law and procedure which was under consideration. The patient was admitted to the hospital's intensive behavioural unit as an informal patient. The patient sought leave to apply for judicial review of the hospital's decision to admit him, for a writ of *habeus corpus* and for damages for false imprisonment and assault. His application was refused at first instance but he successfully appealed to the Court of Appeal who determined that he had been unlawfully detained. The hospital authority appealed to the House of Lords where it was concluded that the patient had not been lawfully detained but had been lawfully re-admitted as an informal patient on the basis of the common law doctrine of necessity. The patient appealed to the European Court of Human Rights on the basis that he had been detained in a psychiatric institution as an informal patient in violation of Art 5(1) of the Convention and that the procedures available to him for a review of the legality of his detention did not satisfy the requirements of Art. 5(4). The European Court of Human Rights held unanimously that there had been a violation of Art. 5(1) as regards the lack of protection against arbitrary detention and that there had been a breach of Art 5(4) which provides that "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be speedily decided by a court and his release ordered if the detention is not lawful." The key factor in leading the Court to this conclusion was said to be that "health care professionals had exercised complete and effective control over the applicant's care and movements from July 22, 1997 when he presented with acute behavioural problems to October 29, 1997 when he was compulsorily detained. He was under continuous supervision and had not been free to leave. Whether the ward was locked or lockable was not decisive. Accordingly, he had been deprived of his liberty within the meaning of Art. 5(1)." The Court also emphasised that "The absence of procedural safeguards failed to protect against arbitrary deprivations of liberty on grounds of necessity. Accordingly there had been a violation of Art. 5(1)." In its judgment, the Court adopted the categorisation of "incapacitated but compliant" as descriptive of the position of the patient. They recorded a submission on behalf of the United Kingdom government that " a finding that the present applicant was detained would mean that the care of incapacitated persons elsewhere (i.e. outwith hospital) (even in a private house or nursing home) would be considered detention, a conclusion which would have onerous legal and other implications for such patients and for any person or organisation having responsibility for their care and welfare." They also argued that stigmatising someone as having been "sectioned" was often contrary to their best interests in therapeutic terms. They further argued that the applicant could not be said to be detained when he had not objected to being in hospital. The restrictions did not amount to involuntary detention but rather to necessary and proper care for someone with the applicant's needs. The applicant, on the other hand, described the suggestion that he was free to leave as "a fairy tale." In its judgment, para 90, the Court said:-

"The Court recalls that the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention, especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action."

Further, in para 113, the Court said:-

"The Court recalls that the lawfulness of detention depends on conformity with the procedural and with the substantive aspects of domestic law, the 'lawful' term overlapping to a certain extent with the general requirement in Art 5(1) to observe a 'procedure prescribed by law.' It is also recalled that, given the importance of personal liberty, the relevant national law must meet the standard of 'lawfulness' set by the Convention which requires that all law be sufficiently precise to allow the citizen - if need be, with appropriate advice - to foresee to a degree that is reasonable in the circumstances, the consequences which a given action might entail."

Earlier the Court in its judgment had set out three minimum conditions for the deprivation of a person's liberty on the basis of unsoundness of mind, namely

" he must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder."

At paragraph 115, the Court stated, " It is further recalled that it must be established that the detention was in conformity with the essential objective of Art.5(1) of the Convention which is to prevent individuals being deprived of their liberty in an arbitrary fashion. This objective and the broader condition that detention be 'in accordance with a procedure prescribed by law' require the existence in domestic law of adequate legal protections and 'fair and proper procedures.'

At paragraph 120, the Court said, "In this latter respect (the aim of avoiding arbitrariness - see para 119) the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted. The contrast between this dearth of regulation and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act is, in the Court's view, significant. In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The nomination of a representative of the patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities."

121. As a result of the lack of procedural regulation and limits, the Court observes that the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit: as Lord Steyn remarked, this left 'effective and unqualified control' in their hands. While the Court does not question the good faith of those professionals or that they acted in what the considered to be the applicant's best interests, the very purpose of procedural safeguards is to protect individuals against any 'midjudgments and professional lapses.'"

At paragraphs 123 and 124, the Court stated:-

"123. The Government's submission that detention could not be arbitrary within the meaning of Art 5(1) because of the possibility of a later review of its lawfulness disregards the distinctive and cumulative protections offered by paras 1 and 4 of Art. 5 of the Convention: the former strictly regulates the circumstances in which one's liberty can be taken away whereas the latter requires a review of its legality thereafter.

124. The Court therefore finds that this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on the grounds of necessity and, consequently, to comply with the essential purpose of Art 5(1) of the Convention. On this basis, the Court finds that there has been a violation of Art. 5(1) of the Convention."

[325] At first sight it may seem odd to be comparing the detention of a sufferer from autism in a mental hospital with the position of a resident of a residential care home where that person is, in terms of the categorisation used in *HL v United Kingdom*, incapacitated but compliant, but if, with the benefit of hindsight one considers what happened in Roddy's case, one could readily substitute the expression "social work professionals" for "health care professionals." And while the decisions turns on an application of the law of England, I am required as a matter of law, to have regard to decisions reached by the European Court of Human Rights which appear to be in point, in the determination of any litigation over which I preside. While I would have preferred to hear proper argument on the issue, I have come to the conclusion that the circumstances in *HL v United Kingdom* are so similar to the present circumstances that the rationale of the decisions also applies in this case. It was the carers who liaised with the general practitioners, with Dr. Quinn from the Learning Disability Service and with the health care professionals at Ninewells Hospital in the various respects in which it was considered that Roddy's health required assessment or treatment. It was the carers who decided what type of accommodation he should reside in and what services should be provided to him. While there was a system of annual review, it is not clear that that system sought to involve Roddy's relatives on any kind of active basis and it is quite clear from the evidence that the relatives were not involved in decisions to admit or not to admit Roddy to hospital. It is not clear to me on what legal basis Roddy was admitted to Maryfield House nor on what legal basis he remained there. In the absence of him having the capacity to consent to residing there, in the absence of any statutory or other legal authority for his presence there, his continuing presence there can only have been on the basis of the consent of a legally appointed substitute decision maker. There was no legally

appointed substitute decision maker. I know of no statutory or other lawful provision which regulates the keeping of a person in a residential home. The Regulation of Care (Scotland) Act 2001, for example, deals with what its title says, the regulation of care. It does not at least in the case of adults prescribe any system for justifying the keeping of an adult in any care home establishment. He appears therefore to have been in Maryfield House subject to the "effective and unqualified control" of officers of Dundee City Council Social Work Department and I find that I am unable to find any material distinction between his circumstances and those of the plaintiff in *HL v United Kingdom.* If that is correct, it would follow that the only current lawful basis upon which anyone capable of being categorised as incapacitated, whether or not they are compliant, can be kept in residential care is if that has been authorised by a legally appointed substitute decision maker.

[326] Even if I am wrong in my immediately foregoing conclusion, I am in no doubt in this particular case, with the dubious benefit of hindsight, that Roddy would have benefited from the appointment of a welfare guardian. As I understand the evidence, Roddy would never have had the capacity to appoint a welfare attorney, so a welfare guardian would be the only appointment of a permanent nature which would have had the scope to deal with the range of decisions which required to be taken on Roddy's behalf by care home staff without lawful authority. As in the *HL* case, I want to make it clear that I am not suggesting that the staff did anything other than act in good faith in their care of Roddy but I am in no doubt that they involved themselves, particularly Ms. Mackie, in decisions which were simply not theirs to make. I have to say that in this they were aided and abetted by the general practitioners who gave no consideration to the legality of taking decisions with the approval of carers but without discussion with relatives. Had a welfare guardian been appointed, it would have been that person's functions to take decisions for Roddy about his health care. To do that the appointee would have had to be fully informed about the conditions from which Roddy was suffering, the outcome of the various investigations he had undergone and the treatment options and their consequences for Roddy. Had that taken place it is inconceivable that Roddy would have died against a background of muddle, poor communications, misunderstanding of the facts and misunderstanding of the law which I have determined pertained.

[327] It is one of the general principles of the Adults With Incapacity (Scotland) Act, 2000 that the consideration of the minimum necessary restriction in the adult's freedom of action should govern and determine what provisions are put in place to assist the adult with his incapacity. I do not in any way demur from that principle but experience suggests that in practice over-emphasis has been placed on expressions such as the "least restrictive option" thus distracting and deflecting from what is necessary. Those responsible for the implementation of the Act need to be reminded that most of the applications coming before courts for the appointment of guardians relate to persons who are profoundly and permanently incapable where the "least restrictive option" is an irrelevancy and emphasis should always be on what is necessary for the protection of the vulnerable adult. Roddy was significantly incapacitated from birth and certainly since the time of his mother's death has been in practical need of a substitute decision maker. In failing to ensure that he had one and in thus failing to make the necessary provisions for the welfare of this vulnerable adult those responsible for that state of affairs contributed significantly to the

confusion surrounding the situation leading to his death. In that respect they might have contributed to his death.

Submissions of Parties:

[328] Before dealing with the submissions, I should say that I am acutely aware that none of the general practitioners nor the local authority were represented at the Inquiry. I did ask the depute procurator fiscal at the outset if all lawful intimation of the Inquiry had been made, as I was surprised at this lack of representation even on the basis of my limited knowledge from such papers as I had been able to read prior to the commencement of the Inquiry. I was told all lawful intimation had been made and was shown a copy of the relevant advertisement.

[329] The Crown made relatively formal submissions about the date, time, place and cause of death about which there is no material issue. In terms of Section 6(1)(c) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act, 1976, it was submitted that it would have been a reasonable precaution to have appointed a welfare guardian to Roddy under the appropriate provisions of the Adults With Incapacity (Scotland) Act, 2000. It was submitted that such an appointment would have provided a point of contact and a decision maker for all professionals involved in Roddy's care. It was further submitted that if there had been a welfare guardian appointed to make decisions such as whether to re-admit him to hospital and pursue aggressive treatment for ulcerative colitis, then his death from ulcerative colitis and bronchopneumonia may have been avoided. While I have not felt able to express that in quite such concise terms, I broadly agree with that submission. Whether this be categorised as a reasonable precaution or a defect in a system of working is, in my opinion, immaterial. Under Section 6(1)(e) - any other facts relevant to the circumstances of the death, the Crown drew attention to the erroneous recording of the blood test results and to the inappropriate and potentially misleading terms of the Discharge Note. However, the evidence is inconclusive as to whether the change about which much evidence was led was made on any copy of the Discharge Note which was issued from Ninewells Hospital and I am accordingly unable to conclude that its terms did in fact mislead anyone. The Crown submitted that it would not be approriate to criticise "Ninewells staff" for the method of discharge. I think that observation is restricted to the implementation of the decision to discharge as opposed to the decision to discharge itself. If that is so then again I substantially agree with the submission but consider for the future that with an incapacitated adult the adult should not be discharged from the ward except to the company of a relative or carer. I do not agree that the decision to discharge was appropriate, though I accept that there was a division of expert evidence on that topic. The problem is that the decisions was flawed as it was made on the basis of inaccurate information about blood test results and without proper consideration of the management of the patient in the community. Finally, reference was made to the "proposed re-admission to Ninewells." It was submitted that there could be no criticism of the ambulance personnel, with which I agree, though training requires to be extended to them about the legal position of a person lacking in capacity when a medical practitioner invokes S.36 of the Mental Health (Care and Treatment)(Scotland) Act, 2003 or where a legally appointed substitute decision maker authorises admission to hospital, though I am not suggesting that ambulance procedures should change and where there is physical resistance to admission, the problem should be placed back in the hands of

the medical practitioner who requested the admission. So far as the medical practitioners are concerned, it is unfortunate that I did not hear evidence from anyone from D.D.O.C. and I am unenthusiastic about criticising anyone from whom I did not hear, particularly having regard to the context in which they are operating, but it does not appear that any of the practitioners sent by D.D.O.C. applied his or her mind to the patient's capacity and what might be done to coerce admission to hospital as opposed to accepting that they had to deal with a "refusal to consent" situation. I am afraid I profoundly disagree with the Crown submission about Dr. Hollins.

[330] I do find myself substantially in agreement with most of the submissions and proposed findings made by Mr. Milligan on behalf of the Donnet family. Leaving aside the issues of time, place and cause of death which, in formal terms, are uncontroversial, he submitted:-

(i) that the junior doctor responsible (possibly Dr. Wallace) could have transposed the correct blood test results so that the consultants were aware that Roddy's C-Reactive protein level was elevated, thus indicating that there was some ongoing inflammation consistent with active bowel disease. Although there was some dispute in relation to causation in this respect, the majority view of the independent experts was that this would have made a difference to his care and treatment. In this context he observed that Section 6(1)(c) only desiderated that the precaution "might" have avoided the death.

(ii) Dr. Hollins, who was the primary medical carer, could have taken a proactive as opposed to reactive approach to Roddy's treatment. This would have required actively involving the family in crucial decisions, most notably when to move from therapeutic treatment to purely palliative treatment between 15th. May, when his condition was still treatable and 22nd. May, when it was not. Particular reference was made in this context to the evidence of Dr. Rafferty at pp 940-941 who agreed with the proposition put to him that at about 15th. May there was a choice to be made between continuing aggressive treatment or confining activity to palliative care.

(iii) In connection with the immediate foregoing precaution, a domiciliary visit could have been arranged with a consultant during this period to assess the treatment options, including surgery if necessary.

(iv) A section 47 certificate may have allowed the treating doctors to be more persistent in providing Roddy with treatment for ulcerative colitis, which is not necessarily or even usually a fatal condition. That could even involve the use of force or sedation in extreme circumstances.

(v) Roddy's discharge from Ninwells Hospital should have been delayed to allow a proper diagnosis to have been made. At the very least, a proper comparison should have been made with that day's blood tests, which would have revealed another elevated C-reactive protein level of 34. When checking this, the earlier error might have been noted.

(vi) Having been discharged, a proper discharge note should have been sent by facsimile transmission to the general practitioners, followed with a copy in the post. It

should not have been issued in the insulting and misleading terms in which it was. Every medical practitioner who gave evidence agreed that the terms of the discharge note were unsatisfactory and that the diagnosis should have been inflammatory bowel disease or ulcerative colitis. Dr. Barron, on whose clinical notes the discharge form appears to have been based, also conceded that it was inappropriately worded and should have referred to an underlying condition of ulcerative colitis that had settled following treatment.

(vii) In any event, his discharge should have been better managed so that he was less intimidated by the prospect of travelling to and from hospital. For example, he could have been taken by a patient transfer vehicle, or taxi, rather than by ambulance. Although there was no evidence about exactly what happened at the Ninewells end, he was very clearly distressed on arrival back at Maryfield. Little or no allowance seems to have been made for the fact that Roddy was an adult with incapacity.

Under Section 6(1)(d) Mr. Milligan submitted that there had been a series of defects in the system of working contributing to Roddy'death, namely:-

(i) The general practice did not allocate any particular practitioner to co-ordinate Roddy's care despite the fact that he was incapable of making his own decisions in relation to treatment. In the end it appears to have been a relatively junior general practitioner, Dr. Hollins, who was left to deal with the complicated and difficult decisions in the final stages of Roddy's life.

(ii) There was inadequate pre-planning for Roddy's inevitable deterioration, despite the fact that this was specifically flagged up by the Department of Neurology in January, 2003. The carers seem to have waited for action from thegeneral practitioners who in turn waited for instructions from the carers. Thomas Campbell, the care manager, when assessing the need for a change of home, did not consult either the family or the general practitioners. More specifically, no one thought to appoint a welfare guardian to co-ordinate the care of Roddy, despite the fact that his care involved numerous professionals in different disciplines. In fact, this option never even appears to have been considered.

(iii) Following on from that, the appointment of a welfare guardian is an expensive and cumbersome procedure. Although it is clearly necessary to have adequate safeguards, it would be helpful to have a simplified procedure in uncontroversial cases in line with the recommendations of the Mental Welfare Commission (see F4 "Authorising Significant Interventions for Adults who Lack Capacity.")

(iv) Consultants and junior doctors at Ninewells Hospital received no speficic training in dealing with patients suffering from physical disorders who also suffered from dementia (or any other form of mental disorder.) Dr. Pullar told the Inquiry that 6 to 8% of his patients suffered from dementia. Dr. Jones made similar comments.

(v) More generally, the Scottish Executive have failed to provide adequate training in the use of the Adults With Incapacity (Scotland) Act, 2000. Mr. McCaw, a very experienced mental health officer, expressed disappointment that the Scottish Executive guidelines did not give any hypothetical examples to offer guidance as to

how far carers can go without breaching the incapacitated adult's rights under Art. 5 of the European Convention on Human Rights. As a result, it is hardly surprising if doctors err on the cautious side and practice defensive medicine.

(vi) Ward 15 at Ninewells only has 31 beds but the average number of admissions is 36 per day. This resulted in Roddy being held on a trolley in a corridor which added to his upset and fear of returning to hospital. There should be a sufficient number of beds to deal with at least the average number of admissions.

Having regard to the provisions of Section 6(1)(e), other facts relevant to the circumstances of the death, he submitted:-

(i) Notwithstanding the comments of Sheriff Dunbar in the Inquiry into the death of James Mauchland, this Inquiry did not commence until long after Roddy's death and was then not allocated a realistic length of diet (5 days, when the Mauchland Inquiry had lasted 26). Thereafter it was continued to three separate further diets spanning a year. As a result many of the witnesses had little or no recollection of key features (see in particular Jacqueline Mackie) and one important witness (Dr. Hill) was now living and working abroad. It also made the preparation of submissions unnecessarily complicated and difficult. This in turn severely reduced the utility of the whole exercise. It is difficult to make much more specific comments than those outlined above when much of the evidence was so vague. For example, how can the court assess the adequacy of the treatment provided by ambulance staff and nurses at Ninewells Hosspital when no one has any recollection of what happened. There must come a point where a Fatal Accident Inquiry, which places great strain on court time and public resources, is held so late that it does more harm than good.

(ii) The two recurrent themes of the Inquiry were (1) lack of communication and (2) lack of co-ordination among the various parties involved in Roddy's care. In particular, there was a very poor interface between social work care and health care. There was some evidence of attempts to address this but at best these efforts were piecemeal.

(iii) A common theme in the medical evidence was that the provisions of the Adults With Incapacity (Scotland) Act, 2000 were (1) little known (2) poorly understood and (3) little used. It seems bizarre in the present case that no formal assessment of mental capacity was ever made of Roddy, given that Section 1(4) of the Act provides that in determining whether an intervention is to be made, account is to be taken of the present and past wishes of the adult with incapacity so far as they can be ascertained.

(iv) It was unfortunate that the local authority were not represented, even though some of their employees gave evidence. This meant that some important productions were only lodged in the course of evidence late in the proceedings and without proper time to consider their significance. The court will be without proper submissions as to what, if anything, is being done to remedy the difficulties identified above.

I should record that Mr. Milligan also helpfully produced a helpful summary chronology of the significant events surrounding Roddy's death.

[331] Mr. Fitzpatrick, for Tayside Health Board, by way of background, reminded me that ulcerative colitis is inflammation of the colon. It is one of a group of conditions generically referred to as inflammatory bowel disease. Its cause is unknown. It is a condition which can fluctuate in its severity and activity. In an acute episode, the colon can become distended and then perforate. Bowel sounds will then be absent. Perforation will cause peritonitis and septicaemia and may thus cause death. As well as clinical examination to detect bowel sounds, abdominal X-ray to investigate whether there is distention of the bowel is both standard and essential. In the absence of any such acute complication, some cases may still require hospitalisation if the disease is active and requiring treatment. The physicians at Ninewells Hospital, Dundee, Ward 15 (which is the acute medical admissions ward), have developed a protocol for dealing initially with inflammatory bowel disease which contains guidance for treatment. For severe outbreaks the recommended treatment is the use of intravenous fluids (to address dehydration) and intravenous steroids, in particular methyl prednisolone, which has proved very successful as an anti-inflammatory treatment. The severity of the outbreak is largely determined by the number of motions daily from which the patient is suffering. A outbreak would be regarded as severe if there were eight or more daily motions. (See Prod. F1). The duration of such intravenous treatment is a matter for the clinical judgment of gastro-enterologists. Other treatments for outbreaks categorisable as less than severe may be by administration of Asacol, a non-steroidal anti-inflammatory agent, in either tablet or enema form - and, as the general practitioners eventually discovered, also available in liquid form - immuno- suppressants, steroid enemas and surgery. It is perhaps worth adding that, at Ninewells, on admission to Ward 15, a patient may be assessed for treatment by a consultant physician of a variety of specialties, but would normally expect to be transferred within 24 hours to the care of the particular specialty ward. On the protocol, there are a number of treatments "reserved for use by gastro-enterologists," and no one expressed any criticism of this. In fact this protocol was regarded by all the clinicians as a useful working guideline document. Mr. Fitzpatrick continued observing that ulcerative colitis did not usually cause death unless there were complications such as perforation of the bowel, peritonitis and septiciaemia, none of which features were found in this case on post-mortem examination. The protocol recommends that if there is no improvement after five days, second line therapy, possibly immuno-suppressants or surgery should be considered. But that if the condition has settled within five days, the patient may be allowed home earlier.

Mr. Fitzpatrick then rehearsed what he considered to be the main issues arising from the expert evidence of Dr. Starr who had been called by the family. These were that ulcerative colitis may be chronic and remitting and relapsing. The condition affects the large bowel all the way down to the rectum. It involves inflammation of the large bowel. It it were possible to look inside the bowel it would present as red and inflamed. It is thought to be an auto-immune condition, occurring where an individual's immune system attacks part of their own body. The cause is unknown. The consequences can be severe and in the worst cases can be fatal. The cells that line the bowel have the binding between them broken down and therefore fluid, blood and proteins can leak across into the bowel; and, vice-versa, toxins from the bowel can enter the body. A sufferer can become very unwell. The bowel can distend and perforate causing peritonitis and death. A patient may lose a lot of blood. It can cause a patient to be unwilling to eat or drink and because of the debilitating

effect of the illness, a patient is at risk of developing other conditions. It can be life threatening and requires urgent treatment. In very serious cases, there is a surgical option of the complete removal of the colon and the creation of a stoma. Six to ten motions a day would be regarded as a severe outbreak.

He then turned to the evidence of the Crown expert, Dr. Clarke, summarising it thus. Blood in the stool is usually one of the cardinal symptoms of inflammatory bowel disorder. Other possible symptoms are abdominal pain, though that was not a major feature, dehydration, eventual fever, increasing debility and anaemia. In an ongoing severe outbbreak, one would expect diarrhoea to continue even if the patient is not eating and drinking - because the inflammation itself causes the fluid loss into the bowel, and therefore there is still diarrhoea. The diarrhoea would be expected to continue for at least a few days, and the administration of intravenous fluids would not affect this.

Briefly, he noted salient points from the evidence of Drs. Badenhurst, Rafferty and Jones, as follows. Dr. Badenhorst said that a flare up of ulcerative colitis may settle without active intervention. Dr. Rafferty said that ulcerative colitis can be episodic in nature - patients will have flare ups from time to time - and then it can sometimes subside again - go into remission. It can happen spontaneously. The cause of a flare up can be a secondary bowel infection, or a variety of things, or no known cause or no good reason. Dr. Jones said that severe disease, in accordance with the Ward 15 protocol, is linked with stool frequency of more than eight stools per day, or evidence of toxaemia. Moderate disease means less than seven motions per day. In the case of both mild and moderate outbreaks, oral therapy is given. For severe disease intravenous steroids are given.

He then went on to address Roddy's background state of health, thus. As at early, 2003, Roddy was a 51 year old Down's Syndrome sufferer with attendant lifelong learning disability. He lived with his mother until shortly before her death when he moved to Maryfield House. He had prior to her death had periods of respite care there. In 1996 he had been admitted to hospital with a middle lobe pneumonia. At subsequent follow up he was noted to have modestly deranged liver function and tests were carried out. He was also referred to a Dr. Dillon, a gastro-enterologist. After investigation, including an endoscopy, he diagnosed mild inflammation of the signoid colon consistent with ulcerative colitis. Roddy underwent a barium enema, an intrusive investigation which he was then able to tolerate, prior to the onset of dementia and while he still had his mother's support, and he was then commenced on oral medication, Asacol tablets, a non-steroidal anti-inflammatory treatment and foam enemas, also Asacol, by way of maintenance treatment to prevent recurrence. In March, 2001, Roddy was first noted to have signs of dementia. In October 2002 he was considered to be becoming disorientated. In late 2002, there was concern that he was beginning to exhibit signs of developing epilepsy, which can be associated with the onset of dementia. He had also been commences on Carbamazepine and consideration was given to whether this was over sedating him, since he had suffered a number of falls within Maryfield House. The dosage was reduced and later Sodium Valproate was substituted as a different anti-convulsant. Sodium Valproate can cause diarrhoea.

Turning to his presentation in 2003, Mr. Fitzpatrick reminded me that Dr. Badenhorst had seen Roddy on 20th. February, 10th. April, 14th. April and 16th. April. On 20th. February, he was noted to be "keeping well" on Sodium Valproate. On 10th. April he was noted to be having 4 to 8 motions a day with mucus. An outbreak of ulcerative colitis was diagnosed and Asacol tablets and enemas were prescribed. On 14th. April he was "looking much better," having had three enemas and only one bowel motion. On 16th. April, Dr. Badenhorst was telephoned by Miss Mackie and told that Roddy was refusing to eat or drink and she was concerned that he was dehydrated. He was not wanting to have enemas. Having examined him, she decided to admit him to Ninewells Hospital. Her referral request refers to "Few weeks of increased stool frequency. Started Asacol tablets and enemas 5 days ago. Initially improved but now refusing all fluids, solids, medication. Diarrhoea 6-10 bouts per day." All of Dr. Badenhorst's references to stool frequency were derived from information from care home staff. The care home notes were not looked at. These notes, according to Miss Mackie, should contain an accurate record of stool frequency, whether the motions may have been loose, and whether there has been any blood in the stool. In terms of the notes, the largest number of stools recorded in any one day, 13th. April, was 5. There were 3 recorded on 15th. April, 2 on the 10th. and only 1 on all other days between 7th. and 16th. April. None of these are recorded as having contained blood. The history of this period of diarrhoea accordingly extends to nine days and not "several weeks" and there is no record of the frequency of motions reported by Dr. Badenhorst in her admissions request. Had she asked to see the care home notes she would have been afforded access to them. There was no issue of confidentiality.

Mr. Fitzpatrick then turned to the period when Roddy was admitted to Ninewells Hospital. He noted that Roddy was reluctant to go but went accompanied by a carer called Bill Taylor. He arrived at 12.10 and checking in was by Dr. Wallace. That was completed by 12.30. Roddy "refused" examination at that time. Dr. Wallace planned abdominal X-ray, routine bloods and intravenous fluids. Roddy was seen at 16.41 by Dr. Pullar when no blood results were (apparently) available. Roddy was "refusing" X-ray but abdominal examination was achieved and was satisfactory ("unremarkable, soft, non-tender and with normal bowel sounds"). The presenting symptoms, on the hypothesis that they were accurately reported, were probably enough to say that Roddy had ulcerative colitis, but the abdominal examination excluded complications. These could only be conclusively excluded by abdominal X-ray. Dr. Pullar started Roddy on intravenous fluids and intravenous steroids in accordance with the protocol, assuming from the reported symptons, including frequency of bowel movement, that there was active ulcerative colitis. The duration of this treatment and therefore the duration of his stay in hospital was a matter for the gastro-enterologists' clinical judgment, to whom Dr. Pullar referred him. Roddy was seen by Dr. Jones on his morning round on 17th. April. It seemed likely to him that Roddy was presenting with colitis and Dr. Pullar had already put in place the appropriate management plan. By then the wrong blood results had been written into the notes by an unknown pre-registration house officer. On clinical examination, Roddy did not have a raised temperature, his pulse and blood pressure were normal. Bowel sounds were normal (not overactive and not obstructive.) X-ray was still considered critical to exclude distension of the bowel. Investigations so far seemed negative. There was little bowel activity - only one movement during the period of admission. Roddy abhorred being in hospital. The final decision would lie with the gastro-enterologists who were yet to review him, but if the abdominal X-ray was

unremarkable, Roddy could probably be discharged. There was a drive to deal with things in the community where possible rather than keeping the patient in hospital, which is a dangerous place due to hospital acquired infection. The condition might be of a level which required routine out-patient treatment only. The gastro-enterologists would decide and organise appropriate treatment. These were Dr. Hill and Dr. Barron. They examined Roddy, probably about mid-day. They noted that his bowels had not moved since admission at mid-day the previous day. In fact there was such a movement shortly after admission, and Dr. Barron said that she was aware of this, despite the terms of her note. They also noted that Roddy was said to be eating and drinking. The abdominal X-ray had been carried out and was normal. He had had only one dose of steroids and normally one would expect further doses before a severe outbreak would settle. The X-ray result excluded very severe ulcerative colitis, but not mild or moderate. On clinical examination, the abdomen was still soft and non-tender and bowel sounds were normal. C-reactive protein was noted to be 4, the correct result being 59. There was no history of blood in the stools - a cardinal feature of ulcerative colitis. He was not biochemically hydrated on either the erroneous or the correct blood results. The relevant values were normal. Temperature and other observations were normal. The whole clinical picture, even with the correct blood results, still indicated discharge rather than ongoing treatment. The view was that he had had an outbreak of ulcerative colitis but that his symptoms had settled because the treatment started by the general practitioner several days previously had been effective. The main indicator in an outbreak of ulcerative colitis is the bowel frequency and the passage of blood, and one bowel motion in 24 hours, without blood, is not consistent with a severe outbreak of ulcerative colitis requiring hospital admission. Knowing that the C-reactive protein level was 34 on 17th April would not have altered management, even comparing it with the putative previous level of 4 or the real previous level of 59.

Mr. Fitzpatrick then turned to what he described as the significance of C-reactive protein level v clinical picture. Dr. Pullar has said that he would not have read a lot into a fall from 59 to 34. It may be the start of improvement or it may be the ups and downs. Dr. Starr said that a level of 59 was difficult to interpret. In a serious, overwhelming infection you would expect the figure to be over 100. He suspected that for sufferers from Down's Syndrome, the presentation may not be normal and therefore we do not know what the normal for Roddy is. Dr. Clarke said that C-reactive protein can be increased by any infection. The levels of 59 and 34 were quite low levels really. In the case of severe ulcerative colitis one might expect levels of over 100 and he had seen levels of up to 170 - so the figures for Roddy were quite low but nevertheless would indicate some inflammation or infection was present. If the correct biochemistry results had been available, while it was very difficult, it might have triggered the wish to perform a flexible sigmoidoscopy to try and more accurately assess the state of the disease. Dr. Rafferty said that the upper limit of normal for C-reactive protein was about 15 but in a good going infection you might often get 400 to 500. With a cold the level could increase to around 50 - 60. In a severe episode of ulcerative colitis you might expect to see 450 - 500 normally. The true values implied that there was some inflammation going on, but you would put that in context and the clinical findings were normal. If you assume the incorrect result of 4, looking at the overall picture....you would think that there is not a very active process going on. He did not think it could be said that there was no inflammatory bowel disease at all. He thought it would be right to say that there was

mild inflammatory bowel disease. If the actual result of 59 was factored in, you would certainly say this is inflammatory bowel disease, but going on the clinical appearances you would not consider it a severe exacerbation. He therefore did not think it was necessary to keep Roddy in hospital any longer especially when he was going back to a nursing home. The C-reactive protein level of 59 was modestly high. If Roddy had had more severe symptoms at the time of admission the medication may well have been stepped up. But the medication he was on during the time he was in seemed to be controlling this effectively and therefore he was allowed home. He thought the assumption of the gastro-enterologists would be that should his condition deteriorate that he would be re-admitted. Dr. Rafferty referred to it being a question of balance. If the patient is or appears to be clinically well, as it sounds as if he had done after his admission when he was eating and drinking well on 17th. April as documented with the nurses, if he had no abnormal temperature, if his pulse rate was normal and his abdomen was soft, why should you keep him in. Dr. Starr's idea that he had pneumonia as at 16th/17th. April is fanciful. You would not want to delay discharge if you thought he was well enough to go home, and if you thought he was settling under treatment. Dr. Rafferty accepted that there was room for a difference of view on the merit of performing a flexible sigmoidoscopy, stating that in many hospitals, it was not considered routine. Roddy was frightened and wanted to get out of hospital quickly. Had he had more bowel disturbance during his period of admission they would have wanted to wait until that had settled prior to discharging him.

Turning to the mode of discharge, he referred to the evidence of Edith Donnet about the telephone call from a staff nurse asking if the relative who worked in Ward 4 could collect Roddy and her telling the staff nurse that Roddy was a resident in a care home and that she should contact its manager. She later heard of the problems getting him out of the ambulance. He observed of Miss Donnet that she had declined to help, having been requested to do so by Miss Mackie, when, at a later date, it was considered appropriate to re-admit Roddy, when her presence may have been of persuasive assistance. James Donnet's position was that he had never been asked to help persuade Roddy to go back into hospital. Miss Mackie said that she was telephoned at 10.00 to be informed that discharge would take place that day. There were further calls at 12.40 and 13.00. He was discharged at 15.00, five hours after the first intimation. If there had been staff available, someone would have been sent in a taxi to collect him. There was authority to do this. She accepted that Roddy could be returned to Maryfield House by ambulance accompanied only by its personnel It was her responsibility to see that he had been accompanied.

On the question whether the presence of a trained learning disability nurse at the hospital would have helped he observed that Edith Donnet had said that only the family understood Roddy and even they struggled.

In conclusion, Mr. Fitzpatrick proposed that, in terms of Section 6(1)(a) of the Act, I should find that Roddy died on 29th. May at 06.10. In terms of 6(1)(b) that the causes of death were (1) ulcerative colitis and (2) bronchopneumonia. He observed that bronchopneumonia was a terminal event, a very common finding in the terminal stages of any illness, particularly for those who have been on a syringe driver, which gives pain relief and causes the patient not to cough allowing secretions to be retained in the chest, and facilitating secondary infection. Under Section 6(1)(c) he

submitted that a reasonable precaution which might have avoided death would have been for anyone who had the opportunity to do so to arrange for Roddy's return to hospital when, following his discharge on 17th. April, he became ill once more. Following his discharge, Roddy remained well for just a few days. He was then seen, amongst others, by Drs. Hollins and Badenhorst. In the face of continuing difficulties, the submission of a blood sample for analysis would have been appropriate. Finally, he submitted that there should be no determination in terms of Section 6(1)(d) that there had been any defective system of working at Ninewells. The transposition of the wrong blood test results was an isolated human error on the part of the junior doctor concerned, rather than a systemic failure, as had been demonstrated by an audit instructed by Dr. Jones.

I was grateful to Mr. Fitzpatrick for his concise and carefully presented submissions.

Conclusions:

1. It is unfortunate, following Roddy's admission to Maryfield House, and subsequent to his mother's death, that none of his general practitioners reacted to intimation from Ninewells Hospital's Gastro-Enterology Unit to the effect that Roddy had failed to attend for regular review. Had Maryfield House staff been aware that he suffered from ulcerative colitis, which they do not appear to have been prior being told this by Dr. Badenhorst on 10th. April, 2003, and had they been told about the benefit from attending for regular review by the gastro-enterologists, there is every reason to believe that they would have ensured his regular attendance for review, as they did faithfully in relation to other medical investigation which he was required to undergo; further, it is reasonable to assume that some staff members at Maryfield House would thus have had a better understanding of the disorder, the need for treatment, and the need properly and effectively to record relevant symptoms; further, the process of regular review would have meant that Roddy remained on the books of the Department of Gastro-Enterology and would not have been a stranger to them; that, in turn, might have led to a better appreciation on the part of the medical and nursing staff of Roddy's intellectual limitations and a better understanding of the management problems he presented to the staff of the residential care home. It might thus have created a set of circumstances where the process of regular review and better knowledge and understanding of the patient could have produced a better outcome from his period of admission in April, 2003. I regret that I cannot describe this as other than fault on the part of his general practitioners who knew that his mother had died, that she had been his principal carer and that he suffered from ulcerative colitis. They were written to in terms by the Dept. of Gastro-Eneterology to the effect that Roddy had failed to attend for review but they do not appear to have responded in any way to that communication. For the avoidance of doubt, I should make it clear that Dr. Quinn, who had much to do with Roddy in her capacity as an associate psychiatrist in learning disability, was unaware that Roddy had ulcerative colitis and no criticism can be made of her in this context.

2. Dr. Jane Wallace, a pre-registration house officer in Ward 15, the acute medical admissions ward, at Ninewells Hospital, Dundee at the material time, 16th. April, 2003, failed to note correctly Roddy's patient identification number (CHI number) on the admissions sheet when she was clerking him into the ward. She was not called to give evidence and therefore had no opportunity to explain the cirumstances in

which she made this error. It is a reasonable inference from the fact that the laboratory held the blood test results for Roddy for "verification of the CHI number" that she wrote the same wrong number on the blood sample label. The laboratory had instructions which she should have been aware of not to issue results of blood tests unless the patient's name and CHI number matched, to avoid confusion of results. One immediate consequence of this was that no blood test results were available to Dr. Pullar when he saw Roddy at 16.41 although in fact the tests had been completed. Dr. Pullar should have known that the tests should have been completed and should have investigated their absence. He might have appreciated then that the wrong CHI number had been applied to the sample. Diane Carter, the Ninewells Laboratory IT manager, had reservations about the quality of the training received by doctors at Ninewells in the CentralVision IT system at that time, describing what took place as primarily "peer training." There should have been a proper system of training for all doctors in the CentralVision system and its operation prior to each doctor receiving an access code to the system. In particular, doctors should have been instructed in the critical importance of recording the patient's CHI number accurately. However, the system has now changed for the better in that the laboratory will not now accept a sample where the patient's name and CHI number do not match and the doctor should thus quickly be aware of an error in one or the other. The IT Department have now taken on a greater role in training doctors in the system's operation prior to doctor's being granted an access code. In my opinion, this is a significant improvement from the situation in April, 2003. Those responsible for the training of medical staff in 2003, however, should have ensured that an adequate system was in place then.

3. It is absurd and a completely unacceptable state of affairs that Ward 15 at Ninewells, being an acute medical admissions ward, has insufficient beds to accommodate its average daily intake of admissions. NHS Tayside must take urgent action to resolve this unacceptable situation, which clearly contributed to Roddy's anxiety and instintive reaction of non-compliance consequent upon his being left for some hours on a trolley in a corridor. It is particularly regrettable when, according to his evidence, Dr. Jones, the consultant in Acute Medicine in charge of the ward, has repeatedly expressed concern about this state of affairs, when he is best placed to assess the significance of the lack of beds for patient care, but has been ignored by those responsible for the management of the hospital. The importance of having adequate facilities for an acute admissions ward is self-evident. The absence of such facilities inevitably creates a climate when some people who might benefit from a longer period of hospital observation are discharged home because they are not acutely ill. That is what happened to Roddy and that might have controbuted to his death.

4. The evidence from Miss Donnet about Roddy's treatment by nursing staff while he was on the trolley in a corridor near Ward 15, which went unchallenged, was appalling. It suggested that not only was there an insufficient number of beds but an insufficient number of nurses to enable to nurse humanely, though the conditions in which patients were kept on trolleys cannot have been conducive to good nursing. It would be reasonable to conclude from Miss Donnet's evidence that Roddy's reluctance to co-operate while there and to return may have been adversely affected by these experiences and it is unacceptable that a patient with mental incapacity should be treated with such inhumanity. A training exercise for nurses in humanity

towards incapacitated patients is required. In particular, despite the issue being highlighted by Sheriff Ian Dunbar in the James Mauchland FAI, nothing appears to have happened to encourage nursing staff to pay more attention to obtaining information and assistance from relatives of incapacitated patients. Had James Donnet been asked to try to persuade Roddy to attend for X-ray and had he been made aware of the critical importance of X-ray, he would have tried to get Roddy's co-operation.

5. On the balance of probability, it is unlikely that the amendment on the yellow copy of the discharge note which had been made by Dr. Hill, given that the amendment did not itself appear to be copied but original handwriting, was written on the principal of the discharge note, which appears to have been sent out with Roddy when he was discharged. It is therefore unlikely that any general practitioner was in fact misled by that amendment, though all the medical witnesses were agreed that, had such amendment been made and copied to the GPs, it would have been inept, misleading and offensive. A number of training issues arise, however, out of what did happen. In the first place, it is hard to comprehend the level of stupidity of the unidentified member of medical or nursing staff who considered it appropriate to consign the discharge note to Roddy's care. It is unsurprising that it does not ever appear to have reached the GP. It should have been sent to the GP y facsimile transmission or other similar electronic means. Secondly, the discharge note was inadequate in that it gave little guidance to the GP about the future management of the patient, especially in relation to out-patient treatment. Thirdly, Dr. Clarke considered it unacceptable, and I agree with him, that the discharge note had not been approved by the consultant in charge. The terms of the subsequent discharge letter were considered appropriate and professional but it is unacceptable that it was written by a doctor who had not dealt with Roddy nor been involved in his treatment, thus enhancing the risk of the transmission of inaccurate information through human error, and it is unacceptable that it took five weeks from Roddy's discharge to the arrival of that letter in the hands of his GPs. Changes must be made utilising modern technology to end this unacceptable state of affairs to ensure that GPs are made aware as soon as possible, and in any event within no more than seven days, by a doctor who played an active role in the patient's in-patient treatment, what was the basis for the discharge, what was the diagnosis and prognosis, what investigations were undertaken and what were their results, what further hospital in or out-patient treatment is planned and what further care or treatment it is recommended should be managed by the GP. It would also be beneficial in the case of a resident of a residential care home or nursing home

if a copy of the discharge note went to the manager of the home.

6. The management of Ninewells Hospital should examine and assess the

establishment in Edinburgh of the availability of a liaison nurse for persons with learning disability who are admitted to general hospital suffering from a physical illness to ascertain whether there would be merit in introducing a similar provision at Ninewells.

7. There might be merit in adding to the CentralVision process some means of flagging that a result from one of the laboratories was outstanding.

8. Something fundamental requires to be done by Ninewells management to reduce the pressure on hospital beds. It was increasingly apparent, listening to the evidence of the doctors based in various hospitals that the pressure caused by an insufficient number of beds may from time to time lead to questionable decisions being made about patient discharge. It is clear with hindsight that Roddy's diagnosis would have been definitive had he co-operated with a fexible sigmoidoscopy and then effective treatment, whether in hospital or, taking proper account of his management difficulties, in the community.

9. The Scottish Executive require to consider the problems associated with providing hospital care to persons who are incapacitated when they develop physical disorders. It is unhelpful both to them and other patients to be admitted to and nursed in a normal ward setting. Sheriff Dunbar, in the Mauchland case, also highlighted the risks inherent in putting such a patient with an inability to communicate when something was wrong, in a side room. I do not consider that it would be appropriate on the evidence I heard to suggest a solution to the problem and so I simply record that both Dr. Starr and Dr. Morrison believed that specialist units, in which an incapacitated patient with a physical disorder would be cared for by a mixture of general and psychiatrically trained nurses working together, and under the care of a consultant psychiatrist and the consultant relevant to the particular medical specialty also working together, would provide a more satisfactory outcome for patients.

10. From the evidence of Diane Carter and the productions which she produced, it is clear at least on the balance of probability, that Dr. Jane Wallace accessed CentralVision, looking for Roddy's blood test results, at about 00.20 on 17th. April, 2003. Though the hand which inserted the results in the records in the admissions sheet is different to that in the rest of the admissions sheet which she wrote, the access code used to gain access to CentralVision was hers, so access was made either by her or by someone to whom she had given her access code. On the balance of probability I conclude that it was her. Having this time used the correct CHI number, which appears on the outer folder of the patient's file, she obtained access to Roddy's CentralVision file. Dr. Jones explained that he had instructed junior doctors to copy the results into the patient's medical file. It had been Dr. Jones, in the course of giving a statement on the circumstances to Det. Con. Marcus Lorente of Tayside Police, who drew attention to the error in the results so copied in this case and that is to his considerable credit. The Crown, however, failed to appreciate the significance of this piece of evidence. It will be recalled that the laboratory had held the blood test results from the sample taken from Roddy on admission pending "verification of the CHI number," as they were instructed to do. So as at 00.20 on 17th. April, 2003, the blood test results from the sample taken on admission were not on the CentralVision system, no doctor having clarified with the laboratory why the results had not been posted. What Dr. Wallace or someone using her access code did was click on the last entry for biochemical and haematological results, which, on the computer's home page, was an entry for 17th. December, 2002. Since all entries are identified by their date, it should have been obvious that this was an entry for 17th. December, 2002, i.e to gain access to the actual results, Dr. Wallace had to click on a box specified as being "17th. December, 2002." Once that dialogue box was opened, whether for biochemistry or haematology, what then appeared on the screen was a series of results which in three separate locations on

the screen indicated that these were results for a sample submitted on 17th. December, 2002, four months earlier. The screen also makes it clear that these results pertain to a sample submitted by a Dr. K. White at N/W Neurology OP, which was another indicator which should have alerted Dr. Wallace to the fact that she was looking at the wrong results. It did not for these were the results that she transposed on to the admissions sheet and put in Roddy's medical file and these are the results thereafter considered by Drs. Jones, Hill and Barron. The results show a normal figure, 4, for C-reactive protein, a critical marker for the presence of inflammation in the body, whereas the correct result was 59, which is abnormally raised. This can only be described as an appalling error and it was an equally appalling error on the part of the Crown not to call Dr. Wallace and give her an opportunity to explain how this occurred. All I can properly conclude, in the absence of evidence from her, is that her behaviour demonstrates a lack of understanding of the operation of the CentralVision system and there is therefore a training issue for doctors. I regret that in this respect I also have to be critical of Dr. Jones. I do this with diffidence for otherwise he was an impressive witness undertaking a very difficult but critical role at Ninewells. However, he was the one who insisted in transposition by hand of the results from CentralVision rather than by attachment of a print out of the results, notwithstanding the presence of a screen and printer on Ward 15. He justified this on the basis that it assisted junior doctors in becoming familiar with the various tests and results and their signficance. Printing out the results, however, would eliminate any prospect of human error in the course of the transposition. In this case, it is likely that he would hnave recognised, given his familiarity with the system, that he was looking at the wrong results. In addition, this system militates against encouraging doctors to look at the series of test results both from the present date and previously in a comparative exercise to see what has changed and the expert consultants considered this was an important task to undertake. I also have to be critical of Drs. Hill and Barron for depending upon the results when they knew or ought to have known that a further blood sample would have been taken and submitted to the laboratory on the morning of 17th. April and that it would have been appropriate, prior to discharge, to consider these more current results. Had they done so, they may well have been surprised to find that the C-reactive protein figure had gone from 4 to 34, which would have run contrary to their clinical findings. They might then have discovered that the wrong set of results had been transposed and have discovered the actual results from admission which might have given them pause for thought as Dr. Clarke told me it would have given him. The 17th. April results were posted to CentralVision at 10.53 on 17th. April and were therefore there long before they saw Roddy on Ward 15. According to Dr. Clarke, they should certainly not have discharged Roddy, knowing that he had been admitted with a C-reactive protein figure of 59, without making urgent arrangements for out-patient follow up which, in their state of misinformation, they did not do. If, as Dr. Jones suggested, print outs make the file to cumbersome and difficult to find information on, then another filing method should be explored. But not to use information direct from the computer is to risk further human error which, next time, might have an even more significant unfortunate consequence and transposing results by hand should be eliminated immediately.

11. It is unfortunate, astonishing and of questionable legality that none of the doctors who were being told about Roddy's deteriorating condition on account of dementia from 2000 onwards considered it appropriate (a) to inform his next-of-kin about his

developing condition (b) to determine formally whether he had the capacity to consent to medical treatment and (c) to inform, after 2001, as his condition further deteriorated, of the need for a formal appointment of a substitute decisions maker to take relevant decisions about Roddy's welfare, including where it was appropriate for him to reside and to determine what medical treatment, if any, he should undergo. The three general practitioners who were asked about these matters, Dr. Hollins, Dr. Badenhorst and the Crown's chosen expert, Dr. Morrison, all demonstrated ignorance of the provisions of the Adults With Incapacity (Scotland) Act, 2000 and, more generally, of the law in relation to a patient suffering from incapacity to a degree in which he was incapable of consenting to medical treatment. There is, patently, a major exercise in dissemination of information to general practitioners required from the Scottish Executive Health Department. This ignorance contributed to the circumstances in which Roddy died as he did in that his relatives did not comprehend what was wrong with him and what the required treatment for ulcerative colitis was. Had they done so, they might have been more active and forceful in encouraging his re-admission to hospital. In any event, they should have been consulted about the question of his re-admission to hospital and have been fully informed of all the medical circumstances so that they could have taken an informed decisions about what should happen. While hospital based doctors may be becoming more familiar with the use of Section 47 of the 2000 Act, and the use of section 47 certificates, there may also be a need for further training for them on the limitations on section 47 contained in sections 49 and 50 and the arrangements therein contained to resolve disputes between welfare guardians and doctors about which they appeared to be uninformed.

12. It was inapproriate for the general practitioners to make a decision not to re-admit Roddy to hospital on the basis of information from the carers. The position should have been discussed with Roddy's relatives so that they were fully informed, especially about the current and likely future progress of his dementia, and then they could have made the decision knowing that if the active ulcerative colitis were not treated effectively, which could best be achieved in a hospital setting, that the prognosis was poor and ultimately an avoidable, painful death would ensue. The general practitioners were at fault in not undertaking this responsibility. Dr. Hollins said he had discussed the position with other doctors in the practice and could reasonably have expected more help from his more experienced colleagues. This failure on the part of the general practitioners in respect that the relatives were not informed so that they could have determined that Roddy should be re-admitted to hospital, using mental health law if appropriate, might have contributed to Roddy's death.

13. There are a number of aspects of Dr. Hollins' performance after Roddy's discharge on 17th. April until his death which are difficult to understand and he seemed unable to explain adequately, but the most significant of these is his failure to make any effort to get Roddy back into hospital on or about 15th. May, 2003 when the ulcerative colitis had developed to a critical stage.

14. Dr. Badenhorst, in her admission referral, had drawn attention to the management problems presented by Roddy in the community. It is regrettable that Drs. Hill and Barron, while noting he was difficult to manage, otherwise ignored this aspect and discharged Roddy back to a residential care home on substantially the

same medicative regime as that with which they had been told he was failing to comply. One of the things they should have considered was whether he required to be in a nursing home. They might also have advised the GPs on the availability of mesalamine in soluble granule form which might have been easier to persuade Roddy to consume. Given these problems, the least they should have done was arrange prompt out-patient follow up and explained the importance of that on the discharge note.

15. It is important that hospital based doctors from consultant down understand that where a patient lacks mental capacity they must undertake if requested to do so by a general practitioner a domiciliary visit in order that they can assist the GP in assessing the value for the particular patient of the particular treatment. There also needs to be improvement generally in communication between GPs and hospital based doctos of all levels but I cannot determine in this case how best that can be achieved.

16. There would be merit in introducing (re-introducing ?) a system whereby sufferers from Down's Syndrome, especially those aged 40 or over, are reviewed at regular intervals in relation to both their mental health and physical health, given the number of health conditions now associated with Down's Syndrome as referred to by both Dr. Starr and Dr. Sadler, the pathologist.

17. The inadequacy of the communication among the general practitioners, Dr. Quinn, various departments at Ninewells but most strikingly Neurology, the social work staff responsible for Roddy's care and its management and funding, and his brother and sister can only be described as breathtaking. It clearly demonstrates as things currently stand the need for someone to be legally appointed to be responsible for the welfare of an adult, with the level of incapacity which he patently had. That should have been obvious to properly trained health and social work professionals. Had a welfare guardian been appointed, that person should have had a better overall understanding of Roddy's state of health and the need to make arrangements to deal effectively with the outbreak of ulcerative colitis. His death from ulcerative colitis might thus have been avoided.

18. There would be merit in amending Section 47(4) of the Adults With Incapacity (Scotland) Act, 2000, so that the definition of "medical treatment" was extended to include "any reasonable period of assessment as an in-patient required to ascertain whether a person is suffering from a mental or physical heaqlth disorder including all investigative processes reasonable considered necessary and appropriate to any such assessment process." This amendment would address some of the concerns expressed by hospital based consultants about the vagueness of the Act's provisions, as they saw them. In addition, and notwithstanding the present provisions of section 36 of the Mental Health (Care and Treatment)(Scotland) Act, 2003, there might also be merit in amending Section 47(4), for the avoidance of doubt, to include in the definition of "medical treatment," "such process or processes as may be reasonably necessary to enforce the patient's attendance at a hospital or other place of treatment where such enforcement is necessary in the cirucmstances to ensure assessment or treatment."

19. Dr. Quinn's attitude towards the Adults With Incapacity (Scotland) Act, 2000 and her responsibilities to her patients and their relatives arising out of it was surprising and disappointing, given her awareness at all times of the extent of Roddy's incapacity, and contrasted sharply with the level of medical care which she devoted to Roddy over many years. She should have recognised the need as a matter of law for a welfare guardian and should have involved a mental health officer. She should have encouraged Roddy's relatives to seek the appointment of a welfare guardian. Her lack of awareness of the Act's provisions and her failure to recognise the importance of having a welfare guardian appointed to Roddy is significant in that the lack of a welfare guardian with a central knowledge of his medical problems may have contributed to Roddy's death. She requires training and instruction on the importance of this legislation and its application to her learning disabled patients.

20. It is a management failure on the part of Dundee City Council Social Work Department not to have established a system whereby an incapacitated resident in residential care who requires to be admitted to hospital or discharged from hospital is not accompanied either by a relative or a carer. This is especially so where the incapacitated adult has communications problems. A system requires to be established urgently and that should encompass the taking of the care home notes with any patient attending hospital on an in or out-patient basis so that the carer is in the best position to provide an accurate history. No incapacitated patient should be allowed top be discharged from hospital unless accompanied by a relative or carer.

21. It should have been apparent to Ms Mackie that it was no longer appropriate for Roddy to remain at Maryfield House following his discharge from Ninewells Hospital on 17th. April, 2003, as the staff there were not qualified and not trained to deal with the nursing management problems Roddy was by then presenting, though they did their best to grapple with these. Had he been transferred to a nursing home before the end of April, as should have happened, it is possible that nursing staff in such an environment would have been more insistent and effective in recognising the need for and effecting re-admission to hospital where treatment may have avoided death from ulcerative colitis and in which environment there would have been a greater awareness of the need to adhere to the medication regime and a greater level of skill at achieving this. Similar considerations apply in relation to the gastro-en terologists at Ninewells and to the general practitioners. Dr. Quinn and Mr. Campbell recognised the need to move Roddy to a nursing home. It is not clear to me why that did not proceed nor why Roddy should have remained at an unsuitable location until the GPs got his health under control.

22. I am also critical of Ms. Mackie in at least influencing if not actually taking decisions which should have been taken by Roddy's relatives and were thus outwith her sphere of responsibility. She played some part in misinforming Dr. Anderson of D.D.O.C. on 22nd. May when it was noted that Roddy had been diagnosed as terminally ill one week earlier. There is no evidence of such a diagnosis. It is for relatives to determine how their relative should be cared for medically, not care home staff, no matter how well intentioned they may have been. I am also critical of Dr. Anderson for starting this process without checking the position with the next of kin or general practitioner of the patient and am inclined to the view that an out of hours medical service should not be permitted to initiate a change from active to palliative treatment with out formal consent of the next of kin or legally appointed

substitute decision maker. In fairness to Dr. Anderson, I was informed by Dr. Morrison that the dosage of diamorphine was not such that it commenced an irreversible process, so the real question is what on earth did Dr. Hollins think he was doing on 23rd. May given that until then he had been engaged in a course of active treatment. He offered no satisfactory explanation for his change of diagnosis.

23. Care managers, like Thomas Campbell, require training on the provisions of the Adults With Incapacity (Scotland) Act, 2000 and its implications for those incapacitated persons for whose practical care the local authority have a responsibility.

24. In the preparation of a care plan for each resident of a residential or nursing home, Dundee City Council must include an assessment of the resident's mental capacity, particularly in relation to being able to consent to being a resident in a residential or nursing home and being able to consent to medical treatment. Where that capacity does not exist then, as a matter of law, a welfare guardian must be appointed, unless there is an existing welfare attorney. They must initiate the process of appointment of a welfare guardian where the circumstances of their residents are such that a welfare guardian is necessary as a matter of law.

25. Where there is no associated application for the appointment of a property and financial guardian, the procedure for the appointment of a welfare guardian could be simplified and rendered less expensive. All that would be required to support an application to the court would be two medical certificates of recent origin demonstrating an incapacity which requires the appointment of a welfare guardian in the interests of the adults, or as a matter of legal necessity. That, together with a report on the adult's circumstances and needs from a mental health officer, should be all that the sheriff requires to determine whether the appointment is appropriate and what powers should be conferred.

26. Another material issue where legislation may be required concerns the competence and legality of social care assistants administering medication to persons resident in care homes (and perhaps also their own homes) who lack capacity to consent to the administration of medication. It is clear that there were times when Roddy was resistant to taking medication. Only Dr. Badenhorst appears to have attempted to address this issue with staff at Maryfield House when she made it clear on 16th. May, 2003, questioning whether Roddy had had his medication consistently and whether his fluid intake was being adequately maintained. It was the position of Dundee City Council Social Work Department, Mr. Burns and Mr. McCaw, that it was not the duty of care home staff to administer medication but that they could assist residents to take medication. In plain English, what that appears to me to mean is that the local authority does not accept responsibility where its residents do not take their medication as prescribed. I suspect that generally in practice social care staff will effectively supervise the administration of medication but it is not satisfactory that their management do not consider this to be their responsibility, though they make the valid point that they are not authorised to compel residents to take medication. As I see it, as the law currently stands, that can only be achieved by medical or nursing staff invoking the doctrine of necessity or utilising the provisions of Section 47 of the 2000 Act or being authorised to enforce medication by a legally appointed substitute decisions maker. As Mr. McCaw said in his evidence, this is the

kind of practical difficulty which results from two separate and distinct agencies being involved in the welfare and health care of one individual, where logic suggests that the individual would be better served by a single agency. That is an argument for another day but the Scottish Executive require to resolve the issue of the responsibilty of ensuring that required medication is administered. I am in little doubt in the present case that Roddy's death was contributed to by his poor compliance with medication and the lack of anyone compelling his compliance.

27. In my opinion, though I would have been comforted more had I had the benefit of full submissions on the matter, the decision in *HL v United Kingdom* is directly applicable to the cirucmstances of the present case where a person who is incapacitated is confined to a residential care home in the absence of any consent from any legally appointed substitute decisions maker, and that detention in a residential care home without such consent would constitute a breach of Arts 5(1) and (4) of the European Convention on Human Rights both by depriving the resident of his liberty and in the absence of any form of process which enables that residence to be regulated or appealed against. It would follow, as a matter of law, that no person could be admitted to residential care if they do not have the capacity to consent to such an admission, without the consent of a welfare attorney or welfare gaurdian or, perhaps, on the basis on an appropriate intervention order under Section 53 of the 2000 Act. It may also be possible to invoke the *parens patriae* of the Court of Session, though I know of no case where that has been done. All care home operators and all local authorities require to be aware of this and thus require to make an assessment of whether or not the resident has the capacity to consent to admission or continued residence as the case may be.