2011 FAI 48

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

INQUIRY HELD	DETERMINATION by ANDREW
UNDER FATAL	MacINNES CUBIE, Esquire, Solicitor
ACCIDENTS AND	Advocate, Sheriff of the sheriffdom of
SUDDEN DEATHS	Glasgow and Strathkelvin following an
INQUIRY (SCOTLAND)	Inquiry held at Glasgow on 11th to
ACT 1976	15th April Two Thousand and Eleven
SECTION 1(1)(a)	into the death of ELIZABETH LOWRIE
SECTION 1(1)(b)	who died on 16 March 2007 at 2.40 pm.

GLASGOW, October 2011. The Sheriff, having resumed consideration of the cause, FINDS AND DETERMINES as follow:

Mrs Elizabeth Lowrie died at Glasgow Royal Infirmary at 1442 on 16 March 2007.

The cause of her death was 1a. Multi-organ failure due to

1b. Necrotising fasciitis of groin (surgically operated).

A reasonable precaution which might have avoided Mrs Lowrie's death would have been for due consideration to have been given to the full contents of the report of the CT Scan performed on 6th March 2007 and for appropriate further investigation and if necessary intervention to have been undertaken.;

A reasonable precaution which might have avoided Mrs Lowrie's death would have been for that report, of the CT scan performed on 6th March 2007, to have been communicated in full to Dr McKee

Representation.

[1] The Crown was represented by Miss Nicol, Procurator Fiscal Depute, Glasgow. Dr Ruth McKee was represented by Mr Andrew Pollock, Solicitor, Glasgow. Dr Fat Wui-Poon was represented by Miss Donald, Solicitor, Edinburgh and Greater Glasgow Health Board was represented by Mr Douglas Ross, Advocate.

[2] I am extremely indebted to all parties for the measured and focused way in which this matter was conducted. The management of the case was considerably assisted by the fact parties had been able to agree the provenance of all the productions by way of Joint Minute and by Crown having arranged affidavits sworn by four witnesses. The parties' representatives were able to focus on the matter at issue and to the credit of all the representatives the matter was concluded before lunchtime on fifth day.

[3] I am satisfied that in conducting the matters all relevant matters were addressed so far as they could be and that, although not represented, the family concerns were addressed.

The scope and purpose of a fatal accident inquiry

[4] The purpose of the Inquiry in terms of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 is for the Sheriff to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction-

> (a) Where and when the death and any accident resulting in the death took place;
>
> (b) The cause or causes of such death and any accident resulting in the death;
>
> (c) The reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided;
>
> (d) the defects, if any, in the 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

(all in terms of Section 6(1) of the Act)

[5] The Court proceeds on the basis of evidence placed before it and although described as an Inquiry, the Sheriff's powers generally do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the Procurator Fiscal and any other party if so advised.

[6] The purpose of a fatal accident inquiry is to enlighten and inform those persons who have an interest in the circumstances of the death. It is to ensure that members of the deceased person's family are in possession, so far as possible, of the full facts surrounding the death. The broader function of such an inquiry can be additionally to ensure that the circumstances are fully examined and disclosed in the public domain.

[7] It is the function of the FAI, where appropriate, to establish whether there were any reasonable precautions which might have prevented the death and to examine whether any defects in the system working were identified which contributed to the death. Thus the objective of such a public enquiry must be to ensure where lessons can be learned and steps taken to avoid any future recurrence, that these are identified and brought to the attention of those who are in a position to implement them. In this connection, it is a legitimate aim of an FAI brought under section 1(b) where there may be serious public concern, that

wherever possible, that concern is assuaged and public confidence restored. This is particularly so where, as here, a public institution such as hospital is involved.

[8] Section 6(3) of the 1976 Act provides that the determination of the sheriff shall not be admissible in evidence or be founded upon in any judicial proceedings, of whatever nature, arising out of the death.

[9] It is well-settled that it is not the purpose of a fatal accident inquiry to determine any questions of criminal or civil liability or to apportion blame between any persons who might have contributed to the accident [or death] (Black v Scott Lithgow Limited 1990 SLT 612 *per* the Lord President (Hope) at p 615G-H).

[10] It is not a forum in which it is appropriate to make finding of fault. It is a fact-finding procedure, not a fault-finding procedure. Lord Cullen in his recent review of fatal accident inquiries: (Report of the Review of Fatal Accident Inquiry Legislation (2009) at paragraph 3.23 considered the role of the sheriff in his final Report. With particular reference to recommendations he expressed the following views at paragraph 3.28:-

> [I]t is, in my view, unsatisfactory that there is uncertainty as to the power of the sheriff to make recommendation arising out of his or her findings, or as to the potential scope for such recommendations. I am in no doubt that the

> sheriff should be able to make recommendations directly related to the circumstances of the individual death. At the same time I consider that there is considerable force in the arguments against the sheriff making recommendations of general application, to which I have referred…
>
> It would be inappropriate, in my view, for an FAI to be treated as if it were a public enquiry taking a nationwide approach and calling for far greater resources. For a sheriff to over-reach what could be supported from his evidence would detract from the respect which his or her recommendations deserve

[11] Accordingly, any recommendations should be recommendations directly related to the particular circumstances of the case and any such recommendations should recognise the limitations of the procedure and the evidence heard and avoid "over-reach". In framing this determination I have in mind the restrictions on the enquiry and the powers to make recommendations.

In the course of this Inquiry, it was accepted that Mrs Lowrie's death was preventable. In other words, it should not have happened.

[12] Mrs Lowrie was sent home on 8th March 2007 notwithstanding the existence of a CT scan report dated 6 March 2007 and verified at 14:40 on that date as follows:

> "The lung bases are normal.
>
> The appendix is well visualised and there is no evidence of appendicitis. Normal looking terminal ileum. No adjacent adenitis.
>
> On image 75 there is an apparent 2cm mass in the ascending colon. I think this is due to faeces but nfurther investigation of this area is suggested for confirmation.
>
> Of more significance the presence of air lying adjacent to the femoral vessels. This is associated with surrounding groin inflammation and a 1cm enhancing node is present.
>
> There is a 4.5cm cystic area in the left hemipelvis probably representing an ovarian cyst.
>
> Previous cholecystectomy is noted. CBD is dilated but no stone is identified. Normal liver, pancreas, adrenals kidneys and spleen"

The report concluded

> "Impression. Inflammatory changes with a small amount of air at present in the right groin. No appendicitis was demonstrated."

The consensus of the evidence was that a CT scan in those terms was sufficiently explicit for a consultant or a doctor at senior level to have recognised the risk to Mrs Lowrie of discharging her without further exploration, and she would have been subject to further testing and

treatment. Such further treatment and testing would have been likely to have prevented her death.

[13] The real issue for the Inquiry was, in the circumstances surrounding her discharge, whether any precautions could and should have been taken may have avoided that error and whether there were defects in the system of work which resulted in the failure to consider the full report and absorb its findings in advance of her discharge.

[14] I wish to pay tribute to Lowrie family. The family were not represented although from time to time Mr Lowrie sat in to hear the evidence. His son and daughter heard most of the proceedings on the first day. As Mr Lowrie observed, the family still felt "very raw" about Mrs Lowrie's death. She was an important and well loved part of the extended family and was plainly still much missed. Although it was clearly difficult for Mr Lowrie to give evidence, he did so with the composure, dignity and an objectivity that can sometimes in such circumstances be difficult to maintain, an objectivity which he also demonstrated in his letter (Crown production number 15), about which I say more later in this determination. I express the condolences of the court in relation to Mrs Lowrie's untimely death.

[15] The evidence was presented very helpfully in a chronological way from Mrs Lowrie's admission, spoken to by Mr Lowrie through to the post-mortem report.

I had little difficulty in concluding that the witnesses who spoke to facts endeavoured to give their best recollection of the circumstances.

I found the following facts established.

(1) Elizabeth Lowrie was born on 2 March 1946 and formerly resided at 41 Edrom Street, Glasgow. On 5 March 2007. She attended her General Practitioner complaining of pain in her lower right abdomen, her right iliac fossa. Her General Practitioner referred her immediately to the Accident and Emergency Department, Glasgow Royal Infirmary.

(2) She complained of being in constant pain for a period of three days or so, the pain was severe and she also had a loss of appetite. She had had a fever. Antibiotics had no effect on her pain.

(3) Having attended Glasgow Royal Infirmary, she was re-examined at 11.13 am by Dr Andrew Russel. She was seen by way of surgical fast track examination.

(4) She was transferred to Ward 60, a surgical receiving ward and was seen at 15.05 by Dr Ganai. Dr Ganai was a Foundation Year 1 doctor, in her first year of training after university. She had been in the surgical receiving ward for only a few days. She took a detailed history. Dr Ganai recorded a rash along the Pfannensteil scar. The rash had not been recorded by Dr Russel.

(5) Following the detailed examination Dr Ganai recorded a plan to take a blood test and to arrange an abdominal ultrasound as well as for a senior medical review.

(6) The senior review was carried out by Dr Hamish McEwan at 5.00 pm. Again, he noted a right iliac fossa tenderness. He formulated a number of possible diagnoses including ovarian sists, appendicitis, renal colic, or urinary tract infection.

(7) At 5.40 pm Dr Ruth McKee, the Receiving Surgical consultant on duty at the Royal Infirmary reviewed Mrs Lowrie. She noted the urinary analysis showed that there was some blood and protein in the urine, which result pointed to a possible urinary tract infection. Abdominal examination confirmed the right iliac fossa tenderness. Mrs Lowrie was allowed food and drink. She was to be reviewed by the consultant the following morning.

(8) At 6.00 pm Mrs Lowrie was given painkillers in the form of co-codamol tablets.

(9) On Tuesday, 6 March at approximately 8.40 am Dr McKee examined Mrs Lowrie again as part of her ward round. Dr Ganai took notes. She was still tender in the right iliac fossa. She was feverish. Dr McKee ordered that a CT scan was undertaken, primarily to exclude the possibility of either appendicitis or a caecal tumour.

(10) Dr Ganai, as was commonly the position of the FY1 doctors, was asked to arrange the CT scan. She completed a radiology request form (Crown Production 4) seeking an urgent CT scan. The form was completed as follows;

> "61 year old female. Acute onset RIAF pain ++ with tenderness for approximately five days. Nausea and associated change in bowel habit. ? appendicitis/caecal tumour.

The history did not disclose any rash on completion of the form; the rash was not significant in terms of the investigation of the suspected underlying abdominal pathology.

(11) At 12.17 pm on 6 March the CT scan was carried out. This was reported on by Dr Poon, Consultant Radiologist. The report was verified at 2.40 pm. The scan is in the following terms

"The lung bases are normal.

The appendix is well visualised and there is no evidence of appendicitis. Normal looking terminal ileum. No adjacent adenitis.

On image 75 there is an apparent 2cm mass in the ascending colon. I think this is due to faeces but nfurther investigation of this area is suggested for confirmation.

Of more significance the presence of air lying adjacent to the femoral vessels. This is associated with surrounding groin inflammation and a 1cm enhancing node is present.

There is a 4.5cm cystic area in the left hemipelvis probably representing an ovarian cyst.

Previous cholecystectomy is noted. CBD is dilated but no stone is identified. Normal liver, pancreas, adrenals kidneys and spleen"

"Impression. Inflammatory changes with a small amount of air at present in the right groin. No appendicitis was demonstrated."

(12) Whilst the result of the scan excluded the concerns of appendicitis and caecal tumour, the existence of air in the right groin is a well recognised indicator of infection and possible necrotising fasciitis, which would ordinarily give rise to further investigation and treatment

(13) Dr McKee saw Mrs Lowrie later that evening in the course of the evening ward round. CT scan result was not available to her. Mr Lowrie was in attendance visiting his wife. He asked about the CT scan. On such enquiry Dr McKee asked one of her colleagues in the surgical team to find out about the scan.

(14) Insofar as it is possible to ascertain what happened at that stage, it appears that an un-named and unidentified doctor from the surgical team was in touch with an un-named and unidentified doctor from the Radiological Department, receiving confirmation that the CT scan excluded appendicitis or a caecal tumour as causes of Mrs Lowrie's illness. It cannot be satisfactorily established what the identities of the two medical practitioners involved were, or how or to whom the gist of the scan report was communicated. Mr Lowrie was told that there was nothing of concern from the scan. That was correct so far as excluding appendicitis and caecla tumour was concerned. It was incorrect so far as the identification of air in the groin area was concerned.

(15) On the morning 7 March Mrs Lowrie was again seen as Dr McKee's ward round at about 8.40 am. Again, the notes were taken by Dr Ganai. The results of the scan were known *insofar as they excluded appendicitis or caecal tumour . It* cannot be established from the evidence how that information was known to the surgical team. On the basis of that information Mrs Lowrie's notes were marked "CT shows no appendicitis".

(16) Dr McKee was unaware of the full contents of the scan report including in particular the reference to the air. On the basis of the information disclosed to her, Dr McKee formed

the impression that the CT scan had not disclosed any matters of concern. Mrs Lowrie's clinical systems at that time were improving. She felt much better. There had been slight improvement in both her CRP and WCC counts. On Thursday, 8 March, Dr McKee again saw Mrs Lowrie for the consultant's ward round. Notes were taken by Dr Morton; the prescription sheets disclosed that Mrs Lowrie's painkilling needs had reduced; both the CRP level and light blood cell count levels appeared to be reducing or at least stabilising. In the absence of the CT scan report, the verbal report of which had not highlighted any concerns; she concluded that cellulitis was a working diagnosis. Dr McKee considered that Mrs Lowrie could be discharged.

(17) Mrs Lowrie returned home on the 8th March. By 10 March 2007 Mrs Lowrie had not improved, and was re-admitted to Glasgow Royal Infirmary again through referral from her General Practitioner. She still had tenderness in her right iliac fossa. She had a high temperature. She was reviewed by Professor Imrie, the Receiving Surgical consultant on 11 March 2007. Clinical examination revealed a right groin abscess, lower abdominal wall cellulites and a high temperature. The plan was for surgical drainage and debridement of the abscess on the same day. A CT scan was performed in anticipation of the surgery. The CT scan disclosed an extensive gas containing abscess cavity.

(18) On 11 March 2007, Mrs Lowrie underwent surgery in relation to the abscess of the right iliac fossa and for debridement of tissue affected by necrotising fasciitis. She underwent

further surgery on 13 March 2007. A second operation to excise tissue affected by necrotising fasciitis is a regular and intelligible consequence initial surgery for such a condition.

(19) Between 13 March 2007 and 16 March 2007 Mrs Lowrie was in the High Dependency Unit and then in Intensive Care Unit as she was not improving. Life was pronounced extinct on 16 March 2007 at 2.40 pm by Dr Charlotte Gilhooly.

(20) A post-mortem examination was carried out on 22 March 2007 by Dr John Clark, the cause of her death was recorded multi-organ failure due to Necrotising fasciitis of groin.

[16] In the event there was no real dispute about the cause of death, nor that an appreciation of the terms of the first CT scan on the 6th March would have alerted any reasonably competent practitioner to the danger arising from the air or gas shown in the scan.

There is no criticism of the doctor who carried out the scan; it was done promptly, properly and identified the relevant areas of concern; the report was clear in discounting the two matters originally giving cause for concern and in identifying the gas.

The issue was whether there was any defect in relation to the provision of the information; there plainly was a material issue, in that the information was not properly passed to those doctors who were treating Mrs Lowrie.

[17] As I assess the position, in a brief unrecorded communication which may have been by telephone or directly, the results of the scan were passed on to the extent only of excluding the two concerns expressed in the referral form; crucially the gas was not mentioned. As I address below, it is a matter of considerable regret that enquiries were not made at the time of the death to identify the personnel who were involved in that exchange, but in the absence of their contribution, the court is significantly handicapped in relation to the findings to be made.

[18] There was expert evidence from three witnesses, all of whom were eminently qualified to be treated as experts in their fields. Dr Dilip Patel is a consultant radiologist at the Royal Infirmary of Edinburgh. He had prepared a report, Crown Production no 7. His evidence was to the effect that the formal verified report by a radiologist (Crown Prodsuction no. 2) is the meaningful report and not the verbal exchange of information; he did accept that consultants would proceed on the basis of information provided verbally by member of their team. He also gave evidence that mention of a rash would have given rise to suspicion of a gas producing infection or necrotising fasciitis. Both his report and evidence excluded any fault on the part off Mr Poon. Mr Peter King is a consultant surgeon at Aberdeen Royal Infirmary. He had, on the instriuctions of the crown prepared three separate reports. The first and second reports were to the effect that necrotising fasciitis should have been diagnosed during the admission between the 5th and 8th March having regard to the information available, but crucially that information included the scan result. That position is accepted by all parties.

The third report, to which he spoke, suggested means of recording the results of tests such as the CT scan., holding that it would be reasonable for each test results to be printed off and kept together; he suggested that a doctors' order sheet be kept, chronicalling all tests, the printed results of which should be kept in the patient records. He did require to draw back from the absolutes of his own evidence that a written report should always be seen, although he deponed that such a procedure would be best practice.Professor Imrie is a surgeon at Glasgow Royal Infirmary who dealt with Mrs Lowrie after her second admission; his evidence accordingly covered his own dealings with her and his observations on the first period of her admission. Professor Imrie also accepted that there were occasions when a verbal report would suffice.

Submissions

[19] The written submissions are available so I propose to give a brief synopsis only.

The Crown submitted that there were defects as follows; there should be a mandatory requirement that the full CT scan results be available and considered prior to any discharge; similarly there should be a mandatory provision that any such report should not be given verbally. I was invited to recommend that, in respect of emergency patients where surgical intervention may be required, the full results of all CT scans should be available and

considered prior to the discharge of any such patient, unless it is clear such intervention is not required.

[20] I was invited to recommend that there should be a checking procedure to ensure that full formal reports are checked, noted and acted upon prior to discharge, including the date and time of such recording a matter said to be supported by Mr King's evidence.

Observations were made about the unsatisfactory nature of the transmission of information; it was submitted that the rash noted by Dr Ganai was significant in relation to the diagnosis of Necrotising fasciitis.

[21] For Dr McKee; Mr Pollock's written submission contained a very helpful narrative as his client saw matters. It will be clear in what respects the court's findings vary from those suggested by Mr Pollock. He submitted that leaving aside the issue of the CT scan, there was no basis for any criticism of Dr McKee's care and treatment of Mrs Lowrie; he acknowledged that if she had known of the full results, her evidence was that she would not have discharged Mrs Lowrie.

[22] He emphasised that her decision was not taken in the absence of the CT scan, but rather in the absence of having seen the written report.

[23] He submitted that Mr King's evidence supported the submission that significant decisions could and would be made on the basis of a verbal report. He submitted that, as a matter of principle, a clinical decision, including the decision to discharge, could be made on the basis of

a verbal report. Dr McKee had relied on a colleague's reporting of the result; that could not be unreasonable, despite Mr King's apparent evidence to the contrary.

[24] He submitted that if there were to be any recommendation, it should be restricted to a recommendation that a reasonable precaution would have been for the unknown doctor who received the information to have communicated the full terms of the report to Dr McKee.

[25] Miss Donald made no submissions, as Dr Poon was no longer subject of criticism.

[26] For the Health Board, Mr Ross accepted on the evidence that three propositions could be made; whilst the scan ruled out appendicitis and caecal tumour, the abnormal findings should have prompted further investigation; that in light of this Mrs Lowrie should not have been discharged; and had appropriate investigation been carried out, Mrs Lowrie's death may have been avoided. He submitted that the focus was on the mystery doctor who apparently knew the results of the scan a t least in respect of excluding appendicitis and caecal tumour.

[27] He suggested a recommendation to the effect that due consideration should have been given to the full report

[28] He accepted that account should have been taken of the scan; however he submitted that just because something had gone wrong, as it plainly had, it did not mean that the system was defective. He submitted that Mr King's evidence about an order sheet being part of the records did not provide a solution. He submitted also that there was no evidential basis for finding that the consultant in charge should read every report .He submitted that such a finding would have implications beyond this health Board. Even Mr King did not make that

unequivocal finding. In any event he submitted, the sheer practicalities of insisting that every report was read could not be easily assimilated into the busy life of a hospital.

[30] I was grateful for the focused and thoughtful submissions. I also have in mind the restrictions on an enquiry such as this as previously noted and in particular the requirement for a sheriff conducting such an enquiry not to overreach him or herself in making recommendations. For these reasons, the recommendation and findings are restricted.

Observations on the evidence.

[31] There is no criticism of Dr McKee's treatment of Mrs Lowrie, proceeding on the basis that she was not at the time of the discharge aware that the scan had gone further than simply excluding appendicitis or caecal tumour. I accept that she was unaware that the scan had been improperly communicated; significantly she was unaware that the report to her was incomplete.

[32] I do not regard the absence of reference to the rash on the referral form for the CT scan to be significant; despite Dr Patel's evidence, it was clear that neither Dr McEwan nor Dr McKee regarded the rash as significant. The CT scan highlighted the air; it was the dissemination of the report that caused the difficulties.

[33] I think it is to overstate matters to invite the conclusion that there was evidence that Mrs Lowrie was suffering from necrotising fasciitis, absent the CT Scan result. At the time that the

incomplete result was given to Dr McKee, the clinical signs were of improvement, and in the absence of the report, the working diagnosis of cellulitis was intelligible and reasonable.

[34] So far as the suggestion, apparently implemented in the area in which Mr King works, of having a separate folder with specific information in relation to acute admissions, I am conscious about the difficulty in making recommendations about the means of recording medical information being altered to include further information ; indeed in this enquiry Dr McEwan expressed concerns about the additional burden imposed by further noting . It is also not clear how that would have assisted in this particular case. The evidence was that the report would have reached the notes.

[35] Mr King was clear in his evidence initially that the formal CT scan result should have been seen and considered by Dr McKee prior to discharge; the crown ask me to find that it was a reasonable precaution that no discharge should proceed in the absence of such consideration. Mr King was described in Mr Pollock's submissions as adopting the most "hard line" position in relation to the unsatisfactory nature of verbally reporting the results of tests such as the CT scan.. However, a number of witnesses, including Dr McEwan, Dr Patel and Professor Imrie recognised that verbal transmission of information was part of the normal currency of a medical team. Mr King even conceded that in some circumstances, doctors can rely on verbal reports. It becomes a matter of facts and circumstances and of degree.

[36] It also respectfully seems to me that words such as "always" and "never" are very extravagant terms in the medical lexicon and it is difficult to see, in the context of the evidence

which I heard (and having regard to the observations made a paragraph [??]), that there is room for any recommendation that reports must always be seen, or that a patient must never be discharged without such a report being seen; such recommendations are in danger of usurping the clinical judgement of the doctor, and of over reaching in terms of appropriate recommendations.

[37] I recognise that it may be a matter of regret, particularly to the family, that no specific recommendations can be made; however I consider that in the absence of evidence in relation to the precise transfer of information about the CT scan result, no such recommendations can properly be made.

Mr Lowrie's written complaint

[38] There is a matter which I wish to address in a little detail although it is not a matter which would have made any difference in the prevention of Mrs Lowrie's death.

[39] Mr Lowrie wrote on behalf of his family a detailed letter (Crown production no 15) raising a number of issues of concern. The letter was thoughtful, well- reasoned and temperate in its nature. This letter elicited a response from the Patient Liaison Officer (Crown Production no 16) which, I am afraid, may have contributed to the apparent inability now, in 2011, to identify the principal actors in relation to how the results of the scan was discovered and that information disseminated.

[40] The letter (no.16) says, at the last paragraphs on the first page

> "Dr McKee was concerned that this picture might represent a tumour in the lower right abdomen and therefore she requested a CT scan. At the time of the ward round that you mention in your letter [5.40pm on the 6th March] the result of the CT scan was not yet available. Dr McKee wished to obtain the detailed results and therefore one of the radiologists was contacted at home that evening to clarify the results. Once the details had been obtained, Dr McKee asked one of the ward doctors to discuss the results with you and your wife, as she was aware that you were concerned. Dr McKee has apologised that she was not able to provide you with any information at the time of the ward round. She did, however, try to ensure that the information was obtained and conveyed to the family as soon as available…
>
> "Dr McKee advises that the CT scan revealed some inflammation in the groin and examination of the skin in this area showed some redness. However this did not appear to be particularly serious and therefore the decision was taken to treat this inflammation with antibiotics."

[41] This letter rather gives the impression that Dr McKee had seen, or at least been *fully* aware of the CT scan result and had not regarded it as significant in the context of identifying the possibility of Necrotising fasciitis. It asserts that an unidentified member of staff "clarified" the result of the test, whatever that may mean. That was potentially misleading.

[42] In the first place, Dr McKee had not seen the scan at the time of discharge, nor had she been made aware of the full terms of the report (although she had no doubt seen it by the time the letter was sent).

[43] In the second place every medical professional who spoke to the scan result considered that it gave rise to an immediate concern which would have provoked further intervention because of the existence of air or gas in the abdominal cavity.

[44] The juxtaposition of the phrases "the CT scan revealed some inflammation in the groin" and "this did not appear to be particularly serious" gives a clear impression that the scan did not give rise to any serious concern. This is plainly incorrect

[45] The consequence of this assertion was to incorrectly focus the issue upon Dr McKee's competence in relation to absorbing and assessing the result of the CT scan, a focus which obviously continued up until the hearing of evidence itself; Dr McKee's representation was no doubt, to some extent at least, informed by that issue. It is evident from the reports prepared by Mr King in April and October 2008 that the issue causing concern was the failure to take account of the results of the CT scan rather than any concerns about the results being fully available to the medical team caring from Mrs Lowrie.

[46] It is perhaps unrealistic in 2011, given the turnover in junior doctors, to expect an ability to identify transient members of a medical team in March 2007; however, at the time the letter was written (in June 2007) it cannot have been beyond the capability of the hospital to identify those junior doctors who had been working then; memories would have been fresher,

particularly given that such memories could have been prompted by Mr Lowrie's apparent ability to describe the physical appearance of the doctor to whom he spoke on the 6th March. However, as a result of this impression that opportunity was lost and neither the court nor the Lowries will ever be able to hear evidence from those principally involved in obtaining the result of the CT scan and passing that information on to the Lowries, Dr McKee and the surgical team.

[47] The letter is open to interpretation; on one view it appears that no clinical advice was taken about the significance of the CT scan result, or the author of the letter would surely have not asserted so boldly that there was nothing concerning about the scan result. That seems an unlikely omission.

[48] If the letter was indeed written in error about the significance of the results then it is most unfortunate; it served to obfuscate matters and act as a barrier to investigation of the real issue (how the information was disclosed and circulated) instead of raising what has become a non issue, the ability of Dr McKee to properly consider the report of the CT scan.

[49] If the significance of the scan was understood, then it is difficult to understand the basis upon which it was sent.

[50] However the letter arose, and whatever its intention, this matter would have made no difference to the death; however, if the letter had contained a less defensive version of the events surrounding the dissemination of the scan results, that would have allowed enquiries to be made about the identity of those doctors involved in obtaining and sharing the results, to

determine what questions were asked and answered, and may have assisted in a thorough enquiry of the circumstances between the verification of the scan at 14.40 on the 6th March and the ward round at 08.40 on the 7th March. It is very regrettable that such an opportunity was lost.

Sheriff Andrew M Cubie