INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRIES ACT INTO THE SUDDEN DEATH OF GRACE FOSTER

SHERIFFDOM OF LOTHIAN AND BORDERS AT LINLITHGOW

DETERMINATION

by

MARTIN G R EDINGTON, WS

Sheriff of Lothian and Borders at Linlithgow

In Inquiry into the circumstances of the death of

GRACE FOSTER, residing latterly at 6 Hallcroft Neuk, Ratho

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

_____

Parties to the Inquiry:-

1. The Procurator Fiscal represented by Miss H Carmichael, Procurator Fiscal, Depute.

2. Lothian Health Board represented by Mrs E Coull, Solicitor.

3. The Foster family represented by one of Grace Foster's daughters, Mrs Catherine Laing.

LINLITHGOW 17th March 2006

The Sheriff, having resumed consideration, **DETERMINES** as follows:-

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act ("the 1976 Act"), that Grace Foster born 27 November 1943 died at St John's Hospital, Livingston between 02.55 hours and 03.00 hours on 28 February 2004.

2. In terms of Section 6(1)(b) of the 1976 Act that her death was caused by:-

(a) early adult respiratory distress syndrome; and

(b) recent surgery for bowel resection and ischiorectal abscess.

3. In terms of Section 6(1)(c) of the 1976 Act that her death might have been avoided by the following reasonable precautions:-

(a) an early in-patient colorectal referral might have been sought as originally envisaged in the medical notes on 11 February 2004;

(b) such a colorectal referral would have been reasonable to Mr Anderson who was the colorectal consultant in St John's Hospital at the time subject to his return from annual leave on 16 February 2004, or to Mr Browning who had considerable colorectal experience having been trained in colorectal surgery at a world-renowned hospital or to any colorectal Consultant at an appropriate hospital in Edinburgh, some fifteen miles away;

(c) such colorectal intervention would almost certainly have led to steps being taken to investigate the apparent anomaly between the patient supposedly improving yet whose blood and haematology results disclosed the opposite. Further investigations would almost certainly have included a CT scan which might well have enabled doctors to trace the underlying cause of Mrs Foster's condition. Such a scan was extremely likely to have disclosed any pericolic abscess or diverticulitis. Such disclosure would have led to treatment either by specific antibiotics or appropriate surgery. Such treatment might then have produced a better outcome for Mrs Foster, including the possibility of a full recovery;

(d) further monitoring of Mrs Foster's haematology and biochemistry results and CT scanning would have been reasonable because of the abnormal results disclosed on 15 and 16 February 2004. Both the ability to monitor these results and to carry out a CT scan were available at the time in St John's Hospital and might have prevented Mrs Foster's death because it would have been easier to establish trends in respect of the levels of haemoglobin, albumin, platelets and white cell count, all of which can be indicators of whether or not there is ongoing sepsis. CT scanning is capable of detecting pericolic abscesses and diverticulitis and had such a source of sepsis been disclosed, a Surgeon would have been likely to treat it by appropriate antibiotics or appropriate surgery with such treatment perhaps enabling Mrs Foster to recover.

4. In terms of Section 6(1)(d) of the 1976 Act there were the following defects in the systems of working which contributed to Grace Foster's death:-

(a) the failure to obtain and/or report the blood and biochemistry results which contributed to the death of Grace Foster as this resulted in blood results which contained significant abnormalities not being brought to the attention of those doctors responsible for her care. Those abnormalities were such that they would almost certainly have required further monitoring and investigation and as indicators of an ongoing process or potential ongoing sepsis, could have resulted in doctors investigating the cause or causes underlying Mrs Foster's condition. Such investigations would have included some form of CT scanning to have detected any pericolic abscess or diverticulitis;

(b) the failure to monitor, record, note and report any diarrhoea from which Mrs Foster suffered during her stay in hospital. Diarrhoea was a significant symptom which was not brought to the attention of the doctors and which could have pointed to a colonic pathway underlying her condition and which would have merited further investigations by CT scans. Said scans could have detected any pericolic abscesses or diverticulitis.

5. In terms of Section 6(1)(e) of the 1976 Act that the following facts are relevant to the circumstances of her death:-

(a) Dr Pandolfi's manner during his visit to Mrs Foster's home on 24 February 2004 caused distress to Mrs Foster;

(b) similarly the two occasions when Mrs Foster was left unsupervised by nursing staff in the bath also caused her considerable distress.

(c) full and accurate medical and nursing notes are absolutely essential to

enable a proper assessment of the patient to be made by all medical

staff involved in the care of the patient.

And Further **RECOMMENDS**

That the appropriate authorities should ensure that full and legible notes are made, using standard abbreviations or phrases, so that these notes can be readily read by anyone involved in the care of the patient and at shift handovers.

NOTE

Background to the Inquiry

I heard evidence over nineteen days from twenty five witnesses in the following order, with the first twenty four being called by the Crown and the twenty fifth by the Health Board:-

1. Catherine Laing, daughter of the late Mrs Foster.

2. Thomas Foster, husband of the late Mrs Foster.

3. Theresa Cheyne, daughter of the late Mrs Foster.

4. Anne Smith, daughter of the late Mrs Foster.

5. Martin Pennie, Nurse.

6. David Anderson, Colorectal Consultant.

7. Andrew Pandolfi, Mrs Foster's GP.

8. Gavin Browning, Consultant.

9. Peter Driscoll, Specialist Registrar General Surgeon.

10. Karen Rose, Pre Registration House Officer.

11. Rebecca Goody, PRHO.

12. Craig Walker, PRHO.

13. Michael Duff, Specialist Registrar Surgeon.

14. Ruth Roper, Tissue Viability Nurse.

15. Bruce Tulloch, Consultant General Surgeon.

16. Professor Anthony Busuttil, Consultant Pathologist.

17. Betty Nicolls, Staff Nurse.

18. Sudhir Prabhu Khanolkhar (known as Prabhu), Staff Grade Surgeon.

19. David Hamer Hodges, retired Colorectal Consultant Surgeon.

20. Diane Lamb, District Nurse.

21. Laura Hughes (formerly Ferrie) District Nurse.

22. Kevin Irvine, General Practitioner.

23. Margaret Bainbridge, Staff Nurse.

24. Carol Houston, Registered General Nurse.

25. Roger Brookes, retired Consultant General Surgeon.

The Background to this Inquiry is helpfully set out in paragraphs 1 to 17 of the joint minute of agreement signed and lodged by all parties. These paragraphs record the following facts:-

1. That Mrs Grace Foster (date of birth 27 November 1943) died at St John's Hospital, Livingston between 02.55 hours and 03.00 hours on 28 February 2004.

2. That on 26 January 2004, Mrs Foster attended her GP and was seen by a locum.

3. That on 3 February 2004, Mrs Foster attended her GP and was seen by Dr Pandolfi.

4. That on 7 February 2004, a telephone call was made to the Primecare out of hours service.

5. That on 8 February 2004, Mrs Foster is seen at home by a GP from the Primecare out of hours service.

6. That on 9 February 2004, Mrs Foster was admitted to St John's Hospital, having been taken by ambulance to the A & E Department of St John's Hospital.

7. That on 9 February, at St John's Hospital, Mrs Foster underwent an operation for incision and drainage of an ischiorectal abscess.

8. That on 12 February 2004 at St John's Hospital, Mrs Foster underwent a further operation for debridement of an ischiorectal abscess.

9. That on 19 February 2004, Mrs Foster was discharged home from St John's Hospital.

10. That on 20 February 2004, Mrs Foster was visited at home by a District Nurse from the Ratho surgery.

11. That on 21 February 2004, Mrs Foster was visited at home by a District Nurse from the Ratho surgery.

12. That on 22 February 2004, Mrs Foster was visited at home by a District Nurse from the Ratho surgery.

13. That on 23 February 2004, Mrs Foster was visited at home by a District Nurse from the Ratho surgery.

14. That on 24 February 2004, Mrs Foster was visited at home by a District Nurse from the Ratho surgery.

15. That on 24 February 2004, Mrs Foster was seen at home by her GP Dr Pandolfi.

16. That on 25 February 2004, Mrs Foster was visited at home by a District Nurse from the Ratho surgery.

17. That on 26 February 2004, Mrs Foster was re-admitted to St John's Hospital, having been taken by ambulance to the A & E Department of St John's.

Section 6(1)(a)

Upon her re-admission on 26 February, Mrs Foster was already in extremis. She was not well enough to undergo immediate surgery and was initially referred to the Intensive Therapy Unit for aggressive organs support. Following the performance of a flexible sigmoidoscopy it became apparent that Mrs Foster would require a laporotomy examination of the intra abdominal and pelvic contents to endeavour to trace her on-going problem. By 27 February it was a matter of agreement amongst surgeons that there may be a source of sepsis within the abdominal cavity. Surgery was then performed later that same day and included a Hartmann's procedure where the sigmoid colon was removed and a total abdominal hysterectomy and bilateral salpingo-oopherectomy were performed. Despite the apparent success of the operation, tragically Mrs Foster's condition deteriorated and she died in the early hours of 28 February 2004.

Section 6(1)(b)

The cause of death was established by Professor Busuttil who found that the cause of death was (a) early adult respiratory distress syndrome and (b) recent surgery for bowel resection and ischiorectal abscess. In his evidence Professor Busuttil stated that the cause of the early adult respiratory distress syndrome was infection which made Mrs Foster ill. This led to multi organ failure. She was placed on a respirator. The cause of death was a combination of the infection, her recent surgery and this requirement for ventilation. There was much evidence about peritonitis but Professor Busuttil's evidence was that, at post-mortem, he found no obvious evidence of peritonitis. In support of his position Professor Busuttil explained that the fluid found in the abdomen was consistent with an early peritonitis. It was blood tinged and not mixed with pus. The fluid could be consistent with ascites. Ascites were not pus and could have a number of different causes.

Mr Tulloh had assisted Mr Jolly at the laparotomy on 27 February. Several litres of straw-coloured, turbid ascites were found but no source for same was spotted. The sigmoid was inflamed and adherent but Mr Tulloh was not sure if the sigmoid colon or the uterus was the cause. As it seemed to him likely that diverticular disease was the cause of perforation of the colon, a Hartmann's procedure and colostomy were carried out along with the removal of the uterus and ovaries which appeared ischaemic. The operation was carried out because Mrs Foster was in septic shock but the source of the sepsis was not traced. The inflammation generally was not severe and was therefore possibly reasonably recent. Mr Tulloh accepted that there could have been a perforation from the sigmoid to the mesocolon. Had that been the case he would have expected induration in the mesocolon. The mesocolon had been tied later but not mentioned in the written note of the operation prepared by Mr Tulloh. When put to him that there were a number of differences between his note and the operation note of Mr Jolly, Mr Tulloh accepted that Mr Jolly may have seen things, including a perforation into the sigmoid mesocolon which Mr Jolly had described as grossly inflamed but which Mr Tulloh had not himself seen or noted. The pelvic floor had appeared normal and Mr Tulloh had not seen any fistula. He accepted that it was not always possible to see a fistula. Mr Hamer Hodges accepted there was no obvious evidence of either peritonitis or a perforation in the pelvic cavity, at least not until the final hours of Mrs Foster's life. Mr Brookes agreed that, with hindsight, there was ongoing sepsis but felt that Mrs Foster had been coping until the pericolic abscess burst at which point her condition deteriorated quickly. Mr Brookes felt that this pericolic abscess had been contained and was separated from the peritoneal cavity by a membrane. It was thus enclosed but ultimately ruptured into the peritoneal cavity resulting in peritonitis. From the opinions expressed by these various doctors it does not appear to me that there is enough evidence to justify the substitution of peritonitis for either of the two causes of death previously stated by Professor Busuttil.

In my view I cannot make a finding as to a specific accident which resulted in the death of Grace Foster. The evidence I heard was insufficiently clear as to when the pericolic abscess ruptured. It was possible that the rupture was before Mrs Foster's re-admission to hospital on 26 February but equally it could have occurred afterwards. If it was the former it may have precipitated the final collapse which led to her death but I am not in a position to make a finding one way or the other.

Section 6(1)(c)

One of the main areas of dispute in this case was the issue of whether or not Mrs Foster's case should have been referred to a Colorectal Consultant as opposed to her case being managed by General Surgeons. Evidence was given by a number of Consultants including Messrs Anderson, Browning, Tulloh, Hamer Hodges and Brookes. It was most unfortunate that Mr Adib, who was one of the doctors principally involved in the care of Mrs Foster, chose neither to attend Court to give evidence nor, despite his being contacted in Australia where he now works, to respond to requests from the Crown for some form of written commentary or precognition. Whilst it was equally unfortunate that Mr Jolly did not attend the inquiry to give evidence, he did at least take the trouble to provide a notarised statement which comprises Crown production 5. It is not for me, in terms of this inquiry, to decide whether or not the doctors concerned took reasonable steps whilst exercising their clinical judgement. The issue under this head is whether or not there existed reasonable precautions which, had they been taken, might have prevented the death of Grace Foster. As has been said a number of times by Sheriffs, it is not the function of an inquiry to make any findings of fault or to apportion blame. One of the purposes of an inquiry is to investigate matters so as to avoid a repetition of the accident. Thereafter having established such a process or event it is appropriate to see what steps might have been taken to avoid the outcome or to identify what defects there were. Reference was made by Mr Jolly in Crown production 5 to the fact that the retrospectoscope is a wonderful tool. That is undoubtedly so, but hindsight is permitted in terms of the statutory provisions to enable such retrospective consideration of matters. Hindsight allows me to come to the conclusion that there were ample signs available to the various doctors at the time which were suggestive of the fact that Mrs Foster was not making the progress that some (but not all) thought she was and that these were matters which merited further investigation prior to her discharge from hospital on 19 February. The evidence of the Colorectal Consultants was generally to the effect that it would have been preferable and certainly reasonable to have referred Mrs Foster to a Colorectal Specialist after her second operation on 12 February but before her discharge on 19 February. It was the evidence of the General Surgeons that such a referral was not necessary.

This leads directly to another issue of considerable dispute in this case, namely the question of whether or not Mrs Foster had diarrhoea during her stay in hospital. To one extent this may be considered irrelevant because the evidence of Messrs Anderson, Browning and Hamer Hodges was to the effect that a referral for colorectal opinion would have been appropriate even in the absence of diarrhoea but all were similarly agreed that had they been advised of the presence of diarrhoea, that would very much have strengthened the likelihood of such a referral. The question of diarrhoea arises in other areas of this case and I will come to those in due course.

There was conflicting evidence in relation to any possible colorectal reference. In the first instance Dr Goody the Pre-Registration House Officer (PRHO) responsible for writing up the clinical notes on 11 February 2004 had written an entry, following discussion with Mr Adib, "for transfer to colorectal under Mr Anderson next week". Without Mr Adib's evidence it is difficult to know exactly what to make of that beyond perhaps the logical conclusion that Mr Adib did consider that the correct way forward was to refer Mrs Foster to a Colorectal Specialist in early course. It may be that the

referral to Mr Anderson was to be delayed until that time because Mr Anderson was not due back from annual leave until 16 February. However, within 24 hours, and indeed it appears in the very next entry in the clinical notes for 12 February as entered by Dr Craig Walker, another PRHO, that plan altered to "F/up in Colorectal out-patient Dept; Mr Anderson". There was other evidence that that would be in 6 to 8 weeks time and indeed Health Board production 2 is a computer printout showing that an appointment was made for Mrs Foster to see Mr Anderson at 10 am on 2 April 2004. No satisfactory explanation was given for this apparent and relatively major change of plan. Mr Brookes did give evidence that he would have followed the latter course but that the out-patients appointment in 6 to 8 weeks time would have been with him, and not a Colorectal Specialist and he would only have referred the case on to a Colorectal Specialist had he found a fistula. This evidence appeared to me to be predicated on the fact that Mr Brookes would have been heavily involved in the care of such a patient from start to finish and therefore fully familiar will all aspects of the case at all times. This was not a feature of the care of Grace Foster, another matter to which I shall return later.

Whilst it would have been reasonable to refer Mrs Foster for an urgent colorectal consultation, that position was underlined by the blood results shown in Crown Production 2, volume 1, page 50 and Health Board Production 1. The haemoglobin level continued to fall and the platelet count continued to rise. In addition the bicarbonate level of 18 was low and indicative of acidosis. Had the blood results of 16 February been available to the consultants in charge of Mrs Foster's case, and there is considerable doubt as to whether they were or not, another matter to which I will revert later, any doctor should have been concerned that this was inconsistent vis-à-vis a patient seemingly on the mend and was likely to have indicated that there was another process going on.

Had a colorectal referral been made prior to Mrs Foster's discharge on 19 February there were a number of options open including an examination under anaesthetic to look for any fistula which might be feeding the wound. Depending on the outcome of that, a CT scan or CT colonography would almost certainly have followed. Such scans can show pelvic abscesses and pericolic abscesses. Should such a diagnosis then have been made, appropriate antibiotics would have been tried failing which immediate surgery as appropriate. There was certainly evidence that such action could lead to full recovery.

Whilst the nursing notes seemed to indicate an improving patient whose wound was getting better and who was mobile, the issue was further clouded in the nursing notes, C P 2 volume 1 page 126, where there was a detailed entry dated 19th February setting out a number of complaints made by telephone on 18th February as expressed by Mrs Foster's family to the nursing staff. It is perhaps significant that one of her daughters, Theresa Cheyne, was herself a staff nurse of some experience. That entry was another matter which ought to have led to a review of the decision to discharge Mrs Foster from hospital. More confusion seemed to be occasioned by the notes indicating that Mr Adib recommended aiming for discharge on 20th February yet it was on 18th February that there was a discussion between Mr Jolly and a nurse about discharge the following day. Mr Jolly states that this discussion was initiated by the nurse and all he did was to check that this had been recommended by Mr Adib and then to agree to it on that basis. Had the notes been

properly read or properly drawn to Mr Jolly's attention he might well not have agreed to discharge one day earlier than planned by Mr Adib. Alternatively, and more sensibly, Mr Jolly might have taken control of the case and carried out his own full and proper checks in respect of Mrs Foster before agreeing her discharge.

There seemed no dispute that the operation on 9 February had been appropriate and there was no real criticism of the requirement for a second operation on 12 February because of the presence of necrotic tissue. There also seemed no dispute that both operations were perfectly appropriate for General Surgeons. The dispute thereafter was, by and large, that the General Surgeons felt that although it would be reasonable for them to have referred Mrs Foster to a Colorectal Surgeon, it had not been necessary. The Colorectal Surgeons tended to the view that the case ought to have been referred to them.

The albumin level of 17 was also something which would cause concern. One explanation was malnourishment which again did not sit comfortably with the picture painted in the notes of a clinically well and improving patient. Had this albumin figure been known to Mr Tulloh then allied to everything else in relation to the blood results, the family's objections, etc. he would have been unlikely to discharge Mrs Foster. He would have been likelier to repeat the blood counts, biochemistry and liver function tests, may well have carried out a CT scan and/or an endoscopy and colonoscopy to check for inflammation, colitis, ischaemic colitis, Chrohn's disease, inflammatory bowel disease or diverticulitis.

It was apparent from Mr Jolly's notarised statement that Mr Jolly had no management of Mrs Foster's care between 12 and 18 February but that rather her care lay between Mr Adib and Mr Tulloh. The latter had not been aware of the family's concerns and was unaware of them having made an appointment to address these concerns with Mr Adib. Mr Tulloh would have expected light-headedness, poor mobility, problems with bathing, etc. to have been recorded in the notes. Significantly Mr Tulloh could not recall having seen the blood results of 16 February and was unable to state that any other person had seen them. It is the responsibility of the very junior doctors to check these results which are available on computer the day they are done. Hard copies often take much longer but it would have been up to the junior doctor who obtained these results to draw his or her concerns to the attention of more senior colleagues. The absence of such results should also have caused senior doctors to ask about them. Mr Tulloh accepted that the family appeared to have tried quite hard to raise concerns, without seeming to have got very far.

Mr Tulloh did not seem to regard Mrs Foster's case as a very rare presentation. Mr Hamer Hodges and Mr Brookes did. I agree it was a very rare and very tragic case.

As far as the diarrhoea was concerned Mr Tulloh accepted that the doctors would be quite unlikely to notice it as such because Consultants in particular spent very little time on the actual ward. He did find it surprising given the family's position that the medical and nursing notes appeared to be silent as regards ongoing diarrhoea.

Mr Hamer Hodges certainly found it odd that there was an intention before the second operation to refer Mrs Foster to the Colorectal Specialist and yet this management plan was altered on 12 February, the day of the second operation. This

was despite the fact that the second operation clearly in his view rendered the case more complicated and outwith the expertise of a General Surgeon. Ischiorectal abscesses are more deeply placed and generally rarer and more complicated than perianal abscesses. Part of what caused Mrs Foster's case to be more complicated was her tachycardia, ongoing sepsis and the ongoing problem with the wound. He was concerned that by 12 February no fistula had been found and not only had the abscess failed to resolve after the operation on 9 February, it had got worse.

Mr Hamer Hodges had also noted that Mrs Foster, up to 16 February, continued to require a substantial amount of analgesics.

Mr Hamer Hodges also felt there was an area of confusion from the nursing notes which suggested that Mr Jolly had approved the discharge. That was suggestive of Mr Jolly being in clinical control and yet Mr Jolly himself in his notarised statement appeared to be doing his best to disassociate himself from clinical involvement. If, as seems likely, Mr Jolly was asked by a nurse about discharge, he should either have referred the matter to Mr Adib or he should have carried out all the appropriate checks himself before agreeing on discharge. It had to be of some concern that Mrs Foster required tramadol, a very strong analgesic, the evening before her discharge.

Although there was much the various doctors did seem to agree about, the two expert witnesses were Mr Hamer Hodges and Mr Brookes. Mr Hamer Hodges' view was that he felt Mrs Foster had suffered a continuous illness which started many weeks previously with the diarrhoea and progressed through the various operations to the abscess with the subsequent rapid decline, re-admission and death. The alternative view preferred by Mr Brookes was that the abscess had been adequately dealt with and that the perforated colon was unrelated to that first abscess. Mr Hamer Hodges' view was that Mrs Foster died as a result of a debilitating illness over a longish period of time. His view was that there had not been a sudden perforation with overt peritonitis but rather that Mrs Foster had gradually deteriorated to the stage where her body could not handle the illness any longer. The likeliest explanation was that a pericolic abscess had formed due to diverticular disease and there was, an admittedly very rare, pericolic sepsis which had gone untreated. Mr Hamer Hodges felt that although there may have been a separate perforation of the sigmoid towards the very end, it was to an extent irrelevant because of the debilitating, complex, lengthy septic illness which Mrs Foster had suffered.

When questioned about the lack of faecal matter or pus at the final operation on 27 February, Mr Hamer Hodges explained that the presence of the turbid fluid was a reaction to what was happening in the pelvis. The General Surgeons carrying out the operation had not had the benefit of a CT scan and so were not aware of where any abscess might be. They searched for but did not find a source of the sepsis. Mr Hamer Hodges explained that the amount of disease was likely to have been very small when compared with the damage which was ultimately occasioned. He felt this was characteristic of a perforated sigmoid following upon diverticular disease. Although he differed from Professor Busuttil, who felt that an abscess of approximately 30 cc's in size would be required before there could have been sufficient discharge from the pericolic abscess to track down, Mr Hamer Hodges felt that Professor Busuttil's findings at post-mortem were consistent with Mr Hamer

Hodges' explanation of sigmoid diverticulitis which had discharged through the pelvic floor into the pararectal tissues rather than into the peritoneal cavity.

Mr Hamer Hodges was also critical of the fact that grossly abnormal blood results had not been recorded in the notes and he gave evidence to the effect that Consultants frequently read notes, they did not simply reply on being briefed by junior doctors and nurses during ward rounds.

Mr Brookes disagreed with a number of the points made by Mr Hamer Hodges, with particular reference to the blood and biochemistry results. He himself diagnosed necrotising cellulitis from the information available to him. He was to my recollection the only doctor who did so. Mr Brookes was of the view that this diagnosis explained the low haemoglobin levels because of this toxic activity. He felt the elevated platelets were due to the ongoing wound in the buttock and pointed out that platelet levels would take a while to start to show change. He put the low albumin level down to the long history of diarrhoea and vomiting and the fact that Mrs Foster's dietary intake had been poor for some time. Mr Brookes was of the view that in his lengthy experience, nursing staff at his hospital were meticulous in writing up their nursing notes. Whilst that may have been his general experience it did not seem to me to be an opinion based on the notes which were put in evidence and which contained a number of mistakes, omissions, factual inaccuracies, ambiguous entries which could be read in more than one way, entries with insufficient detail and, perhaps most worryingly, a surprisingly large number of entries which either could not be read by some of the medical staff, both doctors and nurses, who gave evidence, or where guesses had to be made as to what was probably meant. There was no common abbreviation for a number of entries for example a note that the patient had passed urine might be written in any of eight different ways that I counted e.g. has passed urine, P.U.ing, H.P.U., P.U.D., passing urine, voiding (this was a guess because the word could not be clearly made out) urine, M.P.U. and P.U.'d. I did not feel that the notes in this case were "meticulous". In addition, it seemed to me that the word "communication" featured strongly throughout the evidence. Whilst everyone seemed to agree that good and clear communication was vital, it seemed to be lacking in this case both in terms of oral communication amongst all the qualified staff involved and written communication in terms of the inadequate medical and nursing notes.

Mr Brookes accepted there was a discrepancy between the notes and the position reported by the family in relation to whether or not Mrs Foster had diarrhoea. Mr Brookes accepted he had not been able to ascertain the state of Mrs Foster's bowels between 9 and 18 February and the district nursing notes provided anything but a clear picture given that one district nurse had made an entry that Mrs Foster's bowels had not opened for 7 days, whilst the second district nurse to see her, one day later, made an entry that Mrs Foster's bowels had not opened for 3 or 4 days. It is also significant that there is an entry in the district nursing notes which seems to suggest a denial by Mrs Foster that she had said her bowels had not opened for 7 days.

Mr Brookes made much of the fact that Mr Adib had been happy to manage Mrs Foster's care and had taken a perfectly proper decision to refer her to a Colorectal Specialist 6 to 8 weeks after discharge. Mr Brookes would in fact have seen the

patient himself at that time and only if a fistula had occurred would he then ask for colorectal input. Whilst that may or may not have been appropriate for someone of Mr Brookes' experience, it did seem to me that he had slightly missed the point in that there was confusion firstly over the fact that Mr Adib appeared initially to be suggesting an urgent colorectal consultation within one week of the first operation only for the position to be changed the next day by a different doctor who changed the plan to a colorectal consultation in 6 to 8 weeks time as an out-patient and secondly the general confusion which there appeared to be over who was in fact in charge of this case. With reference to the first of these points the clinical note was written up by the PRHO, Doctor Walker, and appeared to be following a discussion with Mr Prabhu. Dr Walker could not remember the discussion but was adamant that he wrote what Mr Prabhu had told him. Mr Prabhu was equally adamant that he had not told Dr Walker that there should be a follow up in Colorectal Outpatient Department with Mr Anderson. That would not be a decision for him to make, but rather one for a Consultant. With regards to the second point, whilst it appeared to a large extent to be Mr Adib, he was only part-time at St John's and part-time at another hospital in Edinburgh and it was Mr Jolly, ultimately, who appeared to authorise the discharge. All of the Colorectal Surgeons would have preferred to have been involved earlier.

Mr Brookes and Mr Hamer Hodges also disagreed about whether or not the wound should have been examined in theatre to determine whether the wound was healing. Again this may simply be an area of different practice between General Surgeons and Colorectal Surgeons.

Again there was disagreement about whether or not Surgeons should have proceeded with a laparoscopy without the benefit of a CT scan. That seems to me to have been simply a matter of clinical judgement.

Mr Brookes did agree with Mr Hamer Hodges that it had been unnecessary to remove Mrs Foster's uterus but that it was irrelevant to the eventual outcome and it was at least understandable why Messrs Tulloh and Jolly should have proceeded with that part of the operation. He also agreed with Mr Hamer Hodges that this was a very unusual and very rare case with his view being that Mrs Foster had diverticulitis which had perforated into a contained abscess which in turn perforated behind the peritoneal covering of the abdomen before tracking down to the space behind the rectum and into the buttock. Neither he nor Mr Hamer Hodges was surprised this had not been detected. He disagreed with Mr Hamer Hodges that there could have been a direct adhesion from the sigmoid to the pelvic floor. Mr Hamer Hodges felt this could have been disturbed during the operation. Mr Jolly was not available to give evidence on that direct point and Mr Tulloh, who had assisted Mr Jolly, conceded that he could not know exactly what Mr Jolly had or had not found. Mr Brookes felt that any such adhesion would have been sufficiently strong to require dissection away from the pelvic floor during the laparotomy.

Mr Brookes was not critical of the surgeons at St John's and stated that he would have placed considerable emphasis on the appearance and seeming wellbeing of the patient. The nursing notes indicated that she was mobile, walking and getting to and from the bath. Whilst that may be understandable, it was not the picture painted by the family and this was a family who were in attendance daily and provided

considerable assistance in toileting and bathing Mrs Foster. This bath was some distance from her bed and was not the toilet situated only a few feet from Mrs Foster's hospital bed in the side room. Family evidence on this point was that Mrs Foster required a wheelchair to get to and from the bath, and assistance getting into and out of the bath. It was the family who bathed Mrs Foster every day following two incidents which had caused Mrs Foster considerable concern and distress. On the first day after her first operation, a nurse had assisted Mrs Foster into the bath and then left her for what was meant to be a very short time to soak. This nurse, who was not identified in the inquiry, appears to have admitted later that she forgot about Mrs Foster and went for her break. Mrs Foster had not been given, and could not reach, the emergency buzzer and had to sit there until someone eventually came. Following a second, not dissimilar situation where again Mrs Foster had not been handed the emergency buzzer, and eventually struggled out of the bath feeling light-headed before obtaining assistance from a male nurse, Mrs Foster's family offered to deal with bathing Mrs Foster every morning. This assistance appeared to be gratefully accepted by nursing staff as there did not appear to be sufficient staff to ensure that Mrs Foster's bathing requirements were adequately supervised on every occasion. Insufficient attention also seemed to be put upon the one nursing note of considerable length namely a telephone call on the evening of 18 February by a member of the family, Theresa Cheyne, who herself, as indicated previously, has considerable nursing experience.

Mr Brookes did accept that if he had been aware of the level of Mrs Foster's white cell count he would have carried out a CT scan of Mrs Foster's abdomen, the purposes of which would have been to seek any infective process.

Mr Brookes did accept that the full picture of falling haemoglobin levels, low albumin level, the white cell count, rising platelets and low bicarbonate levels did present a picture which was clearly not one of recovery. In that situation he would probably have sought faecal occult bloods, liver function tests, a sigmoidoscopy to check for ulcerative colitis, a CT scan and further blood results. It was not acceptable that the blood results from 16 February did not appear to have been chased up and hence did not appear to have been available for the doctors who discharged Mrs Foster. Mr Brookes conceded that whether or not Mrs Foster had diarrhoea in hospital, the blood results of 16 February did not show a recovering septic situation whereas the notes for the same period suggested the patient was indeed improving. The presence of diarrhoea would have ensured that it required to be investigated further before discharge. Mr Brookes remained of the view that colorectal expertise was not necessary even at this stage.

Mr Brookes gave his evidence as a retired Consultant General Surgeon. Whilst it may be understandable, it did seem to me that his evidence was coloured to an extent by his seeming determination to stick up for what may gradually be becoming the disappearing practice of the general surgeon. His evidence seemed often to be a simple endorsement of what the General Surgeons had done in this case but much of that seemed predicated on his own opinion that everything was fully and properly done e.g. that nursing notes were always meticulous. One of the difficulties with this case seemed to me to be the huge number of doctors from very junior PRHOs all the way up to Consultants who seemed to be involved in the care of Mrs Foster, the lack of general communication between them and possible confusion as to who was

actually the doctor in charge. Mr Brookes was also not inclined to consider matters with hindsight, unless it suited his purposes to do so.

Mr Hamer Hodges seemed less determined than Mr Brookes to defend his hypothesis come what may and it seemed to me that he commented fully and fairly on all points put to him. Where it has been necessary for me to prefer the evidence of one of these eminent consultants over the other, I have tended to prefer the evidence of Mr Hamer Hodges. We will never know whether or not Mrs Foster's death could have been prevented but I am certainly of the view that there were steps which could have been taken which were likely to have given Mrs Foster a better chance of survival.

There was an amount of disagreement between Messrs Brookes and Hamer Hodges in relation to what started Mrs Foster's condition and how it developed. It seems to be agreed that the pericolic abscess which existed from at least 9th February was the source of the ischiorectal sepsis. The exact nature of how that may have tracked down was given different theories and I do not think it necessary for me to second-guess which was or was not the likelier of the two.

It is also perhaps to an extent irrelevant whether or not a general surgeon or a colorectal surgeon was in charge given that there were further investigations which could have been carried out by either e.g. the CT scan. On balance I am of the view, given the overall picture, that the more specialist colorectal input would have been the preferable choice. There is no question but that these precautions were available and therefore would have been reasonable.

Two very distinct lines of evidence were very much apparent in this inquiry. On the one hand there was the position detailed in the medical and nursing notes and the evidence taken from the various witnesses who spoke to these notes. On the other hand there was a somewhat different picture painted in the evidence given by the various members of the Foster family. Mr Tulloh also conceded that he felt Mrs Foster to be pretty frail and slow to recover.

On reading the clinical notes, there is no mention of diarrhoea and the general impression is given of an improving patient who was fit to be discharged home on 19th or 20th February. That evidence was flatly contradicted by the family who had the inestimable benefit of knowing Grace Foster intimately and being very well placed to know her true condition. This was not just a family who popped in for an hour at visiting time but rather a family who accompanied Mrs Foster even on seemingly straightforward visits to her GP and who were heavily involved in bathing her and generally assisting in looking after her for lengthy periods of each day that she was in hospital. It seems inconceivable that they could note copious amounts of diarrhoea whilst no member of the nursing or medical staff saw any such signs at all. Whilst it is possible, with hindsight, to think that the family may have unwittingly exaggerated the amount of diarrhoea, I cannot believe that they invented it all. Their evidence was graphic and entirely credible. I accept that some two years had passed from the date of death until the holding of the inquiry. Nurses see a considerable number of patients and cannot possibly be expected to remember every detail of every patient. Nonetheless it seemed to me there was a distinct lack of evidence from nurses who had looked after Mrs Foster in hospital, and those that did give

evidence frequently could remember very little about the situation. Given that I have not been impressed by the standard of note-taking and keeping, it is not hard to prefer clear and credible evidence given, in a consistent fashion, by all of the family.

It may also be significant that the picture painted by the family of Grace Foster was of a somewhat shy, private yet very independent person who had an actual fear of doctors and hospitals. It seems to me quite likely that Mrs Foster would have minimised such problems that she might have had e.g. with diarrhoea. She is also likely to have said that she was feeling a bit better when perhaps this was not strictly so. She did not appear to fool the family who felt that throughout her stay in hospital Mrs Foster remained light-headed, weak, unwell and in a situation or state which was declining rather than improving. Given Mrs Foster's own nature, it may not be a complete surprise that the nursing notes in particular paint a deceptively incorrect picture. It did not help that when one of the nurses was asked in cross-examination to describe Grace Foster, her description was very vague and did not seem to coincide with the general appearance of Mrs Foster, e.g. hair length and colour which was put in cross-examination by Mrs Laing.

I am strengthened in my view that the evidence of the family is the correct evidence by the fact that even Mr Brookes conceded in cross-examination that had the full blood results, etc. been known at the time of discharge, they should certainly have raised serious concerns to counter the view from the medical and nursing staff and the medical and nursing notes that Mrs Foster was a recovering patient.

Section 6(1)(d)

No evidence was given during this whole inquiry that any doctor had actually seen the blood results of 16th February before Mrs Foster was discharged. It must be significant that both the PRHO doctors, Goody and Walker, accepted in evidence that the blood results were concerning and that, had they seen them, they would have passed on the information to a more senior colleague and then recorded not only the blood results in the medical notes but also the discussion of the abnormalities with their senior colleague. There was also considerable evidence that any doctor seeing those results would have queried the supposed picture of a recovering patient and would almost certainly have delayed discharge to enable further tests to be carried out. It was initially of considerable concern that Health Board production 1, the haematology printout, seemed only to have been printed in December 2005. I suppose it is possible that that was printed purely for the purposes of being produced as a document for evidential purposes in the inquiry. It does not necessarily prove either that this was the first time this document had ever been printed or that it was not. What is of concern however is that there was not with the medical notes a copy of this document which would have suggested it had been printed and placed with the notes at any time before Mrs Foster's death. It therefore seems to me quite clear that this had not been done, for whatever reason. It is my recollection that only Mr Driscoll dissented from the view that the blood results of 16th February would cause any concern. Given Mr Driscoll's very very limited involvement in the case and almost equally limited recollection, I have little difficulty in accepting the evidence given by all the other doctors that these blood results would have given cause for concern and that such concern would almost certainly have led to a delay in discharge and further tests being carried out.

As has been mentioned previously, the question of whether or not Mrs Foster had diarrhoea was one of the most disputed issues in the whole inquiry. It is perhaps worth rehearsing at this stage some of the evidence actually given.

I will endeavour to summarise the evidence given by the members of the family. Different members of the family visited Mrs Foster on different days.

Starting with Mrs Foster's admission on 9th February, Mrs Cheyne, who was the daughter with nursing experience and qualifications, said that on 9th February her mother had a surgical pad and an incontinence pad on her bed. Both were soiled with something brown/green. It was strong smelling and could have been diarrhoea but equally could have been some other form of discharge. The surgical pad had fallen off when Mrs Cheyne helped her mother to the bathroom. Mrs Foster had been light-headed and Mrs Cheyne had reported all of this to the nurses on duty. It was the nurses on that occasion who had cleaned Mrs Foster. In addition on this, and indeed very many subsequent occasions, Mrs Foster's nightdress was also soiled with the same brown/green matter.

Mrs Cheyne's next visit appeared to be 12th February when she attended with her father as the two of them had an appointment that day to meet Mr Adib. Mrs Cheyne found her mother lying, as was usual, on her left side. She was in pain and there was an extremely offensive smell of something which could have been diarrhoea. Mrs Cheyne saw no sign of improvement in her mother who remained weak, light-headed and suffering from diarrhoea. She was however able to make her own way to and from the toilet but again her nightdress needed changed as indeed did the pad on her wound which was held in place by net pants. There was a further small incontinence pad which seemed to be in place in relation to the diarrhoea. It was this pad which fell off, again, when Mrs Foster went to the toilet. It was on this occasion that Mrs Cheyne learned about the second operation and it was perhaps because of that that there was no meeting with Mr Adib.

Mrs Cheyne visited again on 13th February. It was her turn to visit first thing in the morning to deal with Mrs Foster's bath. Once again she found her mother lying on her left side in her bed with the same type of pads which were again soiled, as indeed was the nightdress. Once again Mrs Cheyne reported this to the nurses on duty. The nurses cleaned up the bed whilst Mrs Cheyne bathed her mother. By this stage, Mrs Foster had been moved from the main 6-bedded part of the ward she had been in previously to a private side room with its own toilet facility. The move had been occasioned principally because of the awful smell emanating from Mrs Foster. To reach the bathroom, as opposed to the private toilet, Mrs Foster required a wheelchair. She required assistance into and out of the bath. Once in the bath she was only able to kneel because of the extremely large wound in her right buttock following the second operation. On this occasion Mrs Cheyne took several soiled nightdresses home with her to launder. Before she did so however she did see Mr Adib during what may have been a ward round. Mrs Cheyne knew Mr Adib, having worked with him previously. Mrs Cheyne was adamant she mentioned her concerns about both the diarrhoea and the dizziness or light-headedness from which her mother appeared to be suffering, to Mr Adib. Mr Adib seemed more interested in the fact that matters would now be improving after the second, successful operation. Mrs

Cheyne remembered Mr Adib advising her that he would shortly be leaving for Australia but that her mother was being referred to a colorectal specialist.

Mrs Cheyne next visited on 15th February again in the morning with a view to assisting her mother with her bath. There was almost no change although on this occasion Mrs Cheyne stated there was diarrhoea actually on her mother's legs. Mrs Foster continued to appear weak and could not get to and from her private toilet without requiring to use the bed and the table which straddles the foot of the bed for support.

Mrs Cheyne visited again on 17th February and felt her mother had not improved at all. Again there were several soiled nightdresses requiring laundering and again Mrs Cheyne reported this to the nurses on duty whom she also required to ask for additional pads. In particular Mrs Cheyne was certain she advised nurses her mother had diarrhoea and although she asked to speak to Mr Adib, she was told he was not available. Despite this being only two days before her eventual discharge, Mrs Cheyne was of the view that her mother was pale, weak, sick and not eating.

On 10th February it was Catherine Laing's turn to visit and she did so around 11.00am. At this point her mother was still in the main ward and Mrs Laing was concerned to see her lying on her left side with her back to the window between the ward and the corridor. Mrs Foster's nightdress was up above her waist. The pad was no longer in place and the wound was clearly visible. There was an extremely strong and very unpleasant smell, like diarrhoea or perhaps vomit. The nightdress was badly stained and the bed soiled around the area of Mrs Foster's buttocks. Mrs Laing did not know if this was diarrhoea or if it was something which had discharged from the wound. Mrs Laing found her mother visibly distressed. This was in the immediate aftermath of the first bathing incident previously referred to. Part of Mrs Foster's distress had been occasioned by her feeling of light-headedness and the possibility that it might lead her to faint or collapse. Mrs Laing spoke to nursing staff about this and agreed with them that as it was not always possible for nursing staff to supervise Mrs Foster's whole bath, there was no difficulty with the family stepping into the breach and assisting. This did not need to be confined to visiting hours. Later that same day Mrs Foster, although improved, was clearly embarrassed by the smell and was aware that other patients in the ward seemed to know it was coming from her. As with Mrs Cheyne, Mrs Laing witnessed her mother's pad fall to the floor when her mother went to the toilet. Again the bed was soiled. Again nurses were told and they changed the bed and brought a further supply of pads and pants. It was Mrs Laing who cleaned up her mother.

On 11th February Mrs Laing visited again. It was early morning perhaps around 9.00 or 9.30am and Mrs Laing was distressed to find her mother in tears following a second incident in the bath, again as previously referred to. Following a further complaint about this to the nursing staff, Mrs Laing was again told there was not always a sufficiency of staff to ensure full supervision. Mrs Laing, again as Mrs Cheyne had required to do, took at least 3 and possibly 4 soiled nightdresses home to launder. They were replaced with half a dozen new nightdresses which Mrs Laing had purchased. Some of the staining in the nightdresses was sufficiently severe that it did not come out when laundered. Those nightdresses were subsequently disposed of. Again Mrs Laing found her mother to be unsteady and requiring the wall

to support her when walking. By that evening, Mrs Foster had been moved to the side ward. During the evening Mrs Foster continued to require to go to the toilet for what appeared to be diarrhoea and Mrs Laing continued to have to assist with cleaning her up. The smell remained vile and Mrs Foster remained weak and light-headed. Mrs Laing obtained permission to give her mother another bath and, assisted by her sister, Anne Smith, a wheelchair was obtained and Mrs Foster taken for a bath. On entering the bath, the colour of the water changed to a filthy green colour with a smell so severe that Mrs Laing left the room to be physically sick.

During her evidence, Mrs Laing was not always able to be precise about the dates of her visits but did give evidence of one particular visit when she saw diarrhoea which she had found rubbed into the floor. Mrs Foster had been aware that it was she who had soiled the floor when going to the bathroom and had been unable to clean it up properly herself because of her dizziness. Mrs Foster continued to be weak with very little appetite and was visibly losing weight. Nightdresses continued to be soiled. Mrs Laing did not seem to speak of a visit in which she had not witnessed her mother to be weak, light-headed, suffering from diarrhoea, etc.

On 18th February, Mrs Laing visited during the evening and found her mother very concerned at having been told she was going home the next day. Mrs Foster indicated she did not know how she was going to cope. It is perhaps not surprising given the evidence of Mrs Foster's general age, nature and character, that she did not feel it was her husband's place to clean up after her and look after her to the extent that was going to be required. This evidence from Mrs Laing did not sit happily with other evidence given by staff that Mrs Foster was keen to go home. It may be as simple as a degree of misunderstanding with Mrs Foster perhaps answering in the affirmative to a question from a nurse or doctor asking if she were looking forward to going home. Most people would prefer to be at home than to be in hospital. It does not mean that they are physically well let alone able to cope with being at home.

Anne Smith gave similar evidence to her two sisters but was unable to be precise about dates. On those occasions when she visited in the company of other members of the family, she corroborated their evidence of the events in relation to diarrhoea, the vile smell, etc. Significantly she also felt her mother to be very pale and very weak, indeed exhausted.

Mrs Foster's husband, Thomas Foster, likewise gave evidence. If anything his evidence was understated but was corroborative of that of the rest of the family. His was the expression that the diarrhoea was "running from her". He felt the diarrhoea was clearly there to be seen and that something must be far wrong if nursing and medical staff had not seen any evidence of it. Mr Foster very honestly accepted that his wife did look a little better at her discharge on 19th February, but she still required a wheelchair to get her all the way to the car because she was unable to walk. He also reported that her trousers were soiled by the time the family made the short journey from the hospital to home. If the family evidence is accepted, and largely I do so accept it, then it seems odd to say the least that the medical and nursing records do not contain any mention of diarrhoea. There are a number of references to Mrs Foster's bowels having opened but no note of what was actually passed. Given the staining on the various pads, bedsheets, nightdresses, etc. and the reports by the family to nursing and medical staff of diarrhoea, it seems inconceivable that this was

not noted, let alone monitored carefully. People are frequently shy or private about such matters. It is my view that Mrs Foster was certainly someone who would not welcome sharing such intimate details with relative strangers, even though these people were medically qualified. Evidence was given by nursing staff that the actual question most probably put was "Have your bowels opened today?" In that event it would be no surprise were Mrs Foster to have answered "yes" without going on to disclose how frequently her bowels had opened, let alone that she had had diarrhoea rather than a normal stool.

This is one of the areas where the nursing notes are anything but "meticulous" as Mr Brookes seemed to expect they would be. Evidence was given that on days when the nursing notes contained no reference to bowels either having opened or not opened, silence might infer that Mrs Foster's bowels had not opened. There was contrary evidence to the effect that silence probably meant the question simply had not been asked. It is odd that those nurses who did give evidence, and they were very few in number compared with the number of nurses who must have been involved in Mrs Foster's care, neither saw nor smelt any evidence of diarrhoea. However this does not cause me to doubt that there was indeed diarrhoea given that Mrs Foster's family were so frequently there to assist and clean up and that, being as private and independent a person as she undoubtedly was, Mrs Foster clearly made considerable efforts during the absence of her family to get herself to the toilet unaided, no matter how difficult that may have been. It may be, even if only subconsciously, that nursing staff were less concerned about Mrs Foster than they might otherwise have been in view of the very substantial involvement of a number of very close and clearly very caring family members.

There were further difficulties which I have referred to previously in relation to the district nursing notes following Mrs Foster's discharge on 19th February and I will not repeat any of that other than to say that I found it difficult to rely on notes which were inconsistent and clearly at variance with all the other evidence.

Section 6(1)(e)

The first issue here relates to Dr Pandolfi's visit to Mrs Foster's home on 24th February. The evidence from all the members of the family was very clear that Dr Pandolfi had seemed angry about the strong smell of cigarette smoke in the bedroom and the fact that Mrs Foster remained in her bed rather than anything else. Dr Pandolfi was very careful to explain that he was not angry but admitted that he had expressed himself "in no uncertain fashion" and I have little doubt from his demeanour in the witness box and the family's version of events that Dr Pandolfi was altogether more brusque than he perhaps realised. There was to my mind a compelling piece of evidence which gave some insight into the character of Mrs Foster and her determination to do the best that she could to comply with medical advice, no matter how she might be feeling, and that was the graphic description given by her daughter, Mrs Laing, that following Dr Pandolfi's exhortation to her to get out of bed, to be more mobile, etc., that Mrs Foster crawled backwards downstairs on her hands and knees, despite the considerable pain and discomfort she was experiencing. The experience left her exhausted. It should not be forgotten that this took place two days before she was re-admitted to hospital "in extremis" - a condition from which, despite further surgery, she was not to recover.

The second issued is that of the two bathing incidents. These have been detailed already and I have no doubt that they occurred.

The third issue, as mentioned before, is the quality of note-taking in respect of both medical and nursing notes which seems to me in this case to have left a lot to be desired. Medical notes that simply cannot be read, or are ambiguous or inconsistent, or where different abbreviations have been used to identify the same matter are unacceptable, particularly in a case such as this where a large number of medical and nursing staff were involved in the day to day care of Mrs Foster. It seems to me to be absolutely essential in such a case that proper and adequate notes are taken and maintained so that anyone becoming involved in the care of a patient can read the notes and obtain sufficient, correct information to enable them to make a proper assessment of the patient.

I should perhaps conclude by saying that I am grateful to Miss Carmichael and Mrs Coull for the thorough and careful way in which the evidence was presented. I also think it only right to record that, in the absence of legal representation, Mrs Laing conducted the inquiry on behalf of the family in an exemplary fashion and, despite on occasions her obvious distress, I wish to commend her for the moderate manner in which she proceeded.