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Fatal Accident Inquiries: a New Dawn?

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Why am I speaking about Fatal Accident Inquiries at a clinical negligence seminar?

- Several high-profile FAIs have been held recently and there are more to come.
- Many of those concerned deaths which occurred in a clinical context in which matters of clinical judgement were being examined.
- There are overlaps between clinical negligence issues and medical FAIs and the relevance of clinical judgement has proved troublesome in the latter.

Statutory background

- The current legislation was introduced in 2016.

- Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016:

  "*An Act of the Scottish Parliament to make provision for the holding of public inquiries in respect of certain deaths.*"

- Act of Sederunt (Fatal Accident Inquiry Rules) 2017 – set out the FAI rules.

What is the purpose of an FAI?

- Inquiries into Fatal Accidents and Sudden Deaths (Scotland) Act 2016, s.1 (3):

> "*The purpose of an inquiry is to –*
>
> *(a) establish the circumstances of the death, and*
>
> *(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances*."

- It is not the purpose of an inquiry to establish civil or criminal liability (s.1 (4)).

When will an inquiry be held into a death which occurred in clinical circumstances?

- **<u>Mandatory Inquiries (section 2 of the 2016 Act)</u>**

  - Where the deceased was in legal custody (s.2 (4) (a))
  - Where the deceased was a child who was kept or detained in secure accommodation (s.2 (4) (b)).

- It does not matter whether the death occurred in secure accommodation or a penal institution (s.2 (6)).

  - For example, if the death occurred in a hospital but the deceased was in legal custody at the time.

When will an inquiry be held into a death which occurred in clinical circumstances?

- **Discretionary Inquiries (section 4 of the 2016 Act)**

  - Where the Lord Advocate considers that the death was:

    - (i) sudden, suspicious or unexplained; or
    - (ii) occurred in circumstances giving rise to serious public concern

    such that it is decided that it is in the public interest for an inquiry to be held into the circumstances of the death.

  - Most of the FAIs which concern clinical decision making will be take place under s.4 as opposed to s.2.

Who can participate in the inquiry?

- Section 11 of the 2016 Act sets out that there are several persons who may participate in an inquiry.

  Those are:

  - The deceased's spouse or civil partner or a person living with the deceased as if married to the deceased (s.11 (1) (a) & (b).
  - The deceased's nearest known relative if the deceased did not have a spouse or civil partner (s.11 (c)).
  - Any other person who the sheriff is satisfied has an interest in the inquiry (s.11 (1) (e)).
    - ❖ For example, health boards or the clinicians involved in the deceased's care.

What role do clinical negligence lawyers play in the inquiry?

- Rule 2.4 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017:

  (1) A participant other than the procurator fiscal may –

  ... (b) be represented by a solicitor, an advocate, or both

- Clinical negligence lawyers are well placed to navigate the issues which medical FAIs give rise to.

The sheriff's determination

- Section 26 (1) (a) and (2) require the sheriff, following conclusion of the evidence and submissions, to issue a determination setting out their findings as to:

(a) when and where the death occurred,

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

(c) the cause or causes of the death,

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

(e) any precautions which –

(i) could reasonably have been taken, and

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

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

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

The sheriff's determination

- Section 26 (1) (b) provides that the sheriff may make such recommendations (if any) as to the matters set out in subsection (4).

- Section 26 (4):

> *(4) The matters referred to in subsection (1)(b) are—*
>
> *(a) the taking of reasonable precautions,*
>
> *(b) the making of improvements to any system of working,*
>
> *(c) the introduction of a system of working,*
>
> *(d) the taking of any other steps,*
>
> *which might realistically prevent other deaths in similar circumstances.*

Where do clinical negligence considerations come in?

- These will ordinarily arise in relation as to whether there were any reasonable precautions which could have been taken which might realistically have prevented the death.

- What happens if a clinician exercises their clinical judgement in such a way that results in death, but the manner in which they exercised their judgement at the time was reasonable - could exercising clinical judgement the other way form the basis of a reasonable precaution which if taken might have avoided the death?

- Is the underlying spirit of ***Hunter v Hanley*** applicable to FAIs? Should it be?

Hunter v Hanley 1955 S.C. 200

- "*But where the conduct of a doctor, or indeed of any professional man, is concerned, the circumstances are not so precise and clear cut as in the normal case.* ***In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown.*** *The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.*"

Lord President Clyde at 204 - 205

Inquiry into the Death of Lynsy Myles, Edinburgh Sheriff Court, 27 February 2004

- *"… lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is a clear appropriate testimony which challenges the treatment a patient receives… for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff.* ***Before I can find a precaution to be reasonable in the context of a medical issue, there must either be an admission by the treating doctor that he failed to take a precaution or a course of action which he clearly ought to have taken or took the course of action which, in the exercise of ordinary care, ought not to have been taken. Failing that, there would require to be established by independent evidence, the manner in which the doctor in a particular area of expertise, and with the particular experience, ought to have acted. This clearly requires there to be a standard by which the actings of doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification and reflecting the jurisprudence surrounding medical negligence issues it must avoid the situation whereby medical professionals become hamstrung in their treatment of patients because of concern that their view and their clinical judgement may be called into question by a colleague who takes a different view. That is of course the rationale behind the standard approved in Hunter v Hanley 1955 SC 200.****"*

Inquiry into the Death of Marion Bellfield 2011 FAI 21

- "*… I agree that* ***when one has a situation which solely involves the exercise of clinical judgment, where a range of reasonable actions might be taken, and the choice as to which to take rests on the skill and experience of a doctor based upon such information as is available to him at the time, and the doctor happens to choose a course which results in death, it would be wrong to hold that the selection of another option within the range, which might have prevented the death, was a reasonable precaution which ought to have been taken.*** *Not only does that involve straining the meaning of precaution, but such a finding would be of no real practical benefit to others in the future. A Fatal Accident Inquiry cannot prescribe how doctors or nurses should exercise their judgment. Put another way, the true precaution which ought to be taken in any given case may simply be a requirement that a patient is seen by a suitably skilled doctor, rather than how the doctor exercises his skill and judgment thereafter*."

Inquiry into the Death of Kieran Nichol 2010

- "… *"It was submitted that particular rules apply in the case of fatal accident inquiries that involve medical professionals.* ***It was said that in order for me to hold that there were reasonable precautions that might have been taken by members of the medical profession whereby the death might have been avoided, the standard required to be applied was, by analogy, the one to be found in Hunter v Hanley 1955 SC 200.*** *In other words, I was not entitled to consider evidence of what others say they might have done or do in deciding whether there existed a reasonable precaution.* ***Only expert evidence on what would have been a reasonable precaution for the particular medical practitioner to have taken considered similarly to the Hunter v Hanley professional negligence standard was sufficient.*** *In the absence of the Crown leading such expert evidence, it was argued, I did not have sufficient evidence before me to entitle me to be satisfied that such reasonable precautions existed.* ***I reject that argument. It is based on a misunderstanding of the law in relation to fatal accident inquiries. Entitlement to decide whether I am satisfied that it has been established that there exists a reasonable precaution whereby the death and an accident resulting in the death may have been avoided, in my opinion, only requires it to be demonstrated, with the benefit of hindsight, that the precaution might have prevented the death or accident and, that it was a reasonable precaution in the ordinary sense of that word***."

Sutherland v Lord Advocate 2017 S.L.T. 333

- Judicial Review of a determination brought by a consultant cardiac surgeon.
- The deceased presented at Monklands Hospital with chest pain. He underwent radiological investigations upon the basis of which clinical staff at Monklands suspected that the deceased was suffering from an aortic dissection. The deceased was referred to the Golden Jubilee National Hospital ("**GJNH**") with a view to surgery being undertaken.
- The petitioner was the surgeon on duty at GJNH. He considered that there was uncertainty in the diagnosis. That being so, he arranged a transesophageal echocardiogram ("**TOE**") to be undertaken upon the deceased's attendance at GJNH by a consultant cardiologist. The cardiologist reviewed the scan undertaken at Monklands in the presence of the petitioner and considered that "*no convincing dissection* [was] *seen*."
- No aortic dissection was seen at the TOE and, following an ECG, the treating cardiologist diagnosed pericarditis.
- The petitioner decided that the deceased did not require surgery. The deceased suffered a cardiac arrest and died.

Sutherland v Lord Advocate 2017 S.L.T. 333

- An FAI was held to establish the circumstances of death.

- The sheriff made a finding that a reasonable precaution whereby the death and the accident resulting in the death might have been avoided was for the petitioner to have sought experienced consultant radiology opinion on the CT scan performed at Monklands General Hospital.

- The petitioner sought reduction of that finding on the basis that the sheriff had, amongst other things, misdirected himself in his consideration of hindsight, reasonable foreseeability and what was meant by a reasonable precaution in the context of a decision involving clinical judgement.

Sutherland v Lord Advocate 2017 S.L.T. 333

- It was held at that:

> "[33] *Notwithstanding the subtlety of the argument presented for the petitioner, I am not persuaded that the rationale behind the decision in Hunter v Hanley, or any part of it, has any application in a determination made under s.6(1)(c). An analysis of what would have been a reasonable course of action for the medical practitioner concerned, in the light of information known at the time, is not a relevant consideration in determining whether a reasonable precaution might have resulted in the death being avoided. Whether the death might have been avoided is a matter to be determined on a consideration, with the benefit of hindsight, of the whole facts which emerge from the enquiry, including the according of due weight to relevant expert medical opinion…*"

Sutherland v Lord Advocate 2017 S.L.T. 333

- But:

> "[34] *It was submitted that it would be possible to envisage a situation, involving the exercise of clinical judgment, whereby a doctor was presented with two or more options and could not know which was in the patient's best interests.* ***I accept that in such a situation where the optimal course was not taken, it would not be appropriate to determine that the selection of another of the available options would have been a reasonable precaution. I accept that to do so would distort the ordinary meaning of "reasonable precaution" and would in any event be of no assistance for the future****. I am satisfied, however, that the circumstances of the petitioner's decision, not to operate, were not of that type."*

Sutherland v Lord Advocate 2017 S.L.T. 333

- Why was the decision not to operate not of "that type"?
    - Expert evidence was led at the FAI that another radiological opinion was not required before the decision not to operate was made and that the petitioner could not be criticised.
    - Was the decision not to seek further input a clinical judgement?
    - Would it have been a clinical judgement if, for example, the patient had been treated conservatively as opposed to with surgery?
- In any event, room was left for the underlying rationale behind ***Hunter v Hanley*** to continue to apply to FAIs – but what is its scope?

Inquiry into the Death of Jessi-Jean MacLennan [2024] FAI 1

- The inquiry concerned the death of a baby on 25 November 2019 as a result of complications of left nephroblastoma, which is a rare type of childhood cancer of the kidneys.
- In the lead up to her death, Jessi experienced symptoms of weight loss, bloating and pain. She passed a large blood clot in her nappy and her mother had identified a mass on the left side of her abdomen.
- In the weeks leading up to her death Jessi was seen by several GPs and a paediatrician.
- None of the GPs made a referral for an urgent paediatric opinion.
- The paediatrician who did review Jessi (on 20 October) did not undertake additional investigation of her symptoms by way of abdominal ultrasound or arrange for a complete set of observations to be undertaken.
- Jessi's cancer was not detected and she sadly passed away. The causation evidence accepted by the sheriff was that, had an urgent paediatric opinion been sought, successful treatment was likely to have been administered.
- Expert evidence was led by the Crown which was critical of the care that had been provided.

Inquiry into the Death of Jessi-Jean MacLennan [2024] FAI 1

- One of the GPs was criticised by the expert for not making an urgent referral to paediatrics on 1 November 2019.
- However, the expert accepted during cross-examination that it was reasonable for the GP not to make a referral given the false reassurance of the paediatric opinion which had been obtained some days prior to the consultation.
- The GP did not accept that she could have taken any other reasonable measure at the consultation on 1 November, but she did concede that now, in similar circumstances, she would act differently and have a lower threshold for referral.
- In short: the GP expert's evidence was that it would have been reasonable to refer Jessi for a paediatric opinion but it was also reasonable not to make that referral given that Jessi had recently been assessed by a paediatric doctor.
- That being so, it was submitted on behalf of the GP that the court was not entitled to conclude that the GP could have taken any reasonable precautions at the consultation on 1 November because (i) the GP did not accept that she did not take a reasonable precaution which she could have taken and (ii) the expert witness accepted that not making a referral might also have been seen as reasonable.

Inquiry into the Death of Jessi-Jean MacLennan [2024] FAI 1

- The sheriff found that:
    - On the basis of the GP expert evidence, referral to paediatrics on 1 November was a reasonable course which the GP could have adopted (para.70)
        - ❖ The sheriff did not address the legal submission made that the court was not entitled to conclude that a referral was a reasonable precaution which could have been taken (para.44).
    - Had that referral been made investigations would have been undertaken, the diagnosis would have been made and treatment would have been instituted. On that hypothesis, survival and cure was likely.
    - Thus, a referral on 1 November might realistically have resulted in the death being avoided.
- Was that a finding open to the sheriff?
    - Whilst the decision not to refer was reasonable, was it an exercise in clinical judgement as envisaged in ***Sutherland***?

Inquiry into the Death of Jessi-Jean MacLennan [2024] FAI 1

- The determination is currently being judicially reviewed.
- The hearing is to take place at the end of October.
- Was a referral to paediatrics a reasonable precaution which could have been taken?

Fatal Accident Inquiries: a New Dawn?

- Medical FAIs give rise to complex questions in relation to clinical judgement.
- The case law suggests that different approaches are being adopted to assess the question of reasonable precautions in the context of clinical judgement.
- Has the time come to legislate for the issues which medical FAIs give rise to?
- Or is this an issue which authoritative guidance from the Court of Session would solve?

Fatal Accident Inquiries: a New Dawn?

- Should medical FAIs be treated any differently from other FAIs where there are issues of clinical judgement in play?
  - The purpose of an FAI is to investigate the circumstances of the death, with the benefit of hindsight, to inform subsequent actings with a view to avoiding such a death in the future.
    - ❖ Would a different approach in medical FAIs restrict the public utility of the process?
    - ❖ What is the practical benefit of suggesting clinical judgement, on the facts of a specific case, ought to have been exercised another way?
  - It is not the purpose of an FAI to establish civil liability, but criticism may have serious professional consequences for clinicians – is that a factor that should be considered?

Thank you

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