# INQUIRY INTO THE FATAL ACCIDENTS AND SUDDEN DEAHTS INQUIRY (SCOTLAND) ACT 1976 INTO THE SUDDEN DEATH OF CARMELLA KERR

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

DETERMINATION IN RESPECT OF THE DEATH OF CARMELLA KERR

I find in terms of Section 6(1)(a) of the Act that Carmella (otherwise Carmelina or Carmalina) Kerr, date of birth 30th August 1922, who resided at 98 Riverside Place, Ayr died at the Ayr Hospital, Ayr on the 3rd of February 2004 at 14:35 hours and in terms of Section 6(1)(b) of the Act that the causes of death were - I(a) Large bowel obstruction; I(b) Sigmoid Colon Stenosis; I(c) Diverticular Disease and II Ischaemic Heart Disease.

Since this death happened in hospital while Mrs Kerr was under the care of medical practitioners and nursing staff in a situation which might give rise to considerable public concern it seems to me that it is appropriate in terms of Section 6(1)(e) of the Act for me to make findings in respect of any other facts which are relevant to the circumstances of the death and I do so as follows: -

1. In the days running up towards Friday 30th January 2004 Mrs Kerr had been living with her daughter Mrs Felicia Nimbley in Kilmarnock. She had been unwell and complaining of what she called "turning" in her stomach and was passing diarrhoea. Her daughter urged her to go to the doctor but Mrs Kerr decided she would return to her home in Ayr and visit her own doctor there. At the time she and her daughter believed that Mrs Kerr was suffering from "a bug". By that Friday her daughter was concerned and herself travelled to Ayr and found Mrs Kerr to be quite ill.

2. Mrs Kerr's General Practitioner Dr J Kennedy visited her at home on that day, was told of her sickness and diarrhoea and referred her to Ayr Hospital as she was dehydrated, that journey being accomplished in an ambulance and Mrs Kerr being admitted through the Accident and Emergency department ("A & E").

3. Mrs Kerr presented at hospital with a history of having been treated with antibiotics for a chest infection, slight dehydration and her abdomen was soft with generalised tenderness, no guarding, no mass and her bowel sounds were normal. She had a past history of a hiatus hernia and was taking aspirin because of ischaemic heart disease having had a "heart attack" at some time in the past. She was on a variety of drugs for her various difficulties and suffered from emphysema which made her breathing wheezy.

4. An abdominal x-ray was obtained which showed gross distension of bowel loops and there were signs of infection and dehydration resulting in the obtaining of a surgical opinion that night from the surgical senior house officer ("SHO"). The consultant surgeon in her case was Mr Colin Wilson. At the time of the examination by the surgical SHO there was slight tenderness in part of the abdomen and an x-ray

did not permit of a diagnosis. The impression was that she had viral gastro-enteritis and not a mechanical obstruction. Advice from the surgical SHO was that she be rehydrated pending further investigation of her bowel once she had settled. She was placed in Station 6, a medical ward, in a single room as it was suspected that she might be suffering from gastro-enteritis, which is infectious.

5. On Saturday the 31st of January Mrs Kerr had in the morning passed faeces and had tried to eat yoghurt but was sick. At 18:30 she was seen by medical Pre-registration House Officer ("PRHO") Jorg Felber who read the notes from the admission and previous surgical examination. Dr Felber was on-call for new admissions and was not the ward medical PRHO, that being Dr Fiona Kerr. Dr Felber as a favour to his colleague helped by carrying out some of her duties as he was not busy. At this time there was no system of ward rounds at weekends.

6. Dr Felber as a result of his examination queried that the diagnosis be either gastro-enteritis or a bowel obstruction. He found high-pitched bowel noises and rebound tenderness. As a result he called for another x-ray with the intention of thereafter calling for a surgical review if the x-ray so indicated.

7. Having ordered the x-ray Dr Felber passed to Dr Kerr the task of reviewing the x-ray when it was received on Saturday night. Dr Kerr having decided the x-ray looked worse than the previous called either herself or via her medical SHO for the on-call surgical team to carry out a surgical review.

8. Dr Sanjeet Bhattacharya, then Specialist Registrar in surgery, who was on duty that weekend on a 48 hour shift from Saturday morning to Monday morning and was then on duty on the Monday visited and carried out a surgical review of Mrs Kerr at sometime between 21:00 and 22:00 in the evening. He read the notes from admission - "clerking in" - and checked the printed notes to find her overall past. At the time of this review he was accompanied by D grade staff nurse Mandy Groom whose patient Mrs Kerr was, she being on duty from 19:00 on the Saturday to 07:30 on the Sunday.

9. The surgical review notes by the Registrar are shown in pages 13 and 14 of the medical records, Production 3. The clinical findings and the second x-ray did not at that stage allow of a firm diagnosis and the Registrar concluded that Mrs Kerr could be suffering from either gastro-enteritis or a sub-acute obstruction, further investigation being needed.

10. The Registrar spoke to Nurse Groom who understood him to say that a Gastrografin enema was to be carried out on *Monday*. In her Nurse Notes (page 47) she recorded that the enema was to be carried out on Monday and then upon reading the Registrar's surgical review notes changed that to "mane" meaning the next morning - that is Sunday. The advice left by the Registrar was "Gastrograffin enema - mane - to rule out obst[ructio]n - if does not settle on conservative lines. Continue IV fluids".

[The correct spelling is "Gastrografin".]

11. On Sunday the 1st of February Nurse Groom handed over duties at the end of her shift to D grade staff nurse Tracy Cree who then came on duty from 07:00 to 19:30 on each of said Sunday and Monday 2nd February. Nurse Cree knew from Nurse Groom that the enema was outstanding. There was "slight confusion" over whether that was to be done on Sunday or Monday. She knew that "mane" meant tomorrow (which would be the Sunday). The Nurse Notes page 47 as written by Nurse Groom showed the two words "Monday" and "mane". It is not clear from these notes if "Monday" is scored out with 'mane' written above or if "Monday" is in fact underlined - causing some confusion.

12. At the time, as stated in finding 5, the practice at the hospital was that there was no set ward round by the doctors at the weekend. On the Sunday the ward medical PRHO was Dr Felber not Dr Kerr who was on receiving. The practice then was that unless patients were drawn to the attention of doctors they were not seen.

13. Neither Dr Felber nor any other doctor was paged to see Mrs Kerr on the Sunday and accordingly she was not seen, there being a gap in the medical notes from the examination by the Surgical Registrar on Saturday the 31st of January until Monday the 2nd of February.

14. The care plan devised for Mrs Kerr was entered on a computer system. Nurses did not appear to have access to that to read, but merely to enter further notes into it. The care plan envisaged four-hourly IV transfusions of saline etc. and observations (temperature etc.) at the same intervals. None of these requirements was complied with and the IV fluids throughout Mrs Kerr's stay in hospital ran considerably behind although there were records of when the IV bags were prescribed and put up. Neither medical doctors nor nurses studied these or appreciated properly what was happening.

15. Page 78 of the notes is "TPR and BP chart" which contains the observations on Mrs Kerr. It discloses that at 20:30 on Sunday the 1st of February her temperature had risen to 38 degrees. This was noted by staff nurse grade D Margaret Reid but was not reported to the medical doctor.

16. On Sunday the 1st of February no blood tests were taken for analysis.

17. During the Sunday Mrs Kerr's condition was deteriorating, to the extent that it might have been possible for her to survive an operation carried out on that day although post-operatively her chances of survival until discharge from the hospital would have been slim, surgery at any point during her stay in the hospital being very hazardous.

18. On the morning of Monday the 2nd of February Mrs Kerr was seen by Dr Chantal Nicholson medical PRHO in the company of Dr Claire Copeland medical SHO. This examination took place about 11:00. At that stage Mrs Kerr's diarrhoea and vomiting were noted to be stopped but her temperature was up and her pulse was racing. There were bowel sounds present which indicated that the condition was not critical, the abdomen being very distended but still soft. Dr Copeland realised that the enema had not been ordered which she decided to rectify. The biochemical results from blood tests showed Mrs Kerr was deteriorating and was dehydrated with a possible

septic process. Dr Copeland decided that bloods required to be repeated for further tests.

19. At about 13:00 Dr Nicholson on the instructions of Dr Copeland made a request for the enema to the radiography department via the computer system. That request is the first page of production 5 and discloses a time of 10:00 hours which is incorrect. From a menu Dr Nicholson picked "barium enema" when the request should have been for a water-soluble enema, a barium enema for someone in Mrs Kerr's condition being inappropriate. Under comments Dr Nicholson inserted "gastrograffin" (sic) which clarified the position. The reason for the examination was given as "? obstruction". "Surgeons suggest enema to rule out obstruction". At the top of the form the following is printed "priority: **urgent**". "Urgent" did not in fact mean urgent as there are two categories more urgent than "urgent" namely "emergency" and "today". Dr Nicholson was instructed by Dr Copeland that she was to mark the request "urgent" which Dr Nicholson believed meant within 24 hours. Dr. Copeland believed it meant that day - she hoped in a time slot that afternoon. The true position was and remains that for really "urgent" requests the requesting doctor makes a direct approach by telephone or visit to the radiography department. These requests by computer went, and still go, to administrative staff who are not medically qualified in any way.

20. Dr Copeland's intention, as shown above, was that the enema be carried out that day but not as an emergency. The priority, she thought, was a matter for the consultant radiologist. The other part of Dr Copeland's plan, made on examination of Mrs Kerr, was that once the enema had been carried out the results could be referred to the surgeon for a surgical review.

21.Dr Copeland again reviewed Mrs Kerr later in the afternoon and on her assessment of Mrs Kerr's condition decided that rather than wait for the enema which had still not been carried out, a surgical review should be requested straight away. She discussed this with Dr John Gemmill, consultant physician, who approved of her plan. Dr Copeland asked Dr Nicholson to request a surgical review. Dr Nicholson called the on-call surgical SHO who was foreign and may have been Dutch or German and whose name was Ellen Fisher or perhaps Fischer. This request was made late afternoon. The locum surgical SHO advised that she was with a patient but would come and see Mrs Kerr as soon as possible. When Dr Copeland went off duty at about 17:00 on Monday the 2nd of February she had concerns for Mrs Kerr but had requested the surgical review and the enema and believed they were in hand, the surgeons being aware of the request. She made Dr Farah Kidy, medical PRHO, who was coming on shift aware of the situation in regard to Mrs Kerr. The nurses also had been made aware of what was to be done.

22. On Monday the 2nd of February and Tuesday the 3rd of February between 9am and 5pm the Surgical Registrar on duty was Dr Karen Murphy. The surgical team comprised of her, Mr Wilson and the locum surgical SHO referred to above who was known to Dr Murphy as "Ellen". The locum was given the page. She coped well with her duties as she had previously worked in the British NHS.

23. Dr Murphy became aware of the request for a surgical review made on the instructions of Dr Copeland, that awareness coming at about 16:45, the SHO not

conveying Dr Murphy any sense of urgency. The call to the SHO had been made from Station 6 about 16:30.

24. As Dr Murphy and the SHO were going off duty about 17:00 Dr Murphy decided to see referrals which were already in hand and to hand over this referral to the incoming SHO at 17:00.

25. The actual hand over to the incoming SHO in surgery, Dr Solomon John, was carried out by the locum SHO.

26. The locum SHO made Dr John aware that there was an outstanding request for a surgical referral but did not advise him of any other details. To begin with on his shift Dr John was under some pressure as he had to catch up with a backlog in A & E of surgical admissions or where requests had been made for a surgeon to examine admissions. Monday evenings are busy due to general practitioner referrals being made towards the end of the afternoon. He was then called to the High Dependency Unit where a patient died in the evening and he required to complete the paperwork and speak to the family. He then had to attend theatre and operate round about 21:00 to 22:00. He required also to visit patients who had been dispatched to wards from A & E without being seen by a surgeon. By no later than 04:00 or 05:00 on the morning of Tuesday 3rd February this work had been cleared by him but he had still not seen Mrs Kerr, the subject of the surgical referral. He attended at Station 7 which is the receiving ward from A & E in an effort to trace the subject of the referral by asking the nurses, but unsuccessfully.

27. Dr John could have ascertained the location of Mrs Kerr had he made a few telephone calls round the medical wards. Indeed he could have discovered her identity and location within some 10 to 15 minutes had he taken these steps.

28. During her shift period from 17:00 to 21.00 on Monday 2nd February the PRHO (medical) Dr Kidy dealt with Mrs Kerr only in relation to prescribing further IV fluids. She was aware there was an outstanding surgical review of Mrs Kerr as she was told by Dr Copeland. She was also reminded by E grade staff nurse Maria Das. She took no steps to remind the on-call surgeon Dr John that this review was outstanding, as he received no "bleeps" or "pages" during his shift.

29. Dr Kidy passed to Dr Zoe Clark (now William, but hereinafter referred to as "Dr. Clark"), medical PRHO, at the start of the middle shift, at 21.00 on the Monday, a request that bloods be taken as instructed by Dr Copeland. She did not pass on the information about the outstanding surgical review.

30. Dr. Clark at 21.00 on Monday evening when she came on shift obtained blood samples from Mrs. Kerr and at 02:00 on the 3rd of February saw her again when she re-sited the drip line or venflon. At 02:00 she was aware, having been told by the nursing staff, that there was an outstanding surgical review. The condition of Mrs Kerr at 02:00 did not cause Dr Clark concern and she would not call the surgeon at that time unless there was such concern, leaving the matter until the morning.

31. On the morning of Tuesday the 3rd of February Grade D staff nurse Elizabeth Allan was on shift from 07:00 to 19:30. Upon hand-over to her the enema had not

been carried out although she thought it was supposed to have been done the day before and it required to be chased up. At approximately 07:30 hours she was called to Mrs Kerr's room where Mrs Kerr was found on the floor having fallen from the bed. The sides of the bed were raised to prevent her from coming out but she had managed to climb out over the foot of the bed. At that stage her observations were stable but she was breathless and her blood pressure was raised.

32. On examination by Dr Clark at 08:00 on the Tuesday, Mrs Kerr had abdominal pain, her blood pressure was slightly raised, her peripheries were cold, she was breathless, her abdomen was distended and bowel sounds were absent. Her pulse was very weak and slow. Dr Clark believed Mrs Kerr had suffered an ileus which is a paralysis of the bowel meaning that it is not moving its contents. She took the view that an urgent surgical review was required as well as a review by the medical SHO who at this time was Dr Marc Cram whom she paged about 08:30. She conveyed her concerns to Dr Cram along with her findings on examination, asking him to review Mrs Kerr and if he thought fit thereafter to call the surgeons.

33. At the time Dr Cram was in the High Dependency Unit reviewing a patient and indicated he would come as soon as possible.

34. Dr Cram at about 08:40 hours called Nurse Allan to indicate that he knew of the call to see Mrs Kerr but was detained elsewhere.

35. Dr Cram's decision was that it would be as well if the incoming medical team due on shift at 09:00 dealt with the review of Mrs Kerr for the reasons that they were familiar with her case and dealing with her ongoing care, a judgement which was reasonable in the circumstances given that by the time he would have made his way to Station 6, examined Mrs Kerr, read the notes and started to take action the oncoming surgical team would have been in position and he would simply have passed matters back to them. This decision by Dr Cram had no effect on the eventual outcome for Mrs Kerr.

36. Shortly before the end of her shift (09:00 on the 3rd of February) Dr Clark made the incoming medical PRHO Dr Nicholson aware that there was a surgical review outstanding.

37. At the start of their shifts on 3rd February at about 08:45 Dr Nicholson and Dr Copeland immediately went to see Mrs Kerr. They were joined at about 09:05 by Dr Gemmill the consultant physician. He found her abdomen grossly distended, she was difficult to understand and bowel sounds were absent. No biochemical results from Sunday were available as bloods had not been taken for analysis. This gap in the taking of bloods did not contribute to the ultimate death of Mrs Kerr.

38. At 09:00 on the 3rd of February Dr John handed the surgical page back to the locum surgical SHO known as "Ellen". He made her and Dr Murphy aware that the outstanding review had not been dealt with overnight. These two surgeons were completing their ward round and it was intended that the locum SHO would see Mrs Kerr when that was completed. They were then summoned to an emergency in the theatre leaving Mr Wilson to carry out the rest of the ward round while they commenced operating.

39. Dr Gemmill's immediate plan was for another x-ray as a matter of urgency and that a surgical review required to be done as soon as possible. Upon receipt of the x-ray Dr Nicholson was instructed to page for the surgeons to attend but the response from theatre staff was that no-one would be available as the Surgical Registrar and SHO were both in theatre. Dr Copeland instructed Dr Nicholson to page yet again with no response and yet again ten minutes later with no response. Dr Copeland herself then paged the surgeons, managed to speak to someone and was told that within 10 to 15 minutes a surgeon would attend. After half an hour had elapsed none had appeared and at that stage Dr Gemmill went to find a surgeon himself, which he did in the endoscopy suite. He spoke to Mr Wilson, consultant surgeon, and showed him the x-ray.

40. While the locum SHO and Dr Murphy were in the theatre the SHO was paged about the outstanding review. As soon as she was free the SHO was to go and see Mrs Kerr but in the meantime Dr Gemmill arrived clutching the x-ray of Mrs Kerr to see Mr Wilson. This all took place about 11:00.

41. Mr Wilson's opinion was that there was obviously a serious emergency problem and immediate action was needed. He decided to carry out a flexible sigmoid endoscopy and for this purpose Mrs Kerr was given an enema in Station 6 to empty the rectum.

42. At Station 6 once Mrs Kerr had received the pre-endoscopy enema she was conveyed to the endoscopy suite with a porter and nursing auxiliary escort. Nurse Allan had seven other patients in the ward and made a risk- assessment that it was preferable that she did not accompany Mrs Kerr on the journey to endoscopy. While this is unusual, it is not unique and the fact that no nurse was with her on that short transfer played no part in Mrs Kerr's eventual demise.

43. By this time (12:50 or thereby) Mrs Kerr was deteriorating rapidly. Dr Nicholson was paged and went accompanied by Dr Copeland to the endoscopy suite. Mrs Kerr was "closing down" by this time and Dr Gemmill was called. He in turn called for the consultant surgeon Mr Wilson. Mrs Kerr had deteriorated markedly, which is not unusual, between dispatch from Station 6 and arrival at endoscopy.

44. Strenuous efforts were made by Dr Gemmill and others to stabilise Mrs Kerr in the recovery area near theatre in order that she might be taken to theatre for an exploratory laparotomy, that is an incision in the abdomen for exploratory purposes. Mr MacDiarmid, consultant anaesthetist, and other staff tried to effect stability but were unable to do so and at 14:35 Mrs Kerr died.

45. Upon post-mortem examination the late Mrs Kerr was found to have all three coronary arteries severely occluded - the right coronary artery being down to less than one-tenth of its appropriate diameter and the same applying to the left anterior descending coronary artery. Further deterioration had taken place in other cardiac blood vessels. She had an oat-cell carcinoma in her left lung. In the sigmoid colon there was a tight stenosis or narrowing due to diverticular disease. These findings point to the conclusion of the causes of her death being as set forth at the beginning of this determination.

46. In the light of these findings it is unlikely that whenever carried out during her stay in hospital surgery for the correction of the blockage in her bowel would have been successful in saving her life as although she might have survived the operation her chances of surviving post-operatively to discharging from hospital would have been very small.

NOTE

It is very important that the purpose of a Fatal Accident Inquiry be clearly understood. It is for the purpose of bringing out in public the facts of the case. It is not a trial of anyone nor is it a proper forum for determining fault. It is not an exercise in pillorying or stigmatising any individual or individuals or apportioning blame among them. In terms of Section 1(1)(b) of the Act the Lord Advocate has deemed it to be expedient in the public interest to hold this inquiry into the circumstances of a death that has occurred in circumstances such as to give rise to serious public concern. What can be put in a determination issued is prescribed in Section 6 of the Act and these limitations must be followed in the writing of a determination. Further in terms of Section 6(3) a determination is not admissible in evidence nor can it be founded on in any judicial proceedings of whatever nature which arise out of the death. That is relevant in this case where Mr Murray, Procurator Fiscal, intimated to me that the family of the deceased have reported all the medical personnel concerned to the General Medical Council. If that body decides to take disciplinary proceedings then the gathering of evidence, the testing of it and any finding resulting therefrom set against their professional yardsticks will be entirely a matter for them and to which this inquiry and my determination are not relevant.

There were several conflicts of fact in the evidence as pointed out by Mr Murray, the Procurator Fiscal, and these were as follows: -

(a) There was conflicting evidence from Doctors Felber and Kerr as to which was on ward duty on Sunday the 1st of February - that being the day on which the absence of care for Mrs Kerr began to be apparent. I have decided that the evidence points to Dr Felber being on duty in the wards while Dr Kerr was receiving.

(b) Mr Bhattacharya appeared to have the opinion that nurses should be able to decide if a patient had "settled" in terms of his note at the surgical review on Saturday the 31st of January whereas Nurse Groom said that it would be up to the medical doctors. Mr Bartolo supported the view of Nurse Groom. He took the view that the word "settle" meant not simply that the patient be comfortable and uncomplaining but that the distension of her abdomen should settle.

(c) There was some conflict but not great conflict between Nurse Groom and Nurse Cree as to what was dealt with at the hand-over by the former to the latter (finding number 11 above). It is impossible to determine precisely what happened but the finding I have made explains the result of that.

(d) The request time for the enema shows on the form as being 10 o'clock and Dr McLaughlan, consultant radiologist, said the central hospital clock would provide that time. By contrast Dr Copeland and Dr Nicholson believed that the order was placed

at lunchtime towards one o'clock. That certainly fits with the rest of the evidence and I prefer that evidence to the printed time.

(e) In regard to said request, Mr Murray said that he believed there was some conflict between Dr Copeland and Dr Nicholson who was instructed by Dr Copeland to make the request as to the urgency of that request. Dr Copeland expected that the enema would be done that day whereas Dr Nicholson believed that it would happen within 24 hours. There is in fact no conflict in this matter since both doctors agree that the request made by Dr Copeland was that it be "urgent" which was carried out by Dr Nicholson. The difficulty of course is that each had a different interpretation of what "urgent" meant and in fact neither of these interpretations meant what the system understood.

(f) There is conflict between Dr Nicholson and Dr Copeland (and Dr Gemmill) about the time the surgical review was requested on Monday the 2nd of February, Dr Nicholson believing she did so round about lunch-time whereas the other two witnesses spoke to it being towards the later part of the afternoon towards 16:00. The evidence of Dr Murphy to the effect that she was spoken to by the locum surgical SHO ("Ellen") not long before their shift finished at 17:00 supports Dr. Copeland's version.

(g) The nature the hand-over from said locum to Dr John remains a mystery. Unfortunately that locum was not produced as a witness so what she did or said is unavailable to the inquiry. Dr Murphy who had worked with her all day believed her to be well organised and competent whereas Dr John spoke to her being disorganised and unable to cope. In this matter I prefer the evidence of Dr Murphy. Mr Wilson, consultant surgeon, had some doubts as to the amount or extent of the work which Dr. John asserted was handed over to him and that tends therefore to support Dr Murphy's version and that she is a more reliable witness in this regard.

(h) Following from the immediately preceding paragraph the question of the pressure on Dr John is difficult to resolve. In the absence of some form of records being produced to show the number of admissions and the number of referrals made to him and the other work that he carried out it is difficult for anyone to gainsay his version save that Mr Wilson gave doubting testimony as to the amount of work Dr John would require to do and Dr Murphy recalled that it was not an exceptionally busy Monday. The importance of this is that Dr John alleged that as a result of this over-burdening he was unable to effect the surgical review which had been requested by Dr Murphy *via* the locum SHO just prior to the shift change and which had been passed over to him and obviously therefore of which he was well aware. This also casts doubt on his assertion that *in spite of his doing all that he could* he was unable to trace Mrs Kerr. There was evidence from Mr Wilson that such tracing could take place in a hospital of the size of Ayr within 10 to 15 minutes.

(i) There is conflict between the evidence of Dr Copeland and Dr Kidy as to what took place and was said at the hand-over between them. Dr Copeland gave evidence that she advised Dr Kidy of the outstanding surgical review and that the question of taking bloods was to be "chased up". Dr Kidy had no recollection of this. In support of Dr Copeland Dr Clark gave evidence that Dr Kidy passed to her at a shift change a request to take bloods. This would seem to indicate that Dr Kidy's

evidence is less reliable than that of Dr Copeland and that Dr Kidy did in fact know that there was an outstanding surgical review for Mrs Kerr but she did not tell Dr. Clark.

(j) A similar situation arises in regard to a conflict of evidence between Dr Kidy and Nurse Das. Dr Kidy could not recall being reminded by Nurse Das of this outstanding surgical review. I prefer the evidence of Nurse Das to that of Dr Kidy and Nurse Das is indeed supported by Nurse Boyle.

(k) Similarly Nurse Das supported again by Nurse Boyle testified that she reminded Dr Clark about this outstanding surgical review but the doctor did not recollect that. I accept the evidence of the two nurses that this reminder was given.

(l) There was some difference between Dr Clark and Dr Cram as to what happened on the morning of Tuesday the 3rd of February. Dr Clark gave evidence that she called Dr Cram, her medical SHO, and he said he would come but he was busy. Dr Clark was a bit vague about any reason being given but Nurse Allan supports Dr Cram in that she spoke to his telephoning back to the ward to say he was unable to attend. The outcome is that the facts are that Dr Clark did contact Dr Cram and that he had the presence of mind to realise he would be unable to attend, told the nursing staff on the ward so, and recommended that the on-coming team deal with Mrs Kerr.

I now turn to deal with submissions made to me by Mr Murray, Procurator Fiscal, Ms Borthwick on behalf of Dr. Bhattacharya and Dr. John, Mrs Robertson for Dr. John Gemmill, Dr McLaughlan, Dr Kerr, and Mr. Wilson, and Mr Wightman for Ayrshire and Arran Health Board as successors to Ayrshire and Arran Acute Hospitals NHS Trust which was the operator of the hospital at the time of this occurrence.

There was a clear difference in submission between Mr Murray and the others. Mr Murray thought it appropriate that I consider that findings should be made in terms of Section 6(1)(c) as to reasonable precautions, if any, whereby the death ..... might have been avoided. For reasons given later I am unable to make findings under that subsection or indeed under subsection (d).

He concentrated on crucial points, having considered the conduct of all involved and having also pointed out several system failures rather than precautions. I will deal with system failures later, for these are at the core of this matter.

The crucial points to which he referred were as follows: -

(I) In regard to the action or inaction of Dr Kidy on the Monday evening he said that in spite of being given clear instruction by Dr Copeland to chase up the surgical review, she did not do so. She did not pass that information on to Dr Clark. Had she given a reminder of the surgical request to Dr. John that would greatly have increased the chances that he would have responded.

(II) In regard to the conduct of Dr Zoe Clark who was reminded that the surgical review was outstanding overnight between the 2nd and 3rd of February but took no action, said Mr Murray, she should at least have contacted her SHO for advice or paged the surgeon. He conceded that this doctor was very junior.

(III) In regard to Dr Bhattacharya he argued that there was a failure to follow up a duty of care to Mrs Kerr following the surgical review on the Saturday evening.

(IV) In relation to Dr Copeland he argued that after her examination of Mrs Kerr at 09:00 on the 2nd of February she did not progress matters quickly enough. Partly this was due to confusion as to what the request for a "urgent" enema meant in terms of the system, and partly because she had taken the view that surgeons would not review Mrs Kerr until the enema results were obtained thus meaning that it was not until the later afternoon that in consultation with Dr Gemmill the decision was taken to opt for a surgical review as matters had moved on from the question of the enema.

(V) Mr Murray reserved his main criticism for Dr Solomon John. I have no doubt that a deal of criticism of Dr John is justified and I will deal with that more fully hereafter. Mr Murray indicated that Dr John was unique among the witnesses and those involved in the care of Mrs Kerr and I agree. His failure to carry out his duty to effect the surgical review is concerning. I will return to this event later.

(VI) To complete Mr Murray's submissions there was examination by him of various systems failures that are relevant to the circumstances of the death in terms of Section 6(1)(e). These are apparent from the facts I have set forth above under that subsection and I will deal with them further under the heading of conclusions and recommendations later.

Mr. Murray also by way of an addendum drew attention to some aspects of the care (or failure of care) of Mrs. Kerr which were examined in the course of the inquiry but which he conceded had been shown to have no impact upon her condition; some of these I mention elsewhere but for completeness I marshal them here in a unit: -

1. The decision to isolate Mrs. Kerr in a single room where it might be thought she less visible was justified as one of the original possible diagnoses was gastro-enteritis, highly infectious.

2. The failure to take observations every four hours as set out in the plan was not in evidence shown to have compromised her care.

3. The fact that Nurse Reid did not report to a doctor the high temperature at 20.30 on the Sunday was not a failure in care, Mr. Bartolo indicating that a single such observation need not be reported.

4. The absence of bloods being taken on the Sunday and for most of the Monday was similarly not a matter for criticism.

5. The manner of accompaniment of the transfer to the endoscopy suite did not contribute to exacerbate the already deteriorating condition of Mrs. Kerr and the nurse in charge had made an appropriate risk assessment.

6. At this point I add another fact in a similar category, not mentioned by Mr. Murray in his submission, but which may conveniently appear here. That relates to the admission by Nurse Groom that (Nursing Notes page 47) she changed the advice of

Dr. Bhattacharya given to her on the Saturday night after the surgical review from "sip water" to "ice to suck". Something was made of that by Mr. Murray in examination in chief, but in fact there is little difference in result as explained by Nurse Groom both in the physical nature of what was provided - sipping from a container of ice melting to water - and the sipping from a container of water alone, plus the fact that in any event Mrs. Kerr was asleep for most of the night anyway.

Ms Borthwick addressed me on behalf of her clients and first of all on the law in relation to Fatal Accident Inquiries. I have already written at some length on what the purpose of such an inquiry is - and what it is not - and I do not propose to repeat that. In law it is not for me to apportion blame between and among persons involved in this case. The matter is touched upon in Black V Scott Lithgow Ltd. 1990 SLT 612 at page 615 where the Lord President (Hope) examines Section 3 of the Act under which this enquiry proceeds and writes: -

"There is no power in this section to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident. This is in contrast to Section 4(7) of the 1895 Act [Fatal Accidents Inquiry (Scotland) Act 1895] which gave power to the jury to set out in its verdict the person or persons if any to whose fault or negligence the accident was attributable. It is plain that the function of a sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the sub-section refers in so far as this can be done to his satisfaction."

Ms Borthwick also submitted that it is not appropriate to allow hindsight to colour one's view. That of course is entirely correct and I have no difficulty in accepting it. I am somewhat surprised that she thought that I might need to be reminded of that.

Next and more importantly she turned to deal with sub-section (c) - the "reasonable precautions, if any, whereby the death ... might have been avoided". Her argument, which I accept, was that in order for such finding to be made there must be a precaution that was reasonable in the circumstances which would give a real possibility of preventing the death. She referred to Carmichael, "Sudden Deaths and Fatal Accident Inquiries" second edition page 126. In paragraph 5.53 the learned author says "What is required is not a finding as to a reasonable precaution whereby the death or accident resulting in death "would" have been avoided but whereby the death or accident resulting in the death "might" have been avoided. What is envisaged is not a "probability" but a real possibility that the death might have been avoided by the reasonable precaution". At page 293 paragraph 9.87, *op.cit.* Sheriff Kearney in his determination in *James McAlpine* comments, "the phrase 'might have been avoided' is a wide one which has not so far as I am aware been made the subject of judicial interpretation. It means less than 'would on the probabilities have been avoided' and rather directs one's mind in the direction of lively possibilities". She then turned her attention to various other submissions, which I find it not necessary to repeat, as I will deal with such matters in my conclusions and recommendations.

Mrs Robertson advanced the same argument in regard to sub-section (c) and also sub-section (d) submitting that there had to be some sort of causal link between a proposed reasonable precaution and the death. Mr Wightman, whom I design in short as "for the hospital" adopted Mrs Robertson's submissions in respect of findings under sub-section (c). He made a similar submission in respect of sub-section (d) to the effect that in an inquiry of this nature it was not appropriate to make a finding on the evidence before me that there were defects in any system of working which contributed to the death.

I accept these submissions and do not find correct the submission of Mr Murray that I am empowered to make such findings as he submitted I should under sub-section (c) in respect of certain named individuals, and I similarly accept the submissions to the effect that I cannot make any findings in terms of sub-section (d). The appropriate place for any criticism, and there is justified considerable criticism, is under Section 6(1)(e).

CONCLUSIONS AND RECOMMENDATIONS

The late Mrs Kerr, on the surface and according to her relatives, appeared to be a fit octogenarian who was active both physically and mentally. She had certain medical problems in her past including a "heart attack", a hiatus hernia, emphysema and various other disorders for which she was prescribed a variety of drugs by her General Practitioner. Unfortunately beneath that surface there were lurking serious physical problems which did not fully come to light until the examination by Dr Nairn *post-mortem*, excluding those which were the immediate causes of her death.

In particular her heart was quite severely diseased and the blood supply passing through it was reduced - all three arteries being severely occluded, two of them to the extent of 90% so that their diameter was reduced to only one-tenth of normal, thus giving rise to "ischaemic heart disease" being inserted on the death certificate as another significant condition contributing to the death but not related to the disease or condition causing it. In addition she had a small oat-cell carcinoma - a cancerous tumour - in her left lung which was in its very early stages and had not spread. Accordingly when she presented at her General Practitioner on the 30th of January 2004 with vomiting and diarrhoea (following upon a chest infection a couple of weeks before) showing signs of dehydration and generalised tenderness of her abdomen she was already quite unwell and part way along the gradual progression which led to her death some four days later on the 3rd of February. On the evidence before me, it is probable that surgical or other intervention at any time after her admission to hospital would not have prevented the death of Mrs. Kerr.

On the evidence before me it is improbable that she would have survived any operation to remove the blockage in her bowel and even less probable that she would have survived to be discharged from the hospital after post-operative care. These conclusions require to be reached on the evidence of all those who addressed this issue and they lead inevitably to it being impossible to make findings in terms of Section 6(1)(c) and 6(1)(d) as to do so would be to speculate in the face of the evidence.

The whole picture in this tragedy conveys that at the time in Ayr Hospital there was a major want in many of the systems of where responsibility lay between and among departments; how information was to be recorded and transmitted both within a department and across departments; the keeping of notes generally; access by nurses to the care plan; the monitoring of the administration of intravenous fluids; the monitoring of fluid input and output and record keeping thereof; and in particular the question of what I might call the "Sunday Gap" during which Mrs Kerr deteriorated and during which no-one in any discipline or department seemed to have her care (in the wider sense) under their responsibility as they perceived it.

Leaving aside what happened prior to the Saturday (as there is no criticism in respect of that period) the history begins with Dr Felber examining her and making an appropriate plan whereby he called for a second x-ray. He was actually on receiving but Dr Fiona Kerr on the wards was busier and Dr Felber volunteered to assist. Having made the appropriate moves he then advised Dr Kerr that she should call for a surgical review if she considered the x-ray showed the position as deteriorating. It is worthy of note that both these held positions as PRHOs, very junior, and near the start of their careers.

Dr Kerr appropriately dealt with the x-ray and appropriately called for a surgical review.

This resulted in Dr Bhattacharya examining Mrs Kerr in the presence of Nurse Groom on the Saturday night. He wrote a note, which is ambiguous. He used the word "mane" in his note and something was made of that being confusing, but I am satisfied that those involved knew that it meant "in the morning" - that is on Sunday. So the end result was that the Gastrografin enema was to be conducted on the Sunday unless Mrs Kerr "settled on conservative lines". Difficulties were compounded by Nurse Groom's note at page 47 where the words "Monday" and "mane" are both written to indicate when the enema is to be carried out. It appears she understood Dr Bhattacharya to say "Monday", which she wrote in her notes, but then on reading his note she discovered that the word he had used was "mane". As a result she changed her own note by what she called scoring out Monday and writing "mane". Unfortunately on a reading of that note it could be thought that "Monday" is in fact underlined by way of stress mark rather than eliminated. Dr. Bhattacharya was subject to criticism for his interpretation of the Saturday night X-ray. Dr. McLaughlan believed it was diagnostic of an obstruction and Mr. Bartolo thought similarly. But the tenor of all the evidence on this point is that the clinical findings on examination are also important and taking these along with the X-ray Dr. Bhattacharya's opinion and plan were not inappropriate as there was still a differential diagnosis at that stage. Dr. Bhattacharya was also criticised by Mr. Bartolo for a failure of duty to follow up his review. Mr. Bartolo is a specialist colorectal surgeon in the Western General Hospital in Edinburgh, a large hospital, but he knew not the unfortunate practice at Ayr in 2004 where there was no system putting such a duty on Dr. Bhattacharya as spoken to by Mr. Wilson - to whose evidence Mr. Bartolo said he would bow.

The hand-over between Nurse Groom and Nurse Cree thereafter does not appear to have addressed this ambiguity and Nurse Cree having consulted the notes appeared

unsure as to what was meant but appears to have taken it that the final intention was that the Gastrografin enema be done on the Monday and not the Sunday.

At that time there were no regular ward rounds by doctors on a Sunday and there would be no doctor attending to Mrs Kerr unless there was a call put out by the nurses. That did not happen. The question of who was to decide what "settling on conservative lines" meant was left in the air with no-one being given the task to make that assessment. This meant that Mrs Kerr's condition worsened unnoticed and, in the eyes of her relatives who saw her apparently failing, neglected.

By the morning of Monday 2nd February when Doctors Nicholson and Copeland examined Mrs Kerr the position in regard to her bowel was not critical as there were bowel sounds and her abdomen was soft but very distended. Only at that point did Dr Copeland realise that the enema had still not been carried out and she told Dr Nicholson to make a request through the computer to the radiography department for that. It is apparent that neither Dr Copeland nor Dr Nicholson was *au fait* with the system as each had a different idea of what the word "urgent" meant in such a request and those ideas were again different from what the radiography department took from such a request because there were two categories above urgent namely "today" and "emergency". Dr Copeland thought that the request would be assessed in the radiography department but in fact such requests go to non-medically qualified staff. This arrangement apparently remains the same now some two years down the line as I will consider further later but progress has been made in that all medical and nursing personnel can now see x-ray results on a computer screen in the wards without having to wait for a film to be physically produced.

The next episode in this sorry tale of system failures is and may remain a mystery as it involves a locum surgical SHO who was on her first day at Ayr Hospital and was in charge of the surgical page. There is no criticism of that, it being normal that all doctors may be given pages on their first day in a placement. However that surgical SHO, who may have been called Ellen Fisher or Fischer, she being either Dutch or German, did not give evidence to the inquiry and so her actings or perhaps lack of actings - we do not know - which may have been crucial factors cannot be subject to scrutiny. It was of this SHO that Dr Nicholson on the instructions of Dr Copeland requested a surgical review late on Monday afternoon and that SHO said she would come as soon as she was available. She never did.

The next system failure in so far as we have evidence of it took place at the stage when that SHO handed over to Dr John. At this time it is important to note that Dr Gemmill had become involved late on Monday afternoon and approved of Dr Copeland's plan for that surgical review to be requested.

Dr Murphy the surgical registrar, under whose authority the SHO was working, entrusted to that SHO the hand-over to Dr John. Accordingly apart from what he tells us in evidence there is nothing to be known about the hand-over.

Having considered the evidence of Dr Murphy and the evidence of Dr John I have come to the view that I prefer Dr Murphy's evidence in regard to how the locum SHO coped with her duties rather than that she did not cope as Dr John said.

It is most unfortunate that the inquiry has not been given the opportunity of having the evidence of the missing locum SHO. In the absence of that it is impossible to arrive at a proper conclusion as to what was said and done at the handover to Dr. John or to examine her on the questions of workload, competence and backlog, all which could have been of considerable assistance to this determination.

At this juncture another crucial point in the whole history took place because Dr John in spite of knowing of a surgical referral of a patient in a medical ward did not in my view take sufficient steps to ascertain her whereabouts. The surgical page therefore went unanswered throughout his whole shift, which is clearly not an acceptable situation. I am satisfied on the evidence that had he made that effort he could have found the whereabouts of Mrs Kerr quite easily - indeed his own consultant Mr Wilson said that it would be possible to trace a patient in these circumstances within a maximum of 15 minutes. I also prefer the evidence given to the effect that while it was busy (Monday afternoons always being busy in A & E) the situation was not unusual and I am left with the conclusion that Dr John was not as busy as he alleges he was. Accordingly it appears that while I cannot make a finding under sub-section (c) or (d) as invited by the Procurator Fiscal, there has been a want of attention to his duties on that shift. He knew that there was the referral; and he knew he had not carried it out by the end of the shift. Dr Gemmill in his evidence mentioned that he had never in his experience known a surgical page go unanswered but that is what happened here.

On the medical side during the night from Monday 2nd to Tuesday 3rd February Dr Kidy knew there was an outstanding surgical review. She was very vague in her evidence and repeatedly said she could not recall. I am therefore left with the evidence of Dr Copeland and Nurse Das to the effect that Dr Kidy was well aware there was an outstanding surgical review but during her period on shift took no steps to remind Dr John. I am satisfied that Dr John received no reminders via the pager during his shift.

During the same period Dr Clark had seen Mrs Kerr to obtain blood samples about 21:00 on the 2nd and re-sited the drip-line or venflon about 02:00 on the 3rd. She had been told by nursing staff that there was an outstanding surgical review but her judgement was that Mrs Kerr's condition did not cause her concern and she would not call the surgeon unless there was concern, leaving the matter until the morning. Dr Clark was a very junior doctor at the time and was a very minor cog in the whole apparently uncaring machine in which Mrs Kerr now was enmeshed. The conduct of Dr Clark was criticised by Mr Murray. If Dr Clark had taken some action - even by consulting her SHO - steps could have been taken more quickly to progress Mrs Kerr's case albeit that it is unlikely on a balance of probabilities that such would have had any effect on the unfortunate eventual outcome.

On the morning of the 3rd of February Doctors Nicholson and Copeland resumed their duties to be advised by Dr Clark that the surgical review was still outstanding. Dr Copeland was "very angry" to find that her plan had not been implemented overnight. They saw Mrs Kerr at once and Dr. Gemmill the consultant physician joined them and made a plan for another x-ray and a request for a surgical review to be done thereafter as quickly as possible. Unfortunately the surgical page was not answered at all at least twice and then it was discovered when it was answered that

both the locum SHO and Dr Murphy were in theatre. In spite it being indicated that a surgeon would attend as soon as possible none arrived and eventually Dr Gemmill, "clutching the x-ray" made his way to see Mr Wilson the consultant surgeon. By this time it was about 11:00.

Only at that stage was emergency action put into place. In order to prepare Mrs Kerr for possible surgery an enema was carried out at Station 6 to clear her rectum and she was conveyed to the endoscopy suite for the flexible sigmoid endoscopy procedure, which would enable the surgeons to see what they required to do. There is no criticism can be made of the fact that she went to endoscopy accompanied by a nursing auxiliary as I am satisfied that the nurse in charge on the ward, Nurse Allan, had made an appropriate risk assessment.

Unfortunately between leaving the ward and arriving at endoscopy Mrs Kerr deteriorated very considerably and was almost moribund when Doctors Nicholson and Copeland were paged to her. Dr Gemmill also attended but efforts to stabilise Mrs Kerr in order that she could be taken to theatre for a surgical exploration of her abdomen failed and her death resulted shortly thereafter.

I now turn to look at what I see as the system failures which occurred in this whole sorry process and which have caused Mrs Kerr's relatives distress and anxiety - and indeed anger - over the way in which their mother was dealt with - or on occasions not dealt with - in Ayr Hospital. Their frustration at being unable to obtain information when they wished it as to the condition of and plan for their mother while they saw her deteriorate before their eyes is understandable. Their anger that once they did know what was anticipated to happen, namely the Gastrografin enema, did not happen without any apparent reason apart from inexplicable delay, exacerbated their situation. I am left with a picture of Ayr Hospital as it was then as being inefficient with fragmented responsibilities, no "joined up thinking", no proper hand-over procedures, no chain of command procedures and no way of knowing - on the part of medical or surgical or nurses - in whose court the ball was at any particular time. The evidence seemed to be from the medical side that there was an expectation that a surgeon might report back to them. The evidence from the surgical side seemed to be that Mrs Kerr remained under the care of the medical side and therefore it was the medical side's duty to see what surgeons had written. There was evidence also that it was a dual responsibility but that I think is something that has been realised since this happened. There was no chain of responsibility to follow up Dr. Bhattacharya's surgical assessment on the Saturday night. The question of what that assessment meant was left to be interpreted by nurses who unfortunately seemed to have misinterpreted it - for which I do not blame them. I take the view it was for Dr Bhattacharya to have written a clearer note and to indicate who he expected to make this assessment as to Mrs Kerr settling on conservative lines. There was considerable evidence that it was not for nurses to assess but really for the medical staff but nothing was clearly laid down as a system and no-one followed it up. Dr Bhattacharya's note was criticised by his own consultant Dr Gemmill and by Mr Bartolo. That he was less than precise in the drafting of that note is undoubted. Dr. Felber, who had initiated the X-ray and advised Dr. Kerr to follow it up (which she correctly did) was on the ward duty next day but did no more to follow it up himself. When asked by Mr. Murray what the follow-up procedure was then at Ayr, his evidence was initially that the surgeon should report back to the referring department

-- or that the referring department should enquire - or lastly (in cross by Ms Borthwick) that he could not recall what the system at Ayr was. That, I venture to say, is because there was none.

In his own evidence Dr Gemmill in relation to the question of who was to judge whether the patient had settled or not indicated that it was impossible to tell if anyone had done that assessment. It was a missing part of the sequence. There was no arrangement for regulating the follow-up at the time - it was rather "ad hoc" as he put it, and the "system" then was that on a Sunday (as I have noted above) no medical personnel would see a patient unless their attention was drawn to that patient. Dr Gemmill in response to a direct question from myself about who was holding the ball after Dr Bhattacharya made his plan on Saturday night was clear and unequivocal - he said, as I have recorded it, "The ball has been left somewhere in mid-air - that is the problem" - that, in a nutshell, seems to be typical not only of the post-surgical review situation but of much of the administration in relation to Mrs Kerr's case at that time, and I commend Dr. Gemmill for his honest frankness.

I shall shortly move to deal with recommendations but before doing so should record what I am told in evidence has taken place since in relation to systems and practice at Ayr Hospital: -

This unfortunate case triggered an internal inquiry at the hospital. Mr Wightman on behalf of the current operators of the hospital, successors to the operators in January and February 2004, started his submissions to me by making admissions as follows: -

1. The nursing notes are insufficient.

2. There is a lack of regular recording of observations.

3. At least of two sets of notes taken have not been recorded.

4. The IV administrations were well behind as could have been determined from the therapy prescription sheet - and from the fluid balance chart had it been written up (which was not properly done).

5. On Sunday the 1st of February neither the medical doctor nor a surgeon saw Mrs Kerr. That was agreed to be unacceptable, as there was no system in place for automatic review by a medical doctor or a follow-up by a surgeon. The opportunity to assist Mrs Kerr was lost and that was regretted.

6. Communications inter and intra departments were accepted to be inadequate. Hand-overs were accepted to be inadequate. A new more robust system was now in place as there was no proper system in 2004 where the detail and degree of urgency had been lost.

7. Between Monday the 2nd and Tuesday the 3rd of February a surgical review requested in mid-afternoon on Monday had not been carried out by the morning of Tuesday the 3rd. This was unacceptable and regrettable. The hospital accepted there

was dual responsibility between the medical staff and the surgeons and the system had failed.

8. It was conceded that communications were not effective and that all members of staff involved had some level of responsibility.

9. He adverted again to the absence of the surgical SHO who did not give evidence but intimated that the failure by Dr John to review Mrs Kerr was "deeply regrettable".

Mr Wightman led me to the evidence of corrective actions that had been taken since this incident which were as follows: -

1. Medical hand-overs had been placed on a much more formal basis and there was now a full written hand-over when the shift started at 9 o'clock in the morning. At that hand-over the on-call personnel from overnight are present with the SHOs and consultant coming on duty. A computer-generated list of patients is provided. At the hand-over at night by SHO to SHO matters are now reduced to writing.

2. More senior surgeons carry out automatic review after a surgical review has been carried out. Every patient who has been the subject of such review and who is outwith the surgical wards is recorded on a white board. The consultant sees all these patients within 24 hours of a visit by mid-grade surgeons (this would mean that Mrs Kerr would have been seen automatically by a surgeon on the Sunday after the surgical review by Dr Bhattacharya on the Saturday night).

3. Middle grade medical doctors now review patients within 24 hours after they have originally been seen by the consultant (under this system a mid-grade medical doctor would have seen Mrs Kerr on the Sunday).

4. A system of assessment called MEWS, which is an auto-prompt, has been introduced instead of subjective interpretation of observations by the nurses. If a patient reaches a certain score on this auto-prompt a PRHO requires to review the patient within one hour.

5. The nursing plan is now put with the nurse notes and is written on paper. The previous computer system - under which it seemed nurses were unable to read what the care plan was but could only input - has simply been scrapped.

6. A request for a surgical review is now done under a protocol. Mid-grade surgeons are called to assess and take the decision if they need to "escalate" (i.e. refer to a more senior colleague). I make a recommendation below in regard to this part.

7. A protocol for chasing up surgical reviews has been introduced where medical staff require to chase up the matter after a "reasonable time" via the medical hierarchy if necessary. There is a protocol now to record in the notes who is responsible for undertaking the next step. I deal with this in the recommendations also.

8. The system in radiology remained the same as in 2004 but Mr Wightman submitted that it was not for me to take any view of it, as radiology was not relevant

to the situation. As I have noted above evidence was given that x-rays may now be seen on the computer system in the ward without prints being required. However I do not agree entirely with Mr. Wightman, as I believe that what happened with the radiology request showed a lack of knowledge on the part of the medical staff concerned in making the request. The outcome for Mrs Kerr was not affected but I think it correct to make a recommendation in this respect as I do below.

# RECOMMENDATIONS

I now turn to deal with the recommendations that I make as a result of this inquiry. I am bound to say the list would have been considerably longer were it not for what came out in evidence as to steps which have been taken since this occurrence and which list would have encompassed paragraphs one to five of the preceding section.

The recommendations I make are as follows: -

1. It should be emphasised to all grades that there is a necessity to make proper full intelligible and legible notes of observations that they make, any action which they carry out, and any action which they intend others to carry out: and in that last case, who is to carry it out should be specified. I regard this as absolutely essential in a situation where there is constant shift change and hand-over. Although the question of hand-over has been addressed to an extent, proper and adequate notes form the basis upon which anyone examining the history of a patient has to base an assessment, which history might cover something not dealt with at hand-over.

2. In regard to a protocol for requesting a surgical review - indeed any inter-departmental review - I recommend that such always be made by and to at least a middle-grade member of staff in the referring and referee departments.

3. I recommend that the protocol for "chasing up" an inter-departmental review should have a time limit put upon it and not be left to individuals to estimate what is a "reasonable time". I appreciate that there will be different levels of urgency but there should be a finite time during which if not carried out the referring SHO should be obliged to consider whether or not a further prompt is required and should record that he or she has so considered in the notes and either decided to wait longer or to repeat it - and should assign in the notes a reason for that decision. Although I understand it has already been put in place, an additional paragraph should be inserted to cover as part of this protocol that a record be made in these notes as to who is to be responsible for undertaking the next steps.

4. I recommend that the system for ordering x-rays and other radiological procedures should be re-examined with a view to simplification and that all staff who are authorised to make such requests be clearly instructed as to the way in which the radiology department receives and treats them and as to the implications of the content of such requests and the time limits in which the radiology department will carry them out.

I close this determination by re-iterating what I said at the end of the inquiry. I am obliged to Ms Borthwick, Mrs Robertson and Mr Wightman in the way in which they conducted their examination of witnesses and the making of their submissions. I am

obliged to Mr Murray similarly, and for his organisation and administration of the inquiry and his logistical expertise in producing witnesses on time and at reasonable intervals bearing in mind that by my calculation some 11 out of the 28 witnesses had moved on from their positions at Ayr Hospital and some required to travel a considerable distance.

Lastly it is to be hoped that Mrs Kerr's son John Kerr and her daughter Mrs Felicia Nimbley, who sat through all the evidence, some of it harrowing and distressing no doubt for them, have seen and heard all that evidence relating to their mother's stay in hospital brought forth into the public domain. It is apparent from the evidence laid before me that their mother was a very sick lady upon admission to Ayr Hospital and that her chances of survival were very limited indeed no matter at which stage an operation could have been carried out. Unfortunately for her and for these relatives this traumatic experience was undoubtedly worsened by the failures of the personnel and systems that I have found established. The whole episode is a sorry tale and the only positive outcome is what has been done since to correct the deficiencies illustrated by this case so that neither another patient nor another family should endure and suffer similarly in the future.

To these relatives and the wider family it goes without saying that the sympathy of the court is extended.