

SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2017] FAI 2

B88/16

DETERMINATION

By

SHERIFF PRINCIPAL DUNCAN L MURRAY WS

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)
ACT 1976**

into the death of

IAN JOHN LEITCH BLACK

KILMARNOCK, 21 DECEMBER 2016

The Sheriff, having heard and considered all of the evidence, and the submissions of parties,
finds and determines that:

[a] In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiries
(Scotland) Act 1976:

Ian John Leitch Black, born 30 June 1961 who resided formerly in Newmilns,
Ayrshire died in Glasgow Royal Infirmary at 17:16 on 30 July 2013. The accident
resulting in Mr Black's death occurred at 19 East Edith Street, Darvel, Ayrshire, on
the morning of 22 July 2013.

[b] In terms of section 6(1)(b) of the Act:

The cause of the death of Ian John Leitch Black was:

1a) Pulmonary thromboembolism

Due to

1b) Deep vein thrombosis

Due to

1c) Fractured left hemipelvis

[c] In terms of section 6(1)(c) of the Act the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided:

A reasonable precaution by which the death may have been avoided would have been by Mr Black taking reasonable care for his own health and safety: this by following a safe practice in applying the render to the gable wall. In particular Mr Black should not have worked from the outside of the tower scaffold without precautions to prevent a fall and the ladder he was using should have been secured or held in position.

[d] In terms of section 6(1)(d) of the Act the defects, if any, in any system of working which contributed to the death or any accident resulting in the death:

Having established a safe system of work using a tower scaffold, Mr Black as a consequence of his concern about the rendering “going off” did not follow safe practice by failing to secure the ladder and placing it on a wet tarpaulin. This resulted in the ladder slipping and his falling to the ground. Mr Black also failed to follow a safe practice by working from the outside of the tower scaffold without precautions to prevent a fall.

[e] In terms of section 6(1)(e) of the Act any other facts which are relevant to the circumstances of the death:

No findings are made under sub section (e).

Representation at the Inquiry:

For the Crown: Ms Dunipace, Procurator Fiscal Depute

For the Greater Glasgow Health Board: Ms Watts, Advocate

General Legal Framework

[1] This was a mandatory Inquiry held under section 1(1)(a)(i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. This on the ground that it appeared that the death resulted from an accident where the person who died was at the time an employee and acting in the course of his employment.

[2] Fatal accident inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the 1976 Act and the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977 made under section 7(1) of the Act. The purpose of an Inquiry held in terms of the 1976 Act is for the sheriff to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction:

- (a) where and when the death and any accident resulting in the death took place;
 - (b) the cause or causes of such death and any accident resulting in the death;
 - (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
 - (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death;
 - (e) any other facts which are relevant to the circumstances of the death
- all in terms of section 6(1) of the Act.

[3] The Court proceeds on the basis of evidence placed before it by the Crown and by any other party to the Inquiry. The determination must be based on the evidence presented at the Inquiry and is limited to the matters defined in section 6(1) of the Act. Section 6(3) of the Act sets out that the determination of the sheriff shall not be admissible in evidence or be

founded on in any judicial proceedings, of whatever nature, arising out of the death or out of any accident resulting in the death. While this prohibition is intended to encourage a full and open exploration of the circumstances of a death it also reflects the position that a Fatal Accident Inquiry is not a forum designed to establish legal fault.

The Proceedings, Witnesses and Evidence

[4] Preliminary hearings of the Inquiry were held on 27 April and 28 July 2016. The Inquiry heard evidence on 7, 8 and 9 November 2016. Ms Watts appeared for Greater Glasgow Health Board. The family of the late Mr Black were not represented at the Inquiry. Parties provided a joint minute of agreement and written submissions. A hearing on submissions took place on 24 November.

[5] Evidence was led principally by the Procurator Fiscal Depute, in accordance with the duty under section 4(1) of the 1976 Act. The Crown witnesses were as follows:

Sharon Mary Black, widow of the deceased Ian John Leitch Black;

Gerard Muir, HSE inspector;

Mr Mark Blyth, consultant orthopaedic surgeon at Glasgow Royal Infirmary;

Michael Jacobs, staff nurse at Glasgow Royal Infirmary (as at June 2013);

Lesley Don, lead nurse for orthopaedic surgery at Glasgow Royal Infirmary;

Dr Roderick Neilson, consultant haematologist at Forth Valley Royal Hospital.

Evidence was also led on behalf of the Health Board from Mr John Keating, consultant orthopaedic surgeon at Edinburgh Royal Infirmary.

What happened

[6] Ian John Leitch Black (Mr Black) was a 52 year old married man. He had worked in the construction industry since joining East Ayrshire Council to commence an apprenticeship aged 16. Mr Black and George Brown were directors and employees of B and B Property Maintenance Ltd., a company which was formed around February 2013. There were no other directors or employees of the company. The company carried out maintenance and repair work on domestic properties.

[7] On 22 July 2013 Mr Black and Mr Brown were undertaking repair work to a gable at 19 East Edith Street, Darvel, Ayrshire. Work had commenced a few days earlier. The job required that old render be removed, a crack be repaired, a mesh fixed to the wall and finally a new render finish applied to the gable wall. A tower scaffold was erected to facilitate the work and a ladder was used only to take material up to the working platform. Mr Muir, HM Inspector, who carried out an investigation for the Health and Safety Executive, accepted this to be a safe system of working and that it complied with the duties and obligations imposed by Regulations 6(3), 6(5), 7(1)(b), 9(2)(a) and (b) and 9(3) of the Work at Height Regulations 2005. On 22 July work was nearing completion and the new render was to be applied. Mr Black mixed a quantity of render and passed this to Mr Brown to apply. It was a warm day and the render was hardening too quickly, because of the prevailing temperature. Mr Black sought initially to dampen the render on the gable with a hose. He then ascended a ladder which he placed to the left of the tower scaffold to assist in the application and smoothing of the render. He did not secure the ladder which was set on a tarpaulin. The tarpaulin had been laid out to catch falling render and was wet following the wall having been hosed down. Mr Black was the more experienced contractor and was

responsible for the system of work and how the render was to be applied. His use of the ladder was contrary to the guidance published by the HSE in 2005 IND402 Safe use of Ladders and Stepladders and repeated in HSE “pocket card” INDG405, to the effect that ladders should be secured, placed on firm level ground and that the ground should not be slippery.

[8] Mr Black applied some render to the wall, descended the ladder and re-ascended with a float to smooth the newly applied render. To undertake this task he stepped from the ladder and placed his feet on the outside rail of the tower scaffold. He hooked his right arm around the tower scaffold and smoothed the render. As he stepped back onto the ladder it slipped. Mr Black initially hung on to the tower scaffold before he fell to the ground, a distance of some 12 feet. Mr Black was the author of his own misfortune.

[9] An ambulance was called and Mr Black taken to Crosshouse Hospital, Kilmarnock. Mr Brown telephoned Mr Black’s wife and she attended at Crosshouse Hospital. Mr Black was examined and x-rayed and diagnosed to have a complex left acetabular fracture (hip joint socket), an undisplaced fracture of his left proximal humerus (upper arm) and an intra-articular fracture of his left distal radius (wrist). On 23 July Mr Black was seen by Mr Thomas, orthopaedic consultant at Crosshouse Hospital, who prescribed dalteparin, a low molecular weight heparin (LMWH), which was given to Mr Black. LMWH is the standard thromboprophylaxis for trauma patients with acetabular and pelvic fractures. The LMWH was commenced within twenty four hours of injury. Mr Thomas also arranged for Mr Black to be referred to Glasgow Royal Infirmary for specialist surgery. Mr Black was transferred to a specialist orthopaedic ward at Glasgow Royal Infirmary on Thursday

25 July 2013 in anticipation of his having an operation in the Royal Infirmary on Friday 26 July 2013.

[10] On Mr Black being assessed, following his arrival at Glasgow Royal Infirmary, he had a National Early Warning Score (NEWS) of 3. His catheter was found to be blocked and was flushed to clear. There was evidence Mr Black had contracted a urinary tract infection. The NEWS score is a scoring system in which a score is allocated to physiological measurements and observations. It provides a surveillance system for tracking a patient's clinical condition, so the clinical team may be alerted to any medical deterioration. The admitting doctor completed a VTE (venous thromboembolism) prophylaxis instruction sheet. This risk assessment rated Mr Black as being of "medium risk" of VTE. He was prescribed enoxaparin, another LMWH, continuing the prophylactic therapy to reduce the risk of DVT commenced at Crosshouse Hospital.

[11] On 26 July, Mr Black was observed to have a distended abdomen. This was diagnosed as a paralytic ileus or pseudo-obstruction, which results in constipation and is not uncommon after significant traumatic injuries. Mr Black's condition deteriorated over the weekend of 27 and 28 July. His NEWS score was recorded as 7 at five observations on 28 July. Mr Black was given appropriate care over the weekend of 27 and 28 July. Although record keeping was sub-optimal, this had no deleterious impact on the treatment he received. Mr Black was reviewed on 27 July by the middle grade specialist orthopaedic trainee and seen by a general surgeon who arranged for a CT scan which took place on 28 July. This confirmed a pseudo-obstruction or ileus. Steps were taken to relieve the ileus by means of enemas. Although Mr Black had increased NEWS scores over this weekend he

was best cared for in the specialist orthopaedic ward and there would have been no benefit in his being transferred to a high dependency unit.

[12] Following a bowel movement in the early hours of 29 July, Mr Black's condition showed some improvement, although he continued to remain poorly and had an episode of delirium in the early hours of 30 July. Mr Black was seen by the orthopaedic registrar at 11.00 on the morning of 30 July because of ongoing confusion. Reporting of the CT scan noted evidence of an inter-sphincter haematoma or abscess that was contributing to his GI ileus. He was to be subject to further review by the general surgical team but this never took place as he was being cleaned up following a bowel movement, when the doctor, from the general surgical team, attended to see him.

[13] On 30 July, Mrs Black travelled from Kilmarnock by train with Mr Black's parents and attended at Glasgow Royal Infirmary at approximately 13:30. She found her husband confused and complaining that his left leg was swollen at the calf. She spoke to Nurse Jacobs about this; Nurse Jacobs put a cushioned gutter splint under Mr Black's leg. Mr Black found this uncomfortable and it was removed by Mrs Black shortly thereafter. Mr Black also had a temperature and was given paracetamol with a view to reducing his temperature. Mr Black complained about chest pain when Nurse Jacobs attended to check his drip. Mr Black gestured with his left arm, which was in a cast, across his chest. Around 16:00 shortly before Mrs Black and Mr Black's parents departed for the station there was a further discussion between Mrs Black and Nurse Jacobs. Nurse Jacobs advised that her husband was stable and that the doctors were not coming to see him that day. When Mrs Black said that she wished to see a doctor, Nurse Jacobs said he would make arrangements for Mrs Black to see a doctor the next day. On arrival at the station Mrs Black realised that she had

missed a call while in the taxi, from the hospital to the station, and her voicemail message asked that she call the hospital. When she phoned back she was asked to return to the hospital as her husband was rather unwell. When she arrived at the ward, Nurse Jacobs took her into a side room and told her that Mr Black had been found unresponsive at 16:35 and had passed away thereafter.

[14] On Mr Black being found unresponsive the notes record the cardiac arrest team were paged, CPR was attempted for 30 minutes, but this was unsuccessful and Mr Black was certified dead at 17:16. Nurse Jacobs put an entry in the notes timed at 18:30 on 30 July. This recorded reassurance and support being given to the family and Mr Blyth having discussed arrangements for the issue of a death certificate with the family. Nurse Jacobs retrospectively, and after consultation with senior colleagues, put an entry in the notes on 31 July recording his observations of Mr Black from about 14:00 on 30 July and his having provided a gutter splint and paracetamol.

[15] Mrs Black subsequently complained to the hospital about the treatment which her late husband had received and subsequently also complained to the Scottish Health Services Ombudsman. The Ombudsman upheld Mrs Black's complaint in relation to poor note keeping and noncompliance with the Greater Glasgow Health Board policy on the escalation of clinical care following a NEWS score of 7. The Ombudsman accepted this did not result in a missed opportunity to diagnose Mr Black's deep vein thrombosis or pulmonary embolism.

Submissions

[16] The Crown submitted in terms of Section 6(1)(a) of the Act the death of Mr Black

occurred at GRI on 30 July 2013; his life was pronounced extinct at 17:16 hours on said date and that the accident resulting in his death occurred at 19 East Edith Street, Darvel, Ayrshire on 22 July 2013. In terms of Section 6(1)(b) of the Act, the Crown submitted that the Inquiry should accept the findings of the post mortem examination report and find the cause of death was 1A Pulmonary thromboembolism due to 1B deep vein thrombosis due to 1C fractured left hemi-pelvis. The Crown further submitted that a finding should be made that the cause of the accident resulting in the death was that Mr Black tried to step from the outside of the tower scaffold onto a ladder that had been footed in a wet tarpaulin covering a sloping driveway. The ladder had not been secured in any way, nor was it secured by any person. The ladder slipped, Mr Black initially held onto the scaffolding platform and then fell to the ground. In terms of 6(1)(c) the Crown submitted that it would have been a reasonable precaution whereby the accident resulting in the death might have been avoided for Mr Black not to have worked from the outside of the tower scaffold, without precautions to prevent a fall and for the ladder to be secured or held in position. The Crown made no submission on findings under section 6(1)(c) in relation to the medical care provided to Mr Black. In relation to Section 6(1)(d) the Crown's submission was that the lack of a safe system for working on the outside of the tower scaffolding securing the ladder was a defect in the system of working which contributed to the death.

[17] In relation to Section 6(1)(e) the Crown submitted that while there was no causal connection between the medical treatment received by Mr Black and his death, there was nonetheless a public interest in exploring this in the course of the evidence and therefore it may be appropriate to make a determination. The Crown submitted in particular that there was a failure to adequately and timeously update Mr Black's medical records. It was noted

Mr Blyth, Miss Allen and Ms Don accepted that the medical record keeping during Mr Black's period as a patient in GRI was not of an acceptable standard. The Crown submitted that despite gaps in the record keeping, the evidence supported Mr Black's observations had been taken regularly and recorded and there was nothing to suggest Mr Black's care was compromised. It was submitted Nurse Jacobs accepted in evidence he should have updated Mr Black's medical records before finishing his shift on 30 July 2013 and has learned from this omission.

[18] The Health Board submission on findings in terms of section 6(1)(a) and (b) accorded with those made by the Crown. In terms of section 6(1)(c) the Health Board proposed that a finding is comprised of two separate elements: firstly the Inquiry would require to be satisfied that the basis of the evidence led before it that there was a reasonable precaution which might have been taken by the Health Board's employees but was not taken; and secondly, the Inquiry would require to be satisfied again on the basis of evidence led before it, that the adoption of such a reasonable precaution might have avoided Mr Black's death. In relation to the first part of that analysis it was submitted that the evidence of Mr Blyth, Mr Keating and Dr Neilson was that there was no reasonable precaution which might have been taken and was not taken; and secondly, that it was the unanimous view of every medical witness who gave evidence to the Inquiry that there was no reasonable precaution that might have avoided Mr Black's death. In these circumstances I was invited to make no finding in relation to the medical care under this heading. It was submitted that even were the Inquiry to prefer the evidence of Mrs Black to that of Nurse Jacobs on Mr Black's complaints around 14:00 on the day of his death, no action which Nurse Jacobs could have taken would have avoided Mr Black's death. The Health Board made no submission in

relation to the reasonable precautions by which the accident resulting in Mr Black's death might have been avoided.

[19] The Heath Board made no submissions in relation to 6(1)(d) except to the effect that there was no evidence to suggest a defect in the system of working at the Glasgow Royal Infirmary, and none of a defect which resulted in Mr Black's death. The Health Board accepted that the terms of section 6(1)(e) does not require a causal connection between the fact and the death itself in order for a finding to be made under the subsection. Nonetheless it was submitted that it should be relevant to the circumstances of the death. In response to the concerns expressed by Mrs Black, in evidence, that she had not spoken to a doctor at Glasgow Royal Infirmary prior to her husband's death, it was noted Marie Allan, the charge nurse on the ward, gave evidence that she was available to speak to patients' relatives and discuss any concerns they had. She recalled speaking briefly with Mrs Black but did not recall any specific concerns being raised. It was also noted there was no suggestion that Mrs Black had sought out a doctor and one had refused to speak to her. Reference was made to Mr Keating's evidence that where a patient was an adult and had full capacity to make decisions about their own medical care he would expect them to relay information to their family and it would not be routine for medical staff to brief family members, although if a request was made medical staff would accommodate it. It was submitted that any shortcoming in communication by medical staff with Mrs Black could not be a fact relevant to the circumstances of the death where this resulted from a rare complication associated with the serious injury which Mr Black had sustained.

[20] In relation to the deficiencies in the note keeping by clinicians over the weekend of 27-28 July, this had been readily and properly acknowledged by Mr Blyth. Mr Blyth had

confirmed that the doctor had been spoken to about his failure to complete full documentation. This lapse, it was submitted, could not be said to be relevant to the circumstances of the death where over this weekend period there was no evidence of any symptom or sign relating to the condition which resulted in Mr Black's death. It was further noted that Mr Black had been regularly reviewed by medical staff, a CT scan obtained, and nursing staff had undertaken regular observations throughout the weekend.

[21] It was submitted that following review of Mr Black's medical notes by Ms Don, the lead nurse for orthopaedics, and Mr Blyth, the consultant orthopaedic surgeon ultimately responsible for Mr Black's care while a patient in Glasgow Royal Infirmary, they concluded there had been no opportunity to secure a different outcome. No obvious shortcomings in Mr Black's care had been identified by them in this review and there was no basis for initiating a serious clinical instant review. This resulted in an independent colleague, consultant anaesthetist Dr Susan Geddes, reviewing the case notes and providing her own impartial view on care. Mr Black's case was also discussed at the department's morbidity and mortality meeting, the purpose of which is, amongst other things, to ensure a full and frank discussion of adverse outcomes in the department. Further consideration was given to Mr Black's care when a complaint to the Health Board was received from Mrs Black, and then again when Mrs Black made a complaint to the Scottish Public Services Ombudsman. It was submitted for the Health Board that Mr Keating, a highly eminent surgeon with considerable expertise, and Dr Neilson, consultant haematologist with a specialist interest in blood coagulation, both also endorsed the view that there was no opportunity to secure a different outcome for Mr Black.

[22] The Health Board recognised that a central feature of the evidence before the enquiry was the difference in the recollections of Mrs Black and Nurse Jacobs. This related in particular to matters around 14:00 on the day of Mr Black's death. Ms Watts reviewed the evidence of both witnesses. I was invited to prefer Nurse Jacobs's account which was to the effect that he received a complaint of pain in Mr Black's left heel and calf; when he examined the leg he formed the view this might be related to bed sores and determined that a gutter splint might assist. He denied there had been any reference to chest pain and considered Mr Black's gesture to be directed to pain from his distended abdomen. It was submitted that Nurse Jacobs made a note the day after Mr Black's death, which recorded a complaint of left calf and heel pain around 14:00 on the day of Mr Black's death. It was submitted there was no reason to think that Nurse Jacobs had omitted a key observation from that note other than he did it deliberately to preserve his own position. The Inquiry was invited to take into account that Nurse Jacobs was a nurse who was consistently spoken of as a competent and diligent colleague. It was submitted that he would not have failed to notice a swollen leg or omitted to ask a doctor to review a swollen leg especially if there was any suggestion of chest pain. It was also submitted that the note written the following day was more likely to be reliable than Mrs Black's recollection. It was noted that in contrast she had made no contemporaneous note and her recollection was likely to have been affected by the distress and trauma occasioned by her husband's death that afternoon. It was suggested given the passage of time and the magnitude of stress for Mrs Black that it was inevitable there would be aspects of her recollection which would not be reliable and her discussions with Nurse Jacobs were in this category.

[23] In relation to the circumstances in which Nurse Jacobs's note came to be written on the day following his death were spoken to by both Nurse Jacobs and Ms Don. It was accepted that it would have been better if Nurse Jacobs had written the entry on the day of Mr Black's death. It should have been written as soon as convenient after the observation at 14:00. It was submitted however the delay could be accounted for by the demands of a busy shift and of the distress caused by Mr Black's sudden death, rather than any attempt to mislead any later reader of the notes. The Health Board accepted that were the Inquiry to prefer Mrs Black's account to that of Nurse Jacobs and to believe there was evidence of swelling at 14:00 on the day of Mr Black's death and reported chest and arm pain, this should have resulted in a referral to one of the medical team. It was however submitted that this would have made no difference to the ultimate outcome. The evidence of both Dr Neilson and Mr Keating was that the only treatment which might have been instigated for Mr Black would have been an increase in the dose of LMWH from a prophylactic level, as commenced at Crosshouse Hospital following his accident, to a therapeutic dose. It was submitted that Mr Keating's evidence, which outlined the practicalities of further investigation, which he estimated would take two to three hours, did not in his view afford any possibility of a different outcome.

Observations on the evidence

[24] The principal matter of contention in the evidence was the differing accounts of Mrs Black and Nurse Jacobs. I preferred the account of Mrs Black; I consider that Nurse Jacobs should have referred the pain in Mr Black's leg to a doctor. Even if his initial view was that the most likely explanation was discomfort arising from Mr Black's immobility, the

removal by Mrs Black of the gutter splint shortly after it was put into position might have given him cause to review that position. I cannot reconcile his knowledge that it was removed with his note the following day: "gutter splint placed in situ to good effect".

While I accept that it had been a busy shift and Nurse Jacobs was distressed by the unexpected death of Mr Black, in such a situation it should have been a priority to bring the notes up to date. Given Nurse Jacobs was writing up about advising the family of Mr Black's death in the notes at 18:30 he clearly had the opportunity to record his actions earlier in the afternoon then. It is also extremely difficult to reconcile the fact of his writing in the notes at 18:30 with his possible explanation in evidence that he may not have written the notes up as they had been taken away by medical staff. He clearly had access to them at 18:30. I do not accept Ms Watts' submission that there is only a binary option that they were accurate or written to mislead the later reader. I do not reach the view that Nurse Jacobs's entry in the notes of 31 July was deliberately false, but I do not consider it can be relied upon. Nurse Jacobs explained that he was busy that afternoon and I am not satisfied that he accurately recalled what took place. It is entirely reasonable to accept that Mrs Black was able to recognise that her husband's leg was more swollen than it had been. The post mortem confirms that the leg was swollen. I accept that there may have been some scope for confusion about exactly where Mr Black was gesturing as he drew his left arm in the cast across his body, but I do accept that Mrs Black did say to Nurse Jacobs that her husband was complaining of chest pain. I am therefore left to draw the conclusion that Nurse Jacobs failed to understand that Mr Black was affirming that he had chest pain in response to Nurse Jacobs's question. Nurse Jacobs must have done so for a complaint by the patient of chest pain, as he said, would have resulted in his summoning a doctor. Dr Neilson and

Mr Keating gave evidence that Mr Black's death could not have been prevented, even if the deep vein thrombosis had been diagnosed earlier, so nothing turns on this.

[25] Mr Keating, whom I found an impressive witness, gave a very succinct and clear explanation of the practical realities of the hypothetical situation put to him: if Nurse Jacobs had considered Mr Black's complaint of a swollen lower leg may be associated with a DVT. This would have firstly involved Nurse Jacobs asking one of the doctors on the ward who may, given other pressing duties, have taken thirty or forty minutes before examining Mr Black and thereafter may have discussed matters with more senior colleagues, most probably the specialist trainee in orthopaedic surgery, prior to arranging an ultra sound scan to seek to confirm the possible diagnosis. Even if they had sought to do so immediately on being asked to see Mr Black and on examining Mr Black decided to obtain an ultra sound scan, they would have had to liaise with colleagues in the radiology department to secure a slot for an ultrasound and waited for porters to take the patient to and from the radiology department. Then the result would have had to be reported. This process as estimated by Mr Keating would reasonably be expected to take two to three hours. If the ultrasound had confirmed the DVT the preferred treatment would most probably be to increase the dose of LMWH to a therapeutic dose. This was spoken to by both Mr Keating, Dr Neilson and Mr Blyth. Mr Keating's understanding, confirmed by Dr Neilson, was that LMWH prevented clots from forming and preventing existing clots from growing larger but did not break down existing clots. That process is achieved by the body's inbuilt anticoagulating systems and takes some time. I accepted Mr Keating's analysis and Dr Neilson's evidence that, even accepting Mrs Black's evidence that at 14:00, when her husband first complained of his pain and swelling to his leg, Mr Black's death was already a tragic inevitability

regardless of any intervention by the team caring for him. I also accepted their evidence that Mr Black had received the appropriate level of LMWH from the morning following his admission to Crosshouse Hospital.

[26] I do not require to reach a view on Dr Neilson's evidence that the clot which ultimately led to Mr Black's pulmonary embolism was more likely to have originated from his fractured pelvis than a DVT in his calf. While I note Mr Keating also accepted that statistics suggested that an embolism was much more likely to arise from a DVT located in the larger vein: it is not in dispute that Mr Black suffered a DVT which resulted in his pulmonary thromboembolism. This reflects the cause of death as set out in the post mortem which I accept.

Observations on Findings

[27] The time, place and cause of death were agreed in the joint minute and are uncontroversial.

[28] Mr Black made a tragic misjudgement in trying to use the render which was proving too quickly. In his effort to get the job done he took a risk which resulted in his fall. He was experienced and had planned the job in a correct manner. The difficulties with the render drying too quickly caused him to take what turned out to be a fatal risk. I accepted and agreed with the submission of the Crown and made the findings narrated above in terms of sections 6(1)(c) and 6(1)(d). I also accepted the submissions on behalf of the Health Board that I should make no findings under these sub sections in respect of the medical care and treatment received by Mr Black.

[29] In relation to section 6(1)(e), as Ms Watts submitted, the terms of the 1976 Act do not require that there be a causal connection between the fact relevant to the death and the death itself. The Act envisages a broad view may be taken of matters which are relevant to the circumstances of the death and the circumstances of the death as they may affect the public interest. (*Sudden Deaths and Fatal Accident Inquiries* Carmichael third edition para 5-77). An underlying purpose of the statute is to seek to encourage lessons to be learned.

[30] In respect of Mrs Black's evidence about her interaction with doctors, I accept that she was only spoken to by the doctor at Crosshouse Hospital. It is however clear that she had ample opportunity to interact with the nursing staff and could have asked to speak with a doctor. Indeed in her final discussion with Nurse Jacobs before leaving the hospital around 16:00 on the afternoon of 30 July, he indicated he would make arrangements for her to see a doctor the following day. I make no criticism of any staff at Glasgow Royal Infirmary about Mrs Black not having been spoken to by a doctor, prior to Mr Black's death. I have not heard any evidence to enable me to make any findings or recommendations regarding communications between the relatives or next-of-kin of a patient, particularly a patient who is confused. I therefore make no recommendations about this, but there may be some merit in steps being taken by the Health Board to clarify good practice.

[31] I conclude that the entry by Nurse Jacobs of his observations and actions in relation to Mr Black on the afternoon of 30 July should have been made at the time and certainly before he left the hospital at the end of his shift. This was accepted by the Health Board and indeed by Nurse Jacobs himself, who said he knew it would have been more appropriate for the entry to have been written in the course of the day. I accept Nurse Jacobs was devastated by the death that he had had a heavy day and had not written up anyone's notes.

This omission to write up the notes on 30 July does not require a finding under section 6(1)(e).

[32] There were also recognised shortcomings in the record keeping by medical staff at Glasgow Royal Infirmary, over the weekend of 27 and 28 July, which fell below the expected standard. This was acknowledged by Mr Blyth in his evidence and he confirmed that the individual concerned had been spoken to about his omission to keep proper notes during this period. These shortcomings were also reflected in the finding of the reviews carried out by Dr Geddes and by the Scottish Health Services Ombudsman. The Ombudsman's report found that these shortcomings did not have any part in Mr Black's death. I concur, on the evidence before the Inquiry, these shortcomings had no impact on Mr Black's death.

[33] I would commend both Ms Dunipace and Ms Watts for the efficiency and courtesy with which they conducted the Inquiry. Finally, I should like to extend my sympathy to Mr Black's family and in particular to his widow, Mrs Sharon Black. She was present throughout the Inquiry, and conducted herself with considerable dignity in what must have been most distressing circumstances. I extend my sincere condolences to Mr Black's family and friends for their loss.