SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNFERMLINE

DETERMINATION

of

Sheriff John Craig Cunningham McSherry in Fatal Accident Inquiry concerning the deaths of Joanne Isabel Mackie or Winsborough, 29, Elmwood Terrace, Kelty, Fife and William Anderson, 4, Rosslyn Street, Kirkcaldy, Fife under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

8th August 2011

The Sheriff, having resumed consideration of the cause, Determines:-

Mrs Winsborough.

1. In terms of section 6(1) (a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act), that Joanne Isabel Mackie or Winsborough, (Mrs Winsborough), whose date of birth was 7th May 1975, latterly residing at

29, Elmwood Terrace, Kelty, Fife died at 29, Elmwood Terrace, Kelty, Fife between the hours of 0630 and 1100 on 17th April 2009.

2. In terms of section 6(1) (b) of the Act, that the cause of death was Suppurating Pneumonia, both lungs.
3. In terms of section 6(1) (c) of the Act, there were no reasonable precautions whereby the death might have been avoided.
4. In terms of section 6(1) (d) of the Act, there were no defects in the system of working, which contributed to Mrs Winsborough's death.
5. In terms of section 6(1) (e) of the Act, there were no other facts relevant to the circumstances of Mrs Winsborough's death.

Mr Anderson.

1. In terms of section 6(1) (a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act), that William Anderson, (Mr Anderson), 4, Rosslyn Street, Kirkcaldy, Fife whose date of birth was 1st September 1956, died at Queen Margaret Hospital, Dunfermline, Fife at 1753 hours on 9th September 2009.
2. In terms of section 6(1) (b) of the Act, that the cause of death was
    (a) Pneumonia/ Adult Respiratory Distress Syndrome both lungs
    (b) H1N1influenza virus (Swine Flu).
6. In terms of section 6(1) (c) of the Act, there were no reasonable precautions whereby the death might have been avoided.
7. In terms of section 6(1) (d) of the Act, there were no defects in the system of working, which contributed to Mr Anderson's death.
3. In terms of section 6(1) (e) of the Act, there were no other facts relevant to the circumstances of Mr Anderson's death.

NOTE.

In this enquiry Brian Robertson, Senior Procurator Fiscal Depute, represented the Crown, Miss McKerrow, Advocate, represented the Anderson family, Mr Olson, Advocate, represented the Winsborough family, Mr Wood, Solicitor, represented Dr James Alcock, Mr Paterson, Advocate, represented Dr David Carson and Dr John Barron, and Miss Davie, Advocate, represented Fife Health Board. There were twenty witnesses called to give evidence over a two week period. The parties agreed certain evidence by joint minute. There was some flexibility regarding the calling of witnesses out of order and the first week was primarily devoted to enquire into Mrs Winsborough's death and the second week into that of Mr Anderson. As a result, I have dealt with the death of Mrs Winsborough before that of Mr Anderson. Accordingly, it is not to be presumed that one death takes precedence over the other.

THE FACTS AND CIRCUMSTANCES SURROUNDING MRS WINSBOROUGH'S DEATH.

1. Mrs Winsborough was aged 33 years, was married to Rodger Winsborough and had two children aged 11 and 15. She kept good health and had had no significant health problems. She smoked about fifteen cigarettes a day and occasionally drank but not every week.

2. Before Friday 10th April 2009 she started feeling unwell. She started vomiting every 10-15 minutes and could not keep down food or water.

3. On the morning of Saturday 11th April 2009 she phoned NHS24 and described her symptoms. She was asked to remove intimate piercing, as it might be contributing to infection, take paracetamol and drink water. She may have been advised that it was probably a viral infection. Later on that Saturday she started suffering diarrhoea and her vomiting continued.

4. Her symptoms became progressively worse from that Saturday until Tuesday 14th April 2009. On that Tuesday she went to the Kelty Health Centre and was examined by Dr James Alcock around 10 am. She reported having diarrhoea and vomiting since the previous Friday. She was on the fourth day into the complaint. She had no mobility issues. She reported difficulty in holding down food and drink. She was advised to take small measures, 10-15 millilitres, of water and not to take larger quantities until able to hold down such small measures. She had pain in her stomach. Her abdomen was examined manually and by stethoscope. There was neither focal tenderness nor guardian response to firmer touch. There was nothing untoward in her stomach and abdomen. She was checked in her mouth for hydration status. Her skin tone and pulse were normal.

5. Dr Alcock was of the opinion that she was suffering from gastroenteritis. He told her that more than 50% of gastroenteritis cases were viral in origin. He provided her with a sample bottle to bring back to the surgery for sending for analysis to check that it was a viral and not a bacterial infection.

6. She did not report breathing difficulties and there was no evidence of that. She did not have blue lips and her mouth colouring was normal. He did not check her blood pressure as her pulse was normal.

7. He advised her that she should be seen again, if not tolerating liquids within 24 hours. She should revisit the surgery. He remembered telling her that he would not be there as he was a locum but she should ask at the desk.

8. Dr Alcock described Mrs Winsborough as being quite talkative. He thought that she was looking for 'an immediate cure'. He did not prescribe anti-sickness tablets as he did not like them as they were prone to cause unpleasant side effects. There were no signs that Mrs Winsborough was becoming significantly dehydrated.

9. Around 11.20am Mrs Winsborough telephoned her husband and told him that the doctor had advised her that she was suffering from a viral infection and was to take paracetamol. She said that she did not believe what the doctor had advised and wanted to go to hospital.

10. Her aunt, Frances Easton, saw her just before 12 noon and said she was very pale with no colour. She was speaking quite slowly.

11. Mrs Lee-Anne Wallace, a close friend of Mrs Winsborough, saw her that Tuesday and said that Mrs Winsborough told her that she had been to the doctor and had been told it was a viral infection and to take paracetamol. She

said she wanted to go to hospital. Mrs Wallace arranged for her husband, Andrew Wallace, to drive Mrs Winsborough to Queen Margaret Hospital, Dunfermline and arrived at reception of Accident and Emergency Department at 2.07pm.

12. Mrs Winsborough was sick in the hospital waiting room. Mrs Wallace accompanied Mrs Winsborough when she was seen in a cubicle by Dr David Carson at 2.45pm. The examination lasted approximately twenty minutes. Mrs Winsborough recounted her history of having 5 days of vomiting and diarrhoea. She said that she had seen another doctor that day and had been sent away. She had a sore throat and struggled to keep food down. There was a lot of conversation from Mrs Winsborough and Mrs Wallace. Dr Carson listened to Mrs Winsborough's chest and it was clear. Checking the chest was part of the routine examination of a patient. Her heart was sound and her pulse was slightly fast at 116pm.There was a measure of dehydration. There was slight tenderness on the lower left side of her abdomen, which indicated that there was most likely inflammation of the bowel underlying that area. Her bowel sounds were active. Her central nervous system was 'grossly normal' that is from a general rather than specific observation. There was no sign of a difficulty in that respect.

13. She had talked a lot during examination. She had no difficulty with mobility. Dr Carson thought that she and her friend appeared annoyed at the findings of the previous doctor. They told Dr Carson that Mrs Winsborough had been told she had a viral tummy bug.

14. After his examination, Dr Carson reached the same conclusion. Mrs Winsborough had gastroenteritis or a possible flu like illness. It could also be caused by a bacterial infection and Dr Carson thought that Dr Alcock had taken a stool sample from Mrs Winsborough.

15. Dr Carson did not take a blood sample as the clinical findings already indicated that Mrs Winsborough was showing dehydration. Mrs Winsborough's throat glands were inflamed and this was most likely caused by a viral infection. He examined Mrs Winsborough's chest to check for a bacterial infection. There was nothing to suggest this. Her temperature was 39.8 degrees Celsius and this was high but to be expected from someone suffering an infection.

16. Her blood pressure was taken either by Dr Carson or by a nurse. The reading was recorded by Dr Carson as 100/61. Her pulse was 116bpm. The oxygen saturation machine, oximeter, was not working. This machine takes a reading from the tip of the finger to indicate the functioning of the respiratory system. There were other oximeters available in other cubicles but Dr Carson decided not to use one as his clinical findings indicated that there was no problem with Mrs Winsborough's respiratory system.

17. It was Dr Carson's standard practice to advise a patient to seek further help if symptoms deteriorated and he so advised Mrs Winsborough. Dr Carson's main concern was that Mrs Winsborough was mildly dehydrated and if she

continued to be unable to keep down food and drink, she should seek help from her own GP.

18. Dr Carson did consider whether Mrs Winsborough should be admitted to hospital but decided not to because if she kept the level of dehydration under control this would not be necessary. Most of these viral illnesses improve themselves over a number of days.

19. Dr Carson advised Mrs Winsborough to take Ibuprofen/paracetamol, to rest and encouraged the taking of oral fluids. He advised a follow-up with her GP if required.

20. From the symptoms as observed by Dr Carson, there was nothing to indicate that Mrs Winsborough was, at the time of examination, suffering from pneumonia.

21. Following her examination by Dr Carson, Mrs Winsborough continued to be sick and was not sleeping well. On Wednesday evening 15th April 2009, Mrs Winsborough's father John Mackie, through Mr Winsborough, provided her with anti-sickness tablets that he had been prescribed.

22. On Thursday 16th April 2009, she told Mr Mackie she had taken one tablet and that the sickness had gone but she had heart burn. She said she was feeling a bit better. This was around 3-4 pm. On that Thursday, she appeared worse to Mr Winsborough. She was feeling cold, had blue lips and her eyes were glazed

over. On Thursday evening she had a bath and her skin was like soft rubber, a sign that she was significantly dehydrated.

23. On Friday 17th April 2009 Mr Winsborough went to work at 6.30am. Mrs Winsborough had been sitting up shivering. He intended taking Mrs Winsborough to hospital on his return and "was not taking no for an answer".

24. During the morning he received a call from one of his daughters around 10.30am to come home as Mrs Winsborough was not breathing and her lips were blue.

25. On his arrival there were two ambulances at his house. Mrs Winsborough was lying on the sitting room floor. Paramedics were in attendance followed by police officers. Alan McCusker was a paramedic who attended at 10.56am. Mrs Winsborough was lying on the floor with no vital signs present and was beyond resuscitation.

26. Mrs Winsborough's life was declared extinct at 11am.

27. PC Brian Bargie at the time was with the Sudden Deaths Specialist Unit. He attended the house later on that Friday and retrieved a sample bottle from the rear sitting room window sill of the house. There was a label on it to be filled in by the patient and returned to the Kelty Health Centre. There was no sample as the bottle was completely clean.

THE FACTS AND CIRCUMSTANCES SURROUNDING MR ANDERSON'S DEATH.

1. Mr Anderson was a healthy man aged 53. He never had smoked and only drank socially. He was a squash club champion just six months before his death. He stopped playing because of work commitments. He had been in the RAF and in 2000 he graduated with a psychiatric nursing qualification and worked in care homes. In 2009 he was employed by Kingdom Housing Association working with people with learning disabilities. He also occasionally worked as a security steward at football matches.
2. In June 2009 Mr Anderson and his wife had been on holiday to Cyprus. In August 2009 they spent two weeks on holiday in Tenerife returning on 21st August 2009. On his return Mr Anderson felt fine.
3. His wife was recovering from a serious operation and his daughter Monica Chasiridis was 8 ½ months pregnant.
4. On Sunday 30th August 2009 he was working as security steward at a Raith Rovers v Dunfermline Athletic game where he was soaked.
5. The following day, Monday 31st August 2009, he told his wife, Mrs Linda Anderson, that he felt a bit chesty.
6. The next day, Tuesday 1st September 2009 he went out for a birthday meal and said that he felt a chill.
7. On Wednesday 2nd September 2009 he worked an overnight shift and when he returned home told Mrs Anderson that he 'felt rotten'. He had diarrhoea and went to bed.

8. On Thursday 3rd September 2009 he felt shivery, was vomiting and had diarrhoea. He cancelled his work shifts on Friday 4th and Saturday 5th September 2009. He stayed in bed.
9. On Saturday 5th September 2009 he telephoned NHS24 dedicated flu line. This dedicated line was set up following the Swine Flu Pandemic which was announced in early July 2009.
10. He explained his symptoms of vomiting and diarrhoea. He was advised that he had the symptoms of Swine Flu.
11. He had a telephone triage discussion with a Dr Sahu, who also advised that he probably had Swine Flu and NHS24 through Dr Sahu arranged an early appointment for him at the Out of Hours Service at the Accident and Emergency Department of Victoria Hospital, Dunfermline.
12. Mr Anderson's son in law, Romanis Chasiridis, drove him there. During the journey Mr Anderson told Mr Chasiridis that he was worried he had Swine Flu as he was concerned for his wife and his pregnant daughter.
13. Mr Anderson was seen by Dr John Barron at 6.02pm. Dr Barron had seen many patients suffering from Swine Flu. He had no recollection of the examination and relied upon his medical notes.
14. The medical notes disclose that Mr Anderson complained of flu like symptoms, namely vomiting and diarrhoea. He had shortness of breath. He had generalised headache and fever. He had vomited while in the hospital. He had some green sputum and bilateral loin discomfort. He had a coated tongue and inflamed throat. His pulse was 64/min and was regular. His Blood Pressure, BP, was 100/60 and was normal.. He had lower tract basal

crepitations recognised by crackling sounds of secretions in the lungs. A urine sample was taken.

15. Mr Anderson was diagnosed as suffering from probable H1N1 flu, that is, Swine Flu, and possible Lower Respiratory Tract Infection.
16. He was prescribed Amoxicillin, an antibiotic, and Metoclopramide, anti-sickness medication.
17. He was advised to rest and was given hydration advice and advice regarding prophylactics, respiratory and hand hygiene.
18. Dr Barron assumed that Mr Anderson, as a health professional would know better than the average person about these.
19. Infection control measures in respect of Swine Flu were widely discussed in the medical profession by September 2009.
20. Dr Barron believed that he had asked Mr Anderson to contact the Bennochy Medical Centre as it was noted that the patient was to contact his surgery. He assumed that Mr Anderson would do this on Monday 7th September 2009.
21. Dr Barron saw Mr Anderson in the middle of the Swine Flu pandemic and would have told him that he probably had swine flu.
22. He made no note of advising Mr Anderson about his wife or daughter.
23. His practice was to wait and see if such persons in contact with a patient develop symptoms.
24. As Mr Anderson had the symptoms since at least Thursday 3rd September 2009, that is in excess of 48 hours, Dr Barron did not prescribe Tamiflu.
25. In not doing so he was following National Institute for Clinical Excellence and manufacturer's guidance that Tamiflu is most effective if taken as soon as possible after the symptoms appear and preferably within 48 hours.

26. He did not admit Mr Anderson to hospital as there was no evidence of respiratory distress shock or dehydration.
27. He did not always note negative findings.
28. Swine Flu vaccine was not available until October 2009.
29. Dr Barron had no reason for not telling Mr Anderson that he had Swine Flu.
30. Following Dr Barron's examination, Mr Anderson informed Mr Chasiridis that he was relieved he did not have Swine Flu.
31. He said that he was happy that he could go home without his wife and daughter being at risk.
32. He told Mr Chasiridis that he would not have gone home if he had Swine flu.
33. Mr Anderson collected his medication from the pharmacy at Asda, Kirkcaldy.
34. On returning home he advised Mrs Anderson and his daughter Monica Chasidiris that he was happy he did not have Swine flu and said that he had "ordinary flu" and went to bed.
35. He did not tell his family that he was to contact his GP surgery on Monday.
36. His breathing worsened that evening. It had become heavier and there was a "rattly" noise from his chest.
37. On Sunday 6th September 2009 he spent most of the day in his room in bed.
38. On Monday 7th September 2009 he had a bath and shaved . He told his family that he felt better. He did not speak much.
39. He was concerned about his work and telephoned the Bennochy Surgery for a sick line.
40. On Monday 7th September 2009 he spoke to Nurse Susan Gallacher at 9.30pm. He said that he had been to NHS24 and had Swine Flu and requested an insurance line for his work. He did not collect the line.

41. He told the nurse that the vomiting had stopped and that he felt a bit better after seeing Dr Barron. He said that his temperature had settled.
42. Nurse Gallacher on being told of Swine Flu checked Mr Anderson's file which disclosed the note of Dr Barron's examination and that Mr Anderson was prescribed amoxicillin. The note also had the diagnosis of H1N1, Swine Flu.
43. Mrs Anderson was present when Mr Anderson telephoned the Surgery.
44. His family did not consider that he was looking better. He could not eat properly and was unsteady on his feet. His condition was slightly worse.
45. His wife and daughter asked him to go to his GP. His wife asked him at least two or three times during the day.
46. He refused to do so as he wished to give the antibiotics a chance to work.
47. On Tuesday 8th September 2009 at 1.45 am Mr Anderson suddenly sat up in bed and told Mrs Anderson that he thought he had had a stroke and should go back to hospital.
48. As he was getting dressed he fell over and never regained consciousness.
49. Paramedics arrived within 7 minutes and worked on Mr Anderson for 40 minutes.
50. He was taken firstly to Victoria Hospital and then to the Intensive Care Unit of Queen Margaret Hospital.
51. He had tested positive for Swine Flu.
52. He was certified as dead at 5.53pm on Tuesday 9th September 2009.

SUBMISSIONS.

SUBMISSIONS FOR THE CROWN.

Mr Robertson, Principal Procurator Fiscal Depute, explained that due to the potentially wide range of issues and the overlap or repetition of medical opinion evidence, it was considered by the Crown more appropriate to give an overview of the relevant issues viewed as being of significant concern to the public interest rather than seek to analyse the evidence in detail regarding all potential issues arising.

The Crown had applied for the two inquiries to be conjoined as there are some common themes worth addressing together. This did not reduce the importance or individual impact of each death. He said that the issues which have arisen indicate it has been helpful to consider these cases together rather than look at the circumstances of each death in isolation. Repetition of events in matters affecting the public interest may emphasise the point that there are lessons to be learned.

He went on to detail the factual circumstances of Mrs Winsborough's death.

Bacterial pneumonia can be caused by an infection, or can be a consequence of a viral illness e.g. any form of flu. The mechanism causing the bacterial pneumonia is not known. The most likely cause might be streptococcal B infection, but it is unusual for this to infect lungs and it is unclear how this could have occurred. It is possible that she developed the infection from an infected intimate piercing. It is also possible that the pneumonia was co-existing with the gastroenteritis and unconnected to it.

The Crown position is that it unnecessary to identify the cause of the infection for the purpose of considering public interest issues arising.

Mrs Winsborough was in good health prior to becoming ill in the days leading up to her death. She had no other underlying medical conditions likely to be contributory factors to her death.

He then detailed the circumstances of Mr Anderson's death.

Mr Robertson accepted that Dr Barron had diagnosed swine flu and a lower respiratory tract infection. It is likely that he developed Adult Respiratory Distress Syndrome (ARDS) as a reaction to the swine flu virus infecting his lungs. ARDS is a serious respiratory condition which can develop rapidly.

Like Mrs Winsborough, Mr Anderson was in good health prior to becoming ill in the days leading up to his death. He had no other underlying medical conditions likely to be contributory factors to his death.

Mr Robertson agreed that the cause of death should be certified in each case as:

a. Mrs Winsborough: Suppurating pneumonia of both lungs.

b. Mr Anderson: 1a) Pneumonia/Adult Respiratory Distress Syndrome (both lungs) due to

1b) H1N1 influenza virus infection (swine flu).

Mr Robertson went on to detail the similarities of the deaths:

1. Both were otherwise healthy individuals with no other underlying medical conditions.
2. Neither was old – JW was aged 33, WA was aged 54.
3. Both took ill with D & V/flu-like symptoms. both diagnosed with viral illness.
4. Both went to see doctors of their own volition.
5. Neither was admitted to hospital – both were sent home.
6. Each died 3 days after being seen by a doctor.
7. Both might have been able to survive had they been admitted to hospital.

8. Both were reluctant to go into hospital and both repeatedly declined requests from their family to go back to see a doctor.
9. Both appeared to see no point in seeking further medical help even though their condition was either not improving or in fact worsening or concerned re feeling stupid if they did return for same condition
10. Both doctors (Carson & Barron) could have given better/clearer advice to return if not improving.
11. Neither doctor gave any time-limit required for improvement e.g. 24 hrs.
12. Both families dispute the advice given and have concerns about the treatment given.
13. In both cases, medical records are less than adequate to deal with all concerns raised.

In dealing with Reasonable Precautions whereby the deaths might have been avoided, Mr Robertson thought it reasonable to expect doctors (GPs or specialists) to deal with patients by good management of delivery of clear information. It is reasonably practicable for them to do so. He gave as an example that time limits should be specified, such as symptoms not improving or getting worse within 24/48 hours.

He asserted that it was good practice to deliver helpful and information rather than simply give vague or 'routine' information with little thought for its relevance or value.

As regards admission to hospital, Mr Robertson thought that it was clearly not appropriate to admit to hospital every patient presenting with symptoms of Diarrhoea and Vomiting. Both Drs Carson & Barron said that their clinical judgment was that hospital admission was not appropriate in either case. He did not criticise their clinical

judgement but was of the view that shortcomings in medical notes meant that possible criticisms by the families could not be satisfactorily resolved one way or the other. If records were not adequate, Mr Robertson thought that an air of uncertainty resulted when the doctors are unable to fully explain themselves

In dealing with the factual medical issues concerning Mrs Winsborough, Mr Robertson stated that the position of the Winsborough family and her friends, Mr & Mrs Wallace, is that she was not adequately examined and should have been admitted to hospital as her illness was much worse than the doctors indicated. Mrs Wallace was with her constantly and said her blood pressure was not taken. Dr Carson could not recall but there was a BP reading in the medical records inferring it must have been done. Their stance that she was persistently vomiting and 'unable to keep anything down', and was even doing so at the hospital and in Dr Carson's presence, would suggest hospital admission should have been a more serious consideration than Dr Carson gave it. Dr Carson had memory of events, but was partially reliant upon the records for recollection. He said she had a viral illness and only mild dehydration, and expected her to recover within a week. He concluded there was no medical basis to admit her to hospital.

The conflict in the competing versions of the extent of her symptoms and the degree of her illness is difficult to reconcile. Mr Robertson thought that there is no apparent reason to disbelieve either version.

In dealing with the factual medical issues concerning **Mr Anderson,** Mr Robertson stated that the Anderson family position is that he was not told he had swine flu. Dr Barron said he did specifically tell Mr Anderson that he had swine flu. He had to rely on medical records rather than memory, but said it was normal for him to give this information to any patient when he made a diagnosis. Indeed, he said there was no

reason for him not to do so, as he was regularly seeing similar patients with swine flu and telling them. The Anderson family state this cannot be correct as the deceased said he was specifically told by Dr Barron he had 'ordinary flu'. The deceased was happy and relieved because he was told he did not have swine flu. He had no apparent reason to give his family a false impression or delude himself.

It is difficult to reconcile these competing positions. There is no reason to disbelieve the accounts given by Anderson family, as this was a specific issue of concern to them. Due to the potential vulnerability of Mrs Anderson due to recent surgery and their daughter (8 months pregnant) they had good reason. Equally, there appears no reason to disbelieve Dr Barron. There seems no reason why he should not tell Mr Anderson the correct diagnosis as was his usual practice. His position that he did so is also supported by the practice nurse who spoke two days later to Mr Anderson when she specifically recalls he said he had swine flu. However, for the purposes of this FAI the conflict in versions of events is not necessarily an issue that requires resolution. It is accepted by all parties that in such circumstances a doctor should tell a patient his diagnosis. This is to assist the patient's own self-management of the condition and also to enable him to minimise risk to others, especially vulnerable relatives.

Mr Robertson thought that whatever version was accepted, there seems to have been scope for misunderstanding re both diagnosis and advice, matters which the medical notes available cannot resolve. It was reasonable and inevitable that doctors need to rely on notes for recollection, and as a consequence it must therefore be accepted that their medical notes should be sufficient to allow issues and decisions to be reviewed.

He went on to argue that unless a patient has proper understanding of the risk/condition they face, they are less likely to be able to properly manage their condition. Even if a patient is a health professional, doctors should not treat them differently and assume they will act appropriately when ill. It is important to ensure clarity of communication in diagnosis and advice.

He further argued that it was unreasonable to only provide the information as 'routine' without fully considering the most appropriate course of action relevant to the specific needs of the individual patient. Patient involvement in their decision-making in line with the modern ethos of the NHS that personal involvement in one's own care is beneficial. 'Empowering' patients is recognised as likely to encourage better management of their condition. Proper advice & guidance is crucial if self-management is to work.

The issue of good communication in management/advice of medical care is frequently seen as too obvious to mention, but Mr Robertson thought that it was worth re-emphasising in both the present cases.

Mr Robertson suggested possible prevention measures which could have been taken.

In both deaths, while there was a significant risk of fatality for either case due to the medical conditions, there did exist a possibility that intervention might have provided assistance which might have diagnosed or treated the illness resulting in death. Accordingly either or both deaths might have been avoided. Had either deceased attended at hospital prior to their death, medical treatments were available and possibly death could have been avoided. Possible measures likely to have been of value in identifying or treating the medical problems here would have been x-ray, treatment for respiratory problems (ventilation, oxygen) or hydration (intravenous

fluids). It is true that either or both might nevertheless have died despite treatment. But it is well-established medical knowledge that the earlier the medical intervention, the better the prospect of a better outcome.

As regards the medical practice applied in the present cases, Mr Robertson suggested that failure to giver tailored advice as to what to do if no improvement in symptoms would result in a decision not being properly based on the treatment of a patient as an individual. He deals with this later.

Although not related to the cause of death, advice to take Ibuprofen was not appropriate for diarrhoea and vomiting and was likely to worsen the condition. This could be seen as indicative of a 'routine' approach to advice regarding common conditions rather than tailoring advice appropriate to the individual regarding possible complications or how to respond to worsening illness.

Mrs Winsborough was not prescribed anything and not given assistance despite difficulty in 'keeping down anything' for 4-5 days. There was clearly *persistent* vomiting. It was possible, and foreseeable, that she might soon suffer dehydration and require assistance in rehydration i.e. fluids intravenously. In contrast, Mr Anderson was prescribed antibiotics + anti-sickness medication. Mrs Winsborough was not prescribed anything, yet on one view could be seem to be more 'ill'. She seems to have had more persistent vomiting, and it is perhaps surprising that no intervention was made.

As regards anti-viral treatment, Tamiflu was the appropriate anti-viral medication for swine flu. It is most effective if administered within 48 hrs. National Guidelines in force at the time indicated it should be used in the first 48 hours of symptoms illness. Although subsequent research suggests that it may be beneficial as treatment after 48

hours, this is inconclusive. Mr Anderson was well beyond 48 hrs when seen by Dr Alcock or Dr Carson and Mr Robertson made no submissions on this issue.

As regards medical records, Mr Robertson thought it reasonable that doctors will require to rely on their own and others' medical notes, both for recollection and for proper medical care/review. He felt that there should be proper records kept so that another medical person would be able to assess any change or deterioration in condition rather than simply relying upon an ill patient's impression.

As regards the families' views, the views of Mrs Winsborough's family were that if she had been provided with better information she or they might have been prompted to take action which might have avoided her death.

The views of Mr Anderson's family were that had he been provided with better information, this might have prompted him or them to take action which might have avoided his death.

In both cases, especially for Mr Anderson, there was a reluctance to return for medical help because they did not see any point in it. Such reluctance might have resulted from a lack of clear guidance on this from doctors. Mr Robertson thought that such reluctance could well be overcome by clarity rather than vagueness in medical guidance.

Mr Robertson considered that the position of both families is entirely understandable and in keeping with public expectations of good medical care. Both families can rightly say the public could reasonably have expected more specific guidance to be given. If so, the possibility exists that the deceased might have survived. The likelihood of survival might properly be said to fall somewhere between speculation and a real possibility, but the extent of possibility cannot be quantified.

Mr Robertson argued that it is common practice and reasonably practicable for doctors to deal with patients in way which encourages them to seek further medical help when required. This is achievable by good communication he thought that the approach to medical advice should be *proactive*. Health boards and professional medical bodies should consider having an appropriate system in place to address this and ensure that proper, clear and timed information is given under s.6(1)(d).

While the exercise of clinical judgment is a matter for individual doctors, the principle of providing a patient with an outline of what he/she can *expect* appears sound and in keeping with good practice. This helps to anticipate and reduce the risk of potential problems. Society in general, and the NHS in particular, have in recent years moved towards involving patients in decision-making and 'empowerment' in relation to their own care. Informing gives opportunity to take preventive measures. Decisions on these issues must appropriately involve the patient and their family and vague directions hinder this. Patients and their families/carers should not feel 'there is no point' in seeking further medical help if required.

The issue for medical professionals should be how, not whether, to give information. The need for scope in clinical discretion should not cloud the need for clear guidance, nor should it let routine vagueness replace the importance of individual care.

On Dr Carson's version, Mrs Winsborough had high temperature, low blood pressure and persistent vomiting. She was told by Dr Carson to see her GP if she had 'further problems'. Some patients do consult doctors unnecessarily for minor matters, but this emphasises the need for appropriate guidance to encourage patient to feel free to return. Or perhaps more accurately *to ensure they do not feel discouraged from doing so.* It is recognised that many patients are reluctant to return for medical help even where it is necessary. Mr Robertson believed that there was an onus which fell on the

medical profession to ensure that patients receive assistance in advice as to the likely progress of their condition and what to expect. He did not think that advice need be overly detailed, but it is unhelpful to routinely issue vague guidance without proper attention to the need for *vigilance* in self-management of illness.

As regards s.6(1)(d) of the Act ,defects in system of working, while text messaging is now regularly used by medical practices for reminders to patients regarding appointments, there is no evidence to indicate this would be effective or a justifiable use of resources, nor does it seem practicable to monitor. Mr Robertson did not recommend any practicable precaution which might be reasonably capable of addressing this.

Mr Robertson suggested that, in the case of Mrs Winsborough, had there been an oximeter test carried out to check her oxygen saturation level, it might have detected a respiratory problem meriting further medical investigations or hospital admission. While the machine in Mrs Winsborough's cubicle was not working, similar machines were available and it would have been reasonably practicable to use one of them to do such a test. In making this suggestion, he accepts that it is unclear when the respiratory problems developed and it seems unlikely it would have identified them, but there is a possibility, albeit perhaps remote, that it might have done so.

As regards the medical records, Mr Robertson thought that, in the case of Mrs Winsborough, Dr Alcock's notes are extremely brief and of little assistance in subsequent review and Dr Carson's notes are vague on some matters, especially the question of if and when to return. In the case of Mr Anderson, Dr Barron's notes are vague on the question of if and when to return.

The medical notes made by all 3 doctors are not fully adequate to address questions legitimately raised by the families (irrespective of the substance of the questions).

As regards medical advice, Mr Robertson thought that medical authorities should take note that it appears that some deaths might be avoided by appropriate medical advice (as outlined above)

As regards other medical facts, under s.6(1)(e), Mr Robertson said that it is arguable whether the measures which can be taken might be viewed as more appropriate to fall under the heading of s.6(1)(e) rather than under 6(1)(c) or (d). On the basis that the precautions are reasonable and that there is a possibility they might have led to death being avoided, consideration under (c) or (d) is relevant.

The matters are fully covered in discussion above under s.6(1)(c) due to overlapping of arguments. If the possibility is deemed not to be too remote to be considered a live one to be appropriate under s.6(1)(c) or (d), Mr Roberson argued that these matters should be included under s.6(1)(e).

In conclusion, Mr Robertson stated that the deaths of Mrs Winsborough and Mr Anderson illustrate that deaths can occur rapidly and unexpectedly even for otherwise healthy individuals. Both pneumonia and swine flu can have fatal consequences, but both can be treated. It is indisputable that the earlier treatment is started on an illness, the better the prospects are for survival.

This can occur in circumstances when there is a high risk of mortality even if medical assistance could be available. Reasonably practicable steps can be taken to reduce the risk of a similar event happening to others i.e. there are lessons to be learned. The public interest would expect steps to be taken to reduce foreseeable risks of a death recurring, whether the precise mechanism of death is understood or not. Such reductions in risks are live possibilities.

Mr Robertson submitted that the question for this FAI is not whether any doctor was to blame but whether there are there reasonably practicable steps by which the deaths might have been avoided and then to ask further the question whether other deaths might be avoided.

In practice, a balance requires to be drawn between a) the fact that the vast majority of patients presenting with the symptoms shown by the two deceased are likely to recover within a few days at home and b) steps and processes are required and should exist to properly identify cases where a more serious condition is present but initially presents with similar symptoms. The risk of future deaths, even if not common, is not one that can be ignored simply because the vast majority of people recover will little or no intervention. The balance shows that reasonably practicable measures do exist which indicate that some deaths in the future might be avoidable.

Mr Robertson argued that an understanding of the precise mechanism of death is immaterial. Even if we cannot say which deaths are avoidable and which are not, a proactive approach to patients understanding and being encouraged to return for medical help when required is likely to prevent some deaths. It is unwise to assume that all 'typical' cases (e.g. Diarrhoea and Vomiting or perceived viral illness) will resolve and self-limit. Nor can it be assumed that all patients, even health professionals, will correctly identify the right time when their condition requires further medical help.

SUBMISSIONS FOR RODGER WINSBOROUGH AND FAMILY.

Mr Olson stated that Mr Winsborough's hope is that as a result of this Inquiry lessons can be learned that may prevent a similar tragedy from happening in the future. The

Inquiry has enabled Mr Winsborough to hear from the main persons that were involved in the circumstances leading up to Mrs Winsborough's death and to hear evidence about what caused Mrs Winsborough's death.

Inevitably the evidence has left some questions unanswered and some matters unclear, and Mr Winsborough accepts that the Inquiry's purpose is not to try and resolve all of the conflicts of evidence or to try and fill in any gaps in the evidence.

Mr Olson stated that what the evidence has shown is that Mrs Winsborough died from suppurating pneumonia of both lungs. It seems probable that the pneumonia was caused by Group B streptococci. The medical evidence does not explain why the Group B streptococci pneumonia was triggered – whether caused by some other illness such as gastroenteritis or influenza (although it seems clear if Mrs Winsborough was suffering from influenza it was not swine flu), or by simply the Group B streptococcus by itself. It was not clear whether the course of the Group B streptococcus infection was masked by something else, for example gastroenteritis or an influenza like infection. Mr Olson deals with the evidence of this later in his submissions.

Mr Olson stated that Mr Winsborough believes that the following lessons can be learned and that I should make findings and recommendations under section 6(1) (e) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:-

First – there should be greater awareness that a person who has symptoms of diarrhoea and vomiting can, in exceptional circumstances, become seriously ill and can die.

Mrs Winsborough did not think that she was seriously ill and that she might die, she hoped that she would get better. Mr Winsborough did not know that his wife might be seriously ill and that she might die. If he had known that he would have made sure

that she had sought medical help on the Wednesday or the Thursday. He was going to take Mrs Winsborough to a doctor if she had not improved by the time he got back from work on Friday evening. Unfortunately it turned out that was too late. Mr Winsborough does not believe that they were alone in not knowing about the risks.

The risks are of course known by the medical profession. It is clear from the evidence of all of the doctors that patients who present with diarrhoea and vomiting normally get better within a week. If a patient is not getting better by about 5 days then even if this is being caused by a relatively harmless virus or bacteria, a doctor would be alert to the possibility of the patient becoming dehydrated and other complications, and would be concerned that the patient had a more serious underlying condition that needed further investigation and treatment.

The lesson to be learned from Mrs Winsborough's death is it is important that the patient should know the risk as well. If the patient does not, then if the patient is stoical, is reluctant to trouble her doctor (as Mrs Winsborough was), the patient may try to soldier on in the hope that it will get better because "it is only a virus" with tragic consequences.

Mr Olson submitted that it is not enough for a patient to be told "come back if you are no better in 24 hours" unless the patient understands that there is a reason why the patient should come back. The patient should understand that if she is not getting better in 24 hours that is a matter which would worry her doctor. If no reason is given a patient may think after 24 hours – "I will see if I feel better in the morning, I'll give it another 6,12,18,24 hours". The problem is the patient may, as in the case of Mrs Winsborough become seriously ill very quickly, and if she does not go to a doctor early enough it may be too late. In this case it is not possible to say that if Mrs Winsborough had gone back to see her general practitioner on the Wednesday that the

outcome would have been any different, for all we know the doctor might have reasonably have advised her to go home and come back in another 24 hours. All that we can say is that had she sought medical help on the Wednesday or the Thursday then the outcome might have been different, she might not have died.

Both Mr Nicol and Professor Wall spoke about the practicality of doctors in hospital and general practice giving information to their patients. Professor Wall spoke about the availability of information on the web which could be printed off at the touch of a button. The days of the paternalist doctor telling the patient to do something are long gone, and any modern doctor would hope that the patient participate in their care rather than being a passive recipient. This is something that the medical profession should be considering and reviewing practice.

In addition to the patient knowing, it is important that the public should be aware of the risks as well. If Mr Winsborough had been aware of the risk to his wife's health he would have taken her to see a doctor earlier. If patients are given more information when they go and see their doctor, this may be passed on to their family and friends, and the message will spread out. Mr Winsborough hopes that the holding of this Inquiry and the publicity from it will help to raise awareness. Mr Olson made what he thought was an appropriate comparison with meningitis. It is within general knowledge that a generation or so ago, 20 or 30 years ago, the risks of meningitis were not widely known among the general public. After a series of tragic cases, resulting publicity and campaigns to raise public awareness nowadays knowledge is much greater and a lot of people will have heard of the "tumbler test".

Mr Olson submitted that the important lesson to be learned was that Mrs Winsborough's death did not happen because she didn't want to cooperate with her

doctors or that she decided to run a risk of becoming seriously ill. Mrs Winsborough did not know that she was at risk of becoming seriously ill.

Second - doctors should keep adequate records of consultations with patients which should on occasions include advice to patients:-

"Started D & V on Fri → "wabbit" → sample to lab" on p.203

was not an adequate record. Mr Olson referred to Professor Wall's opinion that it is no excuse that a doctor may have very poor keyboard skills.

The importance of proper record keeping is self-evident – it is important in the care of the patient – if a doctor had seen Mrs Winsborough on the Wednesday or Thursday any doctor looking at that entry would have not got any help from that entry in knowing what Mrs Winsborough's condition was on the Tuesday.

If something unexpected occurs, one may require to work out the progress of a disease or condition from historical records and know what was or was not done.

The other aspect of adequacy of records is the accuracy or possibly precision of those records. In this case if we assume that Dr Carson's record in the A&E notes is accurate at p.25 where it is stated "3) see GP if further problems", if by that he meant "see your GP if you do not get better", that is not what the record says.

It may be that common shorthand used by doctors is "come back if you have any problems". Mr Olson submitted that doctors should be precise about advice so that there is no room for ambiguity and in appropriate circumstances should include a time limit e.g. "if you are not better in 24 hours come back and see a doctor"

Third - Patients should be triaged when they are admitted to Accident and Emergency.

It is clear with the benefit of hindsight that if Mrs Winsborough had been triaged, if her blood pressure, oxygen levels pulse, etc had been taken before she had been seen by Dr Carson then the snapshot picture of her condition at that time would have been clearer. Assuming that the oximeter was not working properly when Dr Carson tried to take a reading, if there had been a protocol for taking that reading as a matter of routine, someone might have gone and got another machine and obtained a reading. The picture would be much clearer.

The evidence.

Mr Winsborough knows what he was told by his wife. He knows what he was told by his friends and family. He has heard the evidence given to the Inquiry. Mr Winsborough believes, as he is justified in doing so, that Leanne Wallace, Andrew Wallace, John Mackie and Frances Easton, have told the truth to the Inquiry. Mr Winsborough accepts that in the absence of any medical evidence that Mrs Winsborough's death might have been avoided had something different been done on the Tuesday when she went to see Dr Alcock or Dr Carson, it is not part of my role in the Inquiry to decide which of the competing accounts is correct. Mr Olson went on to state that Mr Winsborough will always wonder if something could have been done differently and that he will never know.

In so far as Dr Alcock made what Mr Olson described as attacks upon Mrs Winsborough by describing her as a woman who was looking for a pill for every ill and in claiming that she was not good at cooperating with medical advice (cervical smears) and (in cross by Mr Wood) describing her behaviour as "a gross waste of medical time" in seeking to argue that her behaviour was the reason that she had not gone back to see a GP, Mr Winsborough believes that these attacks were unjustified- although Mrs Winsborough did not like going to the doctors her records show that she

was not the sort of person who bothered her doctor with every little complaint. She went to see Dr Alcock because she felt genuinely unwell. She went to see Dr Carson because she felt genuinely unwell. She may have hoped that Dr Alcock could have given her something that might have helped her feel better. Mr Olson suggested that everyone would wish for that. Those attacks have not done anything to reassure Mr Winsborough about how Dr Alcock cared for his wife on that Tuesday.

"Swine flu".

Dr Alcock, Dr Carson, Mr Nicol, Professor Wall and Dr Nawroz all gave evidence that swine flu was not the cause of Mrs Winsborough's death. Dr Toft gave evidence that he thought that swine flu was on the balance of probabilities the cause of Mrs Winsborough's pneumonia.

It is not, of course a matter of counting the number of witnesses in favour of each view.

Mr Olson referred me to a number of legal authorities, namely, ***McTear* v *Imperial Tobacco Ltd* 2005 2SC**, ***Lewis, Manual of the Law of Evidence in Scotland, Davie v Magistrates of Edinburgh 1953 SC 34, Wilkinson, The Scottish Law of Evidence, Dingley v Chief Constable, Strathclyde Police 2000 SC (HL) 77, 1998 SC 548.*** The gist of these authorities is that the court is not bound to follow opinions expressed by expert witnesses. Such witnesses do not usurp the judicial function of the court. The purpose of all this was to persuade me that Dr Toft's reasoning carried little weight. Dr Toft expressed a view that swine flu was likely given the timing (although in cross by Miss Davies he said it might have been another type of flu – 20% of cases were not swine flu). He had not bothered to identify when the first confirmed case of swine flu in the UK was. He simply thought it was in April 2009. He accepted that the first confirmed case was probably a honeymoon couple who arrived back in the UK from

Cancun on 21st April 2009. He accepted that the early cases were associated with contacts with Mexico. He asserted without basis that Dr Narwoz was wrong because the Group B Streptococcus must have been a contaminant. Dr Toft is not a pathologist. Dr Narwoz gave reasons why in his opinion it was not swine flu, namely the damage to the lungs demonstrated in the photographs. He said that given the rapidly developing knowledge about swine flu from a zero point and the limited number of autopsies it could not be said that the damage was determinative of swine flu but that it was associated with swine flu. His reasoning, together with that of Mr Nicol and Professor Wall (about timing) should be preferred.

In his conclusion, Mr Olson stated that the death of Mrs Winsborough has changed forever the lives of Rodger Winsborough and her family. Mr Winsborough hopes that her death may result in lessons being learned and changes being made that might prevent another tragedy.

SUBMISSIONS FOR THE ANDERSON FAMILY.

1. Section 6 (1) (c).

Miss McKerrow invited me to find in terms of section 6(1) (c) of the Act that there were reasonable precautions, whereby the death and any accident resulting in the death might have been avoided.

In doing so she submitted that I need only be satisfied that:

A) the reasonable precaution might have avoided the death.

B) The precaution was a reasonable one.

2. Burden of Proof.

It is the possibility of the death being avoided. The standard is that of a "lively possibility" and is a lesser standard than that of balance of probabilities

3. The reasonable precautions that might have avoided the death of Mr Anderson.

Dr Barron ought to have given clear instructions to Mr Anderson and to have checked that he understood:

a) the diagnosis

b) what he should do if his condition worsened.

4. Evidence in summary

In her submission, Miss McKerrow stated that Mr Anderson's death might have been avoided if the family had been aware that Mr Anderson had swine flu. They would have made Mr Anderson seek further medical help after he had been seen by Dr Barron when by the Saturday evening of 5 September 2009 his symptoms started to get worse.

She accepted that there is a possibility if they had sought further medical advice, at that stage, he would have been sent home as at that stage further medical advice may not have been required. However, the family having the knowledge that they were dealing with swine flu and the potential consequences, could have sought further medical assistance for Mr Anderson on any further deterioration.

This makes live the possibility that medical assistance at some point could have been provided which may have avoided the death.

4.1 Evidence led that death could have been prevented by earlier medical intervention.

Professor Toft, when asked about Mr Anderson's symptoms from Saturday 5th September 2009 after Mr Anderson saw Dr Barron to Monday 7th when his breathing became more rattly, said if the GP called at that stage Mr Anderson would have been admitted to hospital. Both Dr Hewitt and Professor Toft said that Mr Anderson would have had a better chance of survival if admitted earlier.

4.2 Communication of Diagnosis.

There is poor communication by Dr Barron in giving his diagnosis to Mr Anderson.

The evidence is consistent with there being a misunderstanding of what was diagnosed. It was up to Dr Barron to make sure that Mr Anderson understood what he was being told. Dr Barron's evidence is that he told Mr Anderson he had swine flu. The family's position is that Mr Anderson was told he had ordinary flu. There are two competing versions. Either Dr Barron is not telling the truth or the family is not telling the truth. She went on to suggest that it might be that Mr Anderson misunderstood what Dr Barron told him.

In her submission, a misunderstanding due to poor communication by Dr Barron is the more credible version and more consistent with the evidence given by Dr Barron and the Anderson family.

However, there is Susan Gallacher's evidence that Mr Anderson told her he had swine flu. It was submitted that the court should to reject her evidence in that respect and find Mrs Anderson's evidence more credible. Mrs Anderson was present when her husband spoke to Susan Gallagher on the phone and her evidence was that he did not say "swine flu".

Susan Gallagher had the medical notes up when she spoke to Mr Anderson on the phone. She is recalling a conversation she had with Mr Anderson on a day when she was also busy seeing a number of other patients as she was on triage. It is not until she learns of his death, a number of days later, that she refers to the note in the medical records and at that point tries to recall what was said.

It was submitted that it is more credible that she has taken the diagnosis of swine flu from the medical records passed from Dr Barron.

The court should not rely upon her evidence as it does not sit consistently with the more probable explanation that there was a misunderstanding between Mr Anderson and Dr Barron with regard to the diagnosis.

It was submitted that a misunderstanding seems the more credible version.

A) The Court was asked to consider the evidence if Mr Anderson was told and understood that he had swine flu.

Mr Anderson had been told by the NHS 24 call centre Dr that he probably had swine flu. His mood was low when he left the house. He was concerned about his pregnant daughter and wife who had cancer. If he had understood that Dr Barron was telling him he had swine flu, given his concerns for his wife and daughter, it seems incredible he would not have asked advice on what he should do to avoid putting them at risk. He made Dr Barron aware of his concerns in respect of his wife and daughter. Dr Barron said Mr Anderson did not ask for advice on this. It was submitted that he would have asked if told swine flu in light of his concerns.

It was incredible that he would go home and put his 8 month pregnant daughter and unborn grand child and wife at risk. He even slept in the same bed as his wife and told his pregnant daughter he can now cuddle her.

B) On the other hand, the Court was asked to consider the evidence if Mr Anderson misunderstood Dr Barron and was under the impression that he had ordinary flu.

If Mr Anderson misunderstood Dr Barron, thinking he had told him it was flu as opposed "swine flu", his concerns for his pregnant wife and daughter would have been alleviated. Therefore this would not have been something on which he would have sought the Dr Barron's advice. He was also aware he had been prescribed antibiotics. Mrs Anderson said that if he had been diagnosed with swine flu he was

expecting to get Tamiflu. His understanding of being diagnosed with ordinary flu was reinforced by being prescribed antibiotics and not Tamiflu.

When Mr Anderson attended Dr Barron he was unwell and his concentration and listening powers would be affected. This was supported by Professor's Toft's evidence and possibly that of Dr Hewitt.

It was a reasonable precaution for the Dr Barron to take to make sure that Mr Anderson understood what was being diagnosed. That misunderstanding could have been cleared up if Dr Barron had given Mr Anderson some advice on how to deal with going home to the same house as his pregnant daughter and sick wife. It was submitted that this would include advice to the extent of telling them to contact their own GPs.

Dr Hewitt's evidence was that he would have raised this issue. He would have told Mr Anderson that if his wife and daughter get any symptoms at all they should contact their GP. He said that it would be good practice to do this. If Dr Barron had followed good practice and done this, Mr Anderson would have been alerted to the fact he had swine flu and not ordinary flu. This would have been a further check on making sure Mr Anderson understood the diagnosis.

Dr Barron's position was that he would not give advice about that and it would only be when mother and daughter showed symptoms that they would get treated at that time. Mr Anderson would not have been alerted that he had swine flu.

Dr Barron can't recall if he gave any advice on how to deal with swine flu. He accepted Mr Anderson may not have seen the government information leaflet. He assumed that because Mr Anderson was a health care professional he would have better knowledge of that.

This was a dangerous assumption for a doctor to make. He should have given clear advice on hygiene and infection control.

The likelihood is that Dr Barron did not give any advice. Had he done so this would have been a further check that Mr Anderson had not understood the diagnosis.

5. What the Doctor should tell the patient.

It should be noted in the medical notes a time scale of return or if symptoms get worse, or don't improve. It is not certain that Dr Barron advised Mr Anderson of this. All he did was tick the "contact GP Box".

Miss McKerrow adopted the submissions of Mr Robertson in this respect.

6. Precaution a Reasonable one

Miss McKerrow submitted that there should be checks in place to make sure the patient understands the diagnosis and that he should seek further medical advice within a certain time scale or on his condition worsening or not improving.

7. Conclusion.

Miss McKerrow submitted that if I am not satisfied to make findings under section 6 (1) (c) of the Act and that the "possibility" is not a live one or too remote, then the foregoing facts are relevant to the circumstances of the death in terms of section 6(1) (e).

SUBMISSIONS ON BEHALF OF DR JAMES ALCOCK.

Mr Wood, who was concerned with Dr Alcock's involvement with Mrs Winsborough, took no issue with the suggested findings as to where and when her death occurred and the cause of the death under Section 6 (1)(a) and (b). He submitted that the evidence is insufficient to go further and determine what the cause of the pneumonia was. If the underlying cause of pneumonia is not known, the Court should be slow to

try to identify reasonable precautions which might have prevented Mrs Winsborough's death.

Section 6(1)(c).

He submitted that there should be no finding under s.6 (1)(c).He noted that the submissions on behalf of the Winsborough family do not seek finding under Section 6 (1) (c) or (d) but only subsection (e). While "might" in the subsection is less than probable, the possibility must be "lively" and more than speculative. To be relevant a precaution must be both reasonable and must have some causal connection with the death. A precaution is not reasonable just because the Crown in submission so asserts, or even if it appears to the Crown or indeed the court to be common sense, but only if the evidence allows of that conclusion.

He referred to Mr Robertson's assertion that there does exist a possibility that intervention might have provided assistance which might have diagnosed or treated the illness resulting in death, had either deceased attended hospital. Mr Wood submitted that a precaution does not become "reasonable" just because had it been taken the outcome would differ. It is reasonable only if the evidence shows, even with the benefit of hindsight, that it would have been taken by those charged with the patient's care at that time.

Prof Toft cannot say whether either would have survived if admitted earlier. He states that the earlier the treatment, the better the chance of survival, but accepts no justification for admission as at Tuesday 14th as dehydration would have been the only reason and Dr Carson excluded this by checking pulse, BP, looking in mouth and using a CRT test.

If the evidence of Dr Alcock as to his examination is accepted, as Mr Wood submitted it should be, there is no evidence whatsoever to justify a finding that it would have been a reasonable precaution for him to admit Mrs Winsborough to hospital. The Crown asserts that hospital admission would have been reasonable but makes no adverse comment on the examinations of Drs Alcock and Carson which were supported by the Crown expert, Dr Toft, and the family's two experts Dr Nichol and Prof Wall.

He submitted that the basis of the Crown criticism seems to be no more than increased prospect of earlier discovery of pneumonia – despite fact it was not apparent that Mrs Winsborough had pneumonia. He submitted that the Court cannot determine that admission was a reasonable precaution when anyone who is ill, and might however rarely die from that illness, or from a supervening and even rarer condition, should be admitted simply because they will be more closely monitored. As there is no evidence as to when and by whom such admission should be made and that it was reasonable at the time, no finding should be made. It is illogical and contradictory to have conclusion that Drs Alcock/Carson acted in accordance with accepted standards and that they were correct not to admit, but that nonetheless admission was a reasonable precaution because it might have prevented the death. This would risk innumerable precautionary admissions which makes it unreasonable.

It is not clear whether the assertion that medical authorities should take note that some deaths might be avoided by appropriate medical advice is inviting the Court to make a finding under s6 (1) (c) but if so Mr Robertson should specify what advice should be. His failure to do so merely underlines the difficulties involved.

It is not clear whether Dr Alcock's advice "if it didn't improve within 24 hours she should come back" is being criticised. Mr Wood submitted that it was better to allow

the doctor to give such advice as in his experience of the individual patient is appropriate.

In any event to make a finding regarding advice the Court would have to be satisfied the patient "might" have acted differently had the advice been in (as yet unspecified) different terms. In the case of Mrs Winsborough the evidence suggested that she would not have acted differently. Mr Winsborough spoke of her being not keen on troubling doctors. That is confirmed by examination of GP notes which contain frequent (possibly 38) instances of failures to appear primarily in respect of taking cervical smears. The risk being run by her was that of cervical cancer. In addition she did not act on or even mention to her husband the request for a stool sample, which had she done "might" have allowed further medical review.

Mr Wood submitted that if the Court is minded to make finding under Section 6 (1) (c) it should determine that: "it would have been a reasonable precaution for the deceased to have followed the advice given to her by Dr Alcock to return to her General Practitioner if her symptoms did not improve in 24 hours, and that had she done so her death might have been avoided"

Mrs Winsborough's was primarily responsible for her own health and this should not be delegated. The advice given by Dr Alcock was clear and reinforced by Dr Carson. Any increase in dehydration by Wednesday afternoon or Thursday morning might have been apparent.

As regards Dr Alcock's examination, Mr Wood emphasised Dr Alcock's qualifications and experience. He is subject to annual appraisal. His practice was to go out and meet with the patient from the waiting room which he did in Mrs Winsborough's case. She walked past him quickly and kept up conversation with

him. She did not report any breathlessness, sore throat or dizziness. She told Dr Alcock that she was into her fourth day of having Diarrhoea and Vomiting. She was vomiting regularly. She had difficulty keeping any drink down. She complained of pain in her tummy and felt "wabbit". She did not mention her call to NHS24 or the advice given regarding intimate piercing.

Dr Alcock found no focal tenderness, guarding or rebound in her abdomen. The bowel sounds were consistent with gastro-enteritis. Her mouth, skin and lips were normal as was her pulse. Her skin tone was normal and not pale.

His diagnosis was that Mrs Winsborough was suffering from gastroenteritis. There was no sign or symptoms of pneumonia. She was not dehydrated and he would only have admitted her to hospital had she been significantly dehydrated. On reflection he gave evidence that he would not have done anything differently.

He advised Mrs Winsborough to restrict her fluid intake to teaspoonfuls of 10-15 mls. He told her that if her fluid intake did not improve within 24 hours she should return to the surgery. He gave her a stool sample bottle and return instructions. He did not recommend the use of paracetamol or ibuprofen.

Mr Wood submitted that Dr Alcock's evidence should be accepted as credible and reliable as there was no reason for him not telling the truth. His evidence was supported by his contemporaneous notes which Mr Wood admitted were brief and by PC Dargie who found the empty sample bottle. His diagnosis was also supported by Dr Carson.

The evidence from Mrs Winsborough's family is less reliable and in some parts incredible. No one else was present at Dr Alcock's examination of Mrs Winsborough. Mr Winsborough spoke of his wife not looking well from Saturday onwards, breathless on Saturday, and said he noticed her "pausing" as she spoke in subsequent

days. Frances Easton said no more than Mrs Winsborough looked awful and was slow in speech. Mrs Wallace said Mrs Winsborough had blue lips, yellow eyes and was gasping for breath. Frances Easton did not notice anything about her breathing. The family and friends account of Mrs Winsborough was inconsistent. They maintain that Mrs Winsborough was prescribed paracetamol/ibuprofen. They are unaware of the stool sample bottle. they are unaware of the advice to return if not better. The evidence of Dr Nichol established that all of the symptoms noticed by her family except one were not inconsistent with the doctors' findings. She was flushed and red with blue lips and yellow eyes. There was dizziness, hallucination and blurred vision. the only inconsistent finding is breathlessness but both Dr Alcock and Dr Carson are confident it was not exhibited to them.

Section 6 (1) (d).

Mr Wood submitted that as regards Section 6 (1) (d) there should be no finding. There required to be a causal connection for such finding he submitted. While he accepted as stated above that Dr Alcock's note is brief, it is clear that no one read or relied on the note in any subsequent management of Mrs Winsborough. The note did not contribute to her death. Even if Dr Alcock had written a verbatim account of his examination, the outcome would have been the same. Mr Wood did accept that notes of consultation/examination should be in accordance with General Medical Council advice as indicated by Dr Nichol. Any comment on this should be within Section 6 (1) (e).

Section 6 (1) (e).

As regards any other facts relevant to the circumstances of the death, Mr Wood submitted that the Court should make no finding under this head either. He said that, in particular, this section should not be used, as the Crown seeks, as a repository for

"failed" findings under Section 6 (1) (c) or (d). If the statutory test in those subsections has not been met then the Court should not allow there reintroduction by the back door. The subsection is appropriate for ancillary matters. An example he gave was the Lockerbie FAI where issues relating to the funeral arrangements were raised by the families of the deceased.

SUBMISSIONS ON BEHALF OF DR DAVID CARSON.

Mr Paterson confirmed the findings as to where, when Mrs Winsborough's death took place and the cause of her death under Section 6 (1)(a) and (b).

Section 6(1)(c).

Mr Paterson submitted that there should be no finding under this head.

Legal Issues.

It is well settled that a FAI is not a proper forum for determination of questions of criminal or civil liability, ***Black v Scott Lithgow Ltd 1990 SLT 612***. The Court should proceed on the basis of the evidence adduced before the Inquiry and is entitled to apply the wisdom of hindsight in reaching his determination. He referred to ***Chapter 1 of the Determination by Sheriff Principal Brian Lockhart in the FAI concerning deaths at Rosepark Care Home.***

Expert evidence regarding Dr Carson.

The Winsborough family's expert, Mr Neil Nichol, consultant in A&E medicine, considers that Dr Carson took an appropriate history and performed a detailed and appropriate examination. Mr Nichol considers that Dr Carson's conclusion was sound

and his management plan appropriate. Contrary to the Crown's submissions, there was:

a. no evidence criticising Dr Carson's note; and

b. no evidence that Mrs Winsborough was treated casually or routinely.

Dr Toft considers that Dr Carson's clinical record is of a good standard and neither the diagnosis nor the management is open to significant criticism. Dr Toft was asked what he meant by "significant". He replied that one can always criticise the management. However, he offered no criticism of Dr Carson in his evidence.

Mr Paterson submitted that any finding in terms of s6 would be made with the benefit of hindsight, and not on the basis of what Dr Carson could or should have done at the time.

Mrs Winsborough's presenting features at QMH A&E.

Mr Winsborough was at work on Tuesday 14th April. He spoke to Mrs Winsborough on the phone. She was pausing but making sense. Mr Winsborough relies upon a narrative from Lee-Anne Wallace. However, it is noteworthy that he described his wife getting worse after Tuesday. He said that on the Tuesday 16th April her face was pale, white in colour, lips pale and on Thursday 18th her lips had a tinge of blue.

Dr Alcock looked in Mrs Winsborough's mouth. He found her skin tone and pulse normal. No breathing difficulties were reported or observed. Dr Alcock said Mrs Winsborough was quite talkative and she did not report shortness of breath. He was not told about her attendance at NHS 24.

Frances Easton saw Mrs Winsborough in the Tuesday morning before noon. She described her as very pale. She made no comment about blue lips and did not notice anything about Mrs Winsborough's breathing.

Lee-Anne Wallace gave evidence that on the Tuesday Mrs Winsborough was short of breath, gasping, and kept trying to get her breath / couldn't breathe. Mrs Wallace said Mrs Winsborough's lips were blue, like bruised, and she had a coating over eyes, which was yellow. Mrs Winsborough was sick ten times while in hospital; there was no blood in her sick; but when Dr Carson tried to check her throat she was sick; Dr Carson could not have seen in her mouth. Mrs Wallace said that the BP machine was not working and was emphatic that Dr Carson did not take a BP reading. Mrs Wallace said Dr Carson did not examine Mrs Winsborough's chest and did not use stethoscope. Mrs Wallace said Mrs Winsborough told Dr Carson that she could not breathe, had been hallucinating, was dizzy with blurred eyesight and could not drive her car. Mrs Wallace said she did not see Mrs Winsborough again until the Friday.

Mr Paterson submitted that the critical issues are presentation with breathing problems, blue lips (cyanosis), and to a lesser extent the hallucinations. None was noted/found by Dr Alcock or Dr Carson. Nor were those issues noted on the Tuesday, by Mr Winsborough or Mrs Easton. Those witnesses, in my respectful submission, gave their evidence in a dignified and careful manner.

Mrs Wallace's recollection was also inconsistent with her police statement. When confronted with the inconsistencies Mrs Wallace stated it was two years down line while the police had interviewed her the day after Mrs Winsborough's death, when her memory was fresh. Her evidence was inconsistent with Dr Carson's note – BP and chest, heart and bowel sounds are all noted. All would require a stethoscope. It was inconsistent with his recollection of her being hot and flushed and red. Mr Paterson submitted that Dr Carson gave evidence in a studied and measured manner. The Court should have no hesitation in finding him reliable and credible.

Dr Carson told the court that he would not have plucked a BP reading "out of the air", and would have noted breathlessness, cyanosis, hallucination and followed those up. Had Mrs Winsborough been complaining about her breathing, Dr Carson would have noted that as a presenting complaint.

Indeed, the only evidence consistent with Mrs Wallace's is Mr Wallace's evidence. He does not know whether his wife influenced what he remembers.

Mr Paterson submitted that for all of those reasons, the Court should reject as unreliable Mr & Mrs Wallace's evidence insofar as Mrs Wallace's presentation at QMH A&E.

Response to the Crown's submission re reasonable precautions.

Mr Paterson submitted that the Crown's submissions in relation to s6(1)(c) were manifestly flawed for the following reasons:

a. There was no reference to the terms of the sub-section;
b. There was no articulation of the reasonable precaution or precautions desiderated.
c. There was no reference to the expert evidence before the Inquiry either in relation to the precaution desiderated or its reasonableness.

The Crown's submission, aims to rectify what the Crown perceived as gaps in the medical notes. The criticised omissions focus on those notes that, in a perfect world, would resolve every evidential riddle that might present itself further down the line. Mr Paterson submitted that there is no place for such criticism in terms of section 6.

The advice given to Mrs Winsborough by Dr Carson.

a. Factual evidence.

Dr Carson gave evidence that his note "See GP if further problems" indicated that he gave advice to Mrs Winsborough that if she deteriorated she should seek further help. That advice would be given as standard. Dr Carson explained he would be concerned about her level of dehydration so would suggest if the problems continued for the next day or two, she should seek some help. That is Dr Carson's interpretation from notes and what he would say normally. He did not give evidence, as submitted by the Crown, that Mrs Winsborough was told to see her GP if she had further problems. Dr Carson's evidence on that issue is unchallenged. He said he would give that advice without fail. Part of the advice would be that A&E was not the best forum for Mrs Winsborough and it would be best to see her GP who would have access to all Mrs Winsborough's notes and background information.

Notably, because of his experience of Mrs Winsborough's death, Dr Carson now likes to see patients 24 hours later, regardless of their condition.

b. Opinion.

Mr Nichol opined that ideally any patient who has an abnormal physiology i.e. raised BP and pulse, should be reviewed by a senior doctor prior to discharge. He did not think that would have made any difference in Mrs Winsborough's case though the discharge advice might have been more prescriptive, to the effect that if not feeling better within 24/48 hours Mrs Winsborough should see her GP. Mr Nichol felt 48 hours was a reasonable time limit. Professor Wall felt 24-48 hours were reasonable and Dr Toft agreed 24 hours were reasonable. Mr Paterson questioned in what way is Mr Nichol's approach different to the advice Dr Carson gave.

c. To what extent is fixing a timeframe reasonable?

Mr Paterson submitted that must depend upon the clinical presentation and condition and Dr Hewitt's evidence is of assistance. He opined that general advice is sensible.

Otherwise one risks the advice being too prescriptive in circumstances where the doctor may not know how the patient's condition will develop. Equally, recovery timescales will depend upon the particular patient. Hence Dr Hewitt explained that if one makes the timescale short, one sees lots of patients unnecessarily. In his opinion, the advice ought to be couched in clinical terms rather than timescales. Mr Paterson submitted that opinion is pertinent to the particular circumstances of Mrs Winsborough's death where Strep B infection might have been present but could not be known to the doctor.

d. Causation.

Mr Paterson submitted that even if the Court considers any there was any advice which, with the benefit of hindsight, could reasonably have been given to Mrs Winsborough, it should slow to find any link to her death, in terms of section 6(1)(c). There was no evidence from which one may infer that advice would have been followed. Mr Paterson submitted that the opposite is true:

(i) Mrs Winsborough did not mention NHS 24 to Drs Alcock or Carson

(ii) Dr Alcock's advice was not followed

   a. to return if not better within 24 hours – 2/11

   b. to provide a stool sample

(iii) There is no evidence that Dr Carson's advice was followed

   a. to seek help

   b. to take paracetamol and ibuprofen

(iv) On the contrary, the Inquiry heard evidence that Mrs Winsborough took her father's prescribed anti-emetic.

(v) She did not follow advice and attempted to deal with matters herself. Mr Winsborough's evidence was that his wife not someone who liked to go back to hospital, even if not well.

Mr Paterson submitted that if it is considered that any additional advice could, with the benefit of hindsight, reasonably have been provided to Mrs Winsborough, a finding to that effect ought to fall within s.6(1)(e).

Section 6 (1) (d).

Mr Paterson submitted that no such defect was identified in the course of evidence before Inquiry. The Crown's submission in relation to the subsection is again flawed. It fails to address the wording of the Act. Moreover, in relation to the oximeter, the Crown's submission does not address the expert evidence: Mr Nichol gave evidence that the reading would probably have been normal. Dr Toft thought it was of no great significance, in view of the clinical findings. There was no expert evidence that an oximeter reading ought to have been taken.

Section 6 (1) (e).

Mr Paterson referred to his submission, in context of that made in respect of 6(1) (c), insofar as the Crown's submissions are concerned.

Mr Olson's submissions suggest that the patient should "know the risk". However, there are practical problems in the context of Mrs Winsborough's death. Dr Hewitt explained that the doctor may not know how the patient's condition will develop. In the particular circumstances of Mrs Winsborough's death Strep B infection might have been present but could not be known to the doctor. Indeed, it might have been "masquerading" as something else. Dr Nawroz was able to provide only improbable possibilities of how the infection entered into the bloodstream. In short, Mrs

Winsborough's death was extremely unusual and unpredictable. There were no indicators to look out for; the doctors who saw her would not have suspected Septicaemia. Accordingly, Mr Paterson submitted that Mr Olson's analogy with the "tumbler test" does not work.

SUBMISSIONS ON BEHALF OF DR JOHN BARRON REGARDING MR ANDERSON'S DEATH.

Mr Paterson submitted that the Court ought to make no more than formal findings in terms of section 6(1) (a) and (b) of the Act.

He confirmed the findings as to when and where Mr Anderson's death occurred and the cause of death under Section 6 (1) (a) and (b).

Section 6 (1) (c).

Mr Paterson submitted that there were no reasonable precautions which, had they been taken, would have avoided Mr Anderson's death.

a. Expert Comment on Dr Barron.

Dr Hewitt, the only expert GP to give evidence in relation to Mr Anderson's death, testified that Dr Barron carried out a very full and thorough examination, acted consistently with the advice available to GPs at the time, and acted appropriately both in regard to the treatment and advice given. Again, contrary to the Crown's submissions, there was:

a. no evidence criticising Dr Barron's note (Dr Hewitt thought ideally the advice would have been noted but as the advice becomes second nature GPs do not record it); and

b. no evidence that Mr Anderson was treated casually or routinely.

Mr Paterson submitted that any finding in terms of section 6 would be made with the benefit of hindsight, and not on the basis of what Dr Barron could or should have done at the time.

b. Whether Dr Barron advised Mr Anderson of the diagnosis of probable swine flu.

The evidence.

Although Mr Anderson told his family that he did not have swine flu, Dr Barron spoke to his clinical note which reads "Probable H1N1 Flu".

Dr Barron cannot remember the consultation but believes he would have told Mr Anderson the diagnosis. The diagnosis is noted and Dr Barron gave evidence that he normally tells people what their diagnosis is. Dr Barron gave evidence that he has told everyone he saw with swine flu that they have swine. In Mr Anderson's case all his symptoms pointed to it together with the pandemic and time of year.

Mr Paterson submitted that it is important to have regard to the fact that the consultation took place against the background that Mr Anderson, a nurse, was sure he had swine flu and NHS 24 agreed with him that he had all the symptoms of swine flu.

Nurse Susan Gallacher gave evidence that on Monday 7 September Mr Anderson called her at Bennochy Medical Practice. He told her Dr Barron had told him it was likely to be swine flu. She was 100% sure of that.

Against that evidence, Mr Paterson submitted that the Court ought to find on the balance of probability that Dr Barron told Mr Anderson he probably had swine flu.

Ms McKerrow's submitted that had Mr Anderson known and understood that he had swine flu, it seems incredible that he did not ask for advice. Dr Barron gave evidence that he could not recall whether he gave advice to Mr Anderson regarding his wife and pregnant daughter. That evidence has a logical authenticity: Dr Barron can recall nothing about the consultation. However, Dr Barron thought that if he had given that advice, he might have mentioned it in his notes.

Contrary to Ms McKerrow's submission, Dr Barron did not give evidence that he would not have provided such advice. Indeed, Dr Barron said that he would have recommended that Mr Anderson's wife and daughter should wait to see if any signs or symptoms developed.

In any event, there was no articulation of the reasonable precaution or precautions desiderated.

c. The advice given to Mr Anderson by Dr Barron

Dr Barron gave evidence that he asked Mr Anderson to contact his GP to provide a progress report. Dr Barron (electronically) ticked the relevant part of the NHS 24 note to that effect. He gave evidence that he would have asked Mr Anderson to call back if he was not keeping his medication down. He hoped he would have told Mr Anderson to call back if his symptoms were worsening or if he was short of breath. That is his usual practice.

Mr Paterson referred to his submissions on this issue in respect of Mrs Winsborough. Mr Paterson submitted that they are equally applicable here. On Dr Barron's evidence he did not state a timescale within which Mr Anderson should return. Nevertheless, Mr Paterson referred to Dr Hewitt's evidence that he would be content with advice that if not getting better or feeling worse, the patient should call back, as

long as the patient was not staying on his own. Mr Paterson submitted that Dr Barron did, in practical terms, provide a timescale. He told Mr Anderson to call back if his symptoms were worsening or if he was short of breath. His only option was to call NHS 24 until his GP surgery opened on the Monday morning, a period of around 36 hours. Further, Mr Anderson contacted his GP surgery and told Nurse Gallacher that he was feeling better.

In summary:

(a) there is no articulation of the advice desiderated by the Crown/Ms McKerrow

(b) in any event we know that Mr Anderson contacted his GP 36 hours later to advise that he was feeling better

(c) there is no basis for a finding that any advice desiderated might have avoided the death

d. Whether Tamiflu might have prevented Anderson's death.

Dr Hewitt testified that Dr Barron acted consistently with the advice available to GPs at the time and treated Mr Anderson as Dr Hewitt would have expected. He noted that Mr Anderson had had flu symptoms for more than 48 hours and a chest infection was suspected. In his opinion, Mr Anderson was treated appropriately.

Drs Barron, Toft and Hewitt agreed in their evidence that at the time Mr Anderson presented to Dr Barron, the guidelines were such that treatment with Tamiflu was not indicated. Indeed, Drs Barron and Toft were agreed (as was Mr Nichol) that the guidelines indicated a benchmark of 48 hours. Dr Barron spoke to the Fife Health Board prescribing information dated Sept 2009 which states that treatment must start within 48 hours. Dr Hewitt, who spoke to the dozens of documents provided to GPs,

gave evidence that the general consensus was that Tamiflu was most effective if given within the first two days of symptoms.

On the other hand, Dr Toft spoke to a research paper which suggested there may be benefit in administering Tamiflu after 48 hours. Mr Paterson submitted that that falls to be excluded from the Court's consideration in terms of section 6(1)(c) for two reasons:

a. The Inquiry heard no evidence to the practicability of administering Tamiflu in such cases. Indeed, Dr Toft's suggestion was open-ended.

b. Dr Toft emphasised the word "may" and, indeed, suggested "hint" might be more appropriate. He conceded that "hint" was a good word and consistent with what is stated in his report, that there is not sufficient evidence to assess what efficacy, if any, Tamiflu would have had in Mr Anderson's case.

e. Whether admission to hospital on 5 September 2009 by Dr Barron might have prevented Mr Anderson's death.

Drs Toft and Hewitt agreed that, in terms of the Department of Health guidelines as at Sept 2009 Mr Anderson's condition was not such that he should have been admitted to hospital. However, in his evidence, Dr Toft asserted that, in retrospect, taking account of the annexes to his report, persistent vomiting and the suspected LRTI might indicate hospital admission. Mr Paterson submitted that there are a number of difficulties in accepting admission as a reasonable precaution that might have prevented the death.

(i) Dr Toft's expertise. He is not an expert GP. He is not an expert in infectious diseases. Though a physician, specialised in endocrinology with a particular interest in thyroid disease, he is not an expert in respiratory medicine and ARDS.

(ii) It was not clear that the published material referred to fell within Dr Toft's field of expertise. Mr Paterson referred to ***McTear v Imperial Tobacco 2005 2 SC 1 per L Nimmo Smith @ p 141 para 5.15-5.16***

"in the passages I have quoted there is repeated reference to the requirement that the published material must lie within the field of expertise of the witness. It therefore appears to me to be a question of fact to be decided on the evidence in a particular case whether or not published material which had been put to an expert witness did or did not lie within his field of expertise."

(iii)Annex B refers to patients being admitted if persistent vomiting. There was no note by Dr Barron or evidence that Mr Anderson had persistent vomiting.

(iv)Neither Annex refers to LRTI as indicator for admission.

(v) The annexes are dated September and December 2009 respectively. Mr Paterson submitted that the Inquiry has not had the benefit of an expert speaking to what has happened since.

(vi) In short, Dr Toft was not in a position to provide expert evidence and in my submission his opinion evidence ought to carry little weight. The court should be slow to rely upon bare *ipse dixit* no matter how eminent the physician. ***Davie v Magistrates of Edinburgh*** **1953 SC 34 per LP (Cooper) at 40.** ***Wilkinson, The Scottish Law of Evidence*****, 65 & 66.**

(vii) Moreover, there was no explanation or reasoning behind Dr Toft's opinion. He did not explain why one should be concerned with those symptoms. ***Dingley v Chief Constable Strathclyde Police*** **1998 SC 548 per LP (Rodger) @ 604.**

"But the fact that a particular view is widely held, without any persuasive explanation as to why it should be so held, and constitute a conclusion, does not appear to me to be a matter to which a court should give significant weight. Rather similarly, the fact that a particular view was or is held by someone of great distinction, whether he is a witness or not, does not seem to me to give any particular weight to his view, if the reasons for his coming to that view are unexplained, or unconvincing. As with judicial or

other opinions, what carries weight is the reasoning, not the conclusion."

(viii) The Court heard no evidence as to the reasonable practicability of such a precaution.

If the Court is not with him on those reasons, Mr Paterson submitted that there remains the issue of whether admission by Dr Barron might have avoided death. Dr Toft gave evidence that it was possible Mr Anderson would have survived if hospitalised earlier. The proper question for the Inquiry would be whether he might have survived if admitted by Dr Barron. The Inquiry heard no evidence on that. On the contrary, Dr Toft stated it was possible Mr Anderson would have had a chest x-ray and been sent home. Dr Hewitt thought it fairly likely Mr Anderson would have been sent home.

Section 6 (1) (d).

Mr Paterson submitted that this is principally a matter for Ms Davie. Nevertheless, he said that no such defect was identified in the course of evidence before Inquiry.

Section 6 (1) (e).

Mr Paterson submitted that there are no other facts relevant to the circumstances of the death.

SUBMISSIONS ON BEHALF OF FIFE HEALTH BOARD.

Miss Davie explained the law relation to a fatal accident inquiry. I was informed that such inquiry is not a proper forum for determination of questions of

criminal or civil liability. I was referred to ***Black v Scott Lithgow Ltd 1990 SLT 61***. The burden of proof is that of balance of probabilities recently stated by Sheriff Principal Dunlop in a Fatal Accident Inquiry into the death of ***Colin Marr, 2011 FAI 20***. The learned Sheriff Principal also stated that the court should only consider the evidence which has been led to reach a conclusion if it can in relation to the matters set out in section 6(1) of the Act .I was then taken on a trip around what was proposed in future legislation with the purpose, I assume, of advising me of the particular form my determination should take. She helpfully seems to suggest that I should approach the Judicial Studies Committee should I require further assistance.

Miss Davie then suggested findings under section 6 (1) of the Act relation to Mrs Winsborough:

(a) Where and when the death and any accident resulting in the death took place;

She confirmed my findings.

(b) The cause or causes of such death and any accident resulting in the death;

Bacterial pneumonia (Crown Production 1). Dr Nawroz gave evidence that the most likely bacteria was a streptococcal B bacteria isolated from the lungs at post mortem. If that was the agent then the route of infection would be inhalation or infection of the blood stream. Miss Davie suggested that the latter was the more likely cause.

Both Dr Nawroz and Mr Nichol gave evidence to the effect that it was unclear whether Mrs Winsborough's early symptoms were a result of the Strep B infection or whether it manifested later. As regards the suggestion from Dr Toft that the cause of death was swine flu, she adopted the submissions of Mr Olson in that regard.

(c) The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

Miss Davie submitted that there are no reasonable precautions whereby the death might have been avoided.

As regards the Medical presentation, she submitted that the evidence from Mr Winsborough, Frances Easton, John Mackie, Dr Alcock and Dr Carson regarding the symptoms displayed by Joanne Winsborough in the last week of her life is largely consistent. She was clearly unwell from the evening of Friday 10th April 2009. The presentation when she attended at the GP surgery and at A&E on Tuesday was that of a viral infection. Her condition deteriorated and tragically ended in her death on Friday 17th April 2009.

The symptoms and the timing of the symptoms accord with the evidence from Dr Nawroz regarding the possible progression of infection; from Dr Nichol that someone can be relatively well with a chest infection to needing incubation and ventilation within 6-8 hours; and from Dr Toft in his report that the condition may deteriorate within hours and has a significant mortality rate.

The evidence which is at significant variance is that of Leanne Wallace who described symptoms suggestive of respiratory distress and possible hypoxic shock on Tuesday afternoon when she accompanied Mrs Winsborough to A & E. Her position was supported in shorter compass by the evidence of her husband who had discussed the matter with his wife. Miss Davie submitted that Mr Wallace's independence should be doubted.

Mrs Wallace's evidence was not only at odds with that of the Winsborough family but differed from the statement that she gave to police shortly after her death. She found it

difficult to countenance that she could be mistaken in any degree, even when faced with relatively obvious minor differences such as the identity of the machine which was broken in the hospital. She accepted that she wanted to convey the impression that Dr Carson had given only a cursory examination. Miss Davie submitted that her evidence is not reliable and should not be preferred to that of other witnesses.

Medical Treatment.

If the more extreme symptoms described by Leanne Wallace are taken out of account, the medical experts in the form of Dr Toft, and Mr Nichol were supportive of the care given by Dr Carson, including his recorded notes of the consultation.

On the evidence Miss Davie submitted that there can be no criticism of actions of the doctors treating Joanne Winsborough on Tuesday 14th April 2009, nor the systems in place within the health system for the provision of such care. There are no reasonable precautions which can be suggested in respect of the provision of such care. The evidence suggested that even had Mrs Winsborough been admitted to hospital on 14th April 2009 it is likely that she would have been discharged at that point. Accordingly, there is no suggestion relating to her care that day which might have avoided her death.

Issues raised by the Crown.

Miss Davie stated that Mr Robertson has raised a number of issues purportedly under section 6 (1) of the Act. She submitted that there had been no notice given that these issues would form the focus of the FAI. She suggested that they have been alighted on as and when there was any indication in the evidence that a 'gold standard' had not

been achieved in a particular area and collected under the banner of public interest with little regard to the test set out in the legislation.

She referred me to the case of ***Emms v Lord Advocate [2011] CSIH 7*** and submitted that, although the context is clearly different, there is an analogy between the *dicta* in that case and the approach of the Crown in this case. There has been a hope that something might emerge of concern. As and when any potential criticisms have been aired, no matter how directly related to the issues being focused on by the FAI, these have been included as a submission for recommendations. She gave as an example Mr Robertson's submission regarding the prescription of Ibuprofen for Diarrhoea and Vomiting.

Causation.

Dr Carson spoke to the fact that there can be a rapid decline in a patient's condition with pneumonia.

Dr Nichol confirmed that pneumonia was a developing condition and whilst it can be rapidly progressing he considered that by the Thursday, had Mrs Winsborough been admitted to hospital, it is likely that there would have been some physical signs developing. Even had she been in hospital, it was only a possibility that she would have survived. He confirmed that once she developed septic shock at home there was a 75% mortality rate. If she was just suffering from pneumonia then her chances of survival were higher. He accepted that this was all speculation as to what was the disease course at home. He thought that she might have been treatable up to midnight the day before 17th April, the longer after midnight, the poorer her clinical condition.

Dr Nawroz concluded that the suppurating pneumonia was caused by Streptococcal B bacteria. When asked how long the bacterial process would take to develop he

confirmed that, if it went into the blood within a few hours up to 24 hours, it would proliferate then there would be symptoms of blood infection. It would take 4 to 6 days for this to develop into pneumonia or whatever other process. He mentioned that there have been cases where it develops rapidly, say within 24 hours. Whether a person develops pneumonia in 24 hours or 5-6 days depends on their underlying immunity. He expected in Mrs Winsborough's case that it would have been a few days at least.
Dr Toft gave evidence that had she been admitted to hospital she might have survived but it was not possible to say what would have happened at any point.

Miss Davie submitted that the evidence is too speculative to suggest that the outcome for Mrs Winsborough might have been any different even had she been referred to hospital prior to her death. Even if there is a 'lively possibility' that admission to hospital would have avoided her death, this would be premised on there being some catalyst for her going back to a doctor.

Mr Winsborough confirmed that he had encouraged her to return to the doctor, and she did not want to. There was evidence that she had been asked to provide a stool sample and she took no steps to fulfil that further step of potential treatment. She had been asked by Dr Alcock to return within 24 hours and she did not follow that advice. It has been suggested that she was an unwilling attendee at the doctors with reference to her past medical record. The question of what 'might' avoid the death has to be seen in the context of the particular patient. It is entirely unclear that there was any particular measure which would have made Mrs Winsborough see a doctor over the course of the three vital days.

Miss Davie appreciated the point made on behalf of the Winsborough family that, had they appreciated how serious her illness was, they would have taken steps to ensure she returned for medical attention. However, she submitted that what happened to Mrs Winsborough was extremely rare. The suggested precaution of wider public information has to be balanced against the risk and in that context she submitted that would not fall within the ambit of a recommendation under 6(1)(c) as being reasonable.

Oximeter

Dr Nichol confirmed that it was not essential to have carried out oximetric testing. It was probable that on the Tuesday it would have recorded a normal level of O2 saturation levels. It is unlikely that there was significant pneumonia present at that stage. Dr Nichol thought that readings might have been helpful to clarify what happened but he didn't think it would have altered the outcome.

Dr Carson confirmed in evidence that there were other machines available on the ward and that, had there been any clinical indication to test oxygen saturation levels, then the fact that the particular machine in the cubicle was not working would not have been a barrier but in the circumstances it was not appropriate or necessary. He did consider getting one from another cubicle but decided it was not necessary as he didn't see any problem with the respiratory rate on examination.

There is no suggestion from the evidence that the taking of oxygen saturation levels at that point might have avoided the death.

Triage.

Dr Nichol was asked in very general terms whether looking to the future there were any changes which could be made and in response he mentioned that it was unfortunate that a triage had not been done. In cross examination he accepted that he was suggesting matters which could possibly be done. He was not presenting these as reasonable precautions which should be implemented. He further clarified that his reference to having the tests carried out by a triage nurse was made in the context of it being preferable to have an additional set of checks for later verification, rather than because it would have made any difference to the outcome.

In the same vein Dr Nichol made reference to the response which NHS Fife made to the family's complaint letter (productions 2 of Fife Health Board 2nd Inventory). He confirmed that the response suggested that the health board had taken on board the points raised by Dr Nichol as potential changes which could be made. Under cross examination he clarified that he made no criticism of the actions of the Health Board and that the response identified in their letter was reinforcement of systems already in place rather than alterations or changes.

The evidence did not identify any precautions in respect of the systems in place in the hospital which might have avoided the death.

Advice given regarding returning to see doctor.

Dr Alcock was clear in evidence that he told Mrs Winsborough to come back in 24 hours if not starting to hold down fluids within that time.

The hospital records state under the heading "plan" "see GP if further problems". Dr Carson said that he would have advised that, if deteriorated, she should seek further help. That would be his standard practice and that was what the note meant. Generally he would say his main concern was to assess the level of dehydration and if that

deteriorated over the next day or two, she should seek some help. That was how he interpreted the note. If the Diarrhoea and Vomiting continued over the next day or two he was hoping she would see her GP again.

In response to a question as to whether a doctor should include a time limit in advice to patients to return Dr Nichol answered "clearer direction to a patient would be of benefit". In this particular case he thought there was an implication that Mrs Winsborough was reluctant to re-engage and perhaps if it had been clear that she must re-engage then it might have got around that barrier. He candidly confirmed that he had no data or research to back that up. Given the usual timescales for a self limiting infection he confirmed that he would have expected an improvement within 48 hours.

Miss Davie submitted that this falls short of a recommendation on Dr Nichol's part that a timescale of 24-48 hours should always be included.

Professor Wall stated that it was important where dealing with a patient presenting with Diarrhoea and Vomiting to give advice that if not getting better, or getting worse a patient should seek medical advice. He agreed with the advice given by Dr Alcock that if Mrs Winsborough was not better within 24 hours she should come back. He confirmed that it was reasonable to explain why you want them to come back and what the concern is if they are not feeling better. He thought that 24 hours would be a reasonable period to mention in the context of this case.

Dr Carson confirmed that he now tells patients with Diarrhoea and Vomiting to come back within 24 hours, irrespective of how they are faring, as a direct result of this experience. He did not suggest that this is a general recommendation that all doctors should be making.

Dr Toft accepted that it could be appropriate to give a time limit and common sense suggested something like 24 hours for there to be no improvement, but he also said he was sure there was no recommended time limit.

Dr Hewitt confirmed that the generic phrases employed by doctors reflected the fact that they could not predict the course of a patient's illness. He suggested that it would be counter productive to give a specific timescale, the danger being that a patient deteriorates within that time but holds off returning to see a doctor.

Miss Davie believed that the evidence highlights that doctors ensure that there is follow up advice given to patients. This is done routinely. To that end there are stock phrases which are often employed such as "come back if not getting better" or "if get worse". In some situations doctors suggested that a timescale might be appropriate and for this particular case the period of 24 hours was often suggested. Miss Davie submitted that that is quite distinct from suggesting that a timescale is appropriate for all patients, no matter what the symptoms and presentation.

She was critical of Mr Robertson for appearing to take issue with advice by doctors described as being given "routinely" on the assumption that was synonymous with "casually" or "without due consideration".

She submitted that it is going too far to recommend that in every case a timescale ought to be proposed. That is not supported by the evidence. Dr Hewitt indicated that being over prescriptive could be counter productive in circumstances where there is no certainty about the clinical course for each patient.

She noted that Mr Robertson was unable to suggest a proposed recommendation and that this encapsulates the difficulty with this proposal. There is no 'one size fits all' recommendation for an area which relies upon subjective clinical findings and where

outcomes cannot be predicted with any certainty. To suggest that the outcome of this FAI could properly inform a wide recommendation across a spectrum of presentations to doctors is impractical.

Miss Davie submitted that this is too tenuous to fall within the ambit of section 6(1)(c). The rationale would have to be that (i) if Mrs Winsborough had been given a specific timescale within which to return she would have done so, which does not correspond with the evidence and (ii) that had she done so it would have been at a particular time when she was presenting with symptoms which would have led to admission, which is not clear from the evidence.

She submitted that even if it was considered that such a precaution was reasonable, there was insufficient evidence to say that in this case it might have avoided the death.

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

Miss Davie submitted that there was no system of working in this case in respect of which a recommendation could be made.

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

This sub-section is not designed to act as a 'catch-all' general provision for the introduction of recommendations, unless and to the extent that they relate to facts relevant to the circumstances of the death. Miss Davie suggested that any such facts would have to have impacted on the actual death. There are no such other facts relevant to the circumstances of the death on the basis of the evidence led.

Professor Wall was asked a general question regarding anything that might be done to raise people's awareness of the type of risk faced by Mrs Winsborough, in response to which he suggested the possibility of patient information leaflets. He accepted in cross examination that he wasn't suggesting that a leaflet on Diarrhoea and Vomiting be given to a patient every time they presented to the surgery with those symptoms, that it was a matter of clinical judgment how much information to give depending on the circumstances.

Miss Davie then suggested findings under section 6 (1) of the Act relation to Mr Anderson:

Cause of Death

Mrs Anderson described Mr Anderson as a fit man with no previous medical problems. This was confirmed by his GP, Dr Priya.

Dr IM Nawroz carried out a post mortem on Mr Anderson on 15th September 2009. He spoke to his reports dated 17th September and 13th October 2009 (Crown Productions 1 and 2 respectively). The first certifies the cause of death as "Pneumonia/adult respiratory distress syndrome both lungs". Following consideration of the post mortem histology his second report concludes that this was caused by H1N1 influenza virus infection. The death is certified at 1753 hours on 9th September 2009 at Queen Margaret Hospital, Dunfermline.

Whilst there were other co-morbidities present in Mr Anderson, and noted in Dr Nawroz's first report under the heading "Summary of Post Mortem Findings", by themselves they would not have made a difference to the outcome. In particular he confirmed that the left ventricular hypertrophy, or enlarged heart, had no bearing on the findings in this case.

Dr Nawroz produced photographs of slides showing a normal lung microscopic transaction and comparing that with the result for Mr Anderson which indicated an assault on the lining of the lung where protein from the blood had oozed into the airspace rendering it impermeable to gas. Dr Nawroz indicated that this pattern evidenced adult respiratory distress syndrome.

He confirmed that the H1N1 strain of influenza started in 2009 in Britain. Many of those who contracted the virus survived and it is not known what pathological processes their bodies underwent as a result of the virus. Of those who died only a limited amount went to pathology. There is some literature which suggests that the most common pathological change associated at time of death with H1N1 is diffuse alveoli damage/ acute adult respiratory distress syndrome. Whilst a secondary bacterial infection was not originally thought to be that common, in fact such secondary bacterial infection turns out to be regularly seen in post mortems when H1N1 causes death.

He explained that no-one can really claim to have an expertise in the area of swine flu as it is such a new disease. Whilst the pathological process is known, it is not clear why it happens to a particular person, say, whether they have an unusual immune reaction, or whether perhaps it relates to the particular type of H1N1 contracted. It is not clear why some people infected with H1N1 go on to develop ARDS whereas the majority only develop a mild disease which apparently resolves. It is perhaps the case that those who survive also developed ARDS which resolved but from a medical perspective all that is known is that by the time the post mortem is carried out the most common finding is of ARDS. So the indirect conclusion that can be drawn is that if someone contracts H1N1 and then develops ARDS it may be fatal.

On the basis of this evidence it is possible to make findings regarding the place and time of death. It is also possible to make a finding regarding the cause of death.

Contact with medical services.

Dr Barron described the Out of Hours GP service organized by NHS Fife whereby a patient contacts NHS 24 and a decision can be made as to whether they require to be seen. If so an appointment can be made at the local GP Out of Hours centre. A swine flu pandemic had been announced in early July and a dedicated flu-line had been set up under the auspices of NHS 24. This acted as a telephone triage to assess the severity of those infected, and if thought necessary the patient could be referred for examination. Between August to October there was a significant increase in the number of patients calling with swine flu symptoms. Dr Barron himself dealt with hundreds of such patients in that short period of time.

Crown Production 7 is the Primary Care Emergency Service medical records. This indicates that on 5th September 2009 Mr Anderson called NHS 24. Page 218A indicates that the call was passed on from the dedicated flu-line and a history is noted. A Doctor Sahu calls Mr Anderson back and takes a further history following which it is decided that Mr Anderson should attend the GP Out of Hours Service, all of which is noted at page 220. He attended Dr Barron, whose notes are contained at page 221, at around 6pm at the Out of Hours Service at Victoria Hospital, Kirkcaldy.

Dr Barron has no recollection of the consultation with Mr Anderson. He was dependent on his notes as a prompt.

Computer records from Bennochy Medical Practice (Crown Production 6, page 207) show that Mr Anderson contacted his GP practice by telephone on Monday 7th September 2009 regarding obtaining a medical line for his work.

The evidence supports a finding that Mr Anderson had access to medical services when he required such access.

Diagnosis of swine flu.

Mrs Anderson described her husband as having got soaked when working as a steward at a football game on Sunday 30th September. By the Monday he felt chesty and not quite right. It was his birthday the following day and although they went out for a meal he complained of feeling a bit shivery and thought he had a chill. He was working an overnight shift on the Wed/Thur and when he came home on the Thursday he said he felt rotten and went straight to his bed when he came in. He thought he had the flu, felt rotten, generally horrible, was shivery and had vomiting and diarrhoea. He didn't go to work on the Friday but stayed in bed. He felt worse on the Saturday. By the time he phones NHS 24 on Saturday, he thinks he has swine flu. The response from NHS 24 confirms that view on the symptoms described. He will not let his wife or pregnant daughter accompany him on the way to the Out of Hours centre because he thinks he has swine flu and doesn't want them near him.

At the appointment Dr Barron notes a diagnosis of probable H1N1 flu and queries a lower respiratory tract infection. In evidence he confirmed that having made such a diagnosis he would normally tell the patient and he thought he did so in this case. He did not think it was possible that he would have told Mr Anderson that he had 'flu' or

'ordinary flu'. He would have said it was swine flu. When cross examined he confirmed that although the note stated 'probable H1N1' as there was no formal laboratory testing to confirm, he would normally simply tell a patient that they had swine flu.

Mr Anderson was driven to the appointment by his son-in-law, Romanis Chasidiris. He confirmed that on the way to the appointment Mr Anderson was concerned at the thought he might have swine flu, particularly as regarded the risk for his wife and pregnant daughter. He waited outside the consulting room when Mr Anderson saw Dr Barron. Mr Anderson came out to give a urine sample and at that point seemed relieved and told his son-in-law that the doctor didn't think he had swine flu.

His daughter Monica confirmed that her father had not wanted her to accompany him to the hospital as he suspected that he had swine flu. When he returned from the appointment with Dr Barron she said he was no longer anxious and confirmed that the doctor didn't think it was swine flu but was ordinary flu.

However Susan Gallacher, the practice nurse who spoke to Mr Anderson on the Monday 7th September noted that Mr Anderson had swine flu. She confirmed in evidence that this information came from Mr Anderson himself who told her when he saw the OOH GP he was told it was likely it was swine flu. Her recollection was that this was the trigger for her opening up the computer records from the out of hours service. She highlighted the fact that her note refers to 'swine flu' whilst she would likely use the term H1N1. Mrs Anderson stated in her evidence that she was with Mr Anderson when he made this call. Under reference to the note made by Susan Gallacher she suggested that Mr Anderson might have said that he had thought he had swine flu but she couldn't recall that.

Miss Davie conceded that it is very difficult to reconcile the evidence in this respect as it indicates that Dr Barron properly diagnosed Mr Anderson on 5th September and that such diagnosis would have been communicated to him. The evidence further indicates that Mr Anderson's family were told by him, not only that he did not have swine flu, but that Dr Barron had indicated that he had ordinary flu. She said that the further evidence in the case indicates that the course for Mr Anderson is unlikely to have been different whether he was aware that he suffered from swine flu or not.

Treatment.

Miss Davie submitted that there are two issues arising from the diagnosis of H1N1. Firstly, ought anti viral medication to have been administered, and secondly, ought Mr Anderson to have been admitted to hospital.

Anti viral medication.

Dr Barron made a decision that as Mr Anderson had had flu symptoms for more than 48 hours, and did not fall into an 'at risk' group, he did not require to prescribe the anti viral drug Tamiflu, which was the main anti viral at the time. He understood that the drug was most efficacious if given as soon as possible after the onset of symptoms.

This accords with the advice given in Prescribing Information on Antivirals for Outbreak of A/H1N1 Flu (Fife Health Board Productions, number 7) dated September 2009 which states under the heading "Oseltamivir (Tamiflu)" "Treatment should begin as soon as possible after onset of symptoms and must begin within 48 hours of onset of symptoms.".

Dr Toft provided a report (Crown Production 3) which confirms at page 16 that the benefits of antiviral treatment are greatest when started within the first two days of illness. He goes on to state in the report "There may be benefit, including reducing mortality, even for patients whose treatment is started more than 48 hours after illness onset" under reference to a publication contained in Annex A to his report. In evidence he clarified that the underlining of the word 'may' was to emphasis that it was not definite. There was only a hint that later administration of antiviral medication might reduce mortality, it was no more than speculation. He accepted that the information in the publication post dated Mr Anderson's death. From his own experience of treating patients admitted with H1N1 flu in hospital antiviral medication would be given beyond the 48 hours more often to be seen to be doing something rather than because it was effective.

Dr Hewitt gave evidence on behalf of Fife Health Board. He has recently retired having practiced as a GP, with experience in Out of Hours practice, for 36 years. He prepared a report dated 6th September 2010 (Fife Health Board Productions number 1). He is well placed to comment on the actions of Dr Barron, coming from the same area of expertise. He confirmed that the information coming from a variety of sources to GPs regarding swine flu around September 2009 was overwhelming. General practitioners had to filter the advice into practical application. He confirmed the general understanding that antiviral medication was to be prescribed as early as possible following onset of symptoms within the first 48 hours. In addition the antiviral would be prescribed to those in an 'at risk' category, such a pregnant women, even outwith the 48 hour period. Mr Anderson was not in a category where anti viral medication should automatically have been prescribed.

The evidence indicates that the fact that Mr Anderson was not prescribed anti viral medication on 5th September 2009 was appropriate in the circumstances and moreover, had such antiviral medication been prescribed at that stage, it would not have altered the outcome for Mr Anderson.

Admission to hospital

Dr Barron confirmed that at the time of the appointment at 6pm on Saturday 5th September 20009 Mr Anderson displayed no clinical indicators for admission to hospital. Infection with H1N1 would not of itself have led to hospital admission. Whilst he detected signs of a lower respiratory tract infection there were no indicators of respiratory distress such as would have required hospital admission.

Dr Toft includes in his report a summary of the guidelines for admission of patients suffering from H1N1. He confirmed that Mr Anderson did not fall into the category for hospital admission at the time of his examination by Dr Barron. The report makes reference to a possible 'criticism' of Dr Barron for not admitting but in evidence Dr Toft confirmed that this was badly expressed. In reliance on data which post dated Mr Anderson's death and which suggested that persistent vomiting would be an indicator for admission of a patient with H1N1 flu it was possible that Mr Anderson could have fitted such later criteria for admission, although even then Dr Toft accepted that there was only evidence of 'some' vomiting in Mr Anderson's case. He confirmed that in the context of a fit and healthy man such as Mr Anderson with some evidence of chest infection it was reasonable to think that he would get by with antibiotic treatment. Whilst his expertise was in acute admissions he confirmed that he would not have expected to see a patient such as Mr Anderson admitted to hospital on the basis of his

reported condition when he attended Dr Barron. Had he been admitted at that stage it is possible he would have been x-rayed, the x-ray may have been clear and he would have been sent home to continue on his course of antibiotics. The point of the guidelines on admission was to reduce the number of swine flu patients within hospital as it couldn't cope.

Dr Hewitt confirmed that Mr Anderson should not have been admitted to hospital because he had H1N1. In order to stop the spread of infection people were to be kept at home. Admitting patients was not part of the policy unless there were specific clinical indications to do so. That is a matter for clinical judgment. Dr Hewitt is particularly well placed to comment on this issue as he is the clinical lead on Lothian's response managed clinic network which has been set up with the aim of co-ordinating primary and secondary care, part of which involves framing guidance on treatment for health professionals under the auspices of "Lothian Ref Help". He is responsible for the drafting of the advice on lower respiratory tract infections and it is proving particularly difficult to summarise succinctly what is comprised in such clinical judgement.

He confirmed his view that Dr Barron's notes were adequate, suggested a full and thorough examination, he appeared to have made a correct diagnosis and to have given proper treatment and advice.

The evidence indicates that the decision not to admit Mr Anderson to hospital following the consultation with Dr Barron was appropriate in the circumstances.

Causation.

Dr Barron gave evidence that if Mr Anderson had been referred back to him as not improving he would have examined him once more for worsening signs or symptoms. Depending on what presented he may have considered hospital admission but this would have required signs of severe respiratory distress, severe dehydration or shock. A vaccine was not available until October but even had it been available it would not have been prescribed when he presented with symptoms of H1N1 flu.

Dr Toft suggested in his report that in retrospect Mr Anderson ought to have been admitted to hospital by Dr Barron but he accepted that this was on the basis of a study which post dated his death. He also accepted that this suggestion was based on the existence of 'persistent' vomiting, which was not present in the case of Mr Anderson. It would still be a matter of clinical judgment, and in this case he accepted that he is not a GP and he sees patients at the other end, i.e., once they have been admitted.

Dr Toft went on the state that it was only a possibility that, had Mr Anderson been admitted to hospital earlier, he would have survived. Whilst it was not difficult to diagnose ARDS, for example using an x-ray, it was by no means certain that the patient could be saved, despite intensive care in hospital. ARDS can have a very rapid onset. Given the description of Mr Anderson on the Monday night it is reasonable to assume that he was hypoxic at that stage, that is, the ARDS was setting in at that point. Had he been admitted earlier it is possible he would have been x-rayed, the x-ray would be clear and he would have been sent home to continue is antibiotics.

Dr Hewitt gave evidence to the effect that it was pure hypothesis whether Mr Anderson would have survived had he been admitted to hospital earlier. ARDS is exceptionally dangerous and even in the hospital context with all resources at hand, he could have died. ARDS was an idiosyncratic occurrence, not predictable. On the basis

of the findings of Dr Barron, had Mr Anderson been admitted at that stage he would likely have been sent home by the hospital.

The evidence indicates that, had Mr Anderson been admitted to hospital prior to Monday evening, he is likely to have been sent home as not presenting with clinical indications for admission. It is likely that the ARDS developed suddenly on the Monday night over a short period of time. Even had Mr Anderson managed to get to hospital at that time, there is only a possibility that he might have survived.
In the context of sub-section 6(1)(c) suggest that this is not a 'lively possibility'.

Advice regarding patient seeking further medical advice.

Dr Barron has ticked the box on the computer record notes stating "patient to contact surgery". He confirmed in evidence that he would normally ask the patient to return if the anti-emetic was not working or he would, hope he would have said if there was any shortness of breath to phone back, that is, contact NHS 24. That it would be his usual practice to give such advice. In terms of phraseology he thought he would use the expression "if there are worsening symptoms" to get back in touch with NHS24. He did not think that he would stipulate a timescale save for the issue raised in the medical records regarding how bad the vomiting was. In that regard he would want the patient to 'phone back if not keeping down medication. He would assume that the patient would phone back in circumstances where he was more breathless. He would have said to give the antibiotics a couple of days to work, and if not working by then, to phone the doctor. Any timescale would depend on the course of the illness but contact with the practice would be within 48 hours given that is the point at which the practice would be open again after the weekend. The ticking of the box means that he

had asked Mr Anderson to contact the surgery on Mon morning and he did on fact do so.

Dr Hewitt highlights in his report that Dr Barron should have stated specifically what he told the patient to do if the situation should not resolve. He confirmed that this was really by way of evidencing what the doctor would say as part of the general "patter". In relation to the terminology used by doctors when advising patients regarding subsequent contact he agreed that it is often general but thought that reflected the reality of the uncertainty over how a patient will progress. In response to the suggestion that a timescale could be given he highlighted that the course of illness will differ significantly with each patient and he used the example of a person who has flu for 3 days compared to someone who has flu for 5 days. The former is not less ill than the latter, he is simply ill for less time. As a doctor there is a difficulty in attempting to predict the course of an illness in a particular patient and therefore the more general terminology assists. Whilst it is important to give a patient a clear indication of what to expect, if it is unclear what might happen, so the advice might have to be vague. In that regard Dr Hewitt highlighted the fact that the context is important, for example a patient not being on his own, seeming sensible, being surrounded by others who are there to assist if for any reason the patient is unable to take further steps to contact a doctor when required.

It was submitted that this would reflect the position with Mr Anderson. He clearly had some medical knowledge himself, by all accounts was a sensible, clear historian, and was living with others. Advice given to him to contact his GP practice, however generally phrased, has to be seen in that context. There is no indication in the evidence that the outcome for Mr Anderson was affected by the phrasing of Dr Barron

on seeking further medical advice. Indeed, on making the further medical contact as advised Mr Anderson reported feeling better.

The evidence does not support the contention that different advice regarding further medical contact would be a reasonable precaution nor that it might have prevented Mr Anderson's death.

Miss Davie suggested section 6 findings:

(a) where and when the death and any accident resulting in the death took place;

Mr Anderson died in ICU at Queen Margaret Hospital, Dunfermline. His body was certified dead at 1753 hours on 9th September 2009.

(b) the cause or causes of such death and any accident resulting in the death;

The cause of death was Pneumonia/adult respiratory distress syndrome in both lungs caused by H1N1 flu.

(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

On the evidence heard there are no reasonable precautions whereby the death might have been avoided.

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

On the evidence there were no defects in any system of working which contributed to the death or any accident resulting in the death.

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

This sub-section is not designed to act as a 'catch-all' general provision for the introduction of recommendations, unless and to the extent that they relate to facts relevant to the circumstances of the death. On a strict interpretation the sub-section relates purely to facts, and not recommendations. Assuming that the drafting is intended to include recommendations it is suggested they would have to relate to facts which impacted on the actual death. There are no such other facts relevant to the circumstances of the death on the basis of the evidence led.

Conclusion.

As stated in the ***Emms*** case *supra*, the Inquiry should be concerned with deficiencies in systems and procedures which may have caused a number of deaths and are likely to continue to do so unless changes are made.

While the context is different, and there is no suggestion in this case of negligence, Miss Davie submitted that for the purposes of considering the evidence at the end of an FAI the same general approach should be taken. What is at issue is whether there is a question of public concern which arises. There ought to be no assumption that because both parties died soon after contact with medical professionals that there is somewhere a failing to be detected. An FAI is not intended to be a 'goal based' operation whereby some recommendation must be alighted upon. It does not require the addressing of a single example of a brief medical note, or a failure of a particular patient to return for follow up care, or recommending potentially disproportionate steps to avoid what on any view were rare and unexpected deaths.

On behalf of Fife Health Board Miss Davie invited a formal finding in respect of sub-sections 1(a) and (b) in relation to both the Winsborough and Anderson Fatal

Accident Inquiries and if the Court thinks fit, no findings in respect of sub-sections (c), (d), or (e), there being no evidence in support of such findings.

CONCLUSIONS.

Mrs Winsborough.

Section 6(1) (a) of the Act.

In terms of this subsection as to where and when the death and any accident resulting in the death took place I have found that Mrs Winsborough died at 29, Elmwood Terrace, Kelty, Fife between the hours of 0630 and 1100 on 17th April 2009. Mr Winsborough left the address for work at 6.30am and she was clearly unwell but alive. She was sitting and shivering. Between 10.30am and 10.45am he received a call from his daughter advising that Mrs Winsborough was not breathing and her lips were blue. Alan McCusker, a paramedic with the Scottish Ambulance Service arrived at 10.56am and found Mrs Winsborough lying on the living room floor with no vital signs present and she was beyond resuscitation. She was certified dead at 11 am.

Section 6(1) (b) of the Act.

In terms of this subsection as to the cause or causes of such death and any accident resulting in the death I have found that the cause of death was Suppurating Pneumonia, both lungs.

Dr Ibrahim Nawroz, Consultant Pathologist, carried out the post mortem on Mrs Winsborough. In his initial report dated 27th April 2009 he was of the opinion that death was due to Suppurating Pneumonia and was probably septicaemic. After microscope and microbiological examinations he provided a supplementary post mortem histology dated 30th April 2009. Swabs from the lungs isolated heavy growth

of group B streptococci and heavy growth of E coli. The latter growth is likely to be a contaminant but the isolation of group B streptococci is probably significant and given the pneumonia is focally suppurating, the underlying infective micro-organism is likely to have been group B beta streptococci. He accordingly amended the caused of death to Suppurating Pneumonia in both lungs. In evidence he stated that Suppurating Pneumonia is an inflammatory process producing puss in the lung tissue. This infection had passed into both lungs. He conformed that the most likely cause of death was pneumonia due to group B beta streptococci. There are two routes by which it could have reached the lungs, namely by inhalation or infection of the blood stream. It was extremely rare for inhalation to be the route and infection of the blood stream was the more likely cause. He was of the opinion that this was bacterial not viral pneumonia. It was possible that a viral infection had masked the bacterial infection. Equally the bacterial infection might have developed quite independently.

Dr Nawroz was unable to identify how and when the blood infection occurred or how long it may have taken before the pneumonia developed. He said that it may have taken 2, 3, or 4 days but he knew of cases where it could develop within 24 hours.

He was not a clinician but in answer to my question as to the symptomology of such pneumonia he said there would be coughing, blue lips, hypothermia and very high temperature. The patient feels very cold. This matches materially the description of Mrs Winsborough by Mr Winsborough by 6.30 am on the day she died.

Mr Neil Nichol, a Consultant in Emergency Medicine, was an expert witness called on behalf of Mr Winsborough and family. He said that there were two possible courses of the progression of Mrs Winsborough’s condition. The first was that she had a viral infection with a secondary bacterial infection which has caused rapid inflammation of the lungs and death. The second was that there was a very slow

development of the Strep B infection producing toxin at some point becomes more aggressive leading to pneumonia. He thought the latter was speculative. The history of her early stages is consistent with either viral or Strep B infection.

Accordingly, both Dr Nawroz and Mr Nichol are unclear whether Mrs Winsborough's early symptoms were a result of the Strep B infection or whether it manifested later.

The only expert who suggested that the cause of Mrs Winsborough's death was Swine Flu was Dr Anthony Toft, the expert for the Crown, who thought that the first diagnosed case was in early April 2009. He subsequently agreed that it was 21st April 2009. He then suggested that this might not have been the first actual case. He also suggested that at the time of the post mortem Swine Flu was not widely recognized and a pathologist might have overlooked it as a possible cause pf death. I have him noted as appearing to suggest that the Strep B infection might have contaminated the lungs because of the lack of hygiene present at post mortem examination.

Dr Nawroz did not consider Mrs Winsborough to have had Swine Flu.

Mr Nichol was quite clear that Mrs Winsborough was not suffering from Swine Flu as the first identified cases in Scotland were at the end of April 2009 with holiday makers returning from Mexico. There was a clearly identified time track of this strain of influenza coming to the UK. In any event, there was no evidence that Mrs Winsborough or anyone in her community had had any contact with Mexico.

Professor Wall, another expert for the Winsborough family, did not consider Mrs Winsborough as having Swine Flu because her symptoms predated its outbreak.

In giving appropriate weight to Dr Toft's opinion I have regard to the cases to which I was referred namely ***McTear* v *Imperial Tobacco Ltd* 2005 2SC, *Lewis, Manual of the Law of Evidence in Scotland, Davie v Magistrates of Edinburgh 1953 SC 34, Wilkinson, The Scottish Law of Evidence, Dingley v Chief Constable, Strathclyde***

Police 2000 SC (HL) 77, 1998 SC 548. In particular, in ***Dingley*** at p604 Lord Prosser said: *"... the fact that a particular view was or is held by someone of great distinction, whether he is a witness or not, does not seem to me to give any particular weight to his view, if the reasons for his coming to that view are unexplained, or unconvincing. As with judicial or other opinions, what carries weight is the reasoning, not the conclusion."'*

With respect to his Lordship, I agree that this must be the correct approach to the evidence of Dr Toft as regards his opinion as to the cause of death. No matter how eminent he may be in his field of expertise, he is not a pathologist. I consider that his reasons for coming to his view are unexplained and unconvincing. The opinions of the other experts are based on reasons as to the timing of Mrs Winsborough's symptoms in relation to when the outbreak of Swine Flu was clearly recorded. Even Mr Robertson did not ally himself with his own expert witness's opinion in this respect. Accordingly, I have not found that the cause of Mrs Winsborough's death is Swine Flu related.

As the removal of intimate piercing by Mrs Winsborough was raised in the Inquiry as a possible cause of the blood infection, I feel that I should deal with it under this subsection. Dr Nawroz was asked whether the removal of the intimate piercing may have set off some infection. Dr Nawroz said that any abrasion in that area might be a port of infection but he did not wish to comment further as he did not have Mrs Winsborough's clinical history. Mr Nichol said that the piercing itself was a theoretical avenue of infection. He was aware of infections related to piercing but they tended to be of a more common bacteria and were easily treated. He was unaware of any case or anything in the medical literature to demonstrate that there could be a

Strep B problem. While he could not completely discount it, it may be just an unfortunate coincidence.

Having regard to this evidence, I am not of the view that such removal can be found to be the likely cause of Mrs Winsborough's blood infection.

Section 6(1) (c) of the Act.

Given the issues raised in this Inquiry, it may assist if I detail fully the terms of this subsection of the Act: *the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided.*

In terms of Section 6(1) of the Act I am required in this determination to set out these out, so far as they have been established to my satisfaction.

I have found that there were no reasonable precautions whereby the death might have been avoided. The party who asked me to make a finding under this subsection in respect of Mrs Winsborough was Mr Robertson for the Crown. Mr Robertson seemed half-hearted in his submission as he said findings might equally be made under section 6(1) (d) and (e). It is noteworthy that Mr Olson for Mr Winsborough made no submission under this subsection.

In terms of section 6(1)(c), it is well settled that that what is required is not as to a reasonable precaution whereby the death "would" have been avoided but whereby the death or accident resulting in the death "might" have been avoided. Mr Carmichael in ***Sudden Deaths and Fatal Accident Inquiries 3rd Edition at 5-75*** states *"What is involved is not a "probability" but a real or lively possibility that the death might have been avoided by a reasonable precaution."*

I shall deal with the issues raised by Mr Robertson under this subsection in respect of Mrs Winsborough's death.

What to tell the patient.

Mr Robertson submitted that it was reasonable to expect doctors to deal with patients by good management of delivery of clear information. One of the key examples he gave was time-limits if not improving or getting worse –not improving within 24/48 hours. He though it good practice to deliver helpful information rather than give vague or routine information with little thought for its relevance or value.

Dr Alcock's evidence in this respect, which I accept, was that he told Mrs Winsborough that he wanted to see her again to be checked out, if she was not tolerating fluids within 24 hours. He remembers telling her that he would not be at the surgery as he was a locum but she could check at the desk. Mr Robertson does not seem to criticise this advice.

Dr Carson's evidence in this respect taken from his medical notes was that he advised Mrs Winsborough to see her GP if further problems. Mr Nichol regarded this as standard advice but thought a timescale of say 48 hours to see a GP would have been reasonable. Professor Wall said if patients were not getting better it was important to advise that they seek advice. If he had examined Mrs Winsborough he said that he would probably have advised going on with fluids for 24 hours and if not getting better within 24-36 hours a decision would be made regarding admission to hospital.

Dr Toft also agreed that advice should be given but, while there may be no specific time, common sense dictated something like 24 hours if no improvement.

Dr Hewitt was of the opinion that advice should be given to a patient if not improving but this should be general and not specific in timescale. He felt that it depended on the patient getting better rather than pinning down a timescale. However, he suggested 24-48 hours rather than leaving matters vague.

There was no evidence that either Dr Alcock or Dr Carson "gave routine information with little thought for its value". While a time limit may seem reasonable, it depends on the condition of the patient at the time of examination. If, for example, a patient had been advised to contact the GP if no improvement after a specified time had elapsed and there was a rapid deterioration within that time, the patient might delay until the period had expired with serious consequences. Accordingly, I do not accept that there should be an obligation on GPs to specify in every case a time limit within or by which further examination might be sought. In any event, Mrs Winsborough did not return to her GP because she was waiting on any specified time limit given by Dr Alcock to expire or when she clearly was experiencing further problems as advised by Dr Carson.

In terms of this subsection it is not what might be reasonable to expect of doctors but what is a reasonable precaution whereby the death might have been avoided. The evidence was that when by examined by both doctors, Mrs Winsborough's had a viral infection, gastroenteritis. This was regarded by every medical expert including those of the family and the Crown as being a correct diagnosis. Thousands of patients suffer from this and recover within 4-5 days. At the time of examination, Mrs Winsborough appeared no different from the many patients particularly Dr Alcock had examined in his lengthy experience. The same is true of Dr Carson apart from his experience. Mr Robertson does not say in what respect advice to her should have differed from that given to other patients.

The evidence of Mr Winsborough and her family friends was that her symptoms deteriorated since being examined. Mrs Winsborough's symptoms did not improve within 24 hours yet she failed to follow Dr Alcock's advice to see her GP. Similarly, she failed to follow the advice of Dr Carson to see her GP if further problems.

She failed to provide the stool sample so that bacterial infection might be identified. There was no evidence that either doctor had advised Mrs Winsborough that she had “only a virus”. Dr Alcock said that he thought that Mrs Winsborough was seeking a "magic pill" to make her better. Dr Carson said that she clearly was unhappy with the advice given by Dr Alcock.

Mr Winsborough said that she did not like to trouble doctors and there was evidence that on numerous occasions, possibly as many as 38, she had failed to attend the GP surgery for cervical smear tests for cancer following an operation. There is no evidence that she was suffering from the cause of her death, namely Suppurating Pneumonia, when examined. Had she taken the precaution of returning to her GP within 24 hours it is possible that deteriorating symptoms might have been detected. Equally, it is possible that they might not have been. The rare condition from which she died can occur within as short a period as 12 hours according to the experts who gave evidence. It is hard to understand what advice could be expected to have been given to Mrs Winsborough by the doctors when she was examined, possibly as much as 50 hours before the onset of the fatal infection. Mr Robertson appears to suggest, although he is unable to specify exactly what advice should be given, that the doctors should have somehow guessed that such a rare condition might occur and advise accordingly. This would be clearly an unreasonable precaution which does not fall under this subsection.

The advice given to Mrs Winsborough was proper advice which she chose not to follow. More detailed advice, if that could have been given, is likely not to have been followed by Mrs Winsborough. Accordingly, I do not accept Mr Robinson’s submissions in this respect.

Admission to hospital.

Mr Robertson under this heading adopts an approach which again ignores the terms of this subsection. While he finds it difficult to argue with the clinical judgement of Dr Alcock and Dr Carson not to admit Mrs Winsborough to hospital, he relies on what he call "some short comings" in the medical notes that meant possible criticisms by the families concerned could not be satisfactorily resolved one way or another. If records are not "adequate" an air of uncertainty results when the doctors are unable to fully explain themselves. The purpose of this subsection is not to meet possible criticism from relatives of a deceased except where such criticism relates to reasonable precautions whereby the death might have been avoided. Mr Robertson later stated further that a vital reason to ensure that there are proper records is the clinical aspect that another medic should be able to have a proper basis to later assess a change or deterioration in condition rather than relying on a patient's impressions. While this may be the case, there was no evidence whatsoever that Mrs Winsborough sought assistance from another GP, who was unable to properly diagnose and treat her because of any inadequacy in another's medical notes. Further, there was little or no criticism from any of the medical experts that the medical notes of Dr Alcock and Dr Carson were not adequate or proper apart from Dr Alcock's admission that his were brief. None said he was unable to understand anything shown in the medical notes. How the adequacy of medical records in the special circumstances of Mrs Winsborough's death can be regarded as such a reasonable precaution whereby her death might have been avoided is not explained.

Factual Medical Issues.

Mr Roberston under this head states that the position of the Winsborough family and her friends Mr and Mrs Wallace is that Mrs Winsborough was not adequately examined and should have been admitted to hospital as her illness was much worse than doctors indicated. This may be their position but I find it difficult to believe that this is being submitted by the Crown under this subsection when there is absolutely no evidence whatsoever adduced from any medical expert, even those of Mrs Winsborough's family and his own expert for the Crown, that she was not properly examined by Dr Alcock and Dr Carson and that given her condition following such examination she should not have been admitted to hospital. Putting it another way, I have not heard evidence from any medical expert, who supports the view of Mrs Winsborough's family and friends.

Unlike Mr Robertson, I can see that there is good reason as to why there is difficulty in reconciling the competing versions of the extent of her symptoms and the degree of her illness. Mr Winsborough and family friends have no medical knowledge and are not qualified to give such views. They are naturally distressed by the sudden loss of a loved wife, mother and friend. Unlike the medical notes, there is considerable discrepancy in their evidence as to the extent of her symptoms. On the Tuesday when she was examined, Mr Winsborough said that her face and lips were pale and she felt dizzy on the Tuesday morning and said she should not have been driving. It was not until Thursday that her lips had a tinge of blue. Frances Easton saw Mrs Winsborough on Tuesday morning around noon ands described her as very pale and slow in speech and looking poorly. She made no comment about blue lips and shortness of breath. Leeanne Wallace on the other hand supported by her husband said that on the Tuesday Mrs Winsborough was short of breath, her lips were blue, as if bruised and she had a yellow coating over her eyes. She was sick 10 times in hospital; that Dr

Carson could not have seen into her mouth; the blood pressure machine was not working and was quite certain that Dr Carson did not take a BP reading; he did not examine her chest or use a stethoscope; she had told Dr Carson that she could not breathe; had been hallucinating was dizzy with blurred eyesight; and could not use her car. In both examinations her chest was clear. Dr Carson or his nurse took a BP reading which was noted. The machine which did not work was the oximeter not the BP machine. The oximeter was not needed as Dr Carson was satisfied as a result of the clinical findings from his examination of her. For Mrs Wallace to be believed, I would have to hold that Dr Carson's findings, which were almost identical to those of Dr Alcock earlier, were somehow made up. Mrs Wallace said in her police statement on 18th April 2009 said that she had been with Mrs Winsborough when examined by Dr Carson. She did not look well at all. She was sick in the cubicle. Dr Carson took her blood pressure and tried to look down her throat. She was told she had a viral infection and to take paracetamol for pain relief. She makes no mention of any of the other symptoms she claims Mrs Winsborough was suffering from on the Tuesday. I have little difficulty in regarding her evidence and that of her husband as grossly exaggerated and unreliable. To add to the confusion, Mr Winsborough said that Mrs Winsborough had told him after the hospital examination that she had the same viral infection and she should not be at the hospital. She added that she not been checked by Dr Carson. That was not the case. Mrs Winsborough clearly wanted to be admitted to hospital.

As regards hospital admission, the reason Mr Robertson finds it "difficult to argue with the clinical judgement of Dr Alcock and Dr Carson" is that not one of the medical experts, including the Crown's expert Dr Toft, regarded such judgement as

erroneous. They did not regard Mrs Winsborough's symptoms at the time of examination as being of such severity that Mrs Winsborough should have been admitted to hospital. They supported the doctors' decision as she was not showing such a level of dehydration as would have merited it.

The progress of Mrs Winsborough's symptoms is not clear as stated above. Had Mrs Winsborough been admitted to hospital on the Tuesday it is likely that her chest would have been x-rayed. She would have been tested for respiratory problems which would have been negative given the clinical findings. It was likely that she would have been released with exactly the same advice in respect of fluid retention and worsening symptoms. It is not possible for any of the doctors or the medical experts to point to a particular time at which the fatal infection took hold. Dr Toft along with other experts said that the earlier the treatment the better the chance of survival. There would need to be a clinical reason to admit Mrs Winsborough to hospital. Mr Robertson submitted that the death of Mrs Winsborough might have been avoided if she had been admitted to hospital. It is noteworthy that the prevention measures he details are in respect of gastroenteritis not pneumonia. Had she followed Dr Alcock's advice and gone to her GP Surgery on the Wednesday it may be that deterioration might have been detected and she might have been admitted. Mr Winsborough said that her condition deteriorated from the Tuesday evening. She did not go to the surgery as advised and, accordingly, the question of hospital admission is hypothetical.

It would not be a reasonable precaution to admit to hospital everyone who presented with the same symptoms as Mrs Winsborough at the time she was examined by Dr Alcock and Dr Carson.

Even if Mrs Winsborough had been admitted to hospital at the time she became significantly dehydrated the treatment would be of hydration. If admitted, biochemistry checks and a full blood count would have been done. Mr Nichol did not believe that anything would have been revealed. With hydration she may have improved over 2 days but there would have been deterioration into septic shock. Antibiotics would have been given. If she suffered this at home there was a 75% chance of mortality. In hospital there was still 20-25% chance of mortality. So even if she had been admitted to hospital with suppurating pneumonia she may still have died.

It is worth emphasising that in the case of Mrs Winsborough, Mr Hewitt said that she had an unusual presentation where a rare infection might have been masquerading as a simple problem such as gastroenteritis. He was personally aware of only two other deaths similar to that of Mrs Winsborough. The development of what ultimately caused her death was, accordingly, rare and unusual.

Section 6(1) (d) of the Act.

In terms of this section, I have found that there were no defects in the system of working, which contributed to Mrs Winsborough's death. Mr Robertson made reference to text messaging used by medical practices for reminders to patients regarding appointments I would agree that this would not be an effective or justifiable use of resources and would not be practicable to monitor. How this could be construed as a defect in a system of working which contributed to Mrs Winsborough's death was not explained.

He made reference to the oximeter not working. Without any evidence whatsoever he asserted that it might have detected a respiratory problem meriting further medical

investigation or hospital admission. He ignored the fact that the clinical tests carried out by Dr Carson disclosed no such problem. Dr Toft thought any such reading would not have been of significance. Mr Nichol thought that the reading would probably have been normal. No expert said that a reading ought to have been taken. There was no evidence that failure to take the oximeter reading contributed to Mrs Winsborough's death. There is no "might" under this subsection. There has to be a causal connection. There was none.

Similarly, Mr Robertson regards medical records as a system of working. While Dr Alcock's notes may be extremely brief and Dr Carson's notes may be vague on the question of when she was to return to her GP, there is no evidence that any lack of information in these notes caused her death. It is not a matter under this subsection to be concerned about answering questions raised by the family. Mr Robertson believes that medical notes should address such questions irrespective of the substance of the questions. No matter how unrelated the questions might be to the death itself, he believes that a doctor has to provide "fully adequate" notes that address them. This is not worthy of comment.

He believes that medical authorities should note that some deaths might be avoided by appropriate medical advice. That might be true but there was no evidence that any advice given was inappropriate apart possibly from advice to take ibuprofen. There was no evidence that Mrs Winsborough took it or indeed took paracetamol. The obvious point is that medical advice requires to be followed by the patient. The terms of such advice, particularly from Dr Alcock, were not vague. It is still a matter of personal choice in a free society whether or not a patient follows such advice.

Section 6(1) (e) of the Act.

In terms of this subsection I have found that there were no other facts relevant to the circumstances of Mrs Winsborough's death. The tragic reality of Mrs Winsborough's case is that even if she had followed all the advice given and avoided dehydration and her gastroenteritis had improved, she may still have developed a blood infection leading to the Strep Group B pneumonia, which was the cause of her death. Mr Olson conceded that the medical evidence did not shed any light on how this had been caused.

However, even if the Court does not know how her death was caused, I believe that there may be other facts relevant to the death which can be found by the Court. These may be arrangements for funeral such as in the Lockerbie FAI. In past cases before me, I have under this subsection considered defects in procedures such as paramedic delays in attendance might be considered, even although not contributing to the cause of death as casual connection is not required under this subsection. This approach possibly conforms to some of the examples under this subsection given by Mr Carmichael in his authoritative work concerning possible improvement of procedures, clarification of respective interest by doctors and such like ancillary matters. While the subsection refers to "facts", it is not uncommon for recommendations to be made from facts adduced at the Inquiry.

I would treat Mr Olson's submission regarding triaging of patients admitted to Accident and Emergency as relevant under this heading. He submitted that readings should have been taken before Mrs Winsborough was seen by Dr Carson so that a snapshot picture of her condition would have been clearer. The picture is as clear as one wishes it to be. All the readings taken by Dr Carson were appropriate and pointed to a perfectly clear picture of her condition at the time of examination. Triaging would have made no difference to the outcome according to Mr Nichol although it may be

desirable to have an additional set of readings available. I believe it now the practice for triaging to take place in Fife Health Board Accident and Emergency Departments. Accordingly, I have made no finding regarding triage under this subsection.

I do not accept that it is not enough, as Mr Olson has submitted, for a patient to be told to come back if no better within 24 hours. Perhaps had Mrs Winsborough done what she was told by both doctors involved and deterioration was discovered by her GP, she might have realised that she was becoming more ill. In my view, Mrs Winsborough should have done what she was advised to do by both doctors rather than forming her own ideas without any other apparent reason. The case for Mr Winsborough and family is that because they did not realise how ill she was, it must be down to someone other than Mrs Winsborough. Therefore, she could not have been adequately advised by the doctors concerned. In the face of expert evidence to the contrary, this Inquiry was embarked upon by the Crown. The purpose of this Inquiry is not to apportion blame.

Mr Robertson argued that if precautions are reasonable and there is a possibility that they might have led to the death being avoided that consideration under subsections 6(1) (c) and (d) are relevant. That might be the law for (c) but not for (d) which requires an actual causal connection. He argued that if the possibility is deemed not to be appropriate under these subsections, it should fall under (e). There was criticism that the Crown was trying to use (e) as a catch-all subsection. I would agree.

Mr Anderson.

Section 6(1) (a) of Act.

In terms of this subsection I have found that Mr Anderson died at Queen Margaret Hospital, Dunfermline, Fife at 1753 hours on 9th September 2009. Mrs Anderson supported by his GP Dr Pria described him as a fit man with no previous medical problems.

Section 6(1) (b) of the Act.

In terms of this subsection, I have found that the cause of death was

(b) Pneumonia/ Adult Respiratory Distress Syndrome both lungs

(c) H1N1influenza virus (Swine Flu).

Dr Nawroz carried out a post mortem on Mr Anderson on 15th September 2009.he produced two reports. In the first dated 17th September 2009 he certified the cause of death as "Pneumonia/ Adult Respiratory Distress Syndrome (ARDS).In his report of13th October 2009he concludes that this was caused by H1N1 influenza virus infection. Mr Anderson's death was certified at 1553 hours on 9th September 2009 at Queen Margaret Hospital, Dunfermline. I was shown x-ray photographs by Dr Nawroz which showed that Mr Anderson had had an assault on the lining of the lung where protein from the blood oozed into the airspace rendering it impermeable to gas. This pattern was evidence of ARDS.

As regards H1N1 strain of influenza, he confirmed it started in the UK in 2009. The pathological process undergone by those who had it and survived was nit known. There was literature that suggested that the most common pathological change associated with H1N1 was diffuse alveoli damage/acute ARDS. Secondary bacterial infection was regularly seen in post mortems where H1N1 is the cause of the death. The reason is not known why some people who develop H1N1 go on to develop ARDS while the majority only develop mild disease which resolves. The indirect

conclusion that can be drawn is that if someone develops H1N1 and then develops ARDS it may be fatal.

Section 6(1) (c) of the Act.

In terms of this subsection, I have found that there were no reasonable precautions whereby the death might have been avoided.

The reason this matter is before this Inquiry would seem to be that Mr Anderson told his family he did not have Swine Flu. I accept that it is probable that this is what he did tell them. It does not follow from this that the actual medical advice and diagnosis he received was anything other than what it is clearly stated by Dr Barron to be. Dr Barron in evidence said that he had no reason for advising Mr Anderson that he did not have Swine Flu when he did have it. His record of the examination shows "H1N1". No member of his family was present when he was examined by Dr Barron.

What to tell the patient.

Mr Robertson directs the same criticism against Dr Barron as he has against Dr Alcock and Dr Carson. Mr Hewitt in evidence had no criticism of the diagnosis and advice provided by Dr Barron to Mr Anderson. There was no evidence that Mr Anderson had been treated "casually" or "routinely".

Admission to Hospital.

Not one medical expert gave evidence that, given his symptoms at the time of examination by Dr Barron, Mr Anderson should have been admitted to hospital. There was nothing missing from the record of examination that could have led to an alternative view. I repeat my views expressed on Mrs Winsborough's case under this heading.

Factual Medical Issues.

Again there is nothing submitted by Mr Robertson that could be construed as a reasonable precaution whereby the death might have been avoided. There is no reason to disbelieve the family as to what they were told by Mr Anderson. It is equally difficult to disbelieve Dr Barron and his medical records. The purpose of this subsection is not for the Court to attempt to reconcile different evidence in order to satisfy the family of the deceased. I have no difficulty in accepting the evidence of Dr Barron taken from his notes that he must have advised Mr Anderson that he has Swine Flu. Apart from his evidence and the medical records there is further evidence from Nurse Gallacher which I shall deal with later.

It is not for the Court to engage in speculation but deal with the evidence presented. However, in this case, the Crown and Mr Anderson's family, invite the Court to find that there was scope for misunderstanding. The position seems to be that by some unexplained process, Mr Anderson misunderstood the advice and diagnosis received from Dr Barron. Therefore, there must be something amiss in the advice received or the manner in which it was conveyed. This would appear to be pure conjecture.

It may assist to have regard to the facts leading up to Mr Anderson being examined by Dr Barron. On Wednesday 2nd September 2009 Mr Anderson first complained that he 'felt rotten'. He had diarrhoea and went to bed. On Thursday 3rd September 2009 he felt shivery, was vomiting and had diarrhoea. He cancelled his work shifts on Friday 4th and Saturday 5th September 2009. He stayed in bed. On Saturday 5th September 2009 he telephoned NHS24 dedicated flu line. This dedicated line was set up following the Swine Flu Pandemic which was announced in early July 2009.He explained his symptoms of vomiting and diarrhoea. He was advised that he had the symptoms of Swine Flu. He had a telephone triage discussion with a Dr Sahu, who also advised that he probably had Swine Flu and NHS24 through Dr Sahu arranged an

early appointment for him at the Out of Hours Service at the Accident and Emergency Department of Victoria Hospital, Dunfermline. MR Anderson's son in law, Romanis Chasiridis, drove him there. During the journey Mr Anderson told Mr Chasiridis that he was worried he had Swine Flu as he was concerned for his wife and his pregnant daughter.

At the material time Mr Anderson was living in the same house as his wife, daughter and son-in-law. Mrs Anderson said that he had had concern for her as she was recovering from a cancer operation and his daughter was 8 ½ ,months pregnant. His daughter said in evidence that there was no possibility her father would not have told the family he did not have Swine Flu as they used the same toilet, handles and bath. She had had a difficult pregnancy with hospital admission and was "paranoid" about Swine Flu. It was thought at the time that pregnant women were especially susceptible to Swine Flu although the subsequent evidence as spoken to by the experts did not support this. She thought that Mr Anderson should have been given Tamiflu or told to keep away from the family. Accordingly, if Mr Anderson had told his family that he had Swine Flu, his daughter at least would have expected him to keep away from the family. It might be asked why he did not immediately remove himself from the family when told by NHS24 that it was "likely", not "unlikely**"**, he had Swine Flu. In this knowledge, he had his daughter's husband drive him to and from the hospital.

The obvious point is that Mr Anderson had had Swine Flu for possibly 3-4 days before he saw Dr Barron. His wife, daughter and son-in-law had been exposed to the virus living in the same house for this period. There was no reason for him staying away from his family but this would not have been understood by at least his daughter. It is not "incredible" as submitted by Miss McKerrow that he would have put his family at risk. They had already been exposed to the risk for days before. He

as a health professional might have understood this better than most. Dr Barron said that he would not have advised that he stay away from his family.

Mr Anderson's knowledge that he had Swine Flu was supported by Nurse Gallacher. Mr Anderson requested a sick line from his GP Surgery on the morning of 7th September 2009. She was 100% certain that Mr Anderson told her he had Swine Flu as this caused her to open his file and see the entry by Dr Barron that he had H1N1. Mrs Anderson disputed that he had said this. I do not accept her evidence on this point as credible. If it was the case that Mr Anderson was ignorant of the diagnosis, she makes no reference to him showing any surprise during the conversation with the nurse. Her position must be that not only is Nurse Gallagher mistaken that Mr Anderson told her he had Swine Flu but also that she could not have advised him of this, even when it is clearly noted on his medical record. Mr Anderson did not advise his family that he had Swine Flu after this conversation with Nurse Gallacher.

On that Monday Mr Anderson was also less than frank to his family about his worsening symptoms and also to Nurse Gallacher when he assured her that his symptoms had improved from the previous Friday. There was obviously no difficulty experienced by Mr Anderson in getting in touch with his GP surgery on the Monday. The reasons for him choosing to pretend that he was getting better, when it was clear from the evidence of his family that he was not, cannot be answered.

Tamiflu.

The evidence was that this was the most appropriate anti-viral medication available at the material time. In terms of the national guidelines as at the time it was most effective if taken within 48 hours of the onset of symptoms. There was an unhelpful reference by Dr Toft to inconclusive literature that it may be beneficial after 48 hours.

He did not criticise Dr Barron in this respect and no other expert took exception to Dr Barron not prescribing Tamiflu as Mr Anderson had had the symptoms for well in excess of 48 hours. Mr Robertson made no submission in this respect. Neither did Miss McKerrow, but she engaged in a tortuous argument that because he was not prescribed Tamiflu, Mr Anderson must have thought he did not have Swine Flu. I do not accept her submissions in this respect. I am satisfied that he was told he had Swine Flu and was not prescribed Tamiflu for the reason given.

Medical Records.

There was no criticism apart from Mr Hewitt thinking ideally that the advice might be more fully noted. There was no criticism of the advice, diagnosis or plan of management.

Admission to hospital.

The symptoms presented by Mr Anderson when examined by Dr Barron did not merit his admission to hospital in terms of the Department of Health Guidelines as at September 2009. As with Mrs Winsborough, it is possible that Mr Anderson's death might have been avoided by his admission to hospital. However, this comes under the general truism that the sooner someone is treated the better the chance of survival. A GP is not expected to admit to hospital every person who presents as unwell. There may have been checks such as a chest x-ray carried out on Mr Anderson but both Dr Toft and Mr Hewitt believe that he would probably have been released if admitted on the Saturday evening.

Dr Nawroz said that once ARDS set in it was difficult to treat and that the relationship between it and Swine Flu simply was not known. Accordingly, if Mr Anderson had

been admitted to hospital suffering from ARDS, there was no guarantee that he might have survived. The timing could be crucial.

Section 6(1) (d) of the Act.

In terms of this subsection I found that there were no defects in the system of working, which contributed to Mr Anderson's death. I refer to my observations in the case of Mrs Winsborough insofar as they relate to the death of Mr Anderson.

Section 6(1) (e) of the Act.

In terms of this subsection there were no other facts relevant to the circumstances of Mr Anderson's death. I refer again to my observations in the case of Mrs Winsborough insofar as they relate to the death of Mr Anderson.

Final Observations.

Apart from the fact that Mrs Winsborough and Mr Anderson were healthy adults before they became ill and developed a rare condition, I can see no obvious link between the deaths. It is a sad inescapable fact, possibly not understood by some persons in modern times, that otherwise healthy people can become ill and die. What stimulates the actual cause of death is frequently not understood by the medical profession, as in these cases. That is the reason we have medical research. The cause of each death could not have been foreseen at the time each was examined. The cause of death in each case was rare and unusual. It is not known why either of the deceased should have become susceptible.

In both cases the families became aware of worsening symptoms and condition and exhorted Mrs Winsborough and Mr Anderson to seek medical attention. The

Winsborough family saw that Mrs Winsborough was not improving. Gastroenteritis had been the proper diagnosis at the time of her examinations. The best person to determine whether symptoms are improving or not is the patient. It is difficult to understand why she thought that there was “no point” in returning to hospital. When she was seen by Dr Carson her condition had not worsened significantly from when she was seen by Dr Alcock. I could understand her position better if it had worsened significantly and she was being given the same advice as before.

The Anderson family makes much of not realising that Mr Anderson had Swine Flu and seem to equate that with a more serious condition meriting hospitalisation when the medical evidence at the time of his examination did not support this . They would have taken him to hospital, if they had known. How they would do this when he refused to seek further medical assistance is not explained. They could not force him to go to hospital against his will. The evidence is that thousands of people, including many pregnant women, had Swine Flu and recovered without needing to go to hospital or suffering any harmful ongoing effects.

In each case, for possibly differing reasons, the wishes of the family were ignored by the deceased with fatal consequences.

Mr Robertson in his conclusions submitted that a balance required to be drawn between the vast majority of patients presenting with similar symptoms to Mrs Winsborough and Mr Anderson recovering within a few days and steps and processes being required to properly identify cases where a more serious condition is present but initially presents with similar symptoms. He does not advise as to how such latter cases can be identified.

He stated that the risk of future deaths even if not common should not be ignored simply because the majority of patients recover with little or no intervention. There was no evidence that such risk was ignored by the medical profession.

He went on to submit without any evidence whatsoever that reasonably practicable measures do exist which indicate that some deaths in the future might be avoidable. He did not advise what these were.

He wished a proactive approach by the medical profession. He did not advise what form this should take.

He went on to assert that there is an assumption that Diarrhoea and Vomiting cases will resolve and self-limit. In my view. if this is truly the case there would be no reason for doctors indicating that if symptoms do not improve or got worse within 24 hours a further visit to the GP is required.

He said that it should not be assumed that all patients will correctly identify the right time when their condition requires further medical help. That may be true but it also applies to the medical profession itself in connection with rare and unusual conditions. Mr Robertson does not specify who will identify the right time, if the patient is not to be relied upon to identify that he or she is not feeling well. He seems to suggest that some unspecified system of control over patients should be imposed. This would involve a seismic change in the present law.

On the other hand, it may be that common sense dictates that the best person to know how the patient is feeling is the patient.

This Inquiry was instigated by the Crown for the purpose, as far as I can see, of helping to resolve a number of questions raised by the families of the respective deceased. There was no evidence of reasonable precautions whereby the deaths might have been avoided or of any systemic failure on the part of the professionals involved.

No expert evidence was led to this effect, even from Dr Toft, the Crown's expert. There is no suggestion that any symptoms of either deceased had been missed by the doctors concerned. The causes of death, known within a few days of each death, were both rare and unusual. All of this would have been apparent to the Crown before this Inquiry was instigated.

The question may be legitimately asked as to why the Crown felt that it was in the public interest, as distinct from that of the families, to have this Inquiry. The evidence was available before the Inquiry began that there was no satisfactory answer to the questions posed by the families. The public interest justifying an Inquiry seems to be unidentified. In ***Emms v Lord Advocate [2011]CSIH 7,*** there were references to the deceased's medical notes and the possibility of a need for improvement in certain procedures but…" what was being sought was in essence an Inquiry in the hope that something of concern might emerge which none of those who had examined the case thus far had noticed." Mr Robertson's reference to Dr Alcock's lack of computer skills or the prescription of Ibuprofen by Dr Carson *inter alia* could be regarded as examples of this approach, disapproved of by the Inner House.

The justification of an Inquiry such as this must be that it is in the public interest and not be used simply as a forum for questions raised by the families concerned.

John Craig Cunningham McSherry

Sheriff of Tayside, Central and Fife at Dunfermline,

8th August 2011