SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE
AT DUNFERMLINE

[2023] FAI 18

DNF-B133-22

DETERMINATION

BY

SHERIFF SUSAN DUFF

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

into the death of

LINDA ALLAN

Dunfermline, 30 March 2023

DETERMINATION

The Sheriff having considered all the evidence and the submissions of parties,

determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 ("the Act") that:

1. In terms of section 26(2)(a) Linda Allan, born on 18 April 1960, died at 0215 hours on 23 October 2019 in the Intensive Care Unit, Victoria Hospital, Kirkcaldy, Fife KY2 5AH.

2. In terms of section 26(2)(b) no accident took place.

3. in terms of section 26(2)(c) the cause of death was:

    1a Multiorgan failure

    1b In hospital cardiac arrest

1c Complications of perforated gastric ulcer (operated on 21.10.19) with fracture of the proximal tibia (operated on 17.10.2019)

4. In terms of section 26(2)(d) no accident having taken place, no finding is made in terms of this subsection.

5. In terms of section 26(2)(e) the following are precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided.

Had Ms Allan been the subject of daily reviews including a review of her medication on 19 and 20 October 2019, there were opportunities to detect the deterioration in her condition and to take action to prevent her further decline.

Further, when Ms Allan's pain score went from 0 to 10 over the period of just under 7 hours on 19 October 2019, she should have been the subject of escalation to an urgent medical review at that stage which could have resulted in her condition being assessed and action taken to prevent further decline.

Had Ms Allan been escalated to an urgent medical review on 20 October 2019 at around 1800 hours when she was seen by the Advanced Nurse Practitioner ("ANP"), her condition could have been assessed and action taken then to prevent further decline.

Any one of those precautions might realistically have resulted in the death being avoided.

6. In terms of section 26(2)(f) any defects in any system or working which contributed to the death. I did not conclude there were any defects in the system of work that contributed to the death, and make no finding in terms of this subsection.

7. In terms of section 26(2)(g), the following matters are relevant to the circumstances of the death:

i. Record keeping and documenting of Ms Allan's condition was inadequate.

ii. The boarding policy, the policy in place to allow patients to be transferred from one ward to another for non-clinical reasons, was not adhered to resulting in Ms Allan being boarded without her vital signs being taken. The transfer document accompanying her to Ward 10 was not completed.

RECOMMENDATIONS

8. In terms of section 26(4), I make the following recommendations:

1. Every post-operative patient should be seen by an ANP or a doctor and their presentation recorded in the observation notes on a daily basis. As part of that daily review, the medication prescribed to the patient should be considered and adjusted if appropriate. The observation record should narrate that the medication prescribed has been considered and narrate any changes.

2. Any patient who records a low pain score and at the next observation check records a high pain score should be the subject of an immediate referral to an ANP or a doctor.

3. The Fife Early Warning System ("FEWS") Observation Chart should be revised to allow the site of pain to be recorded. Pain scores should be recorded from the point of admission into hospital until discharge.

4. A Fluid Balance Chart should be maintained for every post-operative acute patient until they are ambulant.

5. Refresher training on the action points referred to in Mr Chesney's email of 4 November 2020 should be given annually to all medical practitioners in orthopaedic wards. Records should be kept of who has received this training to ensure that all relevant employees receive it annually.

6. The lead trauma surgeon should continue to review a random selection of records on a monthly basis to ensure that ward rounds are being documented. Any failure to record a ward round should be raised with the doctor responsible for recording it to ensure that good practice is achieved and maintained

7. Annual refresher training should be given to all employees who implement the Boarding Policy on how it works, how patients should be assessed in relation to it and how the paperwork for the Boarding Policy should be completed. Records of who has received this training should be kept to ensure that all relevant employees receive the training annually

8. Annual refresher training should be given to the members of the Hospital at Night ("H@N") team on the escalation process. Again, records should be kept of who has received the training to ensure that all relevant employees receive this training annually.

NOTE

Introduction

[1] This determination follows an inquiry into the death of Linda Allan who died on 21 October 2019 in Victoria Hospital Kirkcaldy.

The Legal Framework

[2] This was a discretionary inquiry held in terms of section 4 of the Act.

[3] The procurator fiscal considered that an inquiry was required as she considered that the death occurred in circumstances giving rise to serious public concern and that it was in the public interest an inquiry be held.

[4] Fatal accident inquiries and the procedures to be followed in the conduct of such inquiries are governed by the provisions of the 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[5] In terms of section 1(3) of the Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances.

[6] Section 26 of the Act requires the sheriff to make a determination which in terms of section 26(2) is to set out the following five factors relevant to the circumstances of the death, in so far as they have been established to their satisfaction.

[7] These are: (i) when and where the death occurred; (ii) the cause or causes of such death; (iii) any precautions that could have reasonably been taken, and if so might realistically have avoided the death; (iv) any defects in any system of working which contributed to the death; (v) any other facts which are relevant to the circumstances of the death.

[8] The provisions in relation to an accident are not relevant to this inquiry.

[9] In terms of section 26 subsections (1)(b) and (4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps.

[10] In order to identify precautions which, had they been taken, might realistically have avoided the death, or to identify defects in the system of working which contributed to the death, it is necessary that the sheriff is satisfied on the balance of probabilities that those precautions or the defects in the system of working contributed to the death.

[11] Further, in order to make recommendations the sheriff has to be satisfied that there is a reasonable possibility that the recommendations may prevent deaths in similar circumstances.

[12] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The court proceeds on the basis of evidence placed before it by the procurator fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry and is limited to the matters defined in section 26 of the Act.

[13] Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability (section 1(4)).

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

Participants and representation

[15] The procurator fiscal represents the public interest in a fatal accident inquiry and Mr Morrison, procurator fiscal depute, appeared. Fife Health Board was represented by Miss Russell, advocate

[16] I am grateful to both Mr Morrison and Miss Russell and Miss Russell's instructing solicitor for their assistance in the conduct of this inquiry. The agreement of evidence and the use of affidavits have greatly assisted the inquiry.

The witnesses to the Inquiry

[17] I had affidavit evidence from the following witnesses:

Sharon Adams, Ms Allan's daughter

Shona Adams, Ms Allan's daughter

Jamie Duff, Ms Allan's partner

Dr Bappa Roy NHS Fife

Andrea Bendowski, NHS Fife

Dr Fiona Bull NHS Fife

Lorna Bellingham, NHS Fife

Dr McCallum Kirkcaldy Health Centre

Pauline Hope NHS Fife

David Chesney, NHS Fife

John Annan, NHS Fife

Dr Paula Murphy, Kirkcaldy Health Centre

Claire Westby NHS Fife

Susan Halfpenny NHS Fife

Sinead Webster NHS Fife

Paul Jenkins, Resolve Medicolegal

Mark Blyth, Glasgow Royal Infirmary, and

Dr Caroline Whymark Resolve Medicolegal

In addition, I heard oral evidence from the following witnesses:

John Annan NHS Fife

Claire Westby NHS Fife

Susan Halfpenny NHS Fife

Sinead Webster NHS Fife

Pauline Hope NHS Fife

David Chesney NHS Fife

Mark Blyth Glasgow Royal Infirmary,

Dr Caroline Whymark, Resolve Medicolegal, and

Paul Jenkins Resolve Medicolegal

The circumstances

[18] This Fatal Accident Inquiry concerned the care of Ms Allan in Victoria Hospital Kirkcaldy in the time before she suffered a cardiac arrest on 21 October 2019.

[19] The 2016 Act requires the Sheriff to make a determination which sets out factors relevant to the circumstances of the death.

[20] It is not the function of a Fatal Accident Inquiry to assess the adequacy of an internal review by the Health Board into the circumstances of the death. Nor is it the function of a Fatal Accident Inquiry to make findings of liability or criminal responsibility.

The cardiac arrest

[21] Ms Allan suffered a cardiac arrest at 0335 hours on 21 October 2019. She was resuscitated and transferred to the Intensive Care Unit. An ultrasound revealed the presence of free fluid in her abdomen and once she was stable, she underwent a laparotomy at 0805 hours on 21 October 2019. On opening the abdomen, a large pre-pyloric perforated chronic ulcer around 1cm in diameter was found. There was around 2 litres of gastric fluid in the peritoneal cavity which included food contents. The abdomen was cleaned out and the ulcer closed and repaired. Ms Allan remained in Intensive Care but her condition continued to deteriorate. She was taken back to theatre at 2145 hours on 22 October 2019. At this time, there was ischemia of the small bowel with gangrenous patches. The colon was noted to be dusky and the liver was thought to be ischemic. It was decided that any further attempt at resection or surgical intervention

was likely to be unsuccessful. It was agreed that Ms Allan would be kept comfortable. Ms Allan died at 0215 hours on 23 October 2019.

Admission to hospital

[22] The chronology following Ms Allan's admission to hospital was not controversial.

[23] On 15 October 2019, Linda Allan was admitted to the Orthopaedic Unit at the Victoria Hospital in Kirkcaldy. She gave a history of stepping over a low wall in a garden which gave way.

[24] She was noted to have an isolated injury to her right knee. X-rays revealed a complex bicondylar tibial plateau fracture of the right knee.

[25] She gave a past history of hyperthyroidism, for which she had a thyroid lobectomy in 2014 and a history of a duodenal ulcer/duodenitis. Her medications were noted to be levothyroxine which is used to treat hypothyroidism, and lansoprazole, which is used to treat duodenal ulcers and duodenitis. It was also noted that she had been prescribed Naproxen, but that entry in her medical notes is followed by a note "no longer takes".

[26] Following her admission for surgery, a CT scan of the right knee was carried out to give more detail about the fracture. Her initial plan for surgery was delayed to allow her surgery to be carried out by a specialist with particular skills to treat the type of fracture that Ms Allan had.

[27] Her surgery was carried out on 17 October 2019.

Before the operation

[28] On 17 October 2019 Ms Allan was assessed by Dr Bull, Consultant Anaesthetist, Dr Bull noted a history of duodenal ulcer but confirmed no reflux symptoms at that time. She listed naproxen and lansoprazole in the drug section and noted that paracetamol had been given earlier that morning. She recorded Ms Allan to be a smoker of 15 cigarettes per day.

During the operation

[29] Dr Bull administered standard general anaesthesia.

[30] Shortly after induction of anaesthesia, there was a period of lowered blood pressure of around 90/50 mmHg for approximately 15 minutes. The expert witness, Dr Whymark, stated that this typically occurs in the period after induction of anaesthesia and prior to the operation commencing when there is no surgical stimulation. This was identified and immediately treated with incremental boluses of two drugs, metaraminol and ephedrine which supported the blood pressure until the surgery began.

[31] At 1000 hours, a bag of intravenous fluid is recorded as being started. This was to provide hydration and support blood pressure. Morphine and paracetamol were given intravenously for pain relief during the operation. The paracetamol was given 4 hours after the morning dose.

[32] Dr Whymark considered that the dose of morphine was generous.

[33] At the end of the operation, the surgeon administered local anaesthetic to the wound.

After the operation

[34] In the recovery room, Ms Allan reported a pain score of zero.

[35] Dr Bull prescribed intravenous morphine, which could have been administered in recovery in that immediate postoperative period. Ms Allan did not receive it because it was not required at that time. Ms Allan was not given naproxen then.

Postoperative instructions

[36] These proposed to restart oral intake as able, to give analgesia as per the drug chart, and to give oxygen to keep saturation above 95%.

[37] Dr Bull prescribed twice-daily long-acting oral morphine 20 mg with an instruction that it be was to be reviewed daily and reduced. This continued at 20 mg for 48 hours. Dr Bull wrote a further prescription for oral morphine 10 mg for breakthrough pain, allowing it to be given more frequently, every one hour, instead of every two hours as was prescribed preoperatively. Dr Bull prescribed naproxen 500 mg orally twice daily to begin that evening. She gave no additional instructions. Ms Allan had previously been prescribed the proton pump inhibitor, lansoprazole, in hospital.

[38] The recovery room care chart shows that at 1340 hours the pain score was zero, the nausea score was zero, blood pressure was 105/58 and all other observations were satisfactory. Ms Allan was deemed fit to return to the ward. When the patient has been

appropriately discharged from recovery to be returned to the ward, the immediate responsibility of the anaesthetist to the patient is at an end.

The prescription of naproxen

[39] At page 64 of Crown production 6, medical records, it is recorded beside naproxen "no longer takes".

[40] The court had affidavit evidence from Dr Paula Murphy, and Dr Heather McCallum, both GP partners at Ms Allan's practice in relation to the prescription of naproxen.

[41] Dr McCallum states that Ms Allan was prescribed naproxen on two occasions in 2019. The first was on 9 April 2019 when Ms Allan attended her GP reporting bursitis on her hip for which she had been taking ibuprofen over the counter. This had not worked so she sought a prescription for naproxen. Ms Allan was prescribed a 28-day supply of naproxen consisting of 56 tablets. That was the maximum number of tablets she could be prescribed without seeing a doctor again. Dr McCallum also prescribed lansoprazole to protect the stomach.

[42] Dr McCallum was aware of Ms Allan's history of gastritis and duodenitis in 2008, noted that Ms Allan had been prescribed lansoprazole in 2008, and had a repeat prescription of that in 2014.

[43] Ms Allan told Dr McCallum on 9 April 2019 that she had not suffered any side effects from the use of naproxen in the past or from recent use of ibuprofen. Ms Allan was advised to stop using the naproxen if she experienced any side effects and to seek

medical help. She did not report any concerns to Dr McCallum regarding her stomach in 2019.

[44] Ms Allan saw Dr Murphy on 18 July 2019 at a routine appointment with a history of pain over the medial arch of her foot that had been ongoing for a few weeks. Dr Murphy thought it could be tendonitis and advised a self-referral to podiatry. Dr Murphy prescribed naproxen for 28 days. Dr Murphy did not prescribe lansoprazole because the prescription in April had been for 2 months when the prescription for naproxen was only for 28 days. There was a repeat prescription for lansoprazole done on 18 August 2019. Dr Murphy warned about taking any other anti-inflammatories, taking on an empty stomach and using a protein pump inhibitor while taking naproxen. She advised desisting in the use of naproxen if there were any gastro-intestinal side effects such as heartburn or indigestion.

The prescription of naproxen by Dr Bull

[45] As the consultant anaesthetist for the operation, Dr Bull took a pre-operation history from Ms Allan. She ascertained that Ms Allan had a history of duodenal ulcer but had no reflux at that time. She prescribed naproxen for pain relief post-operatively. While she gave no specific instructions in relation to the review of naproxen, she instructed that the morphine prescription was to be reviewed and reduced daily. Her immediate responsibility to Ms Allan ceased when Ms Allan returned to the ward.

[46] In the expert opinion of Dr Whymark, the prescription of naproxen in the postoperative period was reasonable given the information available and the potential

benefit intended. It was also reasonable to consider that Ms Allan was unlikely to suffer any harm from it due to her tolerance of two courses of the same drug earlier in the year.

[47] I make no findings in relation to the prescription of naproxen by Dr Bull.

Ms Allan's return to the ward

[48] The following is recorded in the medical notes in the section on Progress/Continuation/Evaluation of Care ("Observation notes") after Ms Allan's return to the ward.

[49] 17 October 2019 1500 hours. Dr Cox, a Foundation Year One doctor ("FYI"), carried out a postoperative review. They recorded:

> "ORIF Right tibial plateau fracture, cefuroxime given intra-operatively;
> FEWS 0
> HR72 BP108/52 RR is 0298.1 on nasal cannula
> Feeling 'rotten' – pain 10/10 at the moment –right leg and foot
> No nausea/vomiting
> No urine yet since theatre
> Has been drinking lots of water, no food yet
> O/E Looks sleepy
> Hands warm cap refill under 2 secs
> Pulse regular and strong 1 x cannula in situ
> HS 1+11+10
> Chest clear, no added sounds
> Adbo soft and non tender
> Both feet warm, pulses sensations + illegible
> Present bilaterally
> Imp- no immediate post op concerns
> Plan- Analgesia. Encourage oral intake
> Mobilise NWB 6 weeks in donjoy brace 0-90 physio
> Removal of clips in 2 weeks
> VTE prophylaxis"

18 October 2019 0100 hours. The observation notes record:

> "Settled overnight
> PRN oramorph and ice therapy
> Frugmin
> Fews stable
> For PT review NWB 6 weeks
> Passing urine"

18 October 2019 1000 hours. The observation notes record:

> "Dressing renewed. Wound clean and dy hinged brace –reapplied. Pain better controlled- ongoing
> Physio remain NIWB"

19 October 2019 1140 hours. Ms Allan was seen by an occupational therapist ("OT").

They have recorded:

> "OT: 11.30- Reviewed PT notes before introducing myself to pt. Pt ++sleepy but confirmed that balance was an issue today. Consented to provision of a free standing toilet frame which will facilitate an easier transfer. Plan-provide a frame for family to take home. Pt says she has adequate support from family who can assist with needs etc"

19 October 2019. 1500 hours. The observation notes record:

> "Analgesia R/V (review). On zomorph illegible feeling very sleepy. pain well controlled. c/o (complaining of) constipation. Bowels not moved 7/1. Commenced laxido and senna"

20 October 2019. 1445 hours. Further visit by the OT who records:

> "OT 1430- Pt continues to be ++sleepy therefore toilet frame ordered for delivery to pt's home on Tuesday. Pt agreeable to this"

20 October 2019. 1500 hours. The observation notes record:

> "patient boarding to ward 10 VHK to allow for further admissions. Happy to move and will inform next of kin"

20 October 2019. 1530 hours. The observation notes record:

> "further bowel movement with difficulty. Zomorph v 10mg as feeling very sleepy."

20 October 2019. 1520 hours. The observation notes record:

> "Handover given to ward 10. To transfer pt after dinner as they don't have a meal for her"

There are no other observation entries for Ms Allan's time in Ward 33.

Care rounding

[50] In terms of the care rounding records, Ms Allan was to be seen every 4 hours.

[51] She returned from surgery at 1400 hours on 17 October 2019. At that time, she is recorded amongst other things as wanting a drink, not being in pain, being comfortable and not worried about anything.

[52] A fluid balance chart was not being used and was not used when Ms Allan was on Ward 33.

[53] On 17 October 2019, at 1800 hours, 2200 hours, 0100 hours and 0500 hours, Ms Allan is recorded as being in pain, being given analgesia, being comfortable and not being worried about anything. The entries at 0100 and 0500 must be into 18 October 2019.

[54] The care rounding records are at pages 30-41 of Crown production 6 the medical notes.

[55] The notes are confusing to follow.

[56] The section headed "Time of Care Rounding" states "06.00am-05.00am- continue overleaf". The times given at the top of the chart for recording are in the 24-hour clock starting at 1800 hours.

[57] The care rounding pages in Crown production 6 are ordered as follows:

17 October 1000 and 1400 hours are on page 38.

17 October 1800 and 2200 hours are on page 39. Also on page 39 are entries for 0100 and 0500 hours which times, presumably, are into the following day but that is not clear.

18 October for recordings in the morning is on page 36. Although someone has filled in the site, the ward, the date and the frequency of the recordings and signed it, there are no recordings on that page.

18 October recordings for 1800 hours onwards are on page 37. However, there are only three recordings at 2100, 0100 and 0500 hours and the same uncertainty about the times of 0100 and 0500 hours referred to above exists.

Page 35 has entries for 1800, 2200 and 0200 hours but the date is unclear. It may be 18 October but if that is the case, there are two pages purporting to record the evening of 18 October on pages 35 and 37 and both give different times.

19 October 1000 and 1400 hours are on page 33.

19 October 1800, 2200 and 0200 hours are on page 34.

20 October from 0600 hours to 1700 hours appears on page 32 but only has one recording on it at 1100 hours.

20 October from 1800 hours to 0500 hours appears on page 31. The time of 1800 has been scored out and 1600 handwritten in. There are two further entries on that page timed at 2000 and 0000 hours.

[58] Concerningly, the observation notes at page 76 of Crown production 6 record Ms Allan as being in Ward 10 by 1625 hours on 20 October. SN Halfpenny gave evidence that Ms Allan had arrived in Ward 10 at around 4pm (1600 hours).

[59] I accepted the evidence of SN Halfpenny about Ms Allan's arrival on Ward 10. Care rounding records were still being completed for Ms Allan when she was no longer on Ward 33.

[60] The contradiction between the care rounding records and the observation notes is concerning.

[61] Recorded throughout the care rounding notes is that Ms Allan's bowels had not moved from the time the record started at 0600 hours on 16 October until an entry on 20 October at 1100 hours where it is recorded that they had.

[62] On 20 October an entry at 1600 hours on page 31 of the care rounding records contradicts the entry on page 76 that Ms Allan had had a further bowel movement at 1530 hours on 20 October.

[63] I note that following the Significant Adverse Event Review ("SAER") that the care rounding records have been replaced with a Care Clock. This prompts nursing staff to ask about and record daily the date of the last bowel movement.

Fife Early Warning System (FEWS)

[64] FEWS is a medical scoring system aimed at identifying early signs of deterioration in a patient. It is based on a patient's vital signs which are allocated a number on the scoring system depending on their values. The numbers are added up to give the total score. A FEWS score of above 3 indicates the nurse has to consider escalation and inform the nurse in charge. If the FEWS score is above 4 or above 3 for more than an hour, the medical team has to be informed and consider infection, admission to the Intensive Care Unit or High Dependency Unit or ward-based care.

[65] Temperature, Heart Rate, Blood Pressure and Respiratory rate are recorded. In addition, there are sections for the following to be recorded:

O2 sat, on 02%, Ward, temperature, pulse, lying BP, standing BP, resp, O2 stat, on02%, AVPU, pain (rest), pain (move), N/V, bowels, weight, EWS regime and Nurse.

[66] Not all sections apply to all patients. For example, Ms Allan did not have her standing BP recorded because she was not standing.

[67] However, as noted, there is a section in relation to bowels and nothing was recorded for Ms Allan on this FEWS record from 15 October 2019 at 1801 hours when the FEWS recording began until the last entry on 20 October 2019 at 2213 hours. This is despite Ms Allan reporting her bowels had not moved since before her admission to hospital until a bowel movement on 20 October noted above.

[68] Notwithstanding the fact that Ms Allan had been admitted to hospital with a leg fracture which it is noted she described as painful, there are no entries in the FEWS scores pre-operatively about pain.

Evidence of observations of Ms Allan in Ward 33

Friday 18 October 2019

[69] Mr Annan who carried out the operation on Ms Allan along with a colleague Mrs Mitchell stated in his affidavit and in evidence that he recalled seeing Ms Allan on Friday 18 October 2019 during the Trauma ward round. He said Ms Allan was in a side room and was comfortable when he saw her. He did not get the impression she had abdominal pain. Had she complained of abdominal pain he would have examined her abdomen. Her presentation then was as he expected it to be postoperatively. He did not record his findings in the notes.

Saturday 19 October 2019

[70] Staff Nurse Clare Westby saw Ms Allan on 18, 19, and 20 October 2019.

[71] She was responsible for the entries in the observation notes at 1800 hours on 18 October, 1500 hours on 19 October and 1500 and 1530 hours on 20 October 2019.

[72] SN Westby stated that at the morning handover on 19 October the night shift staff had reported that Ms Allan had been having issues with constipation overnight and her bowels had not moved in 7 days. SN Westby made an entry in the observation notes at 1500 hours on 19 October to that effect and commenced laxido and senna.

Sunday 20 October 2019

[73] SN Westby had looked after Ms Allan since Friday 18 October and she felt that on Sunday 20 October Ms Allan was more lethargic than she had been. She described Ms Allan as being quite chatty on the Friday, sitting in the chair, not as chatty on Saturday and complaining of constipation overnight and on Sunday being more lethargic although she looked well and her observations were fine.

[74] As a result of Ms Allan's appearance on Sunday, she escalated Ms Allan to a FY1 doctor. That doctor reduced the dose of zomorph.

[75] SN Westby's entry in the observation notes at 1530 hours states "zomorph v 10mg as feeling very sleepy" SN Westby could not remember if the FY1 came to see Ms Allan or if the dose was reduced based solely on their conversation. SN Westby said the normal escalation process, if there were any new concerns, was to escalate to a FY1 doctor. She was concerned enough about Ms Allan's presentation to speak to a FY1 doctor about Ms Allan. Ms Allan was alert and orientated but she was a lot more lethargic. If the doctor had done a physical examination, SN Westby would have expected to see an entry in the observation notes. In addition to that, SN Westby discussed Ms Allan's constipation with an FY1 doctor who prescribed laxatives to be taken regularly. She was unsure whether the doctor examined Ms Allan in relation to the constipation symptoms or whether laxatives were prescribed based on the conversation she had had with the doctor. There are no entries in the observation notes on 20 October 2019 from any FY1 doctor.

[76] Ms Allan told SN Westby that she had some relief following a small bowel movement. When SN Westby saw Ms Allan at 1500-1530, she considered that Ms Allan looked well but sleepy. Ms Allan was happy to board and said she would tell her next of kin. At that time, Ms Allan did not report having pain to SN Westby.

[77] SN Westby did not carry out the boarding assessment but Ms Allan met the criteria for boarding and admission to Ward 10.

[78] At 1625 on 20 October 2019, Ms Allan was initially assessed in Ward 10 by SN Susan Halfpenny who recorded the following in the observation notes:

> "Patient transferred from Ward 33. Patient felt very unwell on arrival- stomach pain, felt very hot. Temp checked 36!. Did have 1 very small bowel movement but still feels very constipated. Phoned ward but they stated she has been very sleepy so zomorph reduced and symptoms probably due to constipation. FEWS of 1 on arrival due to O2 of 89%- now on nasul canula @2 ltrs and beginning to rise."

[79] SN Halfpenny considered that Ms Allan had not been an appropriate patient to be boarded. In Ward 10, which is a nurse-led ward, it is not usual to do a full review of a patient when they arrive from another ward but Ms Allan was fully reviewed. Ms Allan looked like she was in pain and was upset. SN Halfpenny thought something did not look right and that Ms Allan looked almost green. Ms Allan was complaining of abdominal pain and pain in her bowel. SN Halfpenny noted Ms Allan's oxygen saturation at 89% and considered that something was not right when there was no history of respiratory problems.

[80] There was no record of Ms Allan's fluid intake. SN Halfpenny took blood for analysis and asked for a review of Ms Allan as soon as possible. In the meantime, she

tried to make Ms Allan comfortable. She gave Ms Allan laxido. The Hospital at Night Team ("H@N") were contacted to review the patient and Advanced Nurse Practitioner ("ANP") Sinead Webster arrived about an hour after Ms Allan was transferred.

[81] The night shift came on duty at 1900 hours and SN Halfpenny remained on the ward until 2000 to ensure the night shift was managing.

[82] ANP Webster said that she had been contacted by Ward 33 and she was told that Ward 10 had said that Ms Allan was an inappropriate boarder whereas Ward 33 considered that Ms Allan was an appropriate boarder and that she was well. It was unusual for ANP Webster to be contacted by a ward that the patient was no longer on.

[83] At around 1830 hours, ANP Webster attended Ward 10 to examine Ms Allan.

[84] She made the following entry in the observation notes:

> "1850 ATSP re 'feeling unwell'. FEWS 1 SaO2 92%. Patient is constipated and feeling nauseous ++.
> O/E HS/ 1+1 1+0 cool to elbows + mid calf
> JVP (-) no oedema
> Chest- poor inspiratory effort
> ? A/E bi basally
> Poor inspiratory effort 2 ◦ pain
> Abdo distended, scant bowel sounds, bowels open this am, denies flatus, not tender on palpitation but "crampy"
> Commenced on senna and laxido today. Note has been 'sleepy/drowsy' throughout previous entries and zomorph (down arrow for reduced)
> ?? Fluid intake over the last few days.
> Appears dry++
> Plan/ Baseline bloods D. The Ds after these four entries may be a drawn box rather than a D
> Cannulate D
> Iv fluids D fluid balance chart D
> Buscopan for cramps (ticked)
> Ask H@N team to IV D"

[85] ANP Webster found Ms Allan in bed, alert but pale, her hair was dishevelled and she looked tired. Ms Allan said that she was not feeling brilliant and that she felt really constipated. Ms Allan did not look good. ANP Webster had not met Ms Allan before so she did a full examination. She listened to heart and chest sounds, did an abdominal examination and checked her leg wound for bleeding. Respiratory examination revealed poor inspiratory effort with reduced air entry bibasally and Ms Allan was in pain and not able to deep breathe. She felt bloated and uncomfortable on sitting forward and as a result satisfactory chest auscultation was difficult to achieve. Ms Allan said she had opened her bowels a little bit that morning and felt quite crampy. On examination, her abdomen was distended with scant bowel sounds on auscultation. Ms Allan denied flatus. Her abdomen was not tender on palpitation but she described it as "crampy", because Ms Allan had had a bowel movement ANP Webster did not consider that she needed escalated at that time. Had the bowel sounds been tinkling or absent, ANP Webster would have escalated Ms Allan at that time. Ms Allan had dry mucous membranes on visual examination. ANP Webster thought from that that Ms Allan's bowels were starting to move. Ms Allan was alert and orientated but she was in pain and uncomfortable.

[86] ANP Webster considered that Ms Allan was likely to be dehydrated but because there were no fluid balance charts, she could not ascertain how much fluid Ms Allan had taken in. ANP Webster considered acute kidney damage because Ms Allan had just had an operation and had been given strong morphine. ANP Webster took blood because Ms Allan had not had bloods taken since her operation. Although SN Halfpenny said

she also took blood when Ms Allan arrived on Ward 10. ANP Webster asked for a full blood count, urea and electrolytes.

[87] Emergency blood analysis takes 30 minutes to obtain results. Routine blood analysis takes between an hour and an hour and a half. ANP Webster sent the blood for routine analysis because she considered that Ms Allan's symptoms were related to dehydration. The lack of any fluid balance charts meant that ANP Webster had not been able to calculate how much fluid Ms Allan had had. ANP Webster would have expected Ms Allan to have a fluid balance chart. She said that different wards in the hospital did different things in relation to fluid balance charts. She considered that all wards should keep fluid balance charts. In her opinion, the fact that the observation notes said that Ms Allan was drowsy meant that Ms Allan should have had a fluid balance chart to monitor her fluid intake. If Ms Allan had had a fluid balance chart and it had shown an adequate intake of fluid of 1000mls in the last 12 hours and on examination, Ms Allan was cool to the elbows and mid-calf, that would have changed ANP Webster's management of Ms Allan. ANP Webster would have requested emergency blood analysis and given Ms Allan much faster fluids.

[88] The absence of a record of fluid intake meant that ANP Webster considered the cool extremities were due to dehydration rather than another cause.

[89] ANP Webster inserted a venflon cannula in her arm and started fluids. She requested the nursing staff to commence a fluid balance chart. ANP Webster handed Ms Allan's care to a colleague in the H@N team as she was going off duty with the instructions that bloods needed to be chased up and reviewed to see if Ms Allan had an

acute kidney injury. She considered that the bloods and vital values would inform a decision of whether or not Ms Allan needed escalated. She did not escalate Ms Allan to a registrar then because she considered that they would have told her to wait for the blood results. She also considered that Ms Allan's clinical observations then did not indicate an immediate review and Ms Allan would have been handed over to the night shift with her being seen by a doctor in no less than an hour or an hour and a half.

[90] ANP Webster considered that Ms Allan's cool peripheries indicated that she was fluid depleted.

[91] 20 October 2019. 2025 hours, the observation notes state

> "Patient managed to pass urine on bedpan. Only managed about 30ml. Bladder scanned post void showed 130ml. Patient not uncomfortable at this time will continue to monitor output."

[92] 20 October 2019. 2202 hours, a member of the H@N team reviewed the blood results and examined Ms Allan. They made the following entry in the observation notes:

> "New AKI (acute kidney injury)
> Patient dry ++ cold extremities- shut down
> Plan medication review – withheld naproxen co AKI. Patient agreed.
> IV fluids
> Catheter insertion for close monitoring, review morphine, word illegible, ? switch oxycodeine
> Word illegible renal function
> Words illegible
> Ordered on system- suppositories for constipation
> Please escalate any further concerns overnight."

There are five more entries in the observation notes before the entry relating to the cardiac arrest which occurred at 0335 hours and which was written into the observation notes at 0440 hours.

These are:

> "2300 Catheterised due to AKI 2. No issues. Aseptic technique used. IVF continue further bags prescribed. I vols continue. Glycerol suppositories given as per cardex. Continue to monitor.
> 2340 Datix completed- WEB108841 as inappropriately boarded to ward 10.
> 0150 Settled at present. 1° vols continue between 30-50ml/hr. IVF continue. MSU NAD. Bloods due in morning. No result from suppositories. Nothing felt in return when giving supps. Fluid intake encouraged. Meds are per cardex. FEWS 0. Continue to monitor."

There is no entry on the FEWS observation chart at 0150 hours on 21 October 2019.

> 0250 H@N contacted on patient. HNPU (has not passed urine) in past hour advised to give 500ml over 1 hour and if not passed urine after to phone back.

The lack of medical review in Ward 33

[93] SN Westby saw Ms Allan on 18, 19 and 20 October 2019. She observed Ms Allan to be more lethargic on 20 October 2019 and she observed a deterioration in Ms Allan's presentation and spoke to a FY1 doctor about Ms Allan.

[94] If the FY1 doctor did physically examine Ms Allan, they have failed to make any entry in the observation notes. The last entry by a doctor was that of the FY1 doctor on 17 October 2019 when Ms Allan returned to the ward after the operation. I accept that Mr Annan did see Ms Allan on 18 October 2019.

[95] The absence of any entries by a doctor after 17 October 2019 is concerning.

[96] I cannot conclude that Ms Allan was seen by a doctor after SN Westby spoke to a FY1 doctor about her on 20 October 2019 but neither can I conclude that she was not seen by a doctor.

[97] Every patient who has undergone an operation should have a daily documented medical review by a member of their care team who should clearly sign their entry. That would ensure that the patient's recovery can be seen to be proceeding as it should.

[98] Such a daily medical review would record the patient's recovery against clear recovery goals and would highlight the presence of complications or other symptoms and the requirement for any additional investigations or treatments.

[99] Such a daily review would have been likely to have detected the ongoing abdominal symptoms and led to the consideration of differential diagnoses.

The lack of medicines review

[100] Dr Bull had prescribed twice-daily long-acting oral morphine 20 mg postoperatively with an instruction that that prescription was to be reviewed daily and reduced.

[101] While the dose of morphine was reduced in response to Ms Allan appearing very sleepy, there is no evidence before me from which I can conclude that Ms Allan's presentation was considered by a doctor. Ms Allan was complaining of constipation, was taking naproxen and had a history of gastric ulcers. It appears that an assumption was made that the constipation was due to ingesting morphine and no differential diagnosis was considered.

Pain scores

[102] A patient returning from an operation would be expected to improve with the passage of time. FEWS scores were recorded several times a day post-operatively. On Saturday 19 October 2019, Ms Allan's FEWS scores were recorded at 1144 hours when her pain score at rest and when moving was 0. Her FEWS score was taken at 1842 hours when her pain score at rest and when moving was 10.

[103] Over a period of almost 7 hours, Ms Allan's pain level had gone from nothing to the most severe pain.

[104] Despite this recording, it would appear that nothing was done to investigate the cause of this dramatic escalation in pain. At that time, Ms Allan had a FEWS score of 2.

[105] I consider that pain score alone should have prompted a review by a doctor at that stage.

[106] While the FEWS records a pain score, it does not record the location of the pain. The recording of the location of a pain site would allow that additional factor to be considered in the assessment of the condition of a patient.

[107] In Ms Allan's case, had the site of the pain been recorded, and the site was her abdomen, that should have been a trigger for further investigation by a doctor. The absence of recording the site of the pain allows assumptions to be made about the cause of the pain.

Boarding Policy

[108] Crown production 13 sets out the boarding policy for patients within the Acute Services Division.

[109] The purpose of the policy is stated as:

> "1.1 Acute capacity pressures will on occasion require patient transfers out with their speciality base for non-clinical reasons (boarding) to support patient flow and appropriate patient placement across the acute services division NHS Fife. 1.2 This document sets out the procedure that must be followed to ensure patient safety and quality clinical care is maintained"

[110] The Operational system is set out at section 4

> "4.1 When there is a need to board patients to create admitting capacity, all in-patients should be considered for boarding unless one of the following exception criteria apply. If a patient is not suitable to be boarded, the reason for this must be documented in the healthcare record and clearly identified on the ward whiteboard."

[111] One of the exception criteria is "FEWS ›2 or clinical concerns based on professional judgment".

[112] The procedure states at 4.5:

"Vital signs must be checked prior to boarding to ensure there has been no clinical deterioration".

[113] Ms Allan's vital signs were not recorded when she was boarded from Ward 33 to Ward 10. The Nursing Transfer Letter that was completed was not signed or dated by whomever boarded Ms Allan.

[114] SN Westby saw Ms Allan at 1500-1530 and she considered that Ms Allan looked well but sleepy. Ms Allan was happy to board and said she would tell her next of kin. At that time, Ms Allan did not report having pain to SN Westby.

[115] By 1625 on 20 October 2019, Ms Allan was noted in Ward 10 to be very unwell on arrival with stomach pain, feeling very hot and feeling very constipated.

[116] This appears to have been a rapid deterioration but had Ms Allan's vital signs been checked when she was about to leave Ward 33, this may have been picked up and a decision made not to board Ms Allan. Had Ms Allan's vital signs been taken then, that could have provided an opportunity for review by a doctor.

[117] Ward 10 is a nurse led ward and as such has patients in need of less attention than acute wards. I consider the fact that Ms Allan was in a less dependent nurse led ward meant that the H@N advanced nurse practitioner took Ms Allan's location into account in prioritising which patients to see first on 20 October 2019.

Reporting of family's concerns about Ms Allan's presentation

[118] It is noted in the SAER that Ms Allan's family reported that she was looking very unwell: jaundiced, distended abdomen, not passing urine, bowel not opened (on Saturday).

[119] None of the affidavits from Ms Allan's family members, Sharon Adams, Shona Adams and Jamie Duff, state that they raised concerns about Ms Allan's care with Ward 33 when Ms Allan was on Ward 33 or about her care on Ward 33 when she was on Ward 10.

[120] The affidavit of Sharon Adams states that she spoke to her mother, Ms Allan on the morning of 20 October 2019 and told her mother to tell the hospital staff how unwell she felt and how much pain she was in.

[121] SN Westby did not recall Ms Allan's family reporting any concerns to her while she was caring for Ms Allan in Ward 33. SN Westby would have recorded any concerns in the observation notes and discussed them with the nurse in charge, the FY1 or the orthopaedic registrar depending on the nature of any concern.

[122] SN Halfpenny said Ms Allan's partner and daughter were in Ward 10 and were angry at how ill Ms Allan was when she was transferred to Ward 10. They were glad that SN Halfpenny had requested a senior review for Ms Allan and were worried that her bowels had not moved for over a week and she was constipated and sleepy.
SN Halfpenny cannot recall Ms Allan's family raising concerns with her about Ward 33. She said that she would have noted their concerns in the observation notes had they raised them with her. It was SN Halfpenny's practice to inform a family who were unhappy at any aspect of care about the complaints procedure and to note the complaints process had been discussed in the observation notes. She did not report any concerns from the family in the notes as they did not directly state anything other than they were glad that Ward 10 was looking into the possible reasons Ms Allan was in pain.

[123] I am unable to conclude on the basis of the affidavit and oral evidence that the family did raise concerns about the care of Ms Allan with Ward 33 while Ms Allan was in Ward 33 or about Ward 33 when she transferred to Ward 10.

[124] I found SN Westby and SN Halfpenny to be credible and reliable witnesses. I have no doubt that if Ms Allan's family had raised concern about her care in Ward 33 while Ms Allan was in Ward 33 or about her care in Ward 33 when Ms Allan was in

Ward 10, both SN Westby and SN Halfpenny would have documented concerns raised with them by Ms Allan's family in the notes.

Proposed findings as agreed by the parties

[125] Both parties agreed that in terms of section 26(2)(a) Linda Allan, born on 18 April 1960, died at 0215 hours on 23 October 2019 in the Intensive Care Unit, Victoria Hospital, Kirkcaldy, Fife KY2 5AH.

[126] Both parties also agreed that no accident took place and therefore no finding should be made in terms of section 26(2)(b) or 26(2)(d).

Section 26(2)(c): the cause of death

[127] The inquiry has to determine the cause of death. The Crown and the Health Board proposed that the cause of death be:

1a Multiorgan failure

1b In hospital cardiac arrest

1c Complications of perforated gastric ulcer (operated on 21.10.19) with fracture of the proximal tibia (operated on 17.10.2019).

[128] I note that the expert witness, Paul Jenkins considers that in terms of part 2 of the causes of death, chronic peptic ulcer disease should be noted given Ms Allan's longer term past medical history and ongoing prescription of a proton pump inhibitor (PPI Lasnoprazole). Dr Jenkins considers that this history was also likely a contributor to her death, although but for the accident when Ms Allan fell over the wall that led to her

admission to hospital, it is unlikely that it would have led to Ms Allan's death at that particular point in time.

[129] I am not satisfied on the evidence that this should be included in the cause of death.

Section 26(2)(e) reasonable precautions which might have avoided death

[130] Fife Health Board did not propose any reasonable precautions that might realistically have resulted in the death being avoided, stating there had to be a causal connection between any such precautions and the realistic prospect the death might have been avoided.

[131] The Crown submitted that there were three precautions that could reasonably been taken and which, had they been taken, might realistically have avoided the death.

[132] These are

i. For Ms Allan to have been reviewed as a matter of routine by a member of the medical team with responsibility for Ward 33 on 19 and 20 October while Ms Allan was in Ward 33 and for such a review to have included a review of Ms Allan's prescribed medications;

ii. For Ms Allan to have been reviewed by a member of the medical team with responsibility for Ward 33 in the early evening of 19 October following reporting pain scores of 10/10 on both movement and rest, and for such a review to have included a review of Ms Allan's prescribed medications;

iii. For the escalation of care in respect of Ms Allan to a member of the appropriate medical team at the following points during the post-operative period:

a. On the afternoon of 20 October 2019 at around 1800 hours within Ward 10 when Ms Allan was reviewed by Advanced Nurse Practitioner Webster, a member of the Hospital at Night Team;

b. On the evening of 20 October 2019 at around 2200 hours within Ward 10 when Ms Allan was re-reviewed by an Advanced Nurse Practitioner from the Hospital at Night team and Ms Allan's blood analysis results indicated a new acute kidney injury.

[133] I accept the Crown's submissions and the evidence in relation to points i and ii. There is no record of Ms Allan having been seen by any member of the medical team other than the nursing staff and the occupational therapist from 17 October 2019 at 1500 hours and her being seen by ANP Webster on 20 October 2019 at around 1830 hours. A period of more than 3 days or 75.5 hours.

[134] I do accept that Ms Allan was seen by Mr Annan during the 18 October 2019 trauma ward round but that he has not documented that in Ms Allan's records. The lack of proper record keeping makes it impossible to be satisfied whether or not Ms Allan was seen by anyone other than the nursing staff and the occupational therapist after Mr Annan saw her on 18 October 2019 during that period.

[135] Ms Allan was not seen from the time of the trauma ward round on 18 October until the evening of 20 October when she was seen by ANP Webster, a period of more than two days. SN Westby gave evidence that she noticed a deterioration in Ms Allan

from Friday into Saturday and into Sunday when she spoke to a FY1 doctor about her presentation and medication on 20 October 2019.

[136] Had that doctor physically examined Ms Allan, that was a precaution that could reasonably have been taken that might realistically have avoided the death.

[137] Similarly, on 19 October 2019 Ms Allan's pain scores were recorded at 1144 hours as zero when moving and at rest. Despite the fact that over a period of just under 7 hours, her score went from zero to ten, the most severe pain, nothing was done to investigate that or to have her seen by a doctor or other member of the medical team. That was a precaution that could reasonably have been taken that might realistically have avoided the death.

[138] In relation to point iii (a), ANP Webster explained in evidence why she did not escalate Ms Allan at this time. ANP Webster saw Ms Allan at around 1830 hours on 20 October 2019 when she did a full examination of Ms Allan to the extent that Ms Allan was able to participate. ANP Webster considered that Ms Allen's cold extremities were caused by fluid depletion. A fluid balance chart had not been completed for Ms Allan post operatively. ANP Webster said she would have expected there to have been a Fluid Balance Chart but that different wards in the hospital do different things in relation to Fluid Balance Charts. She considered the fact that Ms Allan was noted to be drowsy meant that her fluids should have been monitored. Had ANP Webster seen a Fluid balance Chart and it showed a fluid intake of 1000ml in the preceding 24 hours, and on examination, Ms Allan was found to be cool to the elbows and midcalf, that would have

changed her management of Ms Allan. She would have asked for emergency blood analysis and given Ms Allan much faster fluids.

[139] The Advanced Nurse Practitioners in the Hospital at Night team cover the whole hospital out of hours and they are the first response to requests from wards. It is crucial, in my opinion, that all acute wards in the hospital operate to the same system to ensure that the ANPs are dealing with the same standards of care against which they can measure a patient's condition and what action is required. The absence of a Fluid Balance Chart meant that ANP Webster assessed Ms Allan's cool extremities as being due to fluid depletion. That assessment meant that ANP Webster did not escalate Ms Allan at that time.

[140] Having a Fluid Balance Chart for Ms Allan was a precaution that could reasonably have been taken that might realistically have avoided the death.

[141] Point iii (b) directly relates to the examination and assessment made by ANP Webster earlier in the evening. By 2202 hours, a new acute kidney injury had been diagnosed and was being treated with an instruction to escalate any further concerns overnight. It is unlikely by this stage that escalation was a precaution that could reasonably have been taken and which might realistically have resulted in the death being avoided.

Section 26(2)(f) system failings

[142] Neither the Crown nor the Health Board invited me to make findings in relation to defects in the system of work.

[143] Section 26(2)(f) is concerned with any defects in any system of working which contributed to the death. A finding under section 26(2)(f) requires a positive finding that the defect in the system of working actually contributed to the death. I do not consider it open to me on the evidence to make a finding on the balance of probability that any defects in the system of working contributed to Ms Allan's death.

Section 26(2)(g) other facts relevant to the circumstances of the death

[144] Section 26(2)(g) allows findings to be made which are relevant to the circumstances of the death. I agree with the submissions made by both the Crown and the Health Board that the areas of concern identified in the course of the inquiry should be addressed in terms of this subsection.

[145] This subsection encourages findings to be directed at such relevant circumstances even if there is no finding that they, on the balance of probability, contributed to the death. A number of matters relevant to the circumstances of the death require to be considered having regard to the purpose of an inquiry which is to establish the circumstances of the death and to consider whether any precautions could be taken which may prevent other deaths in similar circumstances.

Record keeping

[146] It is crucial for the continuity of care of a patient that every interaction with the patient is documented. This allows those involved in the patient's care to see their condition for the duration of their stay in hospital and to be able to assess if the patient's

progress is as expected. The proper recording of observations creates a history which informs care.

[147] I have found it impossible to conclude that Ms Allan was seen by a doctor when SN Westby spoke to a FY1 on Sunday 20 October 2019 because there are no notes of examination.

[148] Further, it is concerning that on the face of the medical records, entries were being made in the Care Rounding section of the notes by Ward 33 at a point when Ms Allan was in Ward 10; and that there is an entry in the observation notes at 0150 on 21 October 2019 that refers to a FEWS score of 0 when there is no entry for that time on the FEWS observation chart.

[149] Entries in medical records can only be meaningful in the care of a patient if observations are accurately recorded. It is not helpful for entries to be missed out or put in so it appears that things have been done.

Boarding

[150] It was accepted by the Health Board in the internal review that the boarding of Ms Allan was not in accordance with the Boarding Policy. Her vital signs were not checked prior to her leaving Ward 33 and the transfer document was incomplete and was not signed despite someone having written information on it.

[151] In my view, the failure to complete the transfer document ties in with the standard of record keeping evident elsewhere in the medical records.

Recommendations

[152] Every post-operative patient should be seen by an ANP or a doctor and their presentation recorded in the observation notes on a daily basis. As part of that daily review, the medication prescribed to the patient should be considered and adjusted if appropriate. The observation record should narrate that the medication prescribed has been considered and narrate any changes.

[153] Any patient who records a low pain score and then at the next observation check records a high pain score should be the subject of an immediate referral to an ANP or a doctor.

[154] The FEWS Observation Chart should be revised to allow the site of pain to be recorded.

[155] Pain scores should be recorded from the point of admission to hospital until discharge.

[156] ANP Webster would have taken a different approach to the care of Ms Allan had she been able to consider a fluid balance chart. She said practice varies across the hospital in relation to keeping fluid balance charts for patients post-operatively. It is impossible for reactive ANPs to assess a patient fully unless there is a standard approach throughout the hospital for how patients are dealt with post operatively until they are ambulant.

[157] A Fluid Balance Chart should be maintained for every post-operative acute patient until they are ambulant. This will ensure that reactive practitioners can look at

patients and can assess their fluid intake and output as part of their overall examination of the patient.

Significant Adverse Event Review

[158] The review identified six action points as:

1. Remind prescribers to review medicines at each transition of care;
2. Ensure escalating analgesia requirements are triggers for medical review;
3. Remind prescribers to add aperients when opiates are commenced;
4. Orthopaedic team to agree documentation standards for ward rounds;
5. Reissue NHS Fife's Boarding Policy to all SCNs (Senior Charge Nurses); and
6. Ensure H@N team are aware of appropriate escalation processes for deteriorating patients.

It was noted that the effectiveness of the action would be measured by email confirmation.

Action points 1, 3, 4 and 6

[159] In relation to points 1, 3, 4 and 6 Mr David Chesney was responsible for disseminating the action points. He sent an email on 4 November 2020 to the Orthopaedic Consultant group consisting of 16 surgeons but he had no way of knowing if the information in the email had been disseminated by them. The email referred to below, from Jamie Doyle, was the action taken in relation to point 6.

[160] Mr Chesney's email was in the following terms:

> "Following SBAR (sic) earlier this year, delayed due to COVID, there are a few points for people to be aware of.
>
> 1. Medication should be reviewed at each transition of care.
> 2. Aperients should be considered/ prescribed when opiates are commenced.
> 3. it is important that ward rounds are documented. This should be a written note for trauma patients, with a dictated ward round which can then go on the portal. I think broadly this is what we do already.
>
> thanks"

[161] Mr Chesney said that following the SAER, he introduced a "daily board round" of trauma patients to be undertaken by the on call registrar with the FY1 or ANP. This allowed the opportunity for the team to discuss patients and identify outstanding issues or outstanding work. He said this was created to support the FY1 doctors and ANPs. Even if the on call registrar did not see patients every day, Mr Chesney expected the on call registrar to make contact with the FY1 doctor. This meant that the on call registrar had an overview of the wards.

[162] Further, he was concerned at the lack of recording of observations in Ms Allan notes, he began a randomised audit of ward round documentation to ensure that ward rounds are documented in the records. This audit process continues to be undertaken by the trauma lead surgeon.

[163] These are positive steps that address the lack of medical oversight that was evident in Ms Allan's care.

[164] Ms Allan's death occurred in 2019. It is important that the issues that arose in Ms Allan's case are kept to the forefront of people's minds.

[165] Accordingly, I recommend that refresher training on the action points referred to in Mr Chesney's email of 4 November 2020 is given annually to all medical practitioners in orthopaedic wards. Records should be kept of who has received this training to ensure that all relevant employees receive it annually.

[166] Further, I recommend that the lead trauma surgeon continues to review a random selection of records on a monthly basis to ensure that ward rounds are being documented. Any failure to record a ward round should be raised with the doctor responsible for recording it in the notes to ensure that good practice is achieved and maintained.

Action points 2, 5 and 6

[167] In relation to action points 2, 5 and 6 Mrs Hope said there was an expectation that information would be disseminated to team members by Senior Charge Nurses but there was no process to check with them that the information had been shared or for ensuring adherence. The issue was not discussed at further meetings and that she had not looked at the issues since the email was sent on 16 October 2020.

[168] Jamie Doyle, Clinical Nurse Manager, in charge of the H@N team sent an email on 7 November 2020 to that team in the following terms

> "An action was identified to ensure H@N team are aware of appropriate escalation processes for deteriorating patients. I have given assurances that H@N are all very familiar and experienced with patient escalation processes."

[169] This was despite two ANPs in the team not escalating Ms Allan when she should have been escalated.

[170] It is concerning that despite Ms Allan's untimely death and an internal Significant Adverse Event Review (SAER) little has been done to ensure compliance with systems.

[171] Following the SAER, the only actions taken to disseminate the findings of the SAER in relation to the Boarding Policy and the HAN team was the sending of an email to the Senior Charge Nurses and an email to the HAN Manager asking them to relay the action points to staff. There are no systems in place to record that the information in the email has been disseminated to the relevant employees.

[172] No refresher training was given to any staff about how the Boarding Policy worked, how patients should be assessed in relation to it or how the Boarding Policy paperwork should be completed. No refresher training was given to the members of the H@N team about the escalation process and no consideration was given to how the escalation system could be the subject of ongoing monitoring.

[173] I recommend that annual refresher training is given to all employees who implement the Boarding Policy on how it works, how patients should be assessed in relation to it and how the paperwork for the Boarding Policy should be completed. Records of who has received this training should be kept to ensure that all relevant employees receive the training annually.

[174] I further recommend that annual refresher training is given to the members of the H@N team on the escalation process. Again, records should be kept of who has received the training to ensure that all relevant employees receive this training annually.

Conclusion

[175] The formal findings and the reasons for them are set out above.

[176] The inquiry has established that the care which Ms Allan received post operatively was not at the standard that would have been expected. There were opportunities for her condition to be reviewed which could have altered the tragic outcome in this case.

[177] I offer my most sincere condolences to Ms Allan's family.