SHERIFFDOM OF TAYSIDE, CENTRAL & FIFE AT KIRKCALDY

[2023] FAI 19

KKD-B156-22

DETERMINATION

BY

SHERIFF ELIZABETH McFARLANE

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

into the death of

DEREK COWAN

KIRKCALDY, 23 March 2023

DETERMINATION

The Sheriff having considered all of 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): Derek Cowan, born 20 April 1941, ("Mr Cowan") who resided in Glenrothes, died in Ward 32, Victoria Hospital, Kirkcaldy, at 01:00 hours on 23 August 2019.

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 1(a) dehydration, 1(b) sepsis, 1(c) infected ischaemic tissue damage in feet; 2. Alzheimer's disease; Type II diabetes and chronic kidney disease.

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

5. In terms of section 26(2)(e): Mr Cowan should have remained within Victoria Hospital, Kirkcaldy for on-going care and treatment and should not have been discharged on 15 August 2019.

6. In terms of section 26(2)(f): the process in relation to the discharge of Mr Cowan from Victoria Hospital, Kirkcaldy was defective and, in particular, there was a lack of scrutiny or review in the process of authorisation of his discharge.

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

i. there was a breakdown in understanding between staff at Victoria Hospital, Kirkcaldy and Balfarg Care Home at the time of Mr Cowan's discharge from hospital on 15 August 2019;

ii. that aspects of Mr Cowan's care whilst at Victoria Hospital, Kirkcaldy were substandard;

iii. no referral was made to the Hospital@Home Service on 15 August 2019 as planned by Dr Kelman and noted in Mr Cowan's medical notes on 14 August 2019.

RECOMMENDATIONS

In terms of section 26(1)(b): having considered the information presented at the inquiry and the changes already implemented by Victoria Hospital, Kirkcaldy since the

discharge of Mr Cowan from Victoria Hospital, Kirkcaldy on 15 August 2019, no recommendations are made.

NOTE

1. Introduction and Contents

[1] This determination follows an inquiry into the death of Mr Cowan who died on 23 August 2019 in Victoria Hospital, Kirkcaldy. It contains 13 chapters and an appendix, namely:

1. Introduction and contents
2. The legal framework
3. Participants and representation
4. The inquiry process
5. What happened
6. Areas of factual dispute
7. Proposed findings agreed by parties
8. Section 26(2)(e) reasonable precautions which might have avoided death
9. Section 26(2)(f) any defects in any system of working which contributed to the death
10. Section 26(2)(g) any other facts which are relevant to the circumstances of the death
11. System improvements
12. Recommendations

2. The legal framework

[2] This was a discretionary inquiry under section 4 of the Act. The Procurator Fiscal required that an inquiry be held as she considered that the death occurred in circumstances giving rise to serious public concern and that it was in the public interest for an inquiry to be held.

[3] Fatal accident inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. It is not the purpose of the inquiry to establish civil or criminal liability (section 1(4) of the Act).

[4] 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, insofar as they have been established to their satisfaction. 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.

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

[5] 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.

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

[7] 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. 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)).

[8] 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.

3. Participants and representation

[9] The Procurator Fiscal represents the public interest in a fatal accident inquiry and Mr Morrison, Procurator Fiscal Depute, appeared.

[10] NHS Fife Health Board ("NHS Fife") was represented by Mr Paterson, Advocate. Dr Sophie Baldwin was represented by Ms Harris, solicitor. Dr Nives Gattazzo was represented by Ms MacNeill, solicitor. Dr Muhammed Adrees was represented by Mr Higgins, solicitor.

[11] I am grateful to all those appearing at the inquiry for their professionalism and assistance in the conduct of the inquiry. The cooperation of those appearing and, in particular, the agreement of uncontentious matters by Joint Minute greatly assisted the inquiry.

4. The inquiry process

[12] The First Notice of an Inquiry was received on 11 March 2022. An order was made for a preliminary hearing on 29 April 2022. An application was made by NHS Fife to discharge that hearing and to fix a new preliminary hearing on 13 May 2022. That application was not opposed. Further preliminary hearings were held on 29 August 2022 and 12 September 2022. The inquiry heard evidence on 17, 18, 19 January 2023. On the fourth day that was assigned for the hearing of evidence, it was intimated that the report of Dr Andrew Coull had been agreed and a joint minute lodged to that effect. Thereafter, written submissions were lodged and a hearing on submissions took place on 6 March 2023.

[13] Evidence was led principally by the Procurator Fiscal Depute in accordance with the duty under section 20(1)(a) of the Act. A list of witnesses is included as an appendix. Two witnesses provided affidavits. The witness for NHS Fife, Dr Andrew Coull, Consultant Physician in Geriatric & General Medicine, Liberton Hospital, Edinburgh and the Royal Infirmary of Edinburgh, provided a report dated 5 December 2022 and in terms of the second Joint Minute of Agreement his report was treated as his evidence.

5. What happened

[14] This chapter sets out a narrative of the important parts of what was established on the evidence. Some of this was non-contentious and was agreed by the parties in the Joint Minute of Agreement. In the following section, I will consider the evidence that

was in dispute or on which there was a lack of clarity and I will explain my assessment of that evidence.

[15] Mr Cowan had been ordinarily resident at Balfarg Care Home, Kilmichael Road, Glenrothes, Fife, KY7 6NL having been admitted there on 26 October 2016. He was a registered patient at North Glen Medical practice. The General Practitioner from the practice who usually attended to patients residing within Balfarg Care Home was Dr Craig Morris.

[16] Prior to his death, Mr Cowan suffered from a number of medical conditions, including: epilepsy; Alzheimer's disease; frontal lobe impairment; high blood pressure; aortic stenosis; type II diabetes; hypothyroidism; low mood.

[17] Mr Cowan was prescribed medication which was administered by staff at Balfarg Care Home. Said medication included: metformin hydrochloride; memantine hydrochloride; gilpzide; aspirin; lansoprazole; mirtazapine; phenytoin sodium; colchicine.

First admission to Victoria Hospital

[18] On the morning of 7 August 2019 within Balfarg Care Home, Mr Cowan was reporting significant pain in his right leg. Paracetamol was provided by staff of said Care Home but to no effect. Advice was sought from a triage nurse who advised that an X-ray should be carried out at hospital. Staff from said Care Home escorted Mr Cowan to Victoria Hospital, Kirkcaldy.

[19] At around 2120 hours on 7 August 2019 Mr Cowan was admitted to Admissions Unit 1 within Victoria Hospital, Kirkcaldy. Mr Cowan was assessed at 2210 hours and had a blood sample taken. Signs of infection were present. A possible urinary tract infection and lower respiratory tract infection were queried. Mr Cowan was commenced on intravenous fluids, oral antibiotics, and an analgesia regimen. He underwent a frailty assessment and was found to be suffering from possible delirium. On 8 August 2019 it was confirmed that Mr Cowan had an acute kidney injury (AKI) on a background of chronic kidney disease.

[20] An X-ray of Mr Cowan's right leg and hip was taken which showed no significant concerns.

[21] On 8 August 2019 Mr Cowan was admitted to Ward 32 for continuing care and treatment. On admission to Ward 32 it was noted within Mr Cowan's medical records that he was "alert but confused at times" and that he was on "bedrest due to increased pain".

[22] On 9 August 2019, Dr Adrees, Consultant Physician, reviewed Mr Cowan during his ward round. There were two consultants attached to wards 32 and 13 and they were each responsible for half the patients in those wards. The two consultants at that time were Dr Adrees and Dr Aylene Kelman.

[23] Later on 9 August 2019, Dr Sherlock spoke with Balfarg Care Home staff. Notes of this discussion are recorded within Mr Cowan's medical records and the following is noted:

> "Recently needing full assistance with all care needs, usually walks with a Zimmer frame and assistance of 1. Care staff report he has very bad long and short term memory. Have discussed this with nursing staff who are going to see how his mobility is and if back to baseline would be suitable for home. If problems then they would refer to physio team".

[24] On 10 August 2019 Mr Cowan was transferred to Ward 13 for continuing care and treatment. Prior to Mr Cowan's transfer to Ward 13, an entry was made in his medical records which notes that his observations were stable, and "Derek screams out in pain upon mobilising, pain in right leg/side". It was further noted that his dietary intake was good and that there were "No new issues".

[25] As at 10 August 2019 Ward 13 was a surge capacity ward for use when the hospital was busy with inpatients who required admission to other wards within the hospital.

[26] On 11 August 2019 an entry is recorded in Mr Cowan's medical records noting "Mobility is very poor".

[27] On 12 August 2019 repeat blood samples were taken from Mr Cowan. In light of the blood results, it was recorded within Mr Cowan's medical records that there was a "need to screen for further sources of infection". An abdominal ultrasound was ordered to check Mr Cowan's gallbladder, kidneys and liver and daily blood tests were planned.

[28] On 13 August 2019 Mr Cowan refused to go for an ultrasound scan.

[29] On 14 August 2019 Mr Cowan was assessed during a ward round by Dr Kelman, Consultant in Geriatric Medicine. It is noted that the Acute Kidney Injury had resolved and that Mr Cowan had sepsis with an "unclear source". Dr Kelman also noted that Mr Cowan's right third toe was necrotic and dry. The plan recorded included uric acid

tests and an X-ray of Mr Cowan's feet. Doctor Kelman recorded that "if bloods improving could go back to NH [nursing home] with H@H [Hospital at Home]". This was referred to as the criteria led discharge plan.

[30] An entry is recorded at 1615 hours on 14 August 2019 within Mr Cowan's medical records that Mr Cowan was due to attend for an ultrasound and staff requested an X-ray but that he was very "agitated" and "refused to go" and that "Patient is for bloods today but refusing".

[31] From the date of his admission to Victoria Hospital on 7 August 2019, Linda Ballingall, the long term partner of Mr Cowan, had become increasingly concerned about the care of Mr Cowan and this culminated in a complaint being made by her to the NHS Complaints Team on 14 August 2019. As a result of this, a Stage 2 complaint was investigated and upheld with an apology being sent to Ms Ballingall on 24 September 2019 (Crown Production 12)

Discharge from Victoria Hospital on 15 August 2019

[32] On 15 August 2019 an entry is recorded within Mr Cowan's medical records at 0425 hours which notes that "bloods unable to be taken by ward staff" and further that "H@N [Hospital at Night] reviewed patients bloods and prescribed 'colchicine' for gout".

[33] On 15 August 2019, Dr Sophie Baldwin, a Foundation Year 1 Doctor, was instructed to review the patients on Ward 13 including Mr Cowan. She reviewed Mr Cowan at around 1000hours. In the corresponding entry in Mr Cowan's medical

notes, it is recorded "Derek is comfortable and settled. He has no complaints. The nursing home are ready to take him back today" and "For D/C [discharge] back to nursing home today".

[34] Dr Baldwin was advised by a member of the nursing staff on Ward 13 that Mr Cowan was ready for discharge. Dr Baldwin was not adequately qualified to make that decision and she had some concerns that certain parts of Dr Kelman's plan for discharge had not been undertaken.

[35] Dr Baldwin contacted Dr Nives Gattazzo, Registrar who was conducting a ward round with Dr Adrees elsewhere in the hospital. This contact was made by telephone. The terms of that telephone discussion appear to have been confused and confusing. However, as a result of that conversation, Dr Baldwin signed the discharge letter.

[36] On 15 August 2019 Mr Cowan was discharged from Victoria Hospital, Kirkcaldy back to the care of Balfarg Care Home. The X-ray of Mr Cowan's feet as planned by Dr Kelman was not carried out prior to his discharge. The blood test results ordered by Dr Kelman were not available prior to his discharge.

[37] Mr Cowan should not have been discharged from hospital on 15 August 2019.

[38] Staff at Balfarg Care Home were not expecting Mr Cowan back from hospital. There is confusion as to whether there were discussions between the Care Home and the hospital as to whether Mr Cowan was fit to be discharged back to the Care Home.

[39] On 16 August 2019, Care Home staff telephoned Mr Cowan's General Practitioner. Dr Craig Morris attended to see Mr Cowan that day. It was noted that Mr Cowan was in pain and confused.

[40] On 19 August 2019 Dr Morris again saw Mr Cowan. A referral was made to the "Hospital@ Home" service but there was no capacity within said service. Dr Morris referred Mr Cowan for readmission to Admissions Unit 1 at Victoria Hospital, Kirkcaldy on 19 August 2019 after discussion with Ms Ballingall.

Second Admission to Victoria Hospital

[41] On admission to Victoria Hospital, Kirkcaldy on 19 August 2019 it was noted that Mr Cowan was dehydrated with poor oral intake, that he was non-communicative and that his feet had pressure breaks. A blood sample was taken and on analysis indicated an infection and significantly raised sodium levels indicated dehydration. An infection of the bones was queried.

[42] On 20 August 2019 Mr Cowan was commenced on a syringe driver to administer analgesic medication and later that evening he was moved to Ward 32. Mr Cowan's treatment plan continued on said ward.

The Death of Mr Cowan

[43] On 22 August 2019 Mr Cowan was seen on a ward round by Dr Morag Patterson, Consultant Geriatrician. It was noted that Mr Cowan was critically ill. Dr Patterson discussed Mr Cowan's condition with Dr Catriona Semple, a Vascular Consultant, and both agreed that Mr Cowan's ongoing treatment would likely be mainly palliative in nature. This was discussed with Mr Cowan's partner and next of kin, Ms Ballingall and it was agreed that Mr Cowan would be kept as comfortable as possible.

[44] Mr Cowan died within Ward 32 on 23 August 2019, and life was formally pronounced extinct at 0100 hours the same date.

6. The areas of factual dispute

[45] Ultimately there are three areas of factual dispute which require to be addressed:

i. Whether the staff at Balfarg Care Home agreed that Mr Cowan was fit to be discharged back to the Home on 15 August 2019.

[46] The evidence I heard regarding this issue was contradictory and it would be difficult to say with any certainty whether there was an agreement on the part of the Care Home to have Mr Cowan back on 15 August 2019. Ms Watson, the Care Home manager said she visited Mr Cowan in hospital on 15 August 2019 and given her assessment of him at that time, she advised the female nurse in charge of the ward he was in, that he was not well enough to be discharged back to the home. In her assessment, Mr Cowan would have needed assistance with his feeding, handling and mobility. He did not meet the criteria for a residential unit. When he was returned to the Care Home, they had a duty of care to accept him back but he was re-admitted to hospital after the weekend on the recommendation of Dr Morris, the GP responsible for the care of residents in the home. The notes relating to this do not record such a conversation with the hospital and when questioned about that, Ms Watson said that she had not had a chance to write up the notes before Mr Cowan returned.

[47] Mrs Gillian Harris was a Team Leader at the Care Home at the time of Mr Cowan's discharge from hospital in August 2019. Her evidence and the notes that she made at the time (Crown Production #2, page 11) confirm that he was very poorly on 16 August 2019 and she noted that he should not have been discharged.
Mrs Michelle Coleman a Nursing Assistant at the Care Home said that she had been expecting Mr Cowan back at the Care Home that day but she could not recall how she knew that he was coming back. She agreed that when Mr Cowan returned to the Care Home on 15 August 2019, he was very unwell and she had noted this (Crown Production #2, page 9).

[48] Rona Young is a registered nurse and Patient Flow Co-ordinator within NHS Fife. She was the nurse in charge of Ward 13 on the day of Mr Cowan's discharge from hospital and spoke to Ms Watson, the Care Home manager that day. She said that Ms Watson came to assess Mr Cowan for return to the Care Home and she said that Ms Watson had said that the Home would be happy to accept Mr Cowan back and there were no issues.

[49] Ms Ballingall's evidence in relation to this matter is that when she returned to the Care Home with Mr Cowan on 15 August 2019, the staff were astonished to see him and were horrified at his appearance. They were not expecting him and had to go and make up his bed because his room was not ready.

[50] In the letter of apology sent from NHS Fife to Ms Ballingall on 24 September 2019 (Crown Production #12) at page 2 it states:

> "There was also miscommunication between the ward and the care home manager which resulted in Mr Cowan returning to his home when care home staff were not expecting him."

[51] As indicated, the evidence in relation to this particular aspect of events is unsatisfactory. I find it difficult to accept that the Home would have been happy to accept Mr Cowan back given how unwell he was. This position is supported by the evidence of Ms Ballingall and the terms of the apology letter received by her on 24 September 2019 (Crown Production #12). On the basis that it is agreed by all parties that Mr Cowan should not have been discharged from hospital on 15 August 2019 it seems to me that the position is more supportive of the witnesses from the Care Home who say they were not expecting him back and did not agree with his return. On the balance of probabilities, I accept that the Care Home were not expecting Mr Cowan back and that there was a miscommunication between the ward and the care home staff about this.

ii. Whether there was a defect in the process involved in Mr Cowan's discharge from hospital and how his discharge came about.

[52] It is accepted by all parties that Mr Cowan was not fit for medical discharge on 15 August 2019. How that came about is in dispute. I heard evidence from the four clinicians involved in the care of Mr Cowan. Rona Young and Norma Beveridge also provided evidence in relation to this matter.

[53] Dr Nives Gattazzo was an ST4 specialty registrar in the Victoria Hospital in 2019. She was attached to Ward 32 with two consultants, Dr Adrees a locum consultant and

Dr Kelman. She said that any doctor above the level of FY1 could discharge a patient. An FY2 could make the decision but that would depend on their level of confidence. She also explained that there were occasions when patients were moved to Ward 13 which was a surge capacity ward. Patients were moved to Ward 13 if they were medically fit and waiting to go home. They were referred to as boarding patients. The decision to move a patient to Ward 13 was usually made by a consultant. Dr Gattazzo confirmed that she did the ward round with Dr Kelman on 14 August 2019 and took notes. She was there when Dr Kelman devised the criteria led discharge plan referred to in the medical notes (Crown Production #3 page 105). She recalled that Dr Adrees was the consultant responsible for Ward 13 on 15 August 2019. She was working that day but did not recall any conversation about Mr Cowan. She could not recall any conversation with Dr Baldwin on the phone about Mr Cowan. However, she did say that she trusted Dr Baldwin implying that she believed if Dr Baldwin said she made the call then the call was made. Even although there was no note of the phone call, she did say in Dr Baldwin's defence that the ward was busy. She did also confirm that given her experience of working with Dr Baldwin that Dr Baldwin would have sought the appropriate assistance from a senior colleague especially given there were outstanding tests to be carried out.

[54] Dr Muhammed Adrees was the other consultant responsible for patients alongside Dr Kelman on Ward 32 in August 2019 although he could not specifically recall Dr Kelman being there. He said that the bed manager made the decisions about where a patient should be or if they should be transferred between wards. He also said

that it was not up to the consultants to assign where junior doctors should go. That decision was made by the rota coordinator. He confirmed that a consultant would decide if a patient was fit to be discharged. He did not recall Mr Cowan. He did not recall Dr Baldwin. He did not recall Dr Gattazzo. He did not recall if he was working on 15 August 2019, the day of Mr Cowan's discharge. He was keen to pass the responsibility for discharge to the consultant who was last to see Mr Cowan that being Dr Kelman. He did not recall the telephone call referred to by Dr Baldwin and in his opinion, if was not noted then it did not happen. He reiterated that it was likely that no phone call was made.

[55] Dr Sophie Baldwin gave her evidence by way of affidavit. She was an FY1 doctor started working on Ward 32 on 7 August 2019. This was her first job following qualification. Her evidence was largely uncontroversial with the exception of one particular passage of importance. Dr Baldwin stated that on the morning of 15 August 2019, she was asked by Dr Adrees to see the "border patients" in Ward 13. There were no doctors permanently on the ward and the patients in the ward were usually approaching discharge. The patients were under the care of Ward 32. Dr Baldwin recalled a conversation between Dr Gattazzo who was also present and Dr Adrees as to whether Dr Gattazzo should accompany Dr Baldwin and Dr Adrees said that Dr Baldwin could go herself. When reviewing Mr Cowan, Dr Baldwin recalls checking Mr Cowan's notes from the day before and overnight. She was told by one of the senior nurses that Mr Cowan was to be discharged and the nursing home were ready to take him back. As an FY1, Dr Baldwin would not have been in a position to discharge a

patient so she had to seek advice from a senior clinician. On that basis, Dr Baldwin stated that she called Dr Gattazzo to check if Mr Cowan was still for discharge even though there were still outstanding investigations to be done in accordance with Dr Kelman's plan detailed in the notes the day before. Dr Baldwin recalls telling Dr Gattazzo that there were outstanding tests and an x-ray to be done. She states that she heard Dr Gattazzo discussing the situation with Dr Adrees with whom she was doing a ward round. She heard Dr Adrees tell Dr Gattazzo that the discharge could go ahead and not to worry about the fact that the bloods and x-ray had not been done. Unfortunately, Dr Baldwin did not make a note of that conversation and according to Dr Baldwin this must have been due to other distractions and pressure of time. There were also some questions about the information Dr Baldwin noted relating to Mr Cowan's blood test results that were available at that time. Following the conversation with Dr Gattazzo, Dr Baldwin states that she prepared the discharge letter and Mr Cowan was discharged.

[56] Dr Aylene Kelman, Consultant Geriatrician at Victoria Hospital recalled seeing Mr Cowan on 14 August 2019. She was the Consultant responsible for Ward 32 along with Dr Adrees at the relevant time. They split responsibility for the patients within the ward. Dr Kelman indicated that it was up to senior doctors to decide where junior doctors would be assigned each day. She also confirmed that boarding patients should be seen by senior doctors and that was the accepted practice in August 2019. Mr Cowan was under Dr Adrees' care. She explained that a senior medical practitioner - ideally a consultant - makes the decision that a patient is medically fit to be discharged. It could

be any med.ical practitioner above Foundation level. Dr Kelman recalled seeing Mr Cowan on the ward round on 14 August 2019. She was accompanied by Dr Nives Gattazzo, Registrar and she confirmed with reference to the medical notes of Mr Cowan (Crown Production #3 at page 105) that she had noted a plan which would have allowed him to be discharged if certain criteria were met. These were that his bloods were improving and if he had an x-ray of his feet. She also noted that there was to be a referral to Hospital@Home for their involvement. This would have allowed ongoing hospital-level nursing care within the community at the Care Home. She said that in practice, a referral is made to Hospital@Home by a registered member of the team so either a doctor or a nurse. The plan outlined by Dr Kelman in the notes on 14 August 2019 was referred to by her as criteria led discharge. She would have expected the criteria to have been met before Mr Cowan's discharge and they were not. The discharge letter to which Dr Kelman was directed (Crown Production #15) had been signed by Dr Sophie Baldwin, an FY1 doctor. The letter referred to Dr Kelman as being the Discharging Consultant. Dr Kelman said that this was incorrect. She had not been involved in the discharge of Mr Cowan. She was asked about the discussion that Dr Baldwin said she had with Dr Gattazzo and Dr Adrees by telephone to check that Mr Cowan could be discharged. Dr Kelman accepted that knowing Dr Baldwin she would have sought supervision if she was not clear about what to do. She also confirmed that Dr Baldwin should have been the one to note that discussion but in practice, this was not always possible. If Dr Kelman had been the consultant that

Dr Baldwin spoke to she would have asked Dr Baldwin to document the change in the clinical plan if there was one or she would not have agreed to the discharge.

[57] Dr Kelman indicated that the discharge process since this event has changed, in that there are now dedicated meetings at 9am and 1pm each day to discuss the discharge of patients. Discussions take place as to whether anything has changed which would delay discharge. Dr Kelman believes that if this process had been in place on the date of Mr Cowan's discharge then he would not have been discharged.

[58] Rona Young was the nurse in charge of Ward 13 on 15 August 2019 and said that she had been told at the handover between the night shift and day shift that Mr Cowan was to be discharged. This suggests that the decision as to whether Mr Cowan was medically fit for discharge had been made prior to Dr Baldwin arriving at Ward 13 but it is not clear by whom.

[59] Norma Beveridge is a registered nurse with 35 years' experience. She has worked at the Victoria Hospital for her entire career. Her current role is interim Nursing Director for the Acute Division. In August 2019 she was Head of Nursing for the Emergency Care Directorate. Ms Beveridge was involved in the complaint procedure instigated by Ms Ballingall, Mr Cowan's partner regarding the care of Mr Cowan during his period in hospital prior to his discharge on 15 August 2019. I do not need address this issue because the complaint was upheld. However, Ms Beveridge was asked about the discharge process now in place and she indicated that a number of changes had been made since the death of Mr Cowan. There is now a discharge checklist and this is produced at #2 of the Inventory of Productions for NHS Fife. This had existed in some

form prior to August 2019 but it was not well used. It highlights what now has to be done and provides an aide memoire for the nurse discharging the patient to note the basis upon which the patient has been determined medically fit for discharge. It is used at the Multi Disciplinary Team meeting that now takes place every day and before a patient is discharged. This is part of the Daily Dynamic Discharge process which is being more robustly implemented. The Multi Disciplinary Team meeting is now a fundamental part of the daily work of the ward. A patient's discharge plan is part of that meeting which involves the consultant, registrar, physiotherapist and a member of the nursing staff. Interestingly, the form refers to Hospital@Home as a support service. Despite her years of experience, Ms Beveridge was not able to say how a referral to Hospital@Home was made. She had never done it and did not know who did it.

[60] In addition to these changes, Ms Beveridge spoke about the Care Home Liaison Working Group which has now been established to improve communication and build relationships between the hospital and Care Homes.

[61] There was also a chapter of evidence in relation to the blood test results for Mr Cowan leading up to his discharge on 15 August 2019. Certain blood tests had been requested on 14 August and the results of these were a crucial part of Dr Kelman's plan for the criteria led discharge. The results of the tests were indicative of dehydration and deteriorating renal function. The evidence relative to the final sample of blood taken from Mr Cowan on 14 August 2019 was that it was not checked prior to his discharge. Dr Baldwin's recollection was that there were no blood test results available on 15 August 2019 having been told by the senior nurse who also told her that Mr Cowan

was ready for discharge, that Mr Cowan had refused to have his bloods taken. Dr Baldwin's evidence was that she made Dr Gattazzo and Dr Adrees aware of the fact that there were outstanding blood test results during the telephone call. These blood test results would have indicated on-going infection and dehydration.

[62] My assessment of the witnesses who gave evidence about this issue, with the exception of Dr Adrees, was that they were doing their best to recollect events which were obviously some time ago. They were doing their best to assist the court in explaining and clarifying the process whereby Mr Cowan came to be discharged. I found parts of Dr Adrees' evidence to be quite unhelpful and on some points clearly at odds with the evidence I heard from other witnesses. For example, he said that consultants had no say in where junior doctors were allocated to in the hospital. Dr Kelman refuted that proposition. Dr Adrees said that he was not the consultant responsible for Mr Cowan when Dr Kelman said that he was. Just because Dr Kelman had seen Mr Cowan on 14 August 2019 did not make her the responsible consultant. I formed the impression that Dr Adrees was more concerned in protecting himself against criticism rather than assisting the inquiry in reaching a decision as to why the discharge of Mr Cowan was allowed to happen when it was clearly wrong.

[63] Whilst I accept that Dr Baldwin's evidence was provided by way of affidavit and she was not subject to cross-examination, her evidence about the phone call is supported by Dr Gattazzo and Dr Kelman. They both confirmed that she was a competent and diligent junior doctor and would not have made the decision to discharge Mr Cowan without seeking the appropriate guidance from a senior clinician.

[64] On the balance of probabilities, I believe that the phone call did take place between Dr Baldwin and Dr Gattazzo and whilst Dr Gattazzo could not recall the phone call she was gracious enough to accept that if Dr Baldwin said that she made the call then she was happy to accept that. I was troubled by Dr Adrees' blank refusal to accept the call had been made just because there was no note of it. Others were more accepting of the fact that in a busy ward with other distractions there was a possibility of that not being noted.

[65] Resolving the issue about whether the phone call was made is not the end of the matter. What is not clear, is whether there was some misunderstanding as to what was communicated during that phone call. Dr Baldwin is clear that she heard Dr Gattazzo discussing the matter with Dr Adrees. She heard him say to Dr Gattazzo that Dr Baldwin should not worry about the outstanding investigations and she should proceed with the discharge. Dr Adrees refutes this suggestion and Dr Gattazzo has no recollection of the conversation. It would be surprising that a consultant would make such a statement and this confuses matters. It may be that, given that the information was being relayed through a third party, there may have been some misinterpretation or misunderstanding.

[66] A system whereby an FY1 who has been in post for two weeks is allowed to sign a discharge letter after only being able to have a discussion over the phone with a senior clinician is clearly both inadequate and defective.

iii. Whether Mr Cowan would have tolerated any further medical interventions had he not been discharged on 15 August 2019 and which might have resulted in his death being avoided

[67] The main body of evidence in relation to this matter came from Dr Coull, the expert witness instructed by NHS Fife to prepare a report. It was agreed that his report would form his evidence. The specific remit of Dr Coull's report was to provide an opinion on whether Mr Cowan would have survived beyond 23 August 2019 if he had remained in hospital instead of being discharged to the Care Home on 15 August 2019 taking account of his medical conditions.

[68] At paragraph 4.7 of his report, Dr Coull states that Mr Cowan is likely to have survived beyond 23 August 2019 and if he had consented, tolerated and received adequate rehydration, further radiological investigation and antibiotics. If he had not consented or tolerated these interventions then this would have led to further discussions about his further treatment and whether they were possible or whether Mr Cowan's symptoms should be prioritised over other more invasive treatments.

[69] At paragraph 4.8 of his report, Dr Coull states that Mr Cowan's clinical condition with dehydration, diabetic foot infection and severe peripheral vascular disease on a background of frailty put him at high risk of death from his illness. Even if the treatment had been tolerated and successful it is likely that his life would have been extended only by a few weeks or a small number of months at most.

[70] In the conclusion at paragraph 5.1 of his report Dr Coull states that Mr Cowan was not ready for discharge and he is likely to have survived longer than 23 August

2019 if he had remained in hospital and tolerated interventions such as rehydration and antibiotics.

[71] Finally, Dr Coull concludes at paragraph 5.2 of his report that Mr Cowan was at high risk of dying from his illness and although he may have survived longer than 23 August 2019 if he had tolerated treatment, ultimately his life would have been extended only by a few weeks or a small number of months. He would have been highly likely to succumb to the illness for which he was admitted to hospital on 7 August 2019.

[72] I heard evidence from the medical witnesses with reference to the medical records that there were occasions following his admission to hospital on 7 August 2019 when Mr Cowan refused to allow certain treatments to be carried out. Equally, there were occasions when he clearly had tolerated certain medical interventions following his admission on 7 August 2019. He had an x-ray of his knee on admission and a CT of his pelvis. He tolerated IV fluids although he pulled out the canula on two occasions. However, the IV fluids were ultimately stopped because the Acute Kidney Infection for which he was being treated had resolved. There is also a note in the records on 10 August 2019 that he had a catheter in situ (Crown production #3 page 95). He had bloods taken on 12, 13 and 14 August 2019. He was scheduled to have an abdominal ultrasound on 13 August 2019 but he refused to go. A second attempt was to be made on 14 August 2019 if he was more settled. The notes state that he was to attend but he was very agitated and refused to go for an x-ray of his leg. When he was re-admitted on

19 August 2019, Dr Coull makes reference to him being commenced on IV fluids and a 24 hour syringe driver. These interventions all appear to have been tolerated by him.

[73] In his report at paragraph 4.3 Dr Coull indicates that Mr Cowan was not ready for discharge on 15 August 2019 and further evaluation was required. He states clearly that:

> "The complexity of that evaluation and potential interventions cannot be underestimated given the clinical context. All these interventions would have required careful consideration and discussion with Mr Cowan and his partner. Any tests and treatment for Mr Cowan would require to be completed under the Adults with Incapacity legislation."

Dr Kelman indicated that if Mr Cowan had remained in hospital after 15 August 2019 he would have been treated with intravenous rehydration and antibiotics.

[74] In paragraph 4.4 of his report Dr Coull refers to the rising sodium levels and worsening kidney function on 13 and 14 August 2019. This should have led to consideration of rehydration by different means other than oral means. He goes on to say that Mr Cowan had been resistant to various interventions but importantly states that Mr Cowan had tolerated intravenous therapy earlier in his admission. Again, discussion with Mr Cowan and his partner would have been required and a potential trial of such therapy undertaken to see if it could be tolerated. Other interventions may have identified other issues. At paragraph 4.5 Dr Coull states that Mr Cowan "may have declined or not tolerated" such interventions and if so, this would have led to further discussions between Mr Cowan, his partner and the clinical team as to potential IV antibiotics. If he had not tolerated these treatments or his condition had deteriorated

then further conversations would consider how Mr Cowan's symptom control should be prioritised over further invasive treatments such as intravenous therapy.

[75] It is clear from these parts of Dr Coull's report that Dr Coull has taken into account the fact that certain interventions had not been previously tolerated by Mr Cowan, but from my reading of what he says, that did not mean that there should be no attempt to discuss and potentially try further interventions again.

[76] Ultimately, however, it is Dr Coull's opinion that even if treatment had been tolerated and successful, it is likely that Mr Cowan's life would only have been extended by a few weeks or a small number of months at most. There was no contradictory evidence led.

7. Proposed findings agreed by parties

[77] All parties were agreed that formal findings were appropriate in relation to Section 26(2)(a) - (d).

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

[78] Mr Morrison on behalf of the Crown invited me to make findings under this provision. The wording of the provision does not require reasonable precautions whereby the death **would** be avoided but rather it provides for reasonable precautions whereby the death **might** have been avoided. With reference to the Explanatory Notes to the Act, Mr Morrison highlighted that "A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that

it might have done so. No certainty as to the avoidance of death is required. He therefore proposed a finding that a reasonable precaution would have been for Mr Cowan to remain in hospital for ongoing care and treatment and not to have been discharged on 15 August 2019. In support of that submission, he referred to Dr Coull's report at paragraph 5.1 where he states that:

> "Mr Cowan was not ready for discharge [on 15 August 2019] and he is likely to have survived longer than 23 August 2019 if he had remained in hospital and tolerated interventions such as rehydration and antibiotics."

Whilst Dr Coull offers his opinion as to Mr Cowan's longevity had the discharge not gone ahead, Mr Morrison submitted that this issue is not a matter for this court to address. Dr Coull opines that Mr Cowan would likely have survived beyond the date of his death had he remained in hospital for on-going care and treatment rather than being discharged. This aligns with the evidence of Dr Kelman. This means that Mr Cowan's death at the time on that date and in the circumstances in which it occurred could have been avoided but for the discharge and therefore the continuing intervention and treatment.

[79] Mr Morrison referred to two cases in which it was clear that the period for which a person may have survived if certain steps had been taken was not a matter for such an inquiry as this. (Determination of Sheriff Kenneth Ross re: John Aitken dated 16 August 2011 at paragraph [29] and Determination of Sheriff Douglas Keir re: John Smith dated 6 September 2021 at paragraph [64]). The submissions for the other parties involved in this inquiry seemed to suggest that because Dr Coull said that Mr Cowan was going to die at some point from the illnesses from which he was suffering then this precluded a

finding that the death was avoidable. This is a preclusive approach and not one that the court should take.

[80] Addressing the issue of Mr Cowan's tolerance and consent to ongoing treatment, Dr Coull indicates at paragraph 4.7 that if he had not tolerated or consented to further interventions then this would have led to further discussions about what might be appropriate by way of further interventions. Mr Cowan had tolerated treatments and interventions during his time in Victoria Hospital as spoken to by Dr Kelman and Dr Coull. There is a possibility that he would have done so again. Mr Morrison invited me to find, on the basis of Dr Coull's report and Dr Kelman's evidence that there was a "real or likely possibility, rather than a remote chance" that ongoing treatment might have prevented death. The court could find that the death of Mr Cowan was avoidable in the circumstances in which it occurred.

[81] The court also has to address whether the precaution that could have been taken to avoid death was a reasonable one. The Crown submit that the discharge was inappropriate. Dr Kelman outlined her criteria-led discharge in the ward round noted on 14 August 2019 (Crown Production #3 at pages 104-105). Dr Kelman confirmed that Mr Cowan's blood results from 14 August 2019 were such that he should not have been discharged. There was no evidence before the court that any of the clinicians involved in Mr Cowan's discharge checked these results before his discharge. There was no evidence that Mr Cowan's bloods analysis was improving which was one of the criteria set out by Dr Kelman. In fact, the evidence points to the opposite in that the blood results indicated on-going infection and dehydration. Had those results been checked

and properly analysed then it would have been reasonable for Mr Cowan to remain in hospital for ongoing care and treatment. To have followed the plan put in place by Dr Kelman can be determined to be a reasonable course of action.

[82] On behalf of NHS Fife, Mr Paterson submitted that no determination ought to be made relative to section 26(2)(e) - (g). NHS Fife accept that Mr Cowan should not have been discharged from hospital on 15 August 2019 but this did not cause Mr Cowan's death. As indicated by Dr Coull, Mr Cowan's clinical condition placed him at a high risk of death and he was highly likely to succumb to the illness for which he was admitted to hospital on 7 August 2019.

[83] Mr Paterson reminded the court that the determination must be based on the evidence led at the inquiry and speculation was to be avoided. The court has to determine whether there existed a real or likely possibility, rather than a remote chance, of the death being avoided by the precaution. He referred to the Policy Memorandum relating to the Act at paragraph 178 where it states:

> "The Scottish Government does not believe that it was the intention that the interpretation of the word 'might' should be construed as 'any chance no matter how slim'".

Also at paragraph 179 it states:

> "The use of the word 'realistically' is intended to imply an actual rather than fanciful possibility that the recommendation might have prevented the death."

[84] In relation to the discharge, the principal issue between NHS Fife and the Crown was whether the court should find that by not discharging Mr Cowan, his death could have been avoided. The evidence for this is the agreed testimony of Dr Coull. That

being the case, the Crown accept that when Mr Cowan was admitted to hospital he was moribund. He was in terminal decline and yet the Crown argue that if he had not been discharged then this would have prevented his death. That submission is illogical according to Mr Paterson. The Crown downplay Dr Coull's starting point that Mr Cowan would only have survived beyond 23 August 2019 had a number of interventions been tolerated and the evidence does not allow the court to come to that conclusion. Mr Paterson submitted that the Crown's interpretation of section 26 was too technical. It is not as simple as asking whether, at the time of the death, what happened could have been avoided. The evidence of Dr Coull was that Mr Cowan's death would have occurred weeks or months after 23 August 2019 and the cause of that would have been the reasons for which he was admitted on 7 August 2019. So realistically his death could not have been avoided.

[85] As far as the conflict between the evidence of Dr Baldwin and Dr Adrees is concerned, it would be difficult to resolve that conflict especially where Dr Baldwin was not available to be cross-examined. However, in Mr Paterson's submission it was not necessary for the court to resolve the conflict. The decision to discharge a patient is a medical one. It cannot be taken by a doctor as junior as Dr Baldwin. The investigations included in Dr Kelman's criteria led discharge plan were not carried out. It is unlikely that Dr Baldwin would not have sought guidance from a senior colleague. However, it is equally unlikely that Dr Adrees would have instructed Mr Cowan's discharge knowing that Dr Kelman's criteria were not met. Mr Paterson therefore submitted that there was most likely a breakdown in communication between the junior and senior

doctors. That could be readily inferred. That is not likely to recur under the present system now in place and spoken to by Dr Kelman.

[86] Mr Paterson also referred to the conflict in the evidence between Ms Watson, the Care Home manager and Ms Young, the nurse who Ms Watson spoke to about whether Mr Cowan was fit to return to the Care Home. Mr Paterson suggested that Ms Young's evidence should be preferred because it was supported by what was in fact recorded in the medical notes. Also, Ms Coleman said in her evidence that she was expecting Mr Cowan back at the Care Home. Mr Paterson accepted that this conflict was of little moment but he addressed the matter for the sake of completeness.

[87] On behalf of Dr Gattazzo, Ms MacNeill started by highlighting the fact that the function of the sheriff in a Fatal Accident Inquiry does not include making any finding of fault or apportioning blame between any persons who might have contributed to the accident. She then went through the evidence of Dr Gattazzo which was mainly uncontroversial. The area of conflict surrounds the issue of the phone call made by Dr Baldwin to Dr Gattazzo on 15 August 2019. Dr Gattazzo did not recall the conversation referred to by Dr Baldwin but accepted that it would be common for junior doctors to call those more senior to them for advice or support if needed. She submitted that the evidence before the inquiry around the decision making process for discharge is unclear particularly in relation to the discussions between the medical team caring for Mr Cowan on 15 August 2019.

[88] In Ms Harrison's submission there was no evidence before the inquiry that Dr Gattazzo could have taken any precautions in terms of this section that could have resulted in the death of Mr Cowan being avoided.

[89] On behalf of Dr Baldwin, Ms Harrison invited me to accept the evidence of Dr Baldwin in relation to what happened on 15 August 2019. She said that she was asked by Dr Adrees to review the border patients alone. Dr Adrees said that this decision would not have been his but rather that of the rota coordinator. Dr Kelman disagreed with that proposition and she confirmed that a junior doctor is allocated to a ward by the rota coordinator. The question of which doctor on the ward sees which patients on a particular day is a decision made within the clinician team. Dr Kelman was also clear that it should be a senior doctor who reviewed the border patients and this suggests that Dr Baldwin's evidence that Dr Gattazzo offered to accompany Dr Baldwin that day was indeed in line with the common practice at that time. Dr Baldwin said that she had been told by a nurse when she came to Ward 13 that Mr Cowan was due for discharge. She reviewed his notes and clearly recalls making a telephone call to Dr Gattazzo to discuss the discharge given that Dr Kelman's plan had not been implemented. Ms Harrison highlighted the tension in the evidence about the phone call and invited me to consider whether this phone call was made and if so, the nature of the conversation. The evidence would seem to point to Dr Baldwin having made the call. With regard to the telephone conversation it is possible that there was a miscommunication among the doctors involved in that three way conversation.

[90] Dr Baldwin of course was not able to make the decision to discharge Mr Cowan being a junior doctor and having been in the job for only eight days. She did all that was required of her. She made enquiries of senior colleagues in accordance with usual practice and she genuinely believed that the decision was that Mr Cowan was ready for discharge. She acknowledges and regrets her failure to record the conversation that she says she had with Dr Gattazzo and Dr Adrees. She has made certain changes to her practice following upon that error. Even if she had made such a note however, this would not have had any bearing on Mr Cowan's outcome in Ms Harrison's submission. The decision to discharge Mr Cowan was not one Dr Baldwin could make and she merely completed the administrative task of preparing the discharge letter.

[91] With reference to Dr Coull's report, Ms Harrison reiterated that in Dr Coull's opinion, at its highest, Mr Cowan's discharge on 15 August 2019 accelerated his death and did not avoid it. Therefore the court may conclude that no findings ought to be made under section 26(2)(e).

[92] On behalf of Dr Adrees, Mr Higgins accepted that Mr Cowan was discharged inappropriately on the basis that it was not known if his bloods were improving at that time and the planned x-ray and ultrasound had not taken place. Mr Higgins submitted that it was, however, not clear how Mr Cowan came to be discharged.

[93] Mr Higgins highlighted the conflicting evidence about whether or not the Care Home were happy to accept Mr Cowan back into their care. There was the evidence about the actual discharge itself. The evidence of Dr Baldwin was that she was told by a senior nurse that Mr Cowan was to be discharged. Ms Young, a senior nurse on the

ward that day said that she was advised on handover between the night shift and day shift that Mr Cowan was to be discharged. There was no documentation to confirm that.

[94] Dr Adrees' evidence was that he did not recall the telephone call made by Dr Baldwin. He thought that it was highly unlikely that the call was made as there was no record of it. Mr Higgins said that Dr Adrees did not accept that he was the consultant in charge on 15 August 2019. It is not clear, if that is the case, who Dr Adrees suggests was in charge. The evidence was that two consultants were responsible for the ward, Dr Adrees and Dr Kelman. They were not on the ward together at any time so if one was there, then the other was not. Therefore, if Dr Adrees was there, then it follows that Dr Kelman was not there and Dr Adrees was in charge of the ward.

[95] It is not possible for the court to determine how Mr Cowan came to be discharged on the evidence before it according to Mr Higgins. He suggested that there were a number of reasons or explanations and it would be wrong to hypothesise about which is the most likely. The purpose of the inquiry is not to find fault or blame but to fact find and consider what steps might be taken to prevent other deaths in similar circumstances.

[96] Mr Higgins invited me to prefer the evidence of Dr Adrees where it differed from the other evidence in the case. He invited me to attach little weight to Dr Baldwin's affidavit. It was not possible to assess her credibility and reliability. The fact that Dr Kelman's name was on the Immediate Discharge document (Crown Production #15) would imply that Dr Adrees did not agree to the discharge as suggested by Dr Baldwin but there was no opportunity to question Dr Baldwin about that. There

was insufficient evidence before the inquiry to make a finding under section 26(2)(e) that a reasonable precaution which might have prevented Mr Cowan's death was that he should not have been discharged from Victoria Hospital. Mr Higgins did suggest that if the court considered it necessary to make a finding in respect of the discharge being inappropriate then this should be under section 26(2)(g).

[97] Mr Higgins highlighted the evidence from Dr Kelman and Dr Coull about the treatment that Mr Cowan could have had if he had remained in hospital. The inquiry did not hear from Dr Kelman that even if he had received and tolerated further treatment that this would have led to an improvement or that he would not have succumbed to the conditions from which he was suffering. Reference was made again to Dr Coull's report.

[98] In Mr Higgins' submission, the evidence plainly indicated that it was unlikely that Mr Cowan would have consented to and tolerated further investigations and treatment. In his submission the evidence does not support a finding that not discharging Mr Cowan might realistically have resulted in the death being avoided and therefore no finding should be made under section 26(2)(e).

Decision

[99] In Carmichael's textbook *Sudden Deaths and Fatal Accident Inquiries* (3rd edition) at paragraph 5-75, the author sets out what is considered to be the correct approach to section (6)(1)(c) of the 1976 Act which was the predecessor to section 26(2)(e) of the 2016 Act. He states:

> "What is required is not a finding as to reasonable precautions whereby the death or accident resulting in death 'would' have been avoided, but whereby the death or accident resulting in death 'might' have been avoided…..Certainty that the accident or death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution."

[100] The Explanatory Notes to the 2016 Act clearly envisage a similar approach being taken to section 26(2)(e) of the 2016 Act. At paragraph 72 it states:

> "Subsection (2)(e) requires the determination to set out any precautions which were not taken before the death which is the subject of the FAI, but that could reasonably have been taken and might realistically have prevented the death. The precautions that the sheriff identifies at this point relate to the death which is the subject of the FAI and might not be the same as those recommended to prevent other deaths in the future under subsection (4)(a). In subsection (2)(e)(i), 'reasonably' relates to the reasonableness of taking the precautions rather than the foreseeability of the death or the accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have so done."

[101] This means that no certainty as to avoidance of death is required. Dr Coull states that but for the discharge and therefore continuing intervention and treatment, Mr Cowan's death could have been avoided. He goes on to say that Mr Cowan is likely to have survived longer than 23 August 2019. The question of how long he would have survived having received such treatment or not is not a matter for this inquiry. Dr Coull's position is that the death could have been avoided had Mr Cowan not been discharged. I accept that Dr Coull then goes on to give an opinion as to how long Mr Cowan might have lived thereafter had he not accepted interventions and treatments but Dr Kelman spoke of treatments that she would have attempted had Mr Cowan not been discharged. There was evidence that if certain treatments and interventions were

not tolerated then further attempts would be made to discuss options with Mr Cowan and Ms Ballingall. However, the discharge did go ahead and there was no opportunity to put those treatments in place so that had a direct impact on hastening Mr Cowan's death. This is the evidence of Dr Coull (paragraph 5.2). If those treatments and interventions had been tolerated there was a possibility that they could have been successful and death might have been avoided at least beyond 23 August 2019 (paragraph 4.7).

[102] I do not accept Mr Paterson's interpretation of Dr Coull's report. In Dr Coull's conclusion at paragraph 5 he makes it clear that Mr Cowan "is likely to have survived longer than 23 August 2019 had he remained in hospital on 15 August 2019 and tolerated interventions and treatment." There was evidence from Dr Kelman as to what that treatment might have been and there was evidence that although he had not tolerated some interventions, Mr Cowan had tolerated some interventions. I do not accept that his intolerance in relation to some interventions was sufficient evidence to conclude that he would not tolerate further treatments had he remained in hospital. There was ample evidence to show that he had tolerated certain interventions and treatments.

[103] I accept that Dr Coull places Mr Cowan at a high risk of dying from his illness and ultimately his life may have been extended by only a few weeks or months had he not been discharged and he had the necessary interventions. He would have been highly likely to succumb to the illness for which he was admitted on 7 August 2019. The term "highly likely" is not a certainty and that raises the spectre of Mr Cowan's death

being avoided. Even if death is "highly likely", is a patient not entitled to a level of care and treatment that would make that avoidable? As Mr Morrison pointed out, if a patient is suffering from an end stage disease, for example cancer, then such a preclusive approach would mean that there could never be findings in relation to precautions on the basis that death is inevitable. That cannot be correct and I reject that submission.

[104] The court has to address whether the precaution not to discharge Mr Cowan would have been a reasonable one. It is clear from the evidence that Mr Cowan should not have been discharged. It was plainly wrong. Would the precaution not to discharge him have been a reasonable one in the circumstances? Mr Cowan was clearly not fit for discharge on 15 August 2019. Both Dr Kelman and Dr Coull agree on this. I hardly think I need to go further other than to highlight the evidence that Dr Kelman's criteria led discharge plan was not implemented. Mr Cowan's blood tests were not properly analysed on 15 August 2019 and had they been they would have revealed on-going infection and dehydration that would and should have ruled out discharge. He had not had the x-ray requested by Dr Kelman and no referral was made to the Hospital@Home Service. A reasonable precaution would have been to delay Mr Cowan's discharge to allow Dr Kelman's plan to be implemented.

9. Section 26(2)(f) any defects in any system of working which contributed to the death

[105] Mr Morrison submitted that a finding would be merited under this subsection. The wording of the provision is broad and he proposed that there was a defect in the

process involved in the discharge of Mr Cowan and in particular, there was a lack of scrutiny or review in the process of authorisation of his discharge.

[106] Mr Cowan was not medically fit for discharge and the criteria detailed in Dr Kelman's plan were not met. He was discharged with no referral to Hospital@Home. If this had been in place, Mr Cowan would have had his blood samples monitored and IV fluids or antibiotics administered as required.

[107] The fact that the exact circumstances of his discharge are unclear is in itself further evidence of the defect asserted by the Crown. The four clinicians were unable to give a comprehensive or cohesive account of who was ultimately responsible for Mr Cowan's care or who was ultimately responsible for authorising his discharge. All of the evidence around the discharge process points to a process which lacked checks and balances, accountability and formality. This contributed to the discharge of a patient who was not fit for discharge and which ultimately led to his untimely death.

[108] Mr Morrison highlighted the evidence of Dr Kelman and Norma Beveridge about the changes that have been made to the discharge process since Mr Cowan's death. These include a routine and consistent Multi-Disciplinary team meeting to discuss patient discharges and the use of a prominent nursing checklist. These changes show that the previous system was not working effectively and was indeed defective.

[109] NHS Fife's position in relation to this provision is that there must exist evidence that the defect in question did in fact cause or contribute to the death. Just because Mr Cowan was inappropriately discharged did not necessarily arise from a defect in the system. A communication breakdown is not a system defect. Mr Paterson highlighted

the fact that the only expert evidence before the court relative to the cause of Mr Cowan's death was Dr Coull's report. Although Dr Kelman had indicated in her evidence that had she been made aware of Mr Cowan's blood results taken on 14 August 2019, she would have considered starting IV fluids and stopping his furosemide prescription. Mr Paterson said that there was no evidence before the inquiry as to when that would have taken place or what would have happened had Mr Cowan not been discharged.

[110] Dr Coull's evidence was that Mr Cowan was likely to have survived beyond 23 August 2019 had he not been discharged and he had consented to, tolerated and received adequate hydration, further radiological investigation and antibiotics. Dr Coull's opinion about Mr Cowan's survival beyond 23 August 2019 was predicated on that factual hypothesis. Mr Paterson's submission was that Mr Cowan was not prepared to consent to treatment and investigations. He bases this assertion on the evidence that on 14 August 2019, Mr Cowan had refused an x-ray, was too agitated to attend for an ultrasound and refused blood tests. He refused blood tests on 15 August 2019, the day of his discharge. There were examples of previous non-cooperation as well. On this basis, it was unlikely that Mr Cowan would have consented to, tolerated and received adequate rehydration, further radiological investigation and antibiotics. Therefore, he would not have survived after 23 August 2019, according to Dr Coull. If he had then it would only have been for a matter of weeks or a small number of months. Therefore, the court has no evidence before it that any intervention on 15 August 2019 or in the days that followed might have prevented Mr Cowan's death, far less that the

absence of such intervention caused or contributed to it. On that basis there should be no finding in relation to this provision.

[111] On behalf of Dr Gattazzo, Ms MacNeill also submitted that there must exist evidence that the defect in question did in fact cause or contribute to the death. There was no deficiency in Mr Cowan's medical care prior to his discharge or in Dr Gattazzo's professional conduct as part of the medical team. Although the conclusion of Dr Coull's report was significant in that he states that Mr Cowan should not have been discharged, there was no clear evidence about the discharge process and therefore it would not be appropriate to make a finding that the particular system of working was lacking.

[112] No submissions were made on behalf of Dr Baldwin in respect of this provision.

[113] Mr Higgins on behalf of Dr Adrees submitted that there were no defects in the system of working which contributed to the death from his perspective and accordingly, proposed no findings under this provision.

Decision

[114] The fact that Mr Cowan was wrongly discharged on 15 August 2019 is the starting point for any discussion on this provision. The evidence about the lack of proper communication and a proper, robust system in place for the discharge of Mr Cowan is pretty overwhelming. There were so many areas of confusion that it is not surprising the system failed. There was the confusion about who was actually the consultant in charge of Mr Cowan. There was confusion as to who was responsible for his care on 15 August 2019. There was confusion as to who told Dr Baldwin to review

the patients in Ward 13 alone. There was confusion as to who told Rona Young that Mr Cowan was ready for discharge other than it was at the handover from the night shift to the day shift. There was confusion as to who authorised Dr Baldwin to actually discharge Mr Cowan. It was agreed that someone in a more senior role to her had to have authorised the discharge. I have to say that I find it quite alarming that an FY1 doctor with only two weeks experience in the job was being tasked with the discharge process at all. Then there was the issue of the phone call. I have already indicated that on the balance of probabilities I believe Dr Baldwin made the phone call. However, the confusion about what might have been said or not said or how that might have been interpreted or not interpreted in my opinion highlights a further defect in the process. In addition, there is the evidence of Dr Kelman and Norma Beveridge that since Mr Cowan's death certain more robust procedures have been put in place including a daily Multi-Disciplinary Team meeting where daily discharges are discussed. Dr Kelman's evidence was that in her opinion Mr Cowan's discharge would not have gone ahead had this new, more robust system been in place.

[115] Having determined that not discharging Mr Cowan on 15 August 2019 was a precaution that could have reasonably avoided his death, I have no difficulty in finding that these defects in the discharge process contributed to that wrongful discharge and therefore contributed to his death. Whilst I accept that Dr Coull predicated his opinion about Mr Cowan's survival on Mr Cowan consenting to continuing treatment and interventions, I did not agree with the position that the evidence was that Mr Cowan would not have been prepared to consent to ongoing treatment. That was not the

evidence before the inquiry. He had not consented to or tolerated certain investigations but that was not the whole picture. He had tolerated other treatments and investigations so it is wrong to suggest that he would not have tolerated further treatment or investigations in the future. That would be speculation. I therefore conclude that the precaution not to discharge him could have avoided his death on 23 August 2019.

10. Section 26(2)(g) any other facts which are relevant to the circumstances of the death

[116] On behalf of the Crown, Mr Morrison submitted that findings under this provision do not require any causative link to the death. He invited findings under this provision that there was a breakdown in understanding between the hospital and the Care Home at the time of Mr Cowan's discharge; that aspects of Mr Cowan's care whilst in hospital were substandard; and that no referral was made to the Hospital@Home service as had been planned by Dr Kelman.

[117] On behalf of NHS Fife, Mr Paterson made no submissions in relation to this provision.

[118] On behalf of Dr Gattazzo, Ms MacNeill made no submissions in relation to this provision.

[119] On behalf of Dr Baldwin, Ms Harris made no submissions in relation to this provision.

[120] On behalf of Dr Adrees, Mr Higgins submitted that I could make a finding that a fact relevant to the circumstances of the death is that Mr Cowan's discharge from hospital was inappropriate.

Decision

[121] I agree with the submissions made by the Crown on this section. The evidence before the court regarding communications between the hospital and the Care Home presents a contradictory picture and a breakdown in understanding about Mr Cowan's discharge. This was a fact relevant to the circumstances of Mr Cowan's death.

[122] The standard of Mr Cowan's care has been highlighted by Ms Ballingall and the subsequent NHS response to her complaint (Crown Production #12). Norma Beveridge was tasked to investigate the complaint and confirmed that it was upheld. This was a fact relevant to the circumstances of Mr Cowan's death.

[123] The lack of referral to the Hospital@Home Service may be considered to have been a reasonable precaution which may have avoided Mr Cowan's death. Mr Morrison accepted that it might be considered speculative to suggest that such a referral would have had any bearing on the outcome. However, the failure to make the referral shows a lack of planned through care and monitoring which had been envisaged by Dr Kelman in her discharge plan. Again, I have no difficulty finding that this was a fact relevant to Mr Cowan's death.

11. System improvements

[124] The changes in practice that have been implemented since the discharge of Mr Cowan have been highlighted above. Dr Kelman told the inquiry that there is now a Multi-Disciplinary Team meeting every day at 9am and 1pm. These meetings bring together representatives from various specialties and the issue of a patient's discharge is discussed. Norma Beveridge confirmed the changes that have been made since the death of Mr Cowan. There have been improvements made to processes that were already in place. The decision to discharge a patient is made at the Multi-Disciplinary Team meeting. The meeting is a fundamental part of the daily work of the ward and the discharge plan is part of that meeting. Ms Beveridge spoke about the discharge checklist and how changes were identified to make that a more robust and visible part of the discharge process. The discharge checklist is used by nursing staff to assist in ensuring all relevant matters are covered prior to discharge (Productions for NHS Fife #2).

[125] In addition to these changes a Care Home Liaison Working Group has been established to improve communication and build relationships between the hospital and Care Homes.

12. Recommendations

[126] I have not made any recommendations in terms of section 26(1)(b) as positive changes have been made to the discharge process since Mr Cowan's discharge. There is also a Care Home Liaison Working group that aims to improve communication and build relationships between care homes and the hospital. Whilst I have identified

significant shortcomings in the discharge process at the time of Mr Cowan's death, I accept that there have been proactive and significant changes to that process that have and will hopefully continue to ensure that such an issue does not arise again.

13. Conclusion

[127] Finally, I would like to offer my most sincere condolences to Ms Ballingall and Mr Cowan's wider family and friends. Ms Ballingall sat through the inquiry listening to the evidence with dignity and fortitude and I commend her for that.

Appendix

Witnesses to the Inquiry

1. Ms Linda Ballingall, Mr Cowan's partner (by affidavit)
2. Sharon Watson, Manager at Balfarg Care Home, Glenrothes
3. Gillian Harris, Senior Social Care Worker, Balfarg Care Home, Glenrothes
4. Michelle Coleman, Nursing Assistant at Balfarg Care Home, Glenrothes
5. Dr Nives Gattazzo, ST4 Specialty Registrar, Victoria Hospital, Kirkcaldy
6. Dr Muhammed Adrees, Locum Consultant Physician, Victoria Hospital
7. Rona Young, Patient Flow Co-ordinator, Victoria Hospital, Kirkcaldy
8. Dr Craig Morris, GP at North Glen Medical Practice, Glenrothes
9. Dr Morag Patterson, Consultant Geriatrician, Victoria Hospital, Kirkcaldy
10. Norma Beveridge, Head of Nursing for the Emergency Care Directorate, Victoria Hospital, Kirkcaldy
11. Dr Aylene Kelman, Consultant Geriatrician, Victoria Hospital, Kirkcaldy
12. Dr Sophie Baldwin, FY1, Victoria Hospital, Kirkcaldy (by affidavit)

Witnesses are designed with reference to the post they held in 2019.

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13. Dr Andrew Coull, Consultant Physician, Liberton Hospital/Royal Infirmary of Edinburgh