SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

[2023] FAI 31

PAI-B10-22

DETERMINATION

BY

SHERIFF BRUCE ERROCH KC

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

MRS WILLAMINA SINCLAIR

PAISLEY, 18 JULY 2023

Determination

The Sheriff, having considered the information presented on 12, 13, 14, 15, and 16 December 2022 and 13 January and 20 February 2023 at an Inquiry into the death of the late Mrs Willamina Sinclair held under Section 26 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act"), finds and determines that:

F1 In terms of Section 26(2)(a) (where and when the death occurred)

The late Mrs Willamina Sinclair, born 23 October 1935, died at the Queen Elizabeth University Hospital, Glasgow, on 10 March 2016. Life was pronounced extinct at 11.45.

F2 In terms of Section 26(2)(b) (where and when any accident resulting in the death occurred)

No accident took place**.**

F3 In terms of Section 26(2)(c) of the Act (the cause or causes of death)

The cause of death was peritonitis due to perforation of presumed diverticulum of the sigmoid colon.

F4 In terms of Section 26(2)(d) (the cause or causes of any accident resulting in the death)

No accident having taken place, no finding is made under this sub-section.

F5 In terms of Section 26(2)(e) of the Act (any precautions which could reasonably have been taken and, had they been taken, might realistically have resulted in the death or any accident resulting in the death, being avoided)

There are no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.

F6 In terms of Section 26(2)(f) of the Act (any defects in any system of working which contributed to the death or any accident resulting in the death)

There were no defects in any system of working.

F7 In terms of Section 26(2)(g) of the Act (any other facts which are relevant to the circumstances of the death)

(i) Eastwood Court's records relating to Mrs Sinclair do not contain detailed notes of the events of 9 and 10 March 2016. There is no record of Dr Oates's examination of Mrs Sinclair. There is no record of all calls made by Scottish Ambulance Service to Eastwood Court. There is no record of any clinical observations apart from temperature recordings at 01.00 and 01.20. Record-keeping was therefore inadequate at the time. This has been addressed by Healthcare Management Solutions now providing core training resources on documentation and record-keeping.

(ii) The utility of the use of the National Early Warning Score in care home settings became recognised at a point after Mrs Sinclair's death. The updated version (NEWS 2) is now used at Eastwood Court. It is a comprehensive tool which prompts staff to take specific actions in response to an overall score. The system provides a clear guide on the frequency of monitoring which should be carried out on a patient who is unwell or deteriorating.

(iii) The Significant Adverse Event Review carried out by Scottish Ambulance Service in June 2017 made recommendations in relation to patient safety mechanisms, particularly welfare calls, which were all implemented.

Additional measures were also implemented. Current Scottish Ambulance Service procedures in relation to welfare calls and dispatch of ambulances are more robust than they were at the time of Mrs Sinclair's death. They mitigate the risk of recurrence.

Recommendations

The Sheriff, having considered the information presented at the Inquiry, makes no recommendations in terms of Section 26(1)(b) of the Act.

NOTE

[1] This Determination follows an inquiry into the death of the late Mrs Willamina Sinclair, born on 23 October 1935, who died at the Queen Elizabeth University Hospital, Glasgow, on 10 March 2016.

Particpants and representation

[2] The following parties participated in the Inquiry:

The Crown, represented by Ms O'Donnell, Procurator Fiscal Depute

Healthcare Management Solutions Ltd., represented by Ms Canda

Nurse Mairhead Hughes, represented by Mr Burton

Larchwood Care Homes (North) Ltd., represented by Ms McGready

Dr Matthew Oates, represented by Ms Harris

Scottish Ambulance Service, represented by Mr Brownlee, Advocate

Witnesses

[3] The inquiry considered evidence from the following witnesses:

i. Peter Sinclair (affidavit and in person)

ii. Kenneth McMillan (in person)

iii. Dr Mathew Oates (affidavit and in person)

iv. Mairead Hughes (in person)

v. Kenneth Wylie (in person)

vi. Laurayn MacInnes (affidavit and in person)

vii. Kayleigh Morgan (affidavit and in person)

viii. Stuart Manwell (affidavit only)

ix. David Anderson (in person)

x. Kevin Groombridge (affidavit and in person)

xi. Isobel Donaldson (in person)

xii. Stephanie Jones (affidavit and in person)

xiii. Mark Newton (in person)

xiv. Dr Usman Qureshi (in person)

xv. Julie Bowmaker (in person)

Nomenclature

[4] The following nomenclature is used in this Determination:

- The late Mrs Willamina Sinclair is referred to as "Mrs Sinclair"
- Healthcare Management Solutions Ltd is referred to as "Healthcare"
- Mairhead Hughes is referred to as "Nurse Hughes"
- Larchwood Care Homes (North) Ltd is referred to as "Larchwood"
- Dr Matthew Oates is referred to as "Dr Oates"
- Scottish Ambulance Service is referred to as "SAS"

Dates and times

[5] The Inquiry focussed on the events of 9 and 10 March 2016. Times of day and night are referred to throughout this Determination using the 24-hour clock. For the avoidance of doubt, any time between 13.00 and 23.59 refers to a time on 9 March 2016. Any time after 00.00 (midnight) refers to a time on 10 March 2016.

Abbreviations

[6] The following abbreviations were used by witnesses and are referred to throughout this Determination:

- BP – blood pressure
- CL – Crown Label
- CP – Crown Production
- MAR – medical administration record

- NEWS – National Early Warning Score
- RES – check on ambulance resources
- SAER – significant adverse event review
- TPR – temperature, pulse, respiratory rate

Legal framework

[7] This is a discretionary Inquiry in terms of Section 4 of the Act. The Lord Advocate considered that the death of Mrs Sinclair occurred in circumstances giving rise to serious public concern and that it was in the public interest for a Fatal Accident Inquiry to be held.

[8] Fatal Accident Inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of Section 1(3) of the Act the purpose of an Inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. Section 26 requires the Sheriff to make a determination which, in terms of Section 26(2), is to set out the following factors relevant to the circumstances of the death, insofar as they have been established to his satisfaction. These are:

(a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred,

(c) the cause or causes of the death,

(d) the cause or causes of any accident resulting in the death,

(e) any precautions which –

i. could reasonably have been taken, and

ii. had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,

(g) any other facts which are relevant to the circumstances of the death.

[9] In terms of Section 26(1)(b) and (4), the Inquiry is to make such recommendations (if any) as the Sheriff considers appropriate as to:

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working, and

(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

[10] In order to identify reasonable precautions which, had they been taken, might realistically have resulted in the death being prevented, it is necessary that the Sheriff is satisfied that there is more than a remote chance that they might have done so. The expression therefore envisages not a probability but a possibility. Such a possibility has in the past been described as a "real or likely" possibility. In terms of the explanatory notes to the 2016 Act, the words "real or likely possibility" are used. Reasonableness relates to the reasonableness of taking the precautions rather than the foreseeability of death.

[11] To identify defects in the system of working which contributed to the death, it is necessary that the Sheriff is satisfied on the balance of probabilities that the defects in the system of working contributed to the death. Likewise, in order to make recommendations, the Sheriff has to be satisfied that there is a reasonable possibility that the recommendations may prevent deaths in similar circumstances.

[12] The Procurator Fiscal Depute represents the Crown in the public interest. An Inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Sheriff proceeds on the basis of evidence placed before him by the Crown and by any other party to the Inquiry. The Sheriff's determination must be based on the evidence presented at the Inquiry and is limited to the matters defined in Section 26 of the Act. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability.

[13] The scope of the inquiry extends beyond mere fact-finding. It looks to the future and seeks to prevent deaths occurring in similar circumstances. Where the circumstances have given cause for serious public concern an inquiry may serve to restore public confidence and allay public anxiety.

Summary of evidence

Joint minutes

[14] A substantial joint minute was lodged on Day 1 of the Inquiry covering the following matters under reference to the paragraph numbers therein:

1 - 7: Mrs Sinclair's background and medical history

8 - 44: the events of 9 and 10 March 2016

45 - 47: the post mortem

48 - 49: expert opinion on nursing care

50 - 51: expert opinion on GP care

52 - 57: Scottish Ambulance Service Adverse Review

58 - 59: expert opinion on Ambulance Service care

60 - 66: affidavit evidence of various witness to be their principal evidence-in-chief

67 - 107: various Crown productions to be true and accurate copies

108 - 114: duplicate of paragraphs 60 - 66

115: Crown label 1 to be an accurate copy of a recording of a telephone call.

[15] A further joint minute was lodged on Day 4 of the Inquiry covering the following matters under reference to the paragraph numbers therein:

1 - 4: Crown labels 2, 3, 4 and 5 to be accurate copies of recordings of telephone calls.

Witness evidence

[16] The witness evidence is summarised in paragraphs 17 to 106.

Mr Peter Sinclair

[17] Mr Peter Sinclair is Mrs Sinclair's son. He adopted his affidavit as his principal evidence-in-chef. His mother had been a resident in Eastwood Court since 2014 and suffered principally from vascular dementia. His father (Mr Sinclair Snr) had visited her there every day. His father had been contacted by staff at lunchtime on 9 March 2016 to advise him that Mrs Sinclair had vomited over lunch. In the evening staff had rung Mr Sinclair to say that a GP had been out to see his mother and wished her to be admitted to hospital. His father, Mr Sinclair Snr, had been told by staff to go direct to hospital and await the arrival of the ambulance there. Having gone to hospital and ascertained that no-one had any knowledge of Mrs Sinclair, Mr Sinclair telephoned Eastwood Court three times later in the evening for updates. He and his father left the hospital around midnight, under the impression that the situation must no longer be urgent, given that Mrs Sinclair had not yet been transferred there from Eastwood Court. It was not until around 07.30 that a nurse from the Queen Elizabeth University Hospital had telephoned and advised that Mrs Sinclair had been admitted in the early hours, that she was "poorly" and that it would be better if Mr Sinclair Snr and members of the family attended as soon as possible. On arrival at hospital Mr Sinclair and his father were advised that Mrs Sinclair had been in a very poor state on arrival, that her bowel

was blocked and that any operation could be fatal. Mrs Sinclair then died in the presence of her husband and son.

[18] The family had concerns about the events leading up to Mrs Sinclair's death. They felt that she had suffered in the wait for an ambulance. They felt that there was a failure to identify who was responsible for Mrs Sinclair's care following the GP having requested an ambulance. They considered that communication between Eastwood Court and SAS was not robust. They were concerned about poor record-keeping and patient management. They felt that checks and balances were needed to ensure that the health system functions in an integrated manner.

Mr Kenneth McMillan

[19] Mr Kenneth McMillan is now retired but had been a staff nurse on duty on day-shift (07.30 to 20.45) on 9 March 2016. He had started to work at Eastwood Court on 6 March 2016. Staff had told him that Mrs Sinclair had vomited at around 13.00. He had checked her and found her temperature to be slightly raised but, given that she had just apparently vomited, he was not too concerned. Entries in CP 3 (p2) at 13.00, 16.00, and 18.45 were his. He had provided a statement, CP 6 in August 2016, which he said was true. Mrs Sinclair had vomited again at approximately 16.00. Her observations at 13.00 and 16.00 had been within the normal range, but had not recorded these observations in her care plan. He should have taken a BP reading at 13.00 but did not. There were no signs of distress.

[20] He had called NHS 24 at 19.09 (recorded on CL 1) and had told the call handler that Mrs Sinclair had been vomiting violently since lunchtime, although the vomiting was beginning to subside. His observations recorded at 18.45 were:

- BP 186/86
- Pulse 84
- Temperature 37 °C
- Respiration rate 28

[21] Mr McMillan had been present when Dr Oates had examined Mrs Sinclair. Dr Oates had called an ambulance but Mr McMillan did not recall if the GP had told him what to do if the ambulance did not arrive or if Mrs Sinclair's condition were to deteriorate. In the latter event, however, staff would have rung 999. Mr McMillan handed over to Nurse Hughes at 21.00, telling her that Mrs Sinclair's condition had remained unchanged during the day. He was referred to the Daily Communication Notes CP 3, and indicated that the patient observations (at p 2) were his, but had been written up in the evening rather than contemporaneously. He acknowledged the professional duty to keep good records and follow the Nursing and Midwifery Council (NMC) Code. He could not say that, as at March 2016, he had been aware of whether there was a written policy at Eastwood Court on where observations were to be recorded. He could not say if there had been a written policy on dealing with deteriorating patients or not.

Dr Matthew Oates

[22] Dr Oates was the out-of-hours GP on 9 March 2016 and had been asked by NHS 24 to visit Mrs Sinclair at Eastwood Court. He adopted his affidavit as his principal evidence-in-chief. A call had been made to NHS 24 at 19.18 and a GP visit had been requested within 4 hours. Dr Oates started his consultation with Mrs Sinclair at 20.22. His examination note recorded:

> "Seen with staff". "Dementia". "Non-communicative". "At lunch vomited while feeding". "Since then looks poor colour". "Ongoing vomiting".

[23] He had also recorded "alert that looks pale and slightly clammy" and had recorded the following readings:

- Respiration rate 28
- Heart rate 118
- Temperature 38.3°C
- Oxygen saturation 95%
- BP 160/90

[24] BP had been moderately raised. He had carried out an examination of Mrs Sinclair's lower legs to check for signs of oedema. There were no concerning abdominal features at the time of examination. He diagnosed aspiration pneumonia and recorded his working diagnosis as "?aspiration lrti" (aspiration lower respiratory tract infection). In his clinical judgment at the time, Mrs Sinclair required hospital transfer and treatment but he did not consider that the situation was immediately life-threatening. Dr Oates had drafted a letter for the receiving doctors at the hospital. The

purpose of this was to provide a brief summary of his clinical findings on examination. It stated:-

> "Dear medics, thank you for seeing this 80 year old female NH resident with dementia, unable to communicate. Husband is NOK. Today staff noted vomiting at lunch. Since then increased unwell/of poor colour, increasingly chesty, ongoing vomiting and more. SOB.
>
> O/E, alert, frail, looks pale and clammy. No hx from patient. Bibasal creps, bp 160/90. T 38.3C, HS ok, legs ok. Heartrate 118, respiratory rate 2.8. 02 95%A. ?Aspiration pneumonia".

[25] Dr Oates explained that there were a number of options available when requesting an ambulance. This included an immediate or "blue light" ambulance which, short of calling 999, is the option with greatest urgency and is reserved for patients with immediate life-threatening conditions. The other options are "within 1 hour" and "within 4 hours". (There was also in 2016 a "within 2 hours" option but that is no longer available). All that a GP can do is to request the ambulance in the timescale he considers to be appropriate. A GP cannot, however, control when SAS will in fact send an ambulance.

[26] Dr Oates ordered a 1-hour ambulance. At the time of ordering it, Mrs Sinclair was alert, which meant that her consciousness level was not reduced, her observations were moderately raised outwith normal parameters, and she was being monitored in a supported environment where the nursing staff were observing her. Dr Oates did not consider that her clinical observations were severely deranged enough to warrant a "blue light" ambulance. Given his working diagnosis of aspiration pneumonia, her normal oxygen saturation level and the fact that her most recent BP was not hypotensive were reassuring clinical findings. Dr Oates had no reason to suspect that there would be

any difficulty with the ambulance attending Mrs Sinclair within the hour. Up until this point in 2016 he had not experienced any significant delays or issues when requesting any ambulance. He confirmed that there was no way for Eastwood Court staff to contact him once he had left the nursing home: if there had been a deterioration in Mrs Sinclair's condition, staff would have had to ring 111 or 999 for assistance.

[27] He would have expected SAS to call Eastwood Court if there was a delay in the ambulance being dispatched - that was his experience. In relation to Mrs Sinclair's vital signs at 02.55 when the SAS crew ultimately arrived (recorded in paragraph 22 of the Joint Minute) Dr Oates advised the Inquiry that had he recorded such observations at the time of his own examination he would have ordered a "blue light" ambulance for her.

[28] Dr Oates had considered the terms of the reports from Mr David Anderson (CP 16 and CP 18). He pointed out that Mr Anderson had never practiced as an out-of-hours GP and it seemed unfair and inappropriate for him to comment on the management of a patient by an out-of-hours GP in 2016. Mr Anderson had appeared to assert at pages 23 and 27 of CP 16 that Dr Oates had failed to carry out an abominable examination and that he had failed to consider an alternative pathology to account for the history and clinical findings. However, Dr Oates's electronic clinical record of the consultation had stated "abdo soft" thereby demonstrating that an abdominal examination had indeed been carried out. His examination findings were normal which led him to exclude an alternative pathology. Examination of the abdomen displayed that that it was soft. Therefore, in his clinical judgment at the time of the examination Mrs Sinclair displayed

no signs of acute peritoneal irritation. He did not accept the implication in Mr Anderson's report that the length of his consultation with Mrs Sinclair was indicative of a superficial or cursory examination. He had reached his diagnosis following upon his examination of the patient and was sufficiently concerned about her to arrange an urgent hospital admission.

[29] Dr Oates also took issue with the reference in Mr Anderson's report CP 18 to the NEWS (National Early Warning Score) system. NEWS had not been primarily adopted in the primary care setting in 2016. It was not therefore a relevant standard to be applied in the context of his consultation with Mrs Sinclair.

Nurse Mairead Hughes

[30] Nurse Mairead Hughes had 43 years' nursing experience, 33 of which had been spent in care of the elderly. She had worked at Eastwood Court from 2014 to 2019 and was working night-shift on 9 to 10 March 2016, taking over from Kenneth McMillan. Kenneth Wylie was the nurse in charge of the shift but was based on a different floor; Nurse Hughes was based on Mrs Sinclair's floor. At the start of her shift, Kenneth McMillan told her that Dr Oates had just arrived and was examining Mrs Sinclair, it having been suspected that she had aspirated. Nurse Hughes had recorded the following at 20.45 in the Daily Communication Notes (CP 3):

> "Out of hours GP wishes Wilma to be transferred to hospital. After M Hughes speaking to husband. Who agreed to action. Ambulance within hour."

[31] She had written a statement on 8 August 2016 (CP 6). She had recorded that, prior to Kenneth McMillan going off duty:

> "We went together to review Wilma. She was not vomiting, was very pale. TPR and BP observations within normal limits. She was smiling to staff."

[32] By "observations within normal limits" she meant that Mrs Sinclair's pulse was normal, her BP was within normal limits, she was not hypotensive and, whilst she was pale, that was normal for her. She agreed that if Dr Oates had said that her temperature at 38.3°C was moderately raised then he would be correct but when she took Mrs Sinclair's temperature it was normal. She was unable to explain why Kenneth McMillan had said that she had not carried out any observations after Dr Oates had left and could only go by her handwritten statement which had recorded that he had been present. She was adamant that she had definitely carried out observations. As to these not being recorded in Daily Communication Notes CP 3, the policy was to record such observations either in the patient's TPR chart or in the Daily Communication Notes.

[33] After Dr Oates had left, she and Nurse Wylie had agreed on hourly observations. They had previously experienced delayed ambulances. The purpose of the observations was to see whether or not Mrs Sinclair was deteriorating. Nurse Hughes maintained that she carried out hourly observations at 21.00, 22.00, 23.00, 00.00, and 01.00 hours approximately. She did observations again after around 01.20 and gave Mrs Sinclair paracetamol. She checked TPR and BP each time. Results had been within the normal range and Mrs Sinclair had never shown any agitation or distress.

[34] At around 01.00 she had noticed Mrs Sinclair's temperature to be elevated and gave her paracetamol. This had the effect of bringing her temperature down. Her last observation was at 01.20; the observation at around 02.00 had been carried out by Kenneth Wylie. Mrs Sinclair had been stable at 01.20 apart from the increase in temperature noted at 01.00. Had she had an inkling that Mrs Sinclair was deteriorating Nurse Hughes would have telephoned 999.

[35] She confirmed that there was no means to follow up with a GP if the ambulance did not arrive within the anticipated time. The option would have been to call NHS 24 but her understanding on the night was that SAS had been calling the home on an hourly basis - though she now understood that that had not been the case. She would accept it if SAS said that they first called the Eastwood Court at 00.17.

[36] Nurse Hughes accepted that there appeared to be no TPR chart for Mrs Sinclair. She told the Inquiry she had been told that the charts been mislaid. She agreed there were no TPR charts or BP charts contained in Mrs Sinclair's Daily Communication Notes CP 3 or the records CP 5. She had no explanation as to why that was the case except to repeat that she had been told that they had gone missing. She disagreed with a suggestion that there were no charts within the records because they were never completed in the first place. She accepted that CP 3 and CP 5 suggested that the only observations she had carried out were at 01.00 and 01.20 (recorded in the medication notes at p3 of CP 5) but was "100% certain" that she had carried out more frequent observations. She maintained that the relative records had simply been lost.

[37] In relation to training, she had received more training after 2016 than before. Before 2016 she had had training as part of her induction on matters such as fire and infection control. After Mrs Sinclair's death, training had been provided on the completion of documentation, on sepsis, and on accountability. As at the time of Mrs Sinclair's death she could not say what knowledge she had of policies and procedures at the home in terms of record-keeping and documentation.

[38] Cross-examined on behalf of Larchwood, she explained that when an ambulance was ordered by a GP she would always take hourly observations. She would expect SAS to telephone hourly until the ambulance arrived. She considered that hourly observations were sufficient.

[39] Cross-examined on behalf of Healthcare, she acknowledged the terms of the NMC code CP 38, and the NMC Guidance CP 39, insofar as these related to record-keeping and the duties incumbent on nurses to keep accurate records. Her position was that on 9 and 10 March 2016 TPR charts were available for her use and had in fact been used. She agreed she had obliged to make records in the TPR sheets and MAR sheets. She had used her clinical judgement in relation to the frequency of observations.

[40] Questioned by her own agent, Nurse Hughes confirmed that neither she nor other staff had been trained in the use of NEWS in 2016 and that even now NEWS is not widely used. She had not noticed a deterioration in Mrs Sinclair on the night in question. Had she seen such a deterioration she would have rung 999. There was no written policy at Eastwood Court on how to record clinical observations. She recorded observations on TPR sheets. She had last seen TPR sheets for Mrs Sinclair when she had

entered her observations on them at 01.20, recording the administration of paracetamol. She had then placed the TPR sheets with Mrs Sinclair's notes. With reference to CP 9, the entry at 01.26 on 10 March 2016 "spoken with staff nurse she does not feel update is required, apology and worsening statement given" this is something which she denied saying.

[41] Re-examined by the Procurator Fiscal Depute, the word "update" in the foregoing quotation meant that a 999 call was needed, but Nurse Hughes maintained that she had not said that she did not feel that an update was required. Her position was that she would have rung 999 if there had been a deterioration in Mrs Sinclair's condition. A deterioration would have been signalled by signs such as two breaths per minute. BP below 100 would have been a concern, as would a pulse of over 100. Temperature of 37.7°C and respiration over 20 would have been a concern.

Recall of Nurse Hughes

[42] Nurse Hughes was recalled later in the Inquiry after SAS had produced to the Crown recordings of various telephone calls. CL 4 was played to her – the call made by SAS to Eastwood Court at 01.22. The call handler asks if there is any change in Mrs Sinclair's condition. Nurse Hughes says that her temperature has gone up and that she has given her paracetamol. Mrs Sinclair is pale and clammy. The caller asks if it is aspiration pneumonia. Nurse Hughes says "yes" and the caller goes to speak to a clinician. The caller than comes back and asks if Nurse Hughes thinks that Mrs Sinclair needs "blue-light emergency" and Nurse Hughes says "no." Nurse Hughes agreed with

the foregoing. Questioned by her own agent she indicated that she had no reason to countermand the GP instruction about a 1-hour ambulance being required.

Nurse Kenneth Wylie

[43] Nurse Kenneth Wylie had been the night coordinator at Eastwood Court on 9 - 10 March 2016, starting work at 20.00 and finishing work at 08.00. He did not specifically recall the floor he had been on, but it was usually the second floor. He did not specifically remember Mrs Sinclair but was aware that he had made a statement in 2016 (CP 6) which he had used to refresh his memory. He recalled having come on shift to find Dr Oates already with Mrs Sinclair. He did not attend the examination but was informed afterwards that Dr Oates had ordered a 1-hour ambulance. This was due to suspected aspiration of foodstuff. He and Nurse Hughes had agreed a plan of regular TPR and BP checks until the ambulance arrived. He had checked on Mrs Sinclair at that time and she was responsive and calm. Later in the evening, he had been advised by Nurse Hughes that she had spoken to SAS and had been told that a 1-hour ambulance would not be possible but that an ambulance would be dispatched. He did not directly recall having observed Mrs Sinclair during the course of the evening. He could have been the nurse who spoke to SAS at around 02.00 but did not recall what was said.

[44] In relation to the policy for documenting observations, this would done on either the TPR sheets or on the patient's clinical notes. He accepted that there were no TPR or BP sheets with the Daily Communication Notes (CP 3) or with Mrs Sinclair's records (CP 5). He did not recall the night in question and could not say where such notes were.

[45] Cross-examined on behalf of Healthcare he agreed that he was familiar with the terms of the NMC code (CP 38) and the NMC guidance on record-keeping (CP 39). He agreed that the duty of record keeping was placed on him as a nurse. TPR and BP charts would have been available for his use on 9 and 10 March 2016, although he did not specifically recall them.

[46] Cross-examined on behalf of Larchwood, Nurse Wylie did not specifically recall undertaking any physical observations of Mrs Sinclair. He might have relied on Nurse Hughes but did not recall. Any communications he had had with Nurse Hughes would have been verbal and would not have been recorded.

[47] Questioned on behalf of Nurse Hughes, he agreed that the expectation would be to record observations in the TPR chart or the clinical notes, preferably both. He had no issue with Nurse Hughes's record keeping.

Recall of Nurse Wylie

[48] Nurse Wylie was recalled later in the Inquiry after SAS had produced to the Crown recordings of various telephone calls. CL 3 was played to him: this was the call made by SAS to Eastwood Court at 00.17. He accepted that he had taken the call and agreed that he had told the call handler that Mrs Sinclair's condition appeared to be fairly stable, that she was resident on another floor, and that he had been kept updated. The call handler had told him that if anything changed, Eastwood Court should call 999. CL 5 was played to him: this was the call made by SAS to Eastwood Court at 02.01. He had told the call handler that Mrs Sinclair's breathing was shallower than normal but

wouldn't say that it was laboured. He had then offered to go and check her and came back 47 seconds later. He accepted that a thorough examination of Mrs Sinclair would have taken longer than a minute to perform. As to whether he had used any equipment to check her TPR, his position was that he did not recall the night in question but agreed that it would have taken him longer than 1 minute to use equipment to carry out such checks.

Ms Laurayn MacInnes

[49] Ms Laurayn MacInnes adopted her affidavit as her principal evidence-in-chief. She had been working night-shift as a Clinical Advisor in the SAS control room on the night of 9 - 10 March 2016. She had considered the Sequence of Events (CP 9 and 10). This showed that at 02.01 she had called Eastwood Court. She had recorded:

> "Speaking to nurse at home, has not been looking after the pt so it trying to put me through to someone who has. advises that pt ?aspiration pneumonia pt is apahasic, advanced dementia unable to be put through to ward, nurse will pop through and assess pt for me and come back with update. pt responding as normal for her, shallow breathing, pulse fine, hot to touch, pale/normal for pt. MTS 41-6".

[50] This information had resulted in the decision to upgrade the call to an emergency at 02.09. She assumed that the decision had been made because Mrs Sinclair was aphasic and because her breathing was shallow and she was hot to touch. This indicated an infection. It was the change in her condition which resulted in upgrading the call, not the fact that the ambulance had been requested around five hours previously. She agreed that the ambulance records would show that Dr Oates had

requested an ambulance at 20.47 and that SAS first made contact with Eastwood Court at just after midnight. She could not see that any calls had been made by SAS to Eastwood Court before then.

Ms Kayleigh Morgan

[51] Kayleigh Morgan adopted the terms of her affidavit as her principal evidence-in-chief. She was an ambulance technician employed by SAS initially as a call handler and then as a dispatcher. She confirmed that she had undertaken an RES Allocation at 02.10 on 10 March 2016. She described a RES as essentially being a check on ambulance resources. She had become aware of the job because as soon as an ambulance call is upgraded that call is "populated" on a dispatcher's screen and it is then the dispatcher's job to find a resource. To her knowledge no RES had been undertaken in respect of the matter concerning Mrs Sinclair before her conducting a RES at 02.10. The reason for that was that the job had not been an emergency until it was upgraded.

Mr Stuart Manwell

[52] Mr Stuart Manwell's evidence was given by affidavit, no parties having any questions for him. On 9 to 10 March 2016 he had been a trainee ambulance technician and had attended Eastwood Court with his colleague John Steele, paramedic, at 02.48. He derived his information from the patient record form (CP 8) which had been completed by Mr Steele. This recorded that Mrs Sinclair had vomited at lunchtime the

previous day, possibly aspirated, had pneumonia, and a chest infection. Vital signs were recorded at 02.55 as follows:

Resp rate – 40, SpO2 – 92% on air, heart rate – 98, Blood pressure- 98/58, CBRT – less than 2 seconds. Blood glucose – 10.8.Temperature 37.7°C, GCS noted as 11

Vital signs were recorded again at 03.27 as follows:

SpO2 – 96% on O2, heart rate – 120, Blood pressure – 122/90, GCS – noted as 11

[53] Based on a review of these observations Mrs Sinclair appeared to be significantly unwell and required conveyance to the emergency department for medical intervention. The ambulance had left Eastwood Court at 03.27 under "blue lights" arriving at the Queen Elizabeth University Hospital at 03.55.

Mr David Anderson

[54] Mr David Anderson is specialist in colorectal surgery. He had provided reports CP 16 and 18. He had reviewed files of Eastwood Court and of Queen Elizabeth University Hospital. He had considered statements from nursing staff in Eastwood Court, the *post-mortem* reports, and other documents. Pages 5 to 20 of his report CP 16 contained a review of the documentation he had considered. He accepted that there was an error at page 12, where the reference to temperature at 01.00 should have been to 37.4°*C* and not 37.1°C. He accepted that, in reviewing what Dr Oates had recorded of his observations of Mrs Sinclair, Mr Anderson had omitted to note that these observations contained a BP reading of 160/90 which Mr Anderson should have recorded at page 9 of his report. Mr Anderson advised that the *post-mortem* confirmed

the presence of faecal peritonitis and the likely source was a perforated sigmoid diverticulum.

[55] He explained matters further by reference to the diagram of the bowel contained in his report CP 18. In the diagram, the small bowel lies in close proximity to the sigmoid colon. It is not uncommon therefore that when the sigmoid colon is inflamed and especially if about to perforate, that that loop of small bowel will try to stick to the colon and seal off the bit about to perforate. The small bowel acts as a patch, attempting to seal the inflamed segment. This was nature's way of preventing colonic content spilling out into the abdominal cavity. This often results in the small bowel being both stuck to the diseased area of the sigmoid colon and becoming intimately involved in any inflammation there. Eventually, the patient gets back-up of fluids above the loop stuck to the sigmoid colon.

[56] In CP 16 Mr Anderson recorded that the actual medical/nursing records for 9 March 2016 to be devoid of "hard" clinical information. Staff at Eastwood Court did, however, recognise that Mrs Sinclair had failed to improve over the course of the day on 9 March 2016 and called an out-of-hours GP in a timely fashion when her vomiting failed to abate. He noted that there appeared to be no evidence of any change in Mrs Sinclair's demeanour over the day. A perforated colon from diverticular inflammation tends to be of sudden onset and accompanied by acute severe abdominal pain. Any prolonged or profound vomiting could not be treated by replacement intravenous fluids. It was unlikely that a frail octogenarian, with acute sepsis and intra-abdominal pathology, could maintain fluid balance under such circumstances.

[57] Mr Anderson reported that by the time Mrs Sinclair had arrived at hospital the clinical findings were that of a patient with acute abdominal pathology and a serious one which had developed to acute peritonitis. When seen by Dr Green and Dr White, Mrs Sinclair's observations were:

- Temperature 38.5°C,
- Heart rate 133
- BP 88/67
- Respiratory rate 35
- Oxygen sats 92% on 28% oxygen
- NEWS 14

[58] Mr Anderson explained the significance of a NEWS score of 14: NEWS is a tool which is used to try to score patients. Observations are taken at regular intervals (usually hourly) to determine whether a patient should be escalated to a different level of care. A NEWS chart was reproduced at page 13 of his report CP 18. It showed what was measured: respiration, oxygen, any supplemental oxygen, temperature, systolic BP, heart rate, and level of consciousness. Mrs Sinclair's NEWS score of 14 was a very high figure. It meant that any care had to be in a high-dependency or intensive care setting with extensive monitoring. Clinically, Mrs Sinclair was described as cold and clammy. She was therefore clearly "shocked" as depicted by her hypotensive and tachycardic state. The now-low temperature, having previously been above 38°C, may have reflected peripheral and core shut-down, as she tried to redistribute blood to the essential organs (heart and brain). The increased respiratory rate was almost certainly a

manifestation of her body trying to reverse an acidotic state through hyperventilation. Blood gas results gave a clear picture and showed that Mrs Sinclair was profoundly acidotic (metabolic) and that this was so far advanced that the situation was irretrievable.

[59] Irrespective of the pre-operative clinical and social circumstances of Mrs Sinclair, she would not have been a surgical candidate. In her age group, elective surgery would not be an issue but emergency surgery with the possibility of a stoma might have been another matter. However, the mortality risk in Mrs Sinclair would have been enormous and that, added to her clinical condition pre-operatively and the risk of mortality in the first year after surgery (were she to survive surgery), really precluded such a management pathway.

[60] Mr Anderson reported that, retrospectively, it was possible to deduce with the available clinical, pathological, and biochemical results available that Mrs Sinclair died as a result of patho-physiological decompensation associated with both peritonitis and organ failure secondary to a perforated colon. The *post-mortem* examination favoured diverticulum as the most likely cause.

[61] Mr Anderson had considered the readings taken by the SAS crew at 02.55 and 03.27. The readings taken at 02.55 would show that she was acidotic, hypotensive, and absolutely clinically unwell. By 03.27 she was tachycardic, which suggested peripheral shut-down due to hypovolemic state and a high respiratory rate. By the time she reached hospital she was in severe metabolic acidosis with frank peritonitis, circulatory collapse, and acute kidney failure. Death was the only likely outcome.

[62] Mr Anderson's opinion was that Mrs Sinclair had suffered a perforated colon at Eastwood Court. He was able to say that because the records showed that she was decompensated and had signs of sepsis. It was difficult to say when the perforation had occurred. Certainly, it had occurred by 03.00. It had probably happened sometime in the afternoon, from 13.00 onwards. It was not possible to say if the perforation had started before Mrs Sinclair had started to vomit or after.

[63] Surgery would have been Mrs Sinclair's only chance to remove the colonic perforation and to reverse her physiological decline. However, by the time she arrived at hospital any surgical intervention would almost certainly have been fatal. The *post-mortem* did not support an element of aspiration contributing to Mrs Sinclair's death. What was more likely was that the small bowel which became adherent to the focus of inflammation (later perforation) in the colon, became involved in the inflammatory process as supported by the post-mortem examination. As a consequence, the small bowel segment caught up often fails to allow the passage of food stuffs and drinks as it gets mechanically drawn into an inflammatory phlegmon. In effect, the segment behaves like a small bowel obstruction and fluids back up proximally, filling the upper small bowel and stomach. When this reaches a critical stage the patient begins to vomit. That was the clinical picture observed in Mrs Sinclair over the course of 9 - 10 March 2016.

[64] Mr Anderson considered that, if Dr Oates had examined Mrs Sinclair's abdomen and if there were signs of acute peritoneal irritation, she might have found her way to hospital in a "timelier" fashion. He would have expected signs of peritonitis to trigger a

need for a "blue-light transfer". This would probably have resulted in Mrs Sinclair being referred earlier to the surgical team, not in a state of multi-organ failure and with severe metabolic acidosis as was the case around 04.00. By that time, the window of opportunity for surgery had closed.

[65] Cross-examined on behalf of Nurse Hughes, Mr Anderson agreed with that by 02.55 death was almost certain. With reference to Dr Oates's assessment of Mrs Sinclair, he agreed that if there had been no signs of acute peritoneal irritation a 1-hour ambulance should have arrived by 21.47. Mrs Sinclair would then have been triaged by a nurse and seen by a doctor. It would have been possible to make a working diagnosis of peritonitis within an hour of arriving at hospital. If she had been suitable for surgery she would not have waited terribly long: in the best case, one would expect a severely ill patient to be in theatre within 1 hour of arrival.

[66] Cross-examined on behalf of SAS, Mr Anderson referred to page 30 of his report CP 16:

> "the golden period was really around 2030 to 2100. This was when Dr Oates attended Mrs Sinclair, and an educated differential diagnosis at that point, in an elderly patient with sepsis and vomiting, should have prompted thorough examination and immediate transfer."

Mr Kevin Groombridge

[67] Mr Groombridge is Director and Executive Chairman of Larchwood. Larchwood is an operating company. Since January 2016 Larchwood has operated Eastwood Court under licence. Healthcare was contracted to provide management services to Larchwood. Staff at Eastwood Court were employed by Larchwood. From

January 2016 onwards Healthcare undertook a process of assessing Eastwood Court's policies and procedures and identified certain areas for improvement. At the time of Mrs Sinclair's death, Eastwood Court was in a transitional phase. The implementation of Healthcare's policies, procedures, and documentation was underway but was not complete.

[68] At the time of Mrs Sinclair's death Eastwood Court had no written policy in respect of the recording of clinical observations of residents who were unwell. He understood that there was no written policy at that time for the care of deteriorating residents. Nurses had been expected to exercise their own clinical judgement. They would have been expected as part of normal nursing practice to document clinical observations on the TPR chart or on the Daily Communications Sheet, and to annotate the clinical observations and any signs or symptoms within the clinical records. They would have been expected to exercise their clinical judgment in determining the frequency of observations and patient monitoring. They would have been expected to uphold the professional standards and the duty of care owed to patients under their care. Nurses were expected to comply with the NMC Guidance and Codes such as those produced as CP 38, 39, and 40.

[69] Police Scotland had requested that all records relating to Mrs Sinclair's care at Eastwood Court be provided to them and all documentation had been voluntarily produced. He understood that the records did not include completed TPR charts for the evening of 10 March 2016. TPR charts were available for staff and ought to have been completed. Staff would have been aware of the importance of using them. He was

unable to offer any "plausible explanation" for the absence of completed charts in relation to Mrs Sinclair. By October 2016 a major review of documentation had been completed to rationalise the system in Eastwood Court and bring together essential information. A weekly record book recording all care delivery was developed and introduced by Healthcare (CP 22.9) and a quality care manual update review summary sheet had been introduced (CP 22.8). Healthcare's policy relating to record-keeping is now covered by a number of policies:-

- Care-PR01 Person Centred Care
- Care-PR13 Care Files
- Care-PR14 Recording Professional Information
- Care-PR16 Policy for Clinical Intervention and New Early Warning Score/NEWS 2

[70] In 2016 NEWS had been a standard tool in NHS acute care but had not been widely used in care homes. NEWS is now used at Eastwood Court but that policy had not been implemented at the time of Mrs Sinclair's death.

[71] He was not aware of any policy at the time of Mrs Sinclair's death which specifically detailed the actions which nursing staff should take if an ambulance transfer was not carried out within a specific time. Nurses would have been expected to exercise their clinical judgement, act accordingly, and escalate any concerns to the relevant service. Since the introduction of NEWS, staff would relay key information in line with the NEWS Escalation Action Tracker. This tool allowed nursing staff to clearly relay any concerns and document the plan of action/and or further monitoring which has been

agreed with the relevant healthcare professional. It also provided clear guidance on the frequency of monitoring that should be undertaken on a patient who is unwell or who is deteriorating.

[72] Cross-examined on behalf of Nurse Hughes, Mr Groombridge agreed that there was no adequate record-keeping policy at the time of Mrs Sinclair's death. If the Inquiry had heard evidence that there was no policy at all then that would be correct. In relation to documenting clinical observations on the TPR chart or in the Daily Communications Sheet, either would be expected but recording in the TPR chart would be best if a TPR chart was available. If there was any abnormality it would be better to record it in both the TPR chart and the Daily Communications Sheet. As to what an abnormality was, that was for nurses' own individual judgement. He had never seen Mrs Sinclair's TPR chart. He had heard that there were some difficulties in locating her personal care charts but could not comment on the specifics. He agreed that there had been some issues with the retention of records in 2016. He could not confirm whether that related only to Mrs Sinclair or whether others were involved.

Ms Isabelle Donaldson

[73] Ms Isabelle Donaldson is currently the Learning and Development Manager for SAS. She co-authored the Significant Adverse Event Review (SAER) CP 11. She had listened to Dr Oates' call ordering an ambulance. She had listened to the SAS call at 02.01 Eastwood Court, when the ambulance was upgraded to an emergency response. She had also considered the Sequence of Events (CP 9 and 10) and the review of the

Electronic Patient Record Form (CP 8). She had carried out a review of resourcing. She had ascertained that, from the time Dr Oates ordered the 1-hour ambulance to an ambulance crew ultimately being allocated, all ambulance resources were busy.

[74] She had noted that, after Dr Oates had ordered the ambulance, an SAS dispatcher had "retrieved" the call at 21.00 and 23.30. This simply meant that a dispatcher had seen that a call was outstanding but had not taken any action. The dispatcher had not carried out a check on ambulance resources (RES) at that time. Her opinion was that resource checks should have been carried out at that time: resource checks should be done regularly. The reason that no formal RES had been done was that SAS dispatchers will know where crews are and will know when they are available. This should, however, still be recorded in the system.

[75] The first call by SAS to Eastwood Court was at 00.17. The second call was at 01.23 and the third call at 02.01. A check on the availability of ambulance sources (RES) was not conducted during the course of the call at 02.01 but was carried out at 02.10 after the call had been upgraded to an emergency response. It was possible that if a RES had been carried out earlier a resource might have been available.

[76] Cross-examined on behalf of SAS, Mrs Donaldson confirmed that a 1-hour ambulance call from a GP is treated less urgently than a "blue light". She had carried out a "service review" and had ascertained that between 20.47 and 00.15 there were no available crews in the area. Therefore even had a RES been done, no crews would have been available. The reason that there were no ambulances available was that they were all attending emergency calls which were of a higher priority than a 1-hour GP call.

Ms Stephanie Jones

[77] Ms Stephanie Jones is the Clinical Quality Lead in the national directorate at SAS. She confirmed that the SAER referred to by Ms Donaldson (CP11) had been undertaken following Mrs Sinclair's death. The SAER made four recommendations:-

- Flag system to be developed within the C3 Control and Command System for out of time welfare ring-back calls to be introduced to increase monitoring, clinical governance, and patient safety – the purpose of this recommendation was to ensure out of time calls are visible to colleagues who are responsible for welfare call backs.
- Introduction of a reporting mechanism to ambulance control centre senior management team for them to receive assurance that the welfare ring-back calls are being systematically actioned – the purpose of this, at the time, was to improve governance.
- Strengthen clinical governance process in ambulance control centres and ensure appropriate reporting through SAS clinical governance framework to provide assurance that these patient safety mechanisms are in place and robustly applied.
- Personal Development Plan to be developed for the staff involved.

[78] SAS had provided an action plan and developed a document called the Urgent Welfare Call Back Process (CP 13). The process laid down there applied to requests for 1-, 2-, and 4-hour ambulances but not to emergencies. The process is currently in place

and is essentially an "instruction sheet" for call handlers. The instruction sheet tells the call handler what questions to ask and then lays down pathways to be followed, depending on the answers to the question. Thus, if a patient's condition has worsened, the "red" path is followed and a call will be upgraded to an emergency call, treated as though it had been a 999 call from the outset and processed as per normal 999 call-handling procedures. If a patient's condition has not worsened the "green" pathway will be followed.

[79] The Urgent Welfare Call Back Process includes a system of "tagging" calls. This means that every time there is a call back made by SAS the call will be "tagged". Broadly, under the new system if a GP orders a 1-hour ambulance at 22.00 SAS will make the first call-back at 23.00. It will be "tagged" and thereafter repeated hourly. At 180 minutes after the ambulance has been called, a call-back will be made by a clinician, rather than a call handler. Every time a call-back is made it is recorded. There is a colour coding system in place which shows call-handlers when to undertake the call-backs.

[80] Procedures were now more robust than previously. Previously, all SAS call-handlers dealt with 999 calls as a priority. If there were no 999 calls to deal with, the call-handler would deal with outgoing calls. Outgoing calls are now added to staffing requirements so that SAS knows they have the manpower to deal with outgoing calls. Members of staff are identified on each shift to have the sole responsibility for making outgoing calls. Additionally, since 2020, staff use a "full scripted protocol" - essentially a script to use in emergency and non-emergency calls. Following upon the SAER (CP

11) there was a change in procedure in dealing with a RES. There is now an automatic RES for each 999 call. For calls with lower priority 999 calls, dispatchers are instructed to check availability of ambulances every 20 minutes. Dispatchers look after 15 ambulances per shift and are generally aware when they do and do not have ambulance available so an RES is not always necessary. There is no written policy in relation to the 20 minute check.

[81] Cross-examined on behalf of SAS, Ms Jones confirmed that the recommendations of the SAER had been implemented and some had been improved on. There is a fleet of ambulances dedicated to non-999 calls. This means that there are dispatchers and 90 non-clinical staff to attend to non-999 incidents to allow others to attend 999 calls. These vehicles are "ring-fenced" and dedicated to "timed admissions" rather than emergency responses. This is a development in addition to the four recommendations made in the SAER. The scripted calls are also an addition to the SAER.

Mr Mark Newton

[82] Mr Mark Newton is a Consultant Paramedic who provided a report, CP 25. He adopted his report as his evidence. His report set out the background information and factual chronology with which he had been provided. He had noted that the first contact made by SAS to Eastwood Court has been a welfare check at 00.17. A second welfare check had been made at 01.23. No ambulance was available to take Mrs Sinclair to hospital. Some changes in her condition had at that point been communicated to the call handler: her temperature had risen and she had been given paracetamol. She was

described as being pale and clammy. Mr Newton listened to the recording CL 4 in which Nurse Hughes had conveyed the foregoing information to the call handler. The call handler had asked her if she thought that a blue light transfer was needed and Nurse Hughes said "not at this moment, no". She had told the call handler that Mrs Sinclair's colour was not fantastic, her temperature had increased, and she was sweaty, pale, and clammy.

[83] Had Mr Newton been the call-handler, he would have carried out another triage at that stage. It was important, in situations where there had been a long wait for an ambulance, to establish whether or not there had been a deterioration in the patient's condition. If there had been a deterioration, a re-triage through the despatch system ought to be done. 50% of ambulance services did so. A re-triage was carried out by a non-clinician such a call-handler asking questions to generate a code. Had a re-triage been done at that stage it might have resulted in a regrading of the call. The second option was to triage through a clinician. On hearing CL 4 played, Mr Newton indicated that he had not realised until now that the call handler had spoken to a clinician during the course of the call. In his opinion, the clinician ought then to have assessed Mrs Sinclair's condition.

[84] He had not changed the opinion expressed in paragraph 6.4 of his report that, whilst the care provided by SAS fell below a reasonable standard, there was no causative impact on Mrs Sinclair's prognosis as a result. He was unable to say whether or not ambulance resources would actually have been available if a RES had been carried out before 02.10. Whilst at paragraph 7.9 of his report his view was that, in terms

of NEWS, Mrs Sinclair should have been managed as an emergency response in the first instance, he confirmed that he would defer to a GP's opinion in that matter. His opinion was that the actions taken by SAS following Mrs Sinclair's death reflected the outcomes of the SAER and would significantly mitigate the likelihood of recurrence of such an incident. He considered that the failure by SAS to make hourly checks after Dr Oates' call was something which fell below reasonable standards.

[85] Cross-examined on behalf of Nurse Hughes he repeated his opinion that, having heard the recording of the call from SAS to Nurse Hughes CL 4, a clinician ought to have re-triaged the call at that stage. This might have resulted in an upgrade of the call.

[86] Cross-examined on behalf of Larchwood, Mr Newton agreed that he could not comment on the resources which might have been available at Eastwood Court for patient monitoring but considered that Mrs Sinclair ought to have been monitored on a regular basis. He agreed that constant monitoring was not possible in a care home setting.

[87] Cross-examined on behalf of SAS, he confirmed that he as a clinician would have re-triaged the call at 01.23. Re-triaging should be carried out if there is a change in a patient's condition. He agreed that Nurse Hughes saying that no 999 call was necessary was a factor in deciding whether or not to re-triage. His opinion was that there had been a deterioration after 02.00 but could not comment on the position at 01.23. The likely cause of the upgrade of the call made at 02.01 was Mrs Sinclair's breathing. A change in temperature alone was not enough. He could not say if a re-triage at 01.23 would have affected the speed of the ambulance response. He agreed, however, if the call had been

re-triaged at 01.23 and there had been no change in Mrs Sinclair's condition the situation, there would have been no upgrade. He simply did not know whether that would have happened or not.

[88] He agreed that a 1-hour ambulance ordered by a GP was less urgent than an emergency call and, consequently, if a RES had been done at 21.00 and 23.33, no ambulance would have been sent and welfare checks would have been done. He considered that SAS in 2016 had appropriate policies in place that were similar to those employed by most ambulance services at the time. The issue was the lack of compliance with those policies: the failure to make contact with Eastwood Court until 00.17 represented a failure to comply with standard operating procedures. Based on SAS's own procedures, welfare checks should have taken place within reasonable time windows of 21.47, 22.47 and 23.47. Each failure to perform a welfare check resulted in the possibility of missed opportunities to identify deterioration and/or re-triage or upgrade the incident. The error was staff error and not system error. He was satisfied that the actions taken by SAS in the aftermath of this incident would significantly mitigate the likelihood of reoccurrence. The processes adopted by SAS in the document "Health Care Professional Ambulance Guide" referred to at paragraph 8.5 of his report would go further to reduce the risk of harm and deaths. The additional measures introduced by SAS were very strong and went as far as possible to minimise the risk of adverse events in future.

[89] Mr Newton confirmed that, had a deteriorating picture been presented earlier in the evening of 9 March 2016 he would expect the call to have been re-triaged. He agreed that, from what was known, a deteriorating clinical picture had not been presented.

Dr Usman Qureshi

[90] Dr Usman Qureshi is an independent medical legal advisor who had prepared a report CP 20. He adopted its terms. His report explained the workings of the out-of-hours GP service in Glasgow, starting with a call being made to NHS 24 by a patient or his or her carer, the urgency of the call being assessed, and a GP aiming to visit within the timescale provided.

[91] He explained that normal GP practice was to take a history from the patient (or the patient's carer) on arrival at the appointment, followed by an examination. The examination would consist of recording vital signs, these being temperature, pulse, BP, respiratory rate, oxygen saturation, level of alertness, and physical appearance. The GP would then carry out a systemic examination starting with the most relevant system.

[92] Dr Qureshi had reviewed Dr Oates's notes of his examination. Although Dr Qureshi had noted in his own report that BP had not been taken by Dr Oates he accepted that that was not the case and that BP had indeed been taken and was 160/90 at the time of examination. Dr Oates had recorded that he had found "abdo soft." This referred to the absence of a rigid abdomen. A rigid abdomen would be found in peritonitis or an acute abdominal pathology. Dr Oates had noted "legs OK." Dr Qureshi's opinion was that Dr Oates appeared to have considered a differential

diagnosis involving the abdomen and legs and had formed a working diagnosis based on the most positive signs of the chest. Although the documentation of the history and examination was not detailed, it was not unusual to note only brief and relevant findings only in an out-of-hospital setting due to time constraints. He did not consider that there had been a departure from normal practice and considered that the course adopted by Dr Oates was one which would have been taken by a GP of ordinary skill acting with ordinary care.

[93] Dr Qureshi considered that a 1-hour ambulance transfer as ordered by Dr Oates was appropriate: a 1-hour ambulance is urgent and Mrs Sinclair's condition suggested that she required urgent treatment. However, her condition did not appear to be life-threatening. As to whether there was systemic failure, there was no provision in the NHS 24 system which would have allowed Eastwood Court to consult Dr Oates again should a 1-hour ambulance not have arrived or if Mrs Sinclair's condition had deteriorated. He did not consider it was likely that the system could accommodate such a provision, as out-of- hours GPs had so many other patients to see that it would not be practical. It was neither feasible nor possible for an out-of-hours GP to monitor the ambulance he had ordered: the responsibility for monitoring fell to SAS upon the ambulance being ordered. He considered that to be a failing in the system. His opinion was that Dr Oates had acted in a reasonable manner and had provided reasonable care to Mrs Sinclair on 9 March 2016.

[94] Cross-examined on behalf of Dr Oates, Dr Qureshi confirmed that the length of his consultation with Mrs Sinclair was standard. He confirmed that her TPR readings

were all possible signs of infection. They were consistent with aspiration pneumonia or with a lower respiratory tract infection.

[95] Cross-examined on behalf of Healthcare he clarified what he had meant by saying that the lack of facility for Eastwood Court to be able to contact Dr Oates after his consultation had ended was a failing of the system: he explained that he simply meant that in a perfect world there would be such a facility. However, the current system did allow call-backs from the SAS and the possibility of a "hub doctor" on NHS 24 giving advice to a patient or carer calling NHS-24 after a GP had visited. In that sense therefore, the current systems were adequate.

Ms Julie Bowmaker

[96] Ms Julie Bowmaker is an expert in nursing practice who had provided reports CP 17 and CP 24. She adopted these. She had extensive experience of working in care homes and as a district nurse. She had reviewed the documented history of Mrs Sinclair's care at Eastwood Court on 9 -10 March 2016. She noted that she could find no evidence in the nursing records of a fluid balance chart being initiated: this would be used normally to monitor fluid intake and outtake and would ensure that someone who vomited was not becoming dehydrated and was drinking fluids. She was critical of Kenneth McMillan having completed notes in relation to Mrs Sinclair towards the end of his shift: the NMC requires that records be completed as soon as possible after events, so records should be contemporaneous. Clinical observations ought to have been carried out and recorded. If records have to be written-up later, the NMC code

requires that it should be stated that the entry is retrospective. No note of the outcome of Dr Oates's consultation was contained in Mrs Sinclair's nursing records.

[97] Ms Bowmaker considered the assessments made of Mrs Sinclair to have been "end-of-bed assessments" - where a patient is looked at by a clinician but physical observations are not recorded. In her view, after Dr Oates had stipulated that Mrs Sinclair required a 1-hour ambulance the nursing team at Eastwood Court should have informed him immediately it became clear that there would be a delay in her transfer to hospital. However, she accepted that the Inquiry had heard evidence that there was no means in the NHS-24 system which would have enabled staff to make such contact with Dr Oates after he had left.

[98] She considered that the nursing care provided to Mrs Sinclair was not in accordance with any reasonable, responsible, or logical body of opinion. The failure to record clinical observations was not acceptable. The nursing team had a professional duty of care to monitor Mrs Sinclair's condition and to recognise and respond to her deterioration appropriately. From her review of the records of Eastwood Court, this had not happened: there were individual failures by nursing staff adequately to monitor Mrs Sinclair. This was compounded by the fact that there was no provision in the system to enable staff to contact Dr Oates again should a 1-hour ambulance transfer prove not be possible or if Mrs Sinclair's condition deteriorated.

[99] She had been unable to locate Mrs Sinclair's clinical observation charts or a fluid balance chart. She would expect such things to be contained in Mrs Sinclair's records.

She would expect a record of any clinical observations and what actions had been taken in response to them, especially around the time of the SAS calls-backs.

[100] She was aware that Larchwood had developed a new system to avoid the accumulation of numerous charts and loose pages which could be mislaid. It was of great concern to her that confidential patient records could have been insecurely stored and that, as a result, part of the records for Mrs Sinclair had been potentially "mislaid". The inadequate management of patient records represented a system failure. It was impossible, in her opinion, to determine whether clinical observations were undertaken since this was not documented. She accepted that she could not say definitively whether records had been lost or not.

[101] In relation to the NEWS tool, she was not aware of any statutory obligation compelling a care home to use it but this was now "best practice." Her opinion was that it ought to be an industry standard because it gives an objective way of observing a patient.

[102] She listened to CL 3 being played – the call made by SAS to Eastwood Court at 00.17. This was the call where Nurse Wylie said that Mrs Sinclair's condition was fairly stable. She listened to CL 4 being played. This was the call where Nurse Hughes said that Mrs Sinclair's temperature had gone up and she had given her paracetamol; that her colour was not very good and that she was pale and clammy; that the call handler, having spoken to a clinician, said that if staff had any concerns they should call back on 999. She listened to CL 5 being played. This was the call where Nurse Wylie said that

he would not call Mrs Sinclair's breathing laboured but, having checked her, her breathing was shallower than normal but not laboured with her pulse being ok.

[103] As a nurse, Ms Bowmaker considered that it was appropriate to tell a SAS call-handler a patient's clinical observations if these were available. If she had done observations herself, she would share them with SAS. If a colleague had done them earlier, she would check to see if there had been any deterioration. In relation to the observations made by Nurse Wylie recorded on the call CL 5, the fact that there was a gap of only around 40 seconds between him telling the call handler that he would check on Mrs Sinclair and him returning to the telephone, suggested that his assessment of her was a very brief assessment. The call-handler was asking for specific observations on breathing and temperature and Nurse Wylie had simply said that the Mrs Sinclair "felt warm". It would have been appropriate to look at the TPR and BP charts if there were such things. A proper assessment would have involved taking BP, pulse, respiratory rate, and temperature as well as making visual observations. It would take at least a minute to do such things.

[104] Cross-examined on behalf of Healthcare, Ms Bowmaker agreed that nurses should record observations and annotate them in the clinical records. These should be recorded in the patient's TPR chart. She would expect any analysis to be contained in the "evaluation of care." Nurses should include subjective and objective observations in their recordings and comply with the NMC Codes and Guidance in relation to record-keeping.

[105] Cross-examined on behalf of Nurse Hughes, Ms Bowmaker confirmed when she had prepared her report, she was not aware that Eastwood Court staff had not been NEWS-trained in 2016 but she was now aware of that fact. She was aware that observations at that time were in TPR charts but had expected any analysis to be written up separately. She was also aware that there was no policy in force at Eastwood Court at that time in relation to record-keeping but staff ought to have been aware of the NMC Code. In relation to the existence or otherwise of a TPR chart she was not aware of the position of Nurse Hughes that this had not been located; had there been a TPR chart, that might have caused her to revise her opinion. In the absence of a TPR chart she agreed that it was not possible to say when Mrs Sinclair's condition deteriorated. She was aware that Nurse Hughes had made her final observations on Mrs Sinclair at 01.20. She agreed that there was a significant possibility of a deterioration in her condition between then and the ambulance arriving at 02.55.

[106] Cross-examined on behalf of Larchwood, Ms Bowmaker confirmed that she could not say whether documentation had been lost or not. In relation to there being no provision in the system to consult Dr Oates again should a 1-hour ambulance transfer not be possible or if the patient's condition deteriorated, she accepted that Dr Qureshi's evidence to the Inquiry was that it was not practical for an out-of-hours GP to be contacted again. She considered that the failures in Mrs Sinclair's care had been individual clinical failures rather than systemic failures.

Sumbissions

Uncontroversial matters

[107] Parties were agreed that Mrs Sinclair's death occurred at 11.45 on 10 March 2016 at the Queen Elizabeth University Hospital, Glasgow; and that should be a formal finding in terms of Section 26(2)(a).

[108] Parties were agreed that Mrs Sinclair's death did not result from an accident, so no findings were necessary in terms of Section 26(2)(b) or (d) of the Act.

[109] Parties were agreed that the cause of death was peritonitis due to perforation of presumed diverticulum of the sigmoid colon; and that this should be a formal finding in terms of Section 26(2)(c) of the Act.

[110] None of the parties invited me to make any recommendation in terms of Section 26(1)(b) of the Act.

Crown submissions

Section 26(2)(e)

[111] The Procurator Fiscal Depute summarised the evidence of the various witnesses led at the Inquiry. She criticised the fact that, with the exception of two temperature recordings, one at 01.00 and the other at 01.20 there was no documentation to support the position of Nurse Hughes that hourly TPR and BP checks had been carried out after Dr Oates finished his examination. No observations had been recorded in Mrs Sinclair's Daily Communication Notes during that period. No TPR or BP sheets were contained in Mrs Sinclair's records (CP 3 and CP 5). She was critical of SAS for having failed to

adhere to their own procedure of requiring call-backs to be made every hour to check on the condition of the patient (CP 37). She was critical of Nurse Wylie for failing to have provided SAS with specific details about Mrs Sinclair's clinical condition during the call at 00.17. She was critical of the fact that, except for reference to Mrs Sinclair's temperature increasing, Nurse Hughes did not provide SAS with specific details of clinical observations during the call at 01.22. She submitted that Nurse Wylie could not have conducted a thorough assessment of Mrs Sinclair or have undertaken proper clinical observations within the time of 47 seconds (approx.) which he took to make his way to her room, check on her, and then return to the telephone during the call made by SAS to Eastwood Court at 02.01.

[112] The Procurator Fiscal Depute submitted that it followed with the benefit of hindsight that Mrs Sinclair's death might have been avoided by the application of reasonable precautions. She submitted that Mr Anderson's evidence demonstrated that surgery was Mrs Sinclair's only chance of survival; and that by the time she had arrived at hospital at 04.30 the window of opportunity had passed. Due to the lack of detailed assessments in the Eastwood Court records, Mr Anderson had not been able to comment on exactly when that window had passed.

[113] She submitted that it would have been a reasonable precaution for Kenneth McMillan to have initiated a fluid balance chart to monitor Mrs Sinclair's fluid intake and output; to have monitored her condition by conducting regular clinical observations and recording the results in Mrs Sinclair's notes; and to have contacted NHS 24 sooner.

[114] She submitted that it would have been a reasonable precaution for Dr Oates to have ordered an immediate, "blue light," ambulance rather than a 1-hour ambulance to transfer Mrs Sinclair to hospital. She submitted that it would have been a reasonable precaution for Eastwood Court to have contacted Dr Oates to advise him of the delay with the ambulance. Furthermore, if the SAS call handler was aware at the time of Dr Oates ordering a 1-hour ambulance that there was a significant delay in despatching ambulances, it would have been a reasonable precaution for SAS to have advised him of this. It would have been a reasonable precaution for SAS to comply with its own procedures by contacting Eastwood Court every hour and seeking an update on Mrs Sinclair's condition. It would have been a reasonable precaution for SAS to have undertaken a RES upon receipt of Dr Oates's call and at regular intervals thereafter. It would have been a reasonable precaution for staff at Eastwood Court to have ensured that, following Dr Oates's departure, clinical observations were commenced, monitored, and documented. Furthermore, it would have been a reasonable precaution for nursing staff to have personally and thoroughly assessed Mrs Sinclair when SAS contacted Eastwood Court for an update on her condition.

[115] Had the foregoing reasonable precautions been taken, there was a real or lively possibility that Mrs Sinclair would have arrived at hospital earlier, before she had deteriorated to the point where her death was inevitable; that she would have been fit enough for life-saving treatment; and that on balance of probabilities she would not have died.

Section 26(2)(f)

[116] The Procurator Fiscal Depute submitted that, at the time of Mrs Sinclair's death, Eastwood Court had no written policy specifically for the care of a deteriorating patient. In particular, the NEWS tool was not used at Eastwood Court at the time, whereas NEWS 2 was now used. Had there been a policy, such as NEWS, in place at the time of Mrs Sinclair's death and had staff complied with the policy and used such a tool to monitor her condition, her death could have been avoided. The use of the NEWS tool would have alerted staff to the fact that Mrs Sinclair was deteriorating and they could have escalated appropriately and in accordance with NEWS. It was possible staff might have been prompted to order a "blue light" ambulance for her. The absence of a policy relating to the care of a deteriorating patient (akin to the policy which had been implemented since Mrs Sinclair's death) was a system failure which may have contributed to her death.

[117] She submitted that the lack of provision for an out-of-hours GP to be able to follow up with Eastwood Court or SAS regarding his request for an ambulance might be considered a system failure which had contributed to Mrs Sinclair's death. The lack of provision for Eastwood Court to be able to contact Dr Oates to alert him to any ambulance delay was also a system failure which might have contributed to Mrs Sinclair's death.

Section 26(2)(g)

[118] The Procurator Fiscal Depute submitted that other facts relevant to the circumstances of Mrs Sinclair's death were the lack of detailed notes in the records of Eastwood Court about the events of 9 and 10 March 2016. In particular Dr Oates's diagnosis and his stipulation of the necessity of a 1-hour ambulance were matters not documented in Eastwood Court's records. The calls made by SAS to Eastwood Court at 00.17, 01.22 and 02.01 had not been noted in the records: they ought to have been documented by Nurse Wylie and Nurse Hughes. There was no note in the records of any plan to commence hourly observations on Mrs Sinclair. Apart from the two temperature recordings at 01.00 and at 01.20 there was no record of any observations on Mrs Sinclair following upon the Dr Oates' departure. Nurse Hughes told the inquiry that she had completed TPR and BP charts, but these were not contained in the Eastwood Court records. There was no plausible explanation for their absence. Nursing staff had failed to recognise that Mrs Sinclair was deteriorating. This suggested that close monitoring was not taking place. There had been no written policy in place in relation to the recording of clinical observations.

[119] The Procurator Fiscal Depute submitted that the recommendations which had been implemented by SAS after the SAER would go some way towards ensuring compliance with procedures. Mark Newton had confirmed this.

Submissions on behalf of Healthcare

Section 26(2)(e)

[120] Ms Canda on behalf of Healthcare submitted that there were no precautions in terms of Section 26(2)(e) which could have reasonably been taken and which, had they been taken, might realistically have resulted in Mrs Sinclair's death being avoided. She was critical of the Crown submission that it would have been a reasonable precaution for Eastwood Court to have been able to contact Dr Oates to advise him of the delay in the 1-hour ambulance. However, Dr Qureshi had accepted that there was a system in place with SAS which had provided an adequate safety net. There was no evidential basis for any finding that a provision for nursing staff to be able to contact Dr Oates after he had left Eastwood Court should have been utilised. There had been no evidence about whether Mrs Sinclair would have arrived at hospital earlier had there been such a provision been in place. There had been no evidence about when Mrs Sinclair had deteriorated to a point where her death was inevitable. Mr David Anderson had been unable to estimate the exact time Mrs Sinclair became unsuitable for surgery. He had been unable to confirm whether or not she would have survived surgery. He had expressed the opinion that the mortality risk in Mrs Sinclair would have been enormous. There was no evidential basis to find that had Mrs Sinclair arrived at hospital earlier, she would not have died. There was no evidential basis to find that, had nursing staff been able to contact Dr Oates to advise him on the delay with the ambulance, it may realistically have resulted in Mrs Sinclair's death being avoided.

Section 26(2)(f)

[121] Ms Canda submitted that there were no defects in any system of working which contributed to Mrs Sinclair's death. The Crown had submitted that there was no policy in place at Eastwood Court at the time of Mrs Sinclair's death in relation to how unwell and deteriorating residents should be monitored by staff. The Crown had submitted that the absence of such a policy was a system failure which "may" have contributed to Mrs Sinclair's death. Healthcare submitted, however, that there was no evidential basis for such a finding. The Court had not heard any evidence about how such a policy should have been utilised, had it been in place at the time. The NEWS tool had been spoken to by Mr Groombridge and Ms Bowmaker. However this tool was a standard tool in acute NHS care in 2016 but was not widely used at that time in care homes. There was no requirement for such a policy or tool to be in place in Scotland at the time. It was submitted on behalf of Healthcare that there was no basis for a finding that any policy on how to deal with unwell and deteriorating residents would have been utilised or that, had the system been different, Mrs Sinclair's death could have been avoided. There had been no evidence on how the absence of policy relating to the care of a deteriorating patient contributed to Mrs Sinclair's death.

[122] Ms Bowmaker and Mr Groombridge had both spoken to the importance of documenting clinical observations. Mr Wylie, Nurse Hughes, and Nurse McMillan had all agreed that TPR charts were available for their use and that they were expected to document clinical observations and annotate clinical observations in the clinical records as part of normal nursing practice. They were expected to exercise their clinical

judgment in determining the frequency of observations and patient monitoring. They had all accepted the duties incumbent of them in terms of the NMC Code and the NMC Guidance for recordkeeping for nurses. There was no evidential basis for the Court to find that the absence of a policy relating to the care of a deteriorating patient was a defect in a system of working which contributed to the death of Mrs Sinclair. There was no evidential basis to find that the lack of provision for the GP to follow up with the care home or SAS relating to his request for an ambulance was a defect in a system of working which contributed to Mrs Sinclair's death. The same position was adopted in relation to the lack of provision to Eastwood Court staff to contact Dr Oates to alert him to the ambulance delay: there was no evidential basis to find this to be a defect in a system of working which contributed to Mrs Sinclair's death.

Section 26(2)(g)

[123] No submissions were made under this sub-section.

Submissions on behalf of Mairead Hughes

Section 26(2)(e)

[124] Mr Burton submitted that, in relation to Nurse Hughes, there should be no finding under this subsection. He founded on the fact that at the time of Mrs Sinclair's death there was no written policy at Eastwood Court in relation to where staff were to record their clinical observations on patients: this was down to individual staff practice and had been spoken to by nurses Kenneth McMillan and Kenneth Wylie as well as

Nurse Hughes. Ms Bowmaker had apparently been unaware of this when preparing her report.

[125] Nurse Hughes' evidence was that she had carried out hourly clinical observations on Mrs Sinclair which had been recorded on her TPR chart. Observations did not need to be recorded in both the TPR chart and in the patient's clinical notes, as had been confirmed by nurses Kenneth McMillan and Kenneth Wylie, as well as by Kevin Groombridge. Neither of the nurses had any concerns about Nurse Hughes's record-keeping. It was regrettable that the TPR charts for Mrs Sinclair were not contained in her records CP 3 and CP 5. However, the absence of these records did not mean that Nurse Hughes had failed to carry out clinical observations. Her evidence on record-keeping was credible and reliable and she should not be criticised for the failure of Eastwood Court to maintain adequate records: TPR and BP sheets in relation to Mrs Sinclair should have been kept with her notes and Mr Groombridge had been unable to offer any "plausible explanation" for their absence.

[126] How to deal with a deteriorating patient was not the subject of a written policy, as had been confirmed by Mr Groombridge. This was down to individual clinical judgement. Nurse Hughes had given unchallenged evidence that she had previously escalated a deteriorating patient to a "blue light" ambulance.

[127] Ms Bowmaker had made comments in her report CP 17 to the effect that clinical observations had simply not been carried out, although she accepted that she would have to revise paragraphs 4.2.10, 4.2.11, 4.2.23, and 4.3.2 if it transpired that clinical observations had, in fact, been carried out. Mr Burton invited the Inquiry to accept

Nurse Hughes's evidence that she had carried out and documented observations. If the Inquiry accepted that evidence, any criticism made of Nurse Hughes by Ms Bowmaker became redundant.

[128] Nurse Hughes had given evidence that when she received the call from SAS at 01.23 she did not consider that the outstanding ambulance required to be upgraded to "blue light" based on her hourly observations and exercising her clinical judgement. She had told SAS that Mrs Sinclair's temperature had risen and that her colour was "not fantastic" and that she was pale and clammy. Mr Newton had been critical of SAS's handling of that call and the information provided by Nurse Hughes: he would have expected a clinician to come onto the call and re-triage Mrs Sinclair using the Manchester Triage System. He would have expected the call to have been upgraded, based on Mrs Sinclair being pale and clammy; and a "blue light" ambulance may have been arranged.

[129] Mr Burton submitted that findings under Section 26(2)(e) required a causal link to be established. What had to be considered was the real or lively possibility that death might have been avoided by a reasonable precaution. There had been no evidence as to when the latest opportunity was for an operation to have been performed which might have saved Mrs Sinclair's life: Mr Anderson could not offer an opinion on that matter. Nurse Hughes had carried out her last observations at 01.20. By 02.55, based on the clinical observations of the SAS crew, Mr Anderson's opinion was that death was almost certain. He submitted that it was important to note that there were 95 minutes between

Nurse Hughes's last observations and those made by the SAS crew, leading to scope for deterioration.

[130] Had Dr Oates found there to be signs of acute peritonitis when he examined Mrs Sinclair, a "blue light" ambulance might have been triggered. However, Dr Oates had given clear evidence that there were no such signs and no working diagnosis of abdominal pathology. Even had the 1-hour ambulance ordered by Dr Oates arrived within an hour, i.e. by 21.47, given the timescales involved when the deceased did, in fact, later arrive at hospital and given that there was no working diagnosis of abdominal pathology, it was unlikely that surgery would have been carried out by the early hours of 10 March. Even had a 1-hour ambulance arrived timeously, there would not have been any real or lively possibility that death may have been avoided.

Section 26(2)(f)

[131] Mr Burton submitted that there should be no finding under this sub-section in relation to Nurse Hughes.

Section 26(2)(g)

[132] No findings were invited under this sub-section in relation to Nurse Hughes.

Submissions on behalf of Larchwood

Section 26(2)(e)

[133] Ms McGready submitted on behalf of Larchwood that there was no basis on the evidence to conclude that any reasonable precaution could have been taken by Eastwood Court such as might have realistically prevented the death of Mrs Sinclair. It was submitted that it was misplaced to suggest that there was a failure in the care of Mrs Sinclair by Larchwood or that Larchwood could have taken any reasonable precautions which might realistically have resulted in the death being avoided. Ms Bowmaker has confirmed that the taking and documenting of a patient's observations is a basis, key feature of a nurse's routine practice. It had been acknowledged by Mr McMillan, Ms Hughes, and Mr Wylie that there was a professional observation to comply with the NMC Code and the NMC Guidance for Record Keeping for Nurses and the NMC Standards of Competence. CP 38, 39, and 40 had been referred to in evidence and made it clear that nurses were individually accountable for their actions and admissions in professional practice. The Court had heard evidence that TPR and BP charts were available for completion by nursing staff. There had been evidence from Mairead Hughes that she had completed such charts for Mrs Sinclair, but no explanation from Mr McMillan or Mr Wylie as to why they did not complete them. Larchwood was entitled to expect nurses to comply with their clinical obligations insofar as monitoring patients and keeping appropriate records. There was no evidence at the inquiry suggesting that Larchwood had any reason to believe that the nursing staff on

duty at the time were anything other than competent nurses. There should be no findings in relation to Larchwood in terms of Section 26(2)(e).

Section 26(2)(f)

[134] Ms McGready submitted that no evidence had been led to demonstrate a defect in any system at work such as can be considered causative of Mrs Sinclair's death. On one view, it might be superficially attractive a proposition to suggest that the absence of a formal rollout of the use of NEWS observation charts at Eastwood Court was indicative of a defect in a system of work which contributed to the death of Mrs Sinclair. However the Inquiry required to consider what difference the provision of that material to nursing staff might realistically have made at the time of the incident. It had not been challenged at the Inquiry that staff were expected to exercise their own clinical judgement. The NEWS policy stated in terms that the use of NEWS was not intended to override any clinical judgement. However any failure by nursing staff to make or record basic physiological measurements and to interpret them in the context of the overall clinical position of the patient was an individual failing. NEWS was not a statutory requirement and, indeed, the efficacy of NEWS in pre-hospital settings is still the subject of debate, as confirmed by Dr Oates. It was little more than a speculative leap to conclude that any of the nurses, McMillan, Hughes, or Wylie would have done anything differently, such as might have avoided Mrs Sinclair's death, had the NEWS policy or any other policy relating to the escalation of the deteriorating patient, been in place prior

to the incidents. There was no evidence to support a causative finding under Section 26(2)(f) insofar as relating to Larchwood.

[135] Larchwood had put in place processes to improve the escalation of a deteriorating patient and had adopted the updated NEWS policy (NEWS 2). Observation charts had been initiated and implemented.

[136] In relation to the lack of provision in the system for Eastwood Court staff to have contacted Dr Oates when it became clear that there would be a delay in the one hour ambulance, it was submitted on behalf of Larchwood that there was no evidence to demonstrate any defect in a system of work such as could be considered causative of Mrs Sinclair's death. As Dr Oates had confirmed, there was no provision and the standard advice for care home staff would be to call 999 if they had any concerns about the patient. Dr Qureshi had clarified that such a provision would be impracticable in the context of the out of hours service but that there was always the possibility of staff being able to telephone 111 or 999 to escalate any concerns about a patient. There was no failing in any system of work in respect of Larchwood in this regard.

Section 26(2)(g)

[137] No findings were invited under this sub-section in relation to Larchwood.

Submissions on behalf of Dr Oates

Section 26(2)(e)

[138] Ms Harris submitted on behalf of Dr Oates that his decision to request a 1-hour ambulance was appropriate, considering his own clinical observations and the history of Mrs Sinclair vomiting. Dr Qureshi was an independent GP expert and had confirmed that this was a reasonable decision. There was no evidence from Dr Qureshi or any other GP that there was any alternative management which Dr Oates could or should have adopted, let alone could reasonably have adopted. The Inquiry had to consider whether or not any reasonable precaution might realistically have resulted in the death being avoided. This did not refer to a probability but to a "real and lively possibility" that death might have been avoided. It would not have been reasonable for Dr Oates to have requested a "blue light" ambulance at 20.47. Mr Anderson had agreed with the proposition put to him by the Crown that even if the source of Mrs Sinclair's sepsis had been identified at an earlier stage, she may not have survived surgery. Even if the Inquiry therefore considered that a reasonable precaution would have been for Dr Oates to have requested a blue light ambulance, there was insufficient evidence that this might realistically have resulted in Mrs Sinclair's death being avoided.

Section 26(2)(f)

[139] In relation to any defects in any system of working which contributed to the death, Dr Oates had confirmed in evidence that there was no way for staff at Eastwood Court to contact him following the completion of his home visit. This had been

confirmed by Dr Qureshi who believed that this was a failing in the system, although he explained that the out of hours service would be unable to accommodate such a provision given how busy the service was. It was submitted that the Crown was misplaced in arguing that a reasonable precaution would be for nurses to have been able to contact Dr Oates to advise him of the delay in the one hour ambulance. There was no evidence before the Court to allow a finding to be made that this "gap" in the system contributed to the death of Mrs Sinclair.

Section 26(2)(g)

[140] No findings were invited under this sub-section in relation to Dr Oates.

Submissions on behalf of SAS

[141] Mr Brownlee submitted that the evidence of Laurayn MacInnes, Kayleigh Morgan, Isabelle Donaldson, Stephanie Jones, and Mark Newton were particularly relevant to the position of SAS. His written submissions summarised the evidence of these witnesses, insofar as founded by SAS.

[142] SAS accepted that there were staff-based failures on 9 - 10 March 2016. They accepted that welfare checks and RES checks should have been done between Dr Oates's call at 20.47 and SAS's first call to Eastwood Court at 00.17. Those failures were individual, staff-based failures and not system-based failures. There was no evidence establishing a causative link between those failings and Mrs Sinclair's death. Even if RES checks had been performed timeously, whilst the outstanding call remained a GP

request for a 1-hour ambulance rather than an emergency response, the response time of SAS was unlikely to have changed. Even when SAS had made welfare calls to Eastwood Court, staff there presented a picture of stability with no requirement for an upgrade in the ambulance response. Had hourly welfare checks been performed at 21.47, 22.47, and 23.47 it was likely, on balance of probabilities, that a similar picture would have been described. Had that been the case, the ambulance prioritisation would not have changed and an ambulance would not have been dispatched for Mrs Sinclair any earlier than had in fact been done. Any failure on the part of SAS to perform welfare checks and RES checks had no causative effect on the delayed arrival of the ambulance and thereafter Mrs Sinclair's transfer to hospital for treatment.

Section 26(2)(e)

[143] SAS accepted that it would have been a reasonable precaution, as contended for by the Crown, in terms of Section 26(2)(e) for employees to implement the relevant call-back procedure on the evening of 9 March 2016. SAS also accepted that it would have been a reasonable precaution for SAS employees to conduct more regular RES checks after receipt of Dr Oates's call at 20.47. It was submitted, however, that whilst it may have been reasonable for SAS to implement these precautions, neither of them individually or jointly would have realistically avoided the death of Mrs Sinclair. This was because:

(a) when a 1-hour ambulance was requested at 20.47, emergency "blue light" requests automatically took priority;

(b analysis showed that no ambulance resources were in fact available to attend Mrs Sinclair, even if regular RES checks had been performed;

(c) even if welfare call-backs had been performed hourly it was likely, on balance of probabilities, that this would have resulted in Eastwood Court staff reporting no change in Mrs Sinclair's condition;

(d) in the absence of a reported deterioration in Mrs Sinclair's health there would have been no reconsideration of the ambulance response prioritisation; and

(e) as and when Mrs Sinclair's breathing was reported to have changed at 02.01 and an upgrade in prioritisation of ambulance had been triggered, no ambulance crews were available until 02.35.

[144] Whilst therefore reasonable precautions could have been implemented by SAS, those precautions, even if implemented, would not have realistically avoided Mrs Sinclair's death.

Section 26(2)(f)

[145] Mr Brownlee submitted that any failings on behalf of SAS were individual, employee failings and not systemic failings. This was supported by Mark Newton, the expert paramedic, who did not criticise the SAS systems in place at the time of Mrs Sinclair's death. He submitted that nothing turned on the lack of call-back ability between the GP, Eastwood Court and SAS once it became apparent that the ambulance was going to be late. Even if Eastwood Court had contacted SAS on 111 or 999 to

enquire as to the whereabouts of the ambulance, it was unlikely that they would have provided SAS with information which would have prompted them to upgrade the 1-hour ambulance to a more urgent response. He submitted that the findings and recommendations from the SAER had been fully implemented and that these recommendations, along with the additional measures, went as far as possible to mitigate the risk of reoccurrence.

Section 26(2)(g)

[146] Mr Brownlee submitted that it was relevant that the recommendations from the SEAR CP 11 had been fully implemented, together with additional measures. These went as far as possible to mitigate the risk of recurrence.

CONCLUSIONS

Section 26(2)(a) – (d)

[147] These matters are uncontroversial and I shall make findings as indicated in paragraphs 107 – 109 above.

Section 126(2)(e)(i)

[148] In terms of Section 26(2)(e) of the Act, I require to consider precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in Mrs Sinclair's death being avoided. The issues are separate but related. I shall deal first with reasonable precautions.

[149] The evidence led at the Inquiry showed that Mrs Sinclair had vomited at 13.00 and continued to vomit at 16.00. The vomiting at 13.00 was the first sign that she was unwell. Based on Mr Newton's evidence and with the benefit of hindsight, it is probable that she suffered a perforated colon at some time from 13.00 onwards, setting off the chain of events which ultimately led to her death. Surgery was her only chance of survival. By the time she was ultimately arrived at hospital at 03.55, she was no longer a candidate for surgery and death was inevitable. No-one was able to say exactly when the situation had become irretrievable but I accept Mr Anderson's evidence that the "golden period" was around the time of Dr Oates' examination.

[150] Kenneth McMillan was responsible for Mrs Sinclair's care during the day and evening of 9 March. The Crown submitted that it would have been a reasonable precaution for him to have initiated a fluid balance chart, to have conducted and recorded regular clinical observations and to have contacted NHS 24 sooner. Julie Bowmaker was critical of the lack of any fluid balance chart. However, Mr McMillan was not questioned about this and, in any event, there has to be doubt as to what this would have achieved, given Mr Anderson's opinion that a state of fluid depletion could not be addressed adequately in a care home setting. Mr McMillan's evidence was that he carried out observations on Mrs Sinclair is supported by the entries on p2 of the Daily Communication Notes CP 3 at 13.00, 10.00, and 18.45. Whilst these entries were written up at the end of his shift rather than contemporaneously (contrary to NMC practice), I am satisfied that he did carry out regular observations and that he did record them (albeit briefly) in Mrs Sinclair's notes. There was no evidence to suggest that he ought to

have contacted NHS 24 sooner. Whilst I am satisfied that it would have been a reasonable precaution to have initiated a fluid balance chart, I do not find it to have been a reasonable precaution to have conducted any more frequent observations or to have contacted NHS 24 sooner.

[151] I accept the evidence of Dr Oates as to his examination of Mrs Sinclair, in particular that there were no concerning abdominal signs; and I accept the opinion of Dr Qureshi that Dr Oates provided a reasonable standard of care. Dr Oates had properly considered a differential diagnosis and made a diagnosis consistent with his findings on examination. He cannot be criticised for that or for ordering a 1-hour ambulance. I do not therefore accept the Crown submission that it would have been a reasonable precaution for Dr Oates to have ordered an immediate "blue light" ambulance rather than a 1-hour ambulance.

[152] I accept the evidence of Dr Oates and Dr Qureshi that, whilst Eastwood Court staff were unable to contact Dr Oates after his departure if there was a delay in the 1-hour ambulance, Eastwood Court staff could have contacted 111 or 999 if need be. I do not therefore accept the Crown submission that it would have been a reasonable precaution for nursing staff to have been able to contact Dr Oates to advise him of the delay. Given the lack of any evidence that the SAS call-handler was aware of significant delays at the time Dr Oates ordered the ambulance, I do not accept the Crown submission that it would have been a reasonable precaution for SAS to have advised Dr Oates of delays.

[153] Given Dr Oates' findings on examination between 20.22 and 20.51, (which triggered the 1-hour ambulance request) and Nurse Wylie reporting that Mrs Sinclair's breathing was shallow when SAS called Eastwood Court at 02.01 (which triggered the upgrade by SAS to an emergency response) it is reasonable to conclude that there was a deterioration in her condition during that time. It is of note that no change in Mrs Sinclair's condition appears to have been noticed by staff at Eastwood Court until Nurse Hughes recorded her temperature at 01.00 as being 37.4°C (the medication notes contained in CP 5, page 3). This caused her to administer paracetamol and led to Mrs Sinclair's temperature decreasing to 36.6°C (also recorded in CP 5, page 3). At 01.22, Nurse Hughes still did not think that an emergency ambulance was required.

[154] It is a matter of concern that, apart from the entries in relation to temperature referred to in the foregoing paragraph, there is no documentary evidence which supports Nurse Hughes' evidence that observations were carried out hourly on Mrs Sinclair after Dr Oates left: no such observations are contained in the Daily Communication Notes and no TPR charts have been located. Mr Groombridge was unable to offer what he described as any "plausible explanation" for the absence of TPR charts; and I have concluded that there is, indeed, no plausible explanation.

[155] I am prepared to accept that Nurse Hughes carried out observations on Mrs Sinclair: that is consistent with what was recorded at 01.00 and 01.20. However, on balance of probabilities, I am not persuaded that Mrs Sinclair was monitored closely. That is consistent with the lack of documentation to support such a proposition. It is also consistent with Nurse Hughes's colleague, Nurse McMillan, during the course of

his call with SAS at 02.01, returning to the telephone 47 seconds after offering to check Mrs Sinclair (who was on a different floor). Nurse McMillan himself conceded that it would not have been possible to have carried out observations using medical equipment in such a short period of time.

[156] Based on the evidence presented, I consider it to be more probable than not that, with the exception of the documented observations at 01.00 and 01.20, the observations carried out on Mrs Sinclair were the sort of observations described by Julie Newton as "end of bed observations." I therefore hold that it would have been a reasonable precaution for Eastwood Court staff, following upon the departure of Dr Oates, to have monitored Mrs Sinclair by both making and documenting detailed clinical observations hourly until the ambulance arrived; and by both making and documenting detailed clinical observations when SAS contacted Eastwood Court for an update on her condition.

[157] The evidence demonstrates that SAS failed to comply with its own process of making welfare calls whilst the ambulance was outstanding. Had the 1-hour ambulance arrived within the timescale ordered, Mrs Sinclair would have been admitted to hospital many hours sooner than she was. The SAS ambulance arrived at Eastwood Court at 02.48. Observations were carried out prior to departure for hospital and the ambulance ultimately arrived at hospital at 03.55. It was 04.30 before Mrs Sinclair was admitted to the Immediate Assessment Unit. Therefore, there was 1 hour 42 minutes between the ambulance arriving at Eastwood Court and Mrs Sinclair being admitted to the Immediate Assessment Unit. Based on these timescales, it is reasonable to conclude that,

had an ambulance arrived within an hour of it being ordered at 20.47 – in other words by 21.47 – she would have been admitted to the Immediate Assessment Unit within 1 hour 42 minutes. On that basis it is reasonable to conclude that she would have been admitted by around 23.30. The failure of SAS to send an ambulance within an hour of an ambulance being ordered resulted in a 5-hour delay in hospital admission.

[158] I find that it would have been a reasonable precaution for SAS to have complied with its own welfare call-back procedure and to have contacted Eastwood Court hourly between the time of the ambulance being ordered by Dr Oates and an ambulance ultimately being dispatched. It is not disputed by SAS that such a precaution would have been reasonable.

[159] I find that it would have been a reasonable precaution for SAS to have undertaken a RES upon receipt of Dr Oates's call at 20.47 and at regular intervals thereafter until the call was upgraded at 02.09. It is not disputed by SAS that such a precaution would have been reasonable.

Section 126(2)(e)(ii)

[160] The fact that a precaution could reasonably have been taken does not automatically mean that that precaution might realistically have resulted in a person's death being avoided: there requires to be some causal link between the precaution desiderated and the death. The words used do not refer to a probability of death being avoided. They refer to a "real or likely possibility" that death might have been avoided

by the reasonable precaution. There has to be more than a remote chance of death being avoided.

[161] The difficulty in Mrs Sinclair's case there was no evidence of any observations of concern before Nurse Hughes noticed the increase in her temperature at 01.00 and administered paracetamol. I consider that, had SAS taken the reasonable precaution of conducting hourly welfare checks, on balance of probabilities, they would have been told by Eastwood Court on each occasion (as indeed they were by Nurse Hughes) that the picture was one of stability. There would therefore have been no upgrade in the prioritisation of the ambulance. If there was no upgrade in the prioritisation of the ambulance, Mrs Sinclair would not have arrived in hospital any sooner that she did.

[162] I consider that the evidence therefore demonstrates that there was no more than a chance that Mrs Sinclair's death might have been avoided. Even had she arrived in hospital sooner, Mr Anderson spoke of the substantial risks of surgery, even had it been carried out at an earlier stage. I do not therefore conclude that, had the reasonable precautions I have identified been taken, they might realistically have resulted in Mrs Sinclair's death being avoided.

[163] Given the conjunctive "and" at the end of Section 26(2)(e)(i), it follows that if I am not satisfied that both paragraphs (i) and (ii) are engaged, I am required to make a negative finding in terms of Section 26(2)(e). Whilst I have identified reasonable precautions in terms of Section 26(2)(e)(i) I cannot conclude that, had they been taken, they might realistically have resulted in the death being avoided in terms of Section

26(2)(e)(ii). I therefore find that there were no precautions which could reasonably have been taken which might realistically have resulted in Mrs Sinclair's death being avoided.

Section 26(2)(f)

[164] I have considered whether or not any defects in a system of working contributed to Mrs Sinclair's death.

[165] For such a finding to be made, there requires to be some causative link between the defect in the system and the death. It is not necessary that the defects caused the death, but a finding under Section 26(2)(f) requires a positive finding that the defect in the system of working actually contributed to the death.

[166] It was not disputed that there was no written policy at Eastwood Court in 2016 to guide staff in their care of a deteriorating patient. It was not disputed that the NEWS tool was not a tool commonly used in care home settings in 2016. The tool has been amended to NEWS 2 and NEWS 2 charts are now used at Eastwood Court. I do not consider that a failure to use NEWS in 2016 was a defect in a system of working, given that it was not commonly used in care homes in 2016. I make no such finding.

[167] The evidence at the Inquiry demonstrated that Mrs Sinclair started vomiting at 13.00. Her pathway of decline began at that stage. She deteriorated thereafter, particularly between the departure of Dr Oates at 20.51 and the ambulance being upgraded to an emergency response at 02.09. No deterioration was picked up on until a late stage – and, even then, by SAS staff on the telephone rather than Eastwood Court staff. I have already commented on the evidence suggesting that with limited

exceptions, observations were "end of bed" observations. However, it would be speculative to conclude that had a specific policy been in place in relation to monitoring and caring for a deteriorating patient, staff would have acted in any way other than they did. It would be speculative to conclude that such a policy may have altered the frequency with which observations were carried out and recorded. It would also be speculative to conclude that that may in turn have affected the point in time when a deterioration in Mrs Sinclair's condition was noticed. It would be speculative to conclude that that may have affected the time when the 1-hour ambulance was upgraded to an emergency response. It would be speculative to conclude that that ultimately may have affected the time when Mrs Sinclair arrived at hospital or that she might have been a candidate for surgery. I am not therefore satisfied that the absence of such a policy was a system failure which may have contributed to Mrs Sinclair's death. I make no such finding.

[168] I am not satisfied that the lack of provision for an out-of-hours GP such as Dr Oates to follow up with Eastwood Court or SAS regarding his request for a 1-hour ambulance was a system failure which contributed to Mrs Sinclair's death. There was evidence before the Inquiry to suggest that such a system would have been impracticable in the context of the out-of-hours service. In any event, there was a provision in place for staff to be able to call 999 or 111. There was no evidential basis to suggest that the outcome would have been any different had there been any contact between the GP and Eastwood Court after he had ordered the 1-hour ambulance and left the home. I make no such finding.

[169] The lack of provision for Eastwood Court staff to be able to alert an out-of-hours GP to an ambulance delay is immaterial: there was no evidence to suggest that staff were concerned by any delay in the present case, or that they would have utilised such a provision had it existed, or what effect such a provision might have had. I am not satisfied, on balance of probabilities, that this contributed to Mrs Sinclair's death. I make no such finding.

[170] Any failures identified during the course of the Inquiry seem to have been individual failings rather than systemic failings. Whilst it might be superficially attractive to conclude otherwise, I am not persuaded on balance of probabilities that there was a defect in any system of work that contributed to Mrs Sinclair's death.

Section 26(2)(g)

[171] This paragraph is broadly phrased. The facts established in terms of Section 26(2)(g) must be relevant to the circumstances of the death. This has been interpreted as meaning "the circumstances of the death as they may affect the public interest." No causal connection is required between such facts and the death in question. Looking at the public interest in the present case, I consider the following facts to be relevant:

(a) Eastwood Court's records relating to Mrs Sinclair do not contain detailed notes of the events of 9 and 10 March 2016. There is no record of Dr Oates' examination of Mrs Sinclair. There is no record of all calls made by SAS to Eastwood Court. There is no record of any clinical observations apart from temperature recordings at 01.00 and 01.20.

Record-keeping was therefore inadequate at the time. This has been addressed by Healthcare now providing core training resources on documentation and record-keeping.

(b) The utility of NEWS in care home settings became recognised at a point after Mrs Sinclair's death. The updated version (NEWS 2) is now used at Eastwood Court. It is a comprehensive tool which prompts staff to take specific actions in response to an overall score. The system provides a clear guide on the frequency of monitoring which should be carried out on a patient who is unwell or deteriorating.

(c) The SAER carried out by SAS in June 2017 made recommendations in relation to patient safety mechanisms, particularly welfare calls, which were all implemented. Additional measures were also implemented. Current SAS procedures in relation to welfare calls and dispatch of ambulances are more robust than they were at the time of Mrs Sinclair's death. They mitigate the risk of recurrence.

Recommendations

[172] In terms of Section 26(1)(b) of the Act the Sheriff may make recommendations in relation to any matters mentioned in Section 26(4) which might realistically prevent death in similar circumstances. No party to the Inquiry invited me to make any recommendations. I therefore make none.

Condolences

[173] The Crown and all participants in the Inquiry offered condolences to the family of the late Mrs Sinclair. The loss of a wife and mother is particularly poignant, and must have been all the more so when the family had initially been led to believe that Mrs Sinclair's situation was not life-threatening. They have demonstrated fortitude and dignity throughout. I wish to conclude this Determination by offering my respectful sympathies and condolences to them.