INQUIRY INTO THE DEATH OF MRS MARGARET GRAHAM

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Inquiry into the circumstances of the death of Mrs Margaret Graham

Determination

by

Sheriff Principal Sir Stephen S T Young Bt QC

Inverness, 19 April 2006

The sheriff principal, having resumed consideration of the evidence and submissions thereon, determines as follows:-

[1] The late Mrs Margaret Graham (date of birth 14 January 1934), 6 Craig Phadrig Terrace, Inverness, died at Raigmore Hospital, Inverness, at approximately 5.30 pm on 17 February 2005. The principal cause of her death was Wegener's Granulomatosis. At the time of her death she also suffered from Goodpasture's Disease but the extent to which this contributed to her death is uncertain.

[2] Wegener's Granulomatosis is a very rare disease, and Goodpasture's Disease is even rarer.

[3] I have not thought it necessary to make detailed findings in fact about the circumstances which led up to Mrs Graham's death. There was no material dispute about what happened, and the evidence has all been recorded and this and the documents which were referred to by the witnesses during the inquiry all speak for themselves. I am happy to record that, judging by their respective demeanours, I saw no reason to doubt the credibility or the reliability of any of these witnesses.

[4] The first witness at the inquiry was Miss Sheila Rennie, one of Mrs Graham's daughters. Having completed her evidence she represented the interests of her family throughout the remainder of the inquiry. Considering that she is not legally qualified, I thought that she did so with admirable skill and care (to the extent even of preparing very thorough and helpful written submissions at the close of the evidence), and I like to think that her late mother would have been proud of her.

[5] Some time after the inquiry had been completed Miss Rennie delivered to the sheriff clerk for my attention a large envelope which contained what appeared to be a selection of excerpts taken from the Internet of various articles and the like about Wegener's Granulomatosis and its treatment. I do not doubt that Miss Rennie did this

in good faith and in an attempt to assist me in preparing my determination. But I should say that I have not read these excerpts since they did not form part of the evidence adduced during the inquiry, so that the other parties who were represented did not have an opportunity to comment upon them or, it may be, to challenge their contents. My duty under section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 has been to prepare my determination in light of the evidence and submissions thereon which were presented during the inquiry itself, and it would have been altogether improper for me to have taken into account also material which was not brought out in open court in the presence of all the parties.

[6] I might add here that I did consider the possibility that I might reconvene the inquiry to allow the other parties to read and comment upon the material which Miss Rennie had delivered to the sheriff clerk. I decided not to do so. It is I dare say an experience familiar to every court practitioner that, following the conclusion of proceedings, he or she will think of other points that might have been made to the court or evidence that might have been put before it. But there comes a time in every case where a line must be drawn under the parties' representations and the court must thereafter proceed to reach its decision on the basis of these representations. It does of course sometimes happen that, before issuing its decision, the court may choose for one reason or another to reconvene proceedings to allow a particular point to be explored by the parties. But it is one thing for a court to do this on its own initiative, and quite another for one of the parties uninvited to seek to influence the outcome of a case by presenting further evidence to the court after the proceedings have been concluded.

[7] In judging the actions of those involved in one way or another in the death which is the subject of a fatal accident inquiry, neither the sheriff nor the parties should lose sight of the fact that they have all the advantages of hindsight and the opportunity afforded by the inquiry for a detailed examination of both witnesses and documents. It is important too to recall that those whose actions are under scrutiny will usually have had other persons to think about apart from the deceased. In my own experience I have sometimes detected a tendency among parties at a fatal accident inquiry to overlook this vital point and to proceed, for example, as if doctors and nurses had no other patients to care for apart from the deceased. Needless to say, the same principle applies wherever a duty of care is owed to a number of persons, for example in schools, nursing homes and prisons.

[8] Commonly in an inquiry such as this, in which the acts and omissions of medical practitioners are under investigation, evidence may be led from an independent medical expert who has reviewed the whole case and prepared a report highlighting alleged deficiencies in the care given to the deceased patient. Those medical practitioners who have cared for the patient will then have an opportunity to consider the report in advance of the inquiry and respond to any allegations made against them, if need be by leading evidence from a further independent medical expert. In deciding what findings, if any, he or she should make under section 6(1) of the Act, the sheriff then has the task of assessing the competing accounts of the medical witnesses and deciding which account he should accept and which he should reject. In so doing the sheriff does not pretend to be a medical expert, and it would be wrong of him or her to do so. On the contrary, he or she is carrying out the same

judicial function of weighing up evidence as has to be carried out whenever two competing versions or interpretations of events are put before the court.

[9] Perhaps unusually in this particular inquiry, while I heard at some length from the various doctors in the Ardlarich Medical Practice and at Raigmore Hospital who had treated Mrs Graham, I did not hear any evidence from an independent medical expert to contradict what these doctors had had to say. I can think of various reasons why this might have been so, but it is not for me to speculate which one is correct. Miss Rennie, being a qualified nursing sister and midwife, had the advantage over others present at the inquiry including myself of having rather more familiarity with medical matters than might be possessed by the ordinary layman who has had the good fortune through life to have enjoyed a fair portion of good health. But I intend no discourtesy to Miss Rennie when I emphasise that she is not medically qualified so that, while it was quite proper for her to have raised questions about the treatment given to her mother by the doctors who gave evidence during this inquiry, it would be wrong for me in the absence of some compelling reason (of which there was none in this case) to prefer her assessment of the standard of care given to her mother to that of the doctors who gave evidence.

[10] Under reference to section 6(1)(c) of the Act, it was submitted by the procurator fiscal that, had a renal biopsy been carried out on Mrs Graham, it might have conclusively diagnosed her condition as Wegener's Granulomatosis and allowed better treatment of this condition by medication which might have prevented her death. It was further submitted that there were three occasions when such a biopsy could have been considered and instructed by medical staff at the hospital. These were (1) when the results of the ANCA test and the associated PR3 test became available towards the end of October 2004, (2) when the result of the second ANCA test became available in December 2004, and (3) after Mrs Graham had been seen at the Asthma Clinic at the hospital on 2 February 2005.

[11] Miss Rennie endorsed these submissions and in addition drew attention to her mother's medical history as disclosed in her hospital medical records. She suggested, as I understood her, that when she was admitted to the hospital as an in-patient in September 2004 a full medical, family and social history should have been taken both from Mrs Graham herself and from her medical records and an urgent ANCA test requested at that stage. She submitted that, in addition to the three occasions identified by the procurator fiscal, a renal biopsy could have been performed as early as September 2004 during her mother's stay in the hospital. As she (Miss Rennie) put it: "This would have proved a prime time considering that AAFBs were reported negative, the patient was then apyrexial and in the early stages of corticosteroid treatment (Prednisolone)".

[12] The difficulty I have with this last submission is that, so far as I can see from the record of the evidence, it was never suggested to the hospital doctors who saw her in September 2004 that a renal biopsy should have been carried out while Mrs Graham was an in-patient at the hospital, and there was no medical evidence to suggest that this would have been an appropriate time to instruct a renal biopsy. As for the other three occasions proposed by the procurator fiscal, all I think I need to say is that the hospital doctors who were asked about this gave what seemed to me to be perfectly reasonable and satisfactory explanations why a renal biopsy was not

instructed on any of these three occasions, and I heard no medical evidence to suggest that I should reject these explanations. Besides, it is I think far from clear exactly what would have been disclosed by a renal biopsy carried out on any of these three occasions or whether, had a decision been taken on the last occasion to perform a renal biopsy, this would have been done in time to save Mrs Graham's life.

[13] The procurator fiscal submitted that a further measure which might have prevented Mrs Graham's death was an increased awareness by the general practitioners who treated her in the community of the symptoms of Wegener's Granulomatosis and the potentially serious nature of this condition without appropriate treatment. It was submitted that, had these doctors had a better appreciation of the disease, they might have been able to pick up on potential symptoms and either initiate treatment themselves or refer Mrs Graham back to Raigmore Hospital for specialist advice. Here the procurator fiscal referred in particular to the three occasions when Mrs Graham was seen, firstly by Dr Inkson on 7 and 14 February 2005, and subsequently by Dr MacFarlane on 16 February 2005.

[14] I have a number of difficulties with these submissions. In the first place, as the procurator fiscal rightly acknowledged, given the proximity of these three visits to the date of Mrs Graham's death it is very difficult to say what difference, if any, it would have made to this outcome had the general practitioners been more familiar than they were with Wegener's Granulomatosis. Besides, I am not in the least persuaded by the evidence that I heard during the inquiry that it would have been reasonable to have expected these general practitioners either to have had this familiarity or to have taken steps following receipt from the hospital of Dr Bow's letter of 2 December 2004 to carry out their own independent research into the disease. As already indicated, the evidence amply demonstrated that Wegener's Granulomatosis is a very rare disease and neither Dr Bow's letter nor Dr Ferris' letter of 3 February 2005 gave any indication to the general practitioners that there was any particular urgency about investigating the possibility that Mrs Graham might be suffering from Wegener's Granulomatosis or that she should at once be referred back to the hospital in the event that she was found to be experiencing any specified symptoms.

[15] As between the hospital doctors on the one hand and the general practitioners on the other, I can see the force of the argument that, in the case of a very rare disease such as Wegener's Granulomatosis, it was really up to the hospital doctors to have advised the general practitioners what sort of symptoms they should be looking out for while Mrs Graham remained in the community and what they should do in the event that any such symptoms were observed in her. But again this issue was not explored as fully as it might have been in the evidence and I do not think that it would be right for me to express a concluded opinion on it. In any event, it should be reiterated that it seems doubtful whether, if Mrs Graham had been referred back to the hospital at any time on or after 7 February 2005, this would have afforded a sufficient opportunity to arrest the progress of the disease to the extent that her life could have been saved.

[16] Miss Rennie was critical of the fact that her mother had been prescribed Diclofenac which is a non-steroidal anti-inflammatory drug, and she posed the question whether it was a coincidence that her mother had become ill and displayed the same signs and symptoms after taking Diclofenac both in September 2004 and

in January 2005. This point was put to the general practitioners and, having heard what they had to say in reply, I need only say that I am not myself persuaded that it was inappropriate that they should have prescribed Diclofenac to Mrs Graham.

[17] As a layman in these matters I could not help thinking on several occasions during the inquiry that it was odd that a patient such as Mrs Graham should be treated by experienced general practitioners in the community only to be seen by very inexperienced members of the medical staff of the hospital on her visits to the Asthma Clinic. Here it will be recalled in particular that on 20 October 2004 she was seen by Dr Boileau who was then apparently only two months into her first post as a Senior House Officer, and on 2 February 2005 she saw Dr Ferris who was admittedly a specialist registrar but whose first day it was in the Asthma Clinic.

[18] In expressing these thoughts I intend no criticism of either Dr Boileau or Dr Ferris. But these considerations led me to reflect upon the basic question why patients are referred to a hospital in the first place. The answer is presumably two-fold. In the first place a hospital will have on its staff doctors and nurses who possess a degree of specialist knowledge, skill and experience which is not to be expected of an ordinarily competent general practitioner and his or her staff. And in the second place there are (or should be) available at a hospital specialist facilities for the diagnosis and treatment for diseases which again one would not expect to find at a general practitioner's surgery.

[19] If I am correct in this, then it ought to follow that the staff of a hospital at all levels, but in particular the senior management, should make it their business to ensure so far as is reasonably practicable that a patient who is referred to the hospital does indeed receive the full benefit of these specialisms. As I listened to the evidence during this inquiry, it became readily apparent that this had not happened in Mrs Graham's case. Here it will be recalled in particular that Mrs Graham attended three out-patient clinics at the hospital following her discharge on 24 September 2004. These took place on 20 October 2004, 1 December 2004 and 2 February 2005 and at them Mrs Graham was seen by Dr Boileau, Dr Bow and Dr Ferris respectively. Dr Evans, who had been the consultant chest physician in charge of her care while she had been an in-patient, was present and available to be consulted by his junior colleagues at only the first of these clinics. Thereafter, apart from having discussed with Dr Boileau the result of the positive ANCA test which was received from the Immunology Department on or about 27 October 2004, he evidently had no further involvement in Mrs Graham's care. At the second and third clinics attended by Mrs Graham Dr Hulks, at that time the other consultant chest physician at the hospital (there is now a third), was present and was indeed consulted by both Dr Bow and Dr Ferris. But he (Dr Hulks) had not previously had responsibility for Mrs Graham's care, nor had he seen her medical records. So it was reassuring, and indeed a tribute to the responsible approach of the doctors concerned (in particular Dr Evans who initiated the inquiry), to hear of the Significant Event Analysis Meeting held on 15 March 2005 and the report dated 23 April 2005 which resulted from it.

[20] At the conclusion of this report five recommendations were made for future practice based on the lessons learned from Mrs Graham's case. These were:

1. There should not in future be shared consultant clinics whereby a middle grade doctor does not have direct access to the consultant in charge of the patient's care.

2. There should be closer liaison between middle grade doctors treating a patient and the consultant responsible for care.

3. Notes of patients attending the Asthma Clinic should be previewed by the consultant wherever possible.

4. There should be closer liaison between primary and secondary care, preferably by telephone, should a patient under hospital management develop an apparent intercurrent illness in the community.

5. There should be proper access to online laboratory results in all the outpatient consulting rooms at Raigmore Hospital.

[21] These five recommendations were canvassed at various points during the inquiry, and I understood all the doctors concerned to accept them, at least in broad terms. Indeed those numbered 1 and 3 have already given effect by a reorganisation of the systems in the Chest Clinic at Raigmore Hospital. At the same time, I wonder in retrospect whether they went far enough towards ensuring that a patient does indeed the full benefit of the specialisms which the hospital has to offer. I can see the force of the point made by Dr Evans that it might be unwise to determine the appropriate systems on the basis of the experience of one case alone. But it does occur to me, for example, that it might be preferable that, so far as possible, a patient such as Mrs Graham should see the same doctor at each visit to an out-patient clinic. Moreover, it seems odd that a consultant physician who instructs certain tests to be carried out on a patient does not as a matter of course get to see the results of these tests. Here I have in mind in particular the fact that, although it was evidently seen by Dr Boileau, the PR3 positive test result was not apparently seen by Dr Evans at the time of its receipt from the Immunology Department towards the end of October 2004.

[22] Whether Mrs Graham would be alive today if different systems had been in place at Raigmore Hospital between September 2004 and February 2005 I am unable to say. But I do think that the question has to be asked why it should apparently have necessitated an event such as her death to prompt the review which took place on 15 March 2005. Two possible answers are that the hospital management does not have in place a procedure for the regular review of its systems in all departments or alternatively that, if there is such a procedure, the previous review of the systems in the Chest Unit was not as thorough as it might have been.

[23] These issues were not explored during the inquiry and so it would be wrong for me to make definite findings about them. I would merely express the hope that, if there is not already in place an effective procedure for the regular and comprehensive review of the hospital's systems to ensure that it continues to serve the fundamental purposes for which it exists, then such a procedure should be introduced now.

[24] Some time was taken up during the inquiry with an investigation into why the copy of the hospital discharge letter dated 1 October 2004 which was handed to Miss Rennie following her mother's death showed two diagnoses, namely staphylococcal pneumonia and possible Wegener's Granulomatosis, whereas the copies of the letter in both the general practitioner's and the hospital files showed only a possible diagnosis of pneumonia. It became apparent that the explanation for this was to be found in the programming of the hospital computer systems and I understood Miss Rennie to accept at the end of the day, as I had myself no doubt, that the version of the letter which was originally sent by the hospital and received by Mrs Graham's general practitioner referred only to the possible diagnosis of pneumonia.

[25] In conclusion I think it only right to emphasise that I do not consider that any criticism may properly be made in light of this case of the four general practitioners who gave evidence, namely Drs O'Rourke, Thain, MacFarlane and Inkson. Nothing that I heard during the course of the evidence gave me any reason to think that, if I were a patient of any of these doctors, I should hesitate before consulting him or her in the future.