2011 FAI 9

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT KIRKCALDY

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

DETERMINATION
BY
SHERIFF A G McCULLOCH

IN RESPECT OF

FATAL ACCIDENT INQUIRY

INTO THE DEATH

OF

JESSIE GILLESPIE TAYLOR

Kirkcaldy 14th February 2011

The Sheriff, having considered the evidence adduced, Determines in terms of Section 6(1) of the Act:-

I. That in respect of subsection (a), Mrs Jessie Taylor died at 0845 on 20 September 2009, at Queen Margaret Hospital, Dunfermline, Fife.
II. That in respect of subsection (b) the cause of death was multi-organ failure due to streptococcal sepsis and right lung pneumonia.
III. That in respect of subsection (c) there were no reasonable precautions whereby the death might have been avoided.
IV. That in respect of subsection (d) there were no defects in any system of working which contributed to the death.
V. That in respect of subsection (e) there were no other facts relevant to the circumstances of the death.

REPRESENTATION

[1] The Crown were represented by Mr Robertson, District Procurator Fiscal, Kirkcaldy. The family of the deceased were represented by Mr MacDonald, solicitor, Kirkcaldy. NHS 24 were represented by Mr Ross, Advocate, and Fife Health Board by Mr Heaney, Advocate, both instructed by Central Legal Office, Edinburgh. Dr Middlemiss was represented by Mr Stewart, solicitor, Edinburgh.

[2] The following witnesses were led on behalf of the Crown:

1) Anne Mackie, daughter of the deceased
2) William Moore, partner of the deceased
3) Dr Susan Middlemiss, GP, Fife Health Board
4) Dr Thomas Hartung, Victoria Hospital, Kirkcaldy
5) Dr Marcia McDougal, Queen Margaret Hospital, Dunfermline
6) Dr Anthony Toft, Edinburgh
7) Dr David Swann, Royal Infirmary of Edinburgh
8) Ms Isla Smith, Victoria Hospital, Kirkcaldy, and
9) By Affidavit, Dr Maeve Rahilly, Victoria Hospital, Kirkcaldy

[3] The following witnesses were led on behalf of Fife Health Board:

1) Mr Ian Anderson, Victoria Infirmary, Glasgow
2) Dr Gordon Birnie, Fife Health Board, Kirkcaldy

[4] The following witness was led on behalf of Dr Middlemiss:

1) Dr Andrew Smart, GP, Dunfermline

[5] The following witness was led on behalf of NHS 24:

1) Dr George Crooks, Medical director, Glasgow.

LEGAL FRAMEWORK OF THE INQUIRY

[6] The purpose of an inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 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 causing the death took place
b) the cause or causes of 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 defect, 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

[7] The court proceeds upon the evidence and information placed before it, and the Sheriff's powers generally do not go beyond the making of a determination in relation to the circumstances established to his satisfaction from the evidence following investigation by the procurator fiscal, and other relevant parties. It is not truly an inquiry, and it is not the appropriate forum for determining negligence, or civil liability and thus such inquiries should not enter into a discussion of negligence. This is in contrast to the position which existed under the previous legislation. Accordingly, in the context of this inquiry, it is not the function of the court to look for evidence of fault in the care, management or supervision of the late Mrs Taylor.

EVIDENCE TO THE INQUIRY

[8] The background to this inquiry is relatively straightforward. Mrs Taylor, whose date of birth was 10 December 1943, and thus was aged 65 at the material time, became unwell in early September 2009. She felt shivery, and generally unwell, with flu-like symptoms. She felt better by about Monday 14 September, but by the Wednesday, she was feeling unwell again. She now had diarrhoea, was fevered, and had vomited. Her partner Mr Moore, sought advice by calling NHS24 on Friday, Mrs Taylor having taken paracetamol for a few days. He received advice from the flu line, which had been set up in response to a declared pandemic of swine flu. As she showed no signs of improvement on Saturday, 18 September, he again called NHS 24. Mrs Taylor spoke with the advisor, probably an experienced nurse, and after considering her symptoms, a call-back by a GP was offered. Within one hour, Dr Middlemiss called Mrs Taylor, and having spoken to her, advised her to attend at the Out of Hours GP clinic within Victoria Infirmary, at 1405. Having seen her, and formed a preliminary diagnosis of gastroenteritis, Dr Middlemiss decided to have Mrs Taylor admitted to the hospital. After discussions with the bed co-ordinator, she was admitted to Ward 7, infectious diseases, arriving there at about 1500. She was seen by a nurse, then at

about 1545, she was seen by Dr Egom. His view was that she required Oxygen, intravenous fluids, paracetamol and tests. His preliminary diagnosis was that she had swine flu. In any event, he was unable to give fluids as he failed to obtain venous access. He called for assistance from the Intensive Care Registrar, Dr Basu who arrived at about 1700. He noted a deterioration in Mrs Taylor's condition, that she was in respiratory failure, was dehydrated and that a chest X-ray had not been done. He too attempted to obtain venous access, but failed. By 1745 he had discussed the problems with the Medical registrar, agreeing that a higher level of care was needed, and a central line inserted.

[9] At 1800 Dr Hartung, the Consultant arrived. He had concluded his rounds elsewhere in the hospital, and although he had been advised of Mrs Taylor's admission, he was unaware of the problems surrounding her care. He noted her readings and symptoms, and believed that it was unlikely that she had swine flu, instead he thought that she had either a viral or a bacterial pneumonia. He ordered a chest X-ray, and antibiotics. Derek Ramsay, a nurse-practitioner, had by this time managed to secure an intravenous line. Dr Hartung spoke with the family to advise them of the gravity of the situation. He passed care to Dr Duguid, a consultant anaesthetist, who managed to start a central line. Antibiotics commenced at 1930. The decision was made to consult with the High Dependency Unit at Queen Margaret Hospital, and a team led by Dr McDougall arrived at about 2200. Mrs Taylor was sedated and transferred to Dunfermline, arriving at about 0025. She was further treated there, being stable at first, before deteriorating after 0400. The family were called to see her, before she died at about 0845. Tests revealed that she had streptococcal sepsis and right lung pneumonia, which led to multi organ failure and death.

[10] The family expressed their concerns at events. They considered that something must have gone wrong with Mrs Taylor's care, on the basis that she had walked into the Out of Hours surgery at 1405, been alert and talking at 1800, yet had died the following morning. Perhaps the "hysteria", as it was described, surrounding swine flu had influenced the decisions regarding, and treatment of, Mrs Taylor. It was against this background that this Inquiry was held. The critical evidence came from the various medical witnesses. For the family, and for the Crown, it was said that there were a number of areas that required scrutiny. These were, firstly, the decision of Dr Middlemiss not to admit Mrs Taylor directly to Accident & Emergency after speaking with her on the telephone at 1122; secondly, the decision of Dr Middlemiss,

after discussion with the bed coordinator, to admit to Ward 7 and not A&E after consultation at 1430; and thirdly the delay in administering standard and appropriate treatment in Ward 7.

[11] It is important, therefore to look at the involvement and evidence of Dr Susan Middlemiss. She is a General Practitioner of many years experience, who is employed by Fife Health Board in the Out of Hours service. This service was set up some years ago to provide GP cover between 6pm and 8am weekdays, and all weekend. There is an interface with NHS24, which is a national telephone service offering advice to those who call. This advice can be in the form of reassurance; to self treat; to contact a GP in due course; to arrange an appointment with an Out of Hours GP; to arrange for such a GP to contact the caller; to arranging direct admission to hospital by ambulance. There are wide ranging options, and advisors are assisted by algorithms, which suggest appropriate outcomes. In the instant case, although the algorithm suggested that the patient be admitted to hospital, the advisor decided to ignore the computer, and ask a GP to contact Mrs Taylor. There was no real criticism of this process.

[12] At 1122, less than an hour after Mrs Taylor had spoken with the NHS24 advisor, Dr Middlemiss calls her. She notes the various symptoms, and the time they have been with her. She realises that she needs to be seen for assessment, and offers an appointment for 1405. It was suggested that instead of doing this, she should have told Mrs Taylor to immediately present herself at A&E. Support for this contention came from Dr Toft and, to a lesser extent, Dr Swann. Dr Toft is an eminent physician, now almost retired, with a background in endocrinology. He is a past President of the Royal College of Physicians of Edinburgh, and for many years Physician to Her Majesty the Queen in Scotland. However, he accepted that his expertise did not lie in General Practice, and that his assertion that Mrs Taylor should have been sent to A&E at 1122 was based on his own experience of what he would have hoped would have been done, rather than based on current GP practice. He did not see the purpose of arranging to see the patient at 1405. It was clear to him, and ought to have been equally clear to Dr Middlemiss, that Mrs Taylor was very ill, and needed investigation and treatment as soon as possible. Breathlessness, coffee ground vomit, fevered and shivery were all clues to the severity of her condition. Dr Swann considered that a referral direct to A&E would have been reasonable, as it would allow work to commence on resuscitation of the patient. From her symptoms, she was clearly

dehydrated, needing fluids quickly. The best place for that to be administered quickly would be in A&E.

[13] The suggestion that it would have been appropriate to send her direct to A&E following the telephone call was strenuously disapproved of by Mr Anderson, and Dr Smart. The latter is a GP, who also has considerable experience with NHS24, working there from time to time, as well as working as a GP in practice. He accepted that the notes on the NHS24 printout indicated that Mrs Taylor was in need of treatment. He categorised her as being in a "potential, but not immediate, life-threatening" condition. She was not critically ill, in need of immediate resuscitation. She did not need sending to A&E, but instead to have her come to the Out of Hours clinic for examination and assessment was the correct and appropriate decision. Mr Anderson, a forcefully opinionated witness, disagreed with Dr Toft and Dr Swann in just about all aspects of their evidence. Insofar as their evidence dealt with what went on in A&E departments generally, I consider that he had the personal experience to justify such criticisms. However, I did not consider it was his place to comment on the actings of a GP such as Dr Middlemiss. The same can actually be said of Drs Toft and Swann, who were in my opinion straying beyond their areas of expertise in this regard. Thus I was left with the evidence of Dr Middlemiss, and her explanations of what she did, and reasons for it, together with the opinion of Dr Smart whom I accept as helpful and in point to the Inquiry. With the benefit of hindsight, it undoubtedly would have been beneficial to send Mrs Taylor to A&E following initial contact with Dr Middlemiss, but I make no criticism of her at all in deciding to see Mrs Taylor. Given the underlying fears of swine flu, about which I will say more later, the decision she took at 1122 was reasonable and professional. That disposes of the first area of concern.

[14] Dr Middlemiss saw Mrs Taylor at 1405. She carried out a full examination, according to her testimony. However, she had to accept that her notes did not record that she had sounded her chest. She insisted that she had done so, and that it was clear. Having decided that Mrs Taylor needed admission to hospital for further investigations, and fluids, she called the bed coordinator. This person was Isla Smith, a nurse, of about nine years experience. She was well aware of the instructions given, in the form of protocols and algorithms, for the admission of patients with suspected swine flu. The hospital had developed a policy, which was spoken to by Dr Birnie, the Medical Director, operational division NHS Fife. In summary, a swine flu pandemic had been

declared by the World Health Organisation in about April 2009. This was the first such declaration for many years, and triggered a considerable amount of discussion within NHS, and the wider world. It was the subject of daily updates on the media, and there was a significant input from the Scottish Government and all Health Boards. Contingency planning was carried out, to face what was considered a very serious threat to public health. There was concern that hospitals, and particularly A&E departments therein, would be inundated with potential swine flu patients, which presented the twin problems of treatment and spread of infection. Steps were therefore put in place to prevent, or at least contain the spread of the virus. There was, from the outset, a concern that the particular strain of flu (H1N1) could be as devastating as the viruses that had caused millions of deaths worldwide in previous pandemics. Significant death rates were predicted for Scotland. As matters transpired, the pandemic was (fortunately) not nearly as serious as had been first feared and forecast. There can be no criticism of the steps taken in the light of initial fears, to set up what were undoubtedly necessary precautions and systems for dealing with the possible outbreak of swine flu. These precautions and systems were cascaded through the NHS on an almost daily basis, although by September 2009, the feared numbers had not been realised. The protocols remained in place and, although I was not provided with the actual algorithm in place at the time of Mrs Taylor's admission to hospital, it was generally accepted that it was in terms similar to that dated 29 June 2009 (12/4, first inventory for Fife Health Board). I was also advised that much later editions made it clear that clinicians must also consider alternatives to swine flu as a possible differential diagnosis.

[15] Ms Smith, having heard from Dr Middlemiss, followed the protocol then in place, which suggested to her that the appropriate course of action was to admit Mrs Taylor to hospital, via Ward 7, the infectious diseases ward. Dr Middlemiss did not demur, but noted somewhat cryptically on her notes that "must treat as swine flu". In evidence she said that there was nothing sinister in this notation, she had merely repeated what had been said to her by Ms Smith. She insisted that she agreed with the admission route, arguing that she expected that the treatment that Mrs Taylor clearly needed would be promptly offered in the Ward. Dr Middlemiss did not consider admitting via A&E, as Mrs Taylor did not seem to her to require immediate resuscitation. This decision, to go to Ward 7 rather that A&E was criticised by Drs Toft and Swann, but supported by Drs Anderson and Smart. The basis of the

criticism was that Dr Middlemiss had not appreciated the real severity of Mrs Taylor's condition, which necessitated the very urgent administration of Oxygen, fluids and antibiotics. These, it was argued would have been more rapidly provided in A&E which was inherently organised to deal with such matters quickly. The reality, however, is that there was no guarantee that things would have moved any quicker in A&E than they actually did in Ward 7. Mrs Taylor would still have to be triaged on arrival from the Out of Hours clinic. Saturdays can be very busy in A&E; Dr Binnie having noted that the average wait time that day had been in the order of 90 minutes, but that no-one had exceeded the 4 hour waiting benchmark. One of the reasons that patients such as Mrs Taylor, where swine flu could not be ruled out, were not sent to A&E was the requirement not to spread swine flu. Any such patient, if treated in A&E would cause the room used to be out of action for an hour or more as it would require deep cleansing after the swine flu suspect had been moved on. Although it was accepted by Dr Smart that but for the swine flu situation, admission would have been via A&E, I do not consider that Dr Middlemiss, and Ms Smith can be criticised for taking the Ward 7 route. One must always guard against the benefit of hindsight. The symptoms presenting at the time did not impress such urgency that immediate resuscitation was required. Looking back, it can be seen that in fact she ought to have been commenced on fluids and antibiotics much sooner, but I do not find that the decision to send Mrs Taylor to Ward 7 can be criticised.

[16] In due course, Mrs Taylor arrived in Ward 7, and was seen by a nurse at about 1500. Details are taken, and she is noted by now as being "? Swine flu". Her readings showed a deterioration from those noted by Dr Middlemiss. The nurse properly asked for a Doctor to see her, and at about 1540, Dr Egom arrived. He too carried out checks, noted symptoms and prepared a plan. He correctly recognised the need for Oxygen, an intravenous line and fluids. His diagnosis was swine flu. However he failed to gain intravenous access, and summoned assistance. All experts agreed that this was the right thing to do, and Dr Basu arrived . He repeated the readings, and by now it was clear to all that Mrs Taylor was deteriorating. He also failed to gain intravenous access, and after consulting a colleague, considered that a "higher level of care" was required. Again, this view cannot be criticised. Dr Hartung arrived at 1800, and examined Mrs Taylor. He doubted the swine flu diagnosis, correctly (as it transpired) recognising pneumonia. He noted no X-ray yet carried out, and no IV lines. Shortly after Dr Hartung arrived, nurse Ramsay also arrived, and secured

venous access. The time was not noted, but was estimated at 1840. For a variety of reasons, fluids and antibiotics did not reach Mrs Taylor until 1930. These reasons included the arrival of the portable X-ray equipment, Dr McDougall and her team putting in a central line, and ongoing tests. Subsequently, the decision to engage the team at Queen Margaret Hospital, her transfer and treatment there were heard about, but no criticism at all is laid there, and I agree that what was done from about 1945 onwards was done entirely appropriately.

[17] This leaves consideration of events in Ward 7 between admission at 1500, and 1945. Criticism from the family, supported by Drs Toft and Swann, was levelled at what appears to be a significant, and possibly critical, delay in actually doing anything substantive for Mrs Taylor. All who considered what was actually done agreed that it was appropriate, but the overall picture was of delay, and that delay may have had a bearing on the outcome. It was generally accepted that the quicker that antibiotics and fluids are administered, the better the outcome. Part of the criticism levelled by Drs Toft and Swann was that things would have moved much quicker in A&E. That may well be so, but it is an inappropriate comparison, given that I have found that the decision to admit to the Ward, rather that A&E, was reasonable. Notwithstanding their views on the likely speed of treatment in A&E, I do consider that the evidence as a whole does give the impression of delay. It took over an hour, after Dr Egom had failed to gain intravenous access for Dr Basu to arrive, and himself fail. It was another 45 minutes before he called a colleague. The arrival of nurse Ramsay, who actually secured the first line seems to have been by chance. He was part of a team that "roamed" the hospital Out of Hours to assist as may be necessary. It does not appear that he had specifically been summoned to help. The (correct) decision to gain access by central line took over an hour to be implemented. Dr Hartung accepted that there had been delay within Ward 7. He would have expected that antibiotics would have commenced sooner, and a chest X-ray carried out quicker. He was aware of statistics that confirmed the sooner antibiotics were administered, the greater the chance of survival. However he pointed out that Mrs Taylor had already been ill for some time, before arriving in the Ward. Mr Anderson accepted that there had been delay in commencing treatment in Ward 7, but that the intended and actual treatment had been correct. He considered that Mrs Taylor had needed urgent rather than immediate treatment.

[18] The questions for the Inquiry are governed by the Statute. Was there a reasonable precaution that could have been taken? I do not consider that there was. It is fair to say that there were choices to be made at various stages of contact between Mrs Taylor and the medical authorities. However, in all the prevailing circumstances, and considering the symptoms as they presented at various times through the day, I do not consider that there were any reasonable precautions that could have been taken. It is quite likely that had she been admitted through A&E, either by ambulance, or from the Out of Hours clinic, she may have received the necessary treatment sooner; but the decisions to deal with her as actually happened were quite justified. Hindsight might suggest that it would have been better to treat her with greater urgency, to recognise the serious underlying condition, and admit to A&E. The decisions not to do so cannot be criticised.

[19] The second question is whether there was a defect in any system of working which may have contributed to the death. There were no submissions that applied to this section, and on considering the matter, I do not consider that there were defects in the systems of working. All those involved with her care carried out their functions and duties properly, and in accordance with procedures.

[20] The final question is to consider any other facts which are relevant to the circumstances of the death. In this regard, there was a submission that the admission to a Ward on a Saturday afternoon, when staffing levels were below those of a weekday, made it more likely that there would be delay. This was not supported by the evidence. Victoria Hospital had an appropriate level of suitably qualified staff on duty, and on call, to meet anticipated demand. The difficulty of gaining venous access would have been the same on a weekday, and medical personnel within the Ward would also have been of a similar number. It is a matter of conjecture as to whether admission on a weekend played any part in the outcome, and as such I am unable to comment further on this point.

[21] The second submission under subparagraph (e) related to the background of swine flu, and that this changed how she would otherwise have been dealt with. To some extent, I would agree. It is clear that but for the possibility of swine flu, the NHS 24 nurse advisor would have followed the computer suggestion of admission via A&E. It is also clear that the bed co-ordinator would not have sent Mrs Taylor to Ward 7, but instead either to A&E or (more likely) to Ward 14, acute medical admissions. In that latter case it is likely that she would have encountered Dr Hartung earlier in the

afternoon, with the result that she would have been correctly diagnosed, and IV access obtained sooner. I am clear however, that the decisions taken were correctly taken at the time. However, I cannot disregard the fact that protocols and algorithms for dealing with patients such as Mrs Taylor were changed as a result of the declared pandemic. It took some time before these algorithms were amended to ensure that clinicians always considered possibilities beyond H1N1. At the time Mrs Taylor came into contact with NHS 24, the Out of Hours GP service, and Victoria Hospital, the position was to treat as if the patient had swine flu, unless their condition was so serious that immediate A&E attention was required. That in my view clearly had a bearing on the speed of treatment she received. The section, however, is worded in such a way that I can only make a finding there if the factor was relevant to the circumstances of the death. As it cannot be said with any degree of certainty that the death could have been avoided by earlier treatment, I cannot say that delay in treatment was a circumstance relevant to the death. It was clearly unfortunate, and no doubt lessons have been learned. Dr Hartung in particular was concerned at the delays that had occurred.

[22] Finally, in thanking all those who gave evidence for their patience and attention to detail, I would express my sympathies to the members of Mrs Taylor's family, who sat through the whole proceedings with great dignity.