FATAL ACCIDENT INQUIRY REGARDING MAUREEN SMYTH v.

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

DETERMINATION

BY

Simon Charles Pender, Esquire,

Sheriff of South Strathclyde

Dumfries and Galloway at

Hamilton

IN

FATAL ACCIDENT INQUIRY

regarding

Maureen Smyth, formerly of39 Bankhead Avenue, Bellshill

Hamilton: 26th February 2001

The Sheriff having resumed consideration of the Inquiry DETERMINES as follows:

Under section 6 (1) (a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act"), that the death of Maureen Smyth (born 8th September 1951) of 39 Bankhead Avenue, Bellshill, took place within her dwellinghouse at 39 Bankhead Avenue, aforesaid, between the hours of 1.00 am and 1.15 pm on 22 July 1999.

Under section 6 (1) (b) of the Act, that the cause of death was:

1 (a) Streptococcal meningitis and infective endocarditis due to

1 (b) Streptococcal septicaemia.

2 Chronic alcoholism.

Under section 6 (1) (e) of the Act, that there are other facts which are relevant to the circumstances of the death, details of which facts are set out fully in the Note appended to this Determination.

Makes no determination under section 6 (1) (c) or section 6 (1) (d) of the Act.

Note:

This Inquiry called before me on 1st August 2001. Evidence was led on that day, on 2nd August, and on 28th Sept 2001. Miss Cameron, procurator fiscal depute, presented the evidence. Mrs Coull appeared on behalf of Dr Arthur, Dr Baird and Lanarkshire Acute Hospital NHS Trust. Mr Griffiths appeared on behalf of Dr Raeburn, Dr Park, and Dr Alagar. There was no representation for the family of the late Maureen Smyth.

The following witnesses were called by Miss Cameron:

Mrs Carol Gage, the daughter of Maureen Smyth.

Patrick McAtasnay, a friend of Maureen Smyth.

Kevin Docherty, the son of Maureen Smyth.

Dr David Park, of Bruce Medical Centre, 388 Main Street, Bellshill.

Dr Stewart Raeburn, of Bruce Medical Centre.

Dr Marjorie Black, consultant forensic pathologist in the Department of Forensic Medicine and Science, University of Glasgow.

Dr Robert Girdwood, consultant microbiologist at Stobhill Hospital, Glasgow.

Dr Dougald Baird, consultant microbiologist at Hairmyres Hospital, East Kilbride

Dr Shunmugan Alagar, of Medicare, Newmains.

Dr Geoffrey Carlin, of the Surgery, Airdrie.

Dr Angus Arthur, of 2 Crown Terrace, Glasgow.

Dr David Willox, of 44 Croftfoot Road, Glasgow.

Dr E. McKenna, of Bruce Medical Centre.

Neither Mrs Coull nor Mr Griffiths called any witnesses. No other witnesses were called on behalf of the family of the late Maureen Smyth.

What is required of the Sheriff in his determination is regulated by section 6 of the Act. In terms of that section he is to set out the time, the place and the cause of death, and any accident resulting in the death. If established on the evidence to the Sheriff's satisfaction, he may also set out in his determination any reasonable precautions whereby the death and any accident resulting in the death might have been avoided, any defects in any system of working which contributed to the death or any accident resulting in the death, and further any other facts which are relevant to the circumstances of the death.

It is well settled that is not the purpose of a fatal accident inquiry to determine any question of civil or criminal fault or liability, and of course the determination in a fatal accident inquiry cannot be founded upon in any subsequent proceedings.

In this inquiry there was little factual dispute. On the evidence it seems to me that the sequence of events leading up to Maureen Smyth's death was as follows.

On Friday 9th July 1999 Maureen Smyth attended at the accident and emergency department of Monklands General Hospital, complaining of pain in both feet, and of being unable to walk. She also complained of fevers and rigors three days before. She had a slightly raised temperature, and slightly low blood pressure (although she was not hypotensive). She was seen by Dr Arthur who diagnosed acute gout. He also queried the possibility of septic arthritis, although he did not think it was likely, particularly in view of the fact that joints in both feet were involved. He took a blood sample for the purposes of investigating urate level, and to exclude the presence of infection. It was Dr Arthur's evidence that if he had thought that a joint was infected he would have admitted the patient.

He explained that it is routine to ask the laboratory for full blood cultures if the patient has a sore joint and is pyrexic. But this is a precautionary measure. In this case the symptoms were consistent with gout. The patient was noted as being a heavy drinker, the joints were swollen, red and hot and there was a slightly elevated urate level. In addition the white blood cell count was slightly elevated. This, said Dr Arthur, can be a response to inflammation and/ or infection, although Dr Arthur was of the view that there would be a higher white blood cell count than was present in this case if there were a severe infection. Dr Arthur gave Maureen Smyth painkillers, and an intra-muscular injection of an anti-inflammatory drug, and a drug to lower the urate level. She showed a good response to these, and accordingly Dr Arthur discharged her into the the care of her general practitioner. An x-ray had also been carried out to exclude any injuries.

Because Maureen Smyth could not walk she did not go home, but rather went to stay with her friend Patrick McAtasney. She stayed with him until Tuesday 13th July, by which time her condition had improved. During that time she returned home only once, on Sunday 11th July, for the purpose of making a meal for her son Kevin Docherty. She was accompanied by Patrick McAtasney. During the time she was staying with Patrick McAtasney she did not see any doctor.

On Saturday 10th July 1999 Dr Baird, the consultant microbiologist who was on call that weekend, received the preliminary results of the blood cultures. He was told that a Gram-negative infection had been detected. Dr Baird explained that this could indicate various sorts of infection in the patient, ranging from a perhaps relatively minor urinary tract infection to a life-threatening septicaemia. It was not possible to tell from the laboratory findings. Accordingly he telephoned the accident and emergency department at Monklands General Hospital, only to discover that Maureen Smyth had been discharged. He therefore telephoned Dr Raeburn, a GP in the practice attended by Maureen Smyth. He informed Dr Raeburn that the patient had a potentially serious infection, and said that that a check should be made on her condition. He stressed that urgent investigation was required.

Dr Baird explained that the next stage was to carry out further blood cultures to identify the organism and carry out antibiotic sensitivity tests. This usually takes 18 to 24 hours.

On Sunday 11th July Dr Baird was telephoned at home by a different technician in the laboratory at Monklands. He was surprised to learn that a group B Streptococcus had been grown. He explained that this can be even more serious than a Gram-negative infection, and can indicate, for example, abscesses in organs. He regarded it as very serious in adults, often being associated with a very serious underlying pathology. Being very concerned, he telephoned the GP surgery again and was diverted to a weekend deputising service. A doctor telephoned back. Dr Baird did not know the name of the doctor. He explained to the doctor that there was a lady in the community (namely Maureen Smyth) with a potentially very serious, and possibly life-threatening, blood infection. He exhorted the doctor to make sure that something was done. He informed the doctor of the nature of the infection, and expressed the view that hospitalisation would be necessary. He explained further that he would not have recommended any particular antibiotic to the doctor, since he was of the

view that intravenous antibiotics would be required, and the doctor would not be able to administer them. I was satisfied on the evidence that no such recommendation was made.

The doctor who received the telephone call from Dr Baird on Saturday 10th July, namely Dr Raeburn, attempted to find a telephone number for Maureen Smyth without success. He explained that that day was busy, and he decided not to visit Maureen Smyth, but rather to arrange for a house call on the Monday, by which time the final cultures from the laboratory should be available. However, because he was busy he omitted to make an entry in the house call return book, and as a result no house call was made on the Monday. Dr Raeburn noted in the clinical notes kept at his surgery in respect of Maureen Smyth that on the 10th July Dr Baird phoned with a positive blood culture from "yesterday", and that there was no phone number to contact the patient. Dr Raeburn gave evidence that he accepted that with hindsight he should have gone to see Maureen Smyth immediately on 10th July. He regretted not having done so.

The doctor from the deputising service who spoke to Dr Baird on Sunday 11th July 1999 was Dr Alagar, who is a staff paediatrician at Wishaw General Hospital, and who works for Medicare part-time. Dr Alagar, with reference to production 3, the Medicare slip completed in part by him, said that he had spoken to the bacteriologist who had informed him that streptococcal bacteria had been grown in Maureen Smyth's blood. It was Dr Alagar's evidence that he must have seen Maureen Smyth, because he had written "Maureen is okay" in the Medicare slip. However, he could not remember having seen her. On 11th July Maureen Smyth was staying with Mr McAtasney, and was not at her own house except for a period of about 40 minutes on that day, when she went there with Mr McAtasney to cook her son's dinner. Dr Alagar did not have Mr McAtasney's address. It was the evidence of Mr McAtasney, which I accept, that no doctor called at his house, or while they were at Maureen Smyth's house. However, Maureen Smyth's son, Kevin Docherty, gave evidence that on one occasion when he was at home a doctor came to drop off tablets and a prescription. He had filled the prescription for his mother. Although Kevin Docherty was not clear as to the date upon which this had happened, he thought the doctor had come on a day at the weekend and not on a weekday. Dr Alagar confirmed that that he had issued a prescription for Augmentin on 11th July 1999. On the balance of probabilities I have concluded that when Dr Alagar attended on 11th July, he found that Maureen Smyth was not at home, and left a prescription for Augmentin. It may, of course, be that Dr Alagar was able to obtain some information from Maureen Smyth's son as to how she was, but that is a matter of speculation. It certainly seems to me that the absence of any mention in the Medicare slip of Maureen Smyth's painful and swollen feet, and the earlier diagnosis of gout, which were the matters most concerning Maureen Smyth, supports the conclusion that Dr Alagar did not, in fact, see her on that day.

Dr Alagar explained that the Medicare slip completed by him would have been delivered to the GP surgery during the following morning by a driver. It would appear that the Medicare slip was never brought to the attention of any doctor within the surgery. I comment later on the system within the surgery of dealing with Medicare slips.

On the evidence of Dr Raeburn I am satisfied that the report from the microbiology department at Monklands hospital, which forms part of Production 1, and which contains the information that a group B Streptococcus had been grown, dated 13 July 1999, was received at the GP surgery on 14th Jul 1999. It is stamped "Speak Dr/nurse" and "File". Dr Raeburn explained that the stamps indicate that the patient should speak to a doctor or a nurse, and that the report should be filed. He further explained that the results of the test would not necessarily be written up in the medical notes. He further explained that at the time the system was that such reports would, on arrival, go to the practice manager, who is not a medically qualified person. She would review the reports and decide which should be brought to the attention of a doctor. According to Dr Raeburn the system was in trouble at the time, largely due to staff shortage. The practice manager was off work on maternity leave. Two other members of staff were also off work. There was therefore a delay in failing the report. He said that even the by the time of the inquiry hearing the surgery was still short staffed, due to lack of funding. There was a need for more secretarial staff, particularly for filing. I comment later on the system within the surgery for dealing with such reports.

On 13th July 1999, the day that Maureen Smyth returned to her own home, an emergency visit was made in the evening by Dr Carlin of Medicare. He arrived at 21.05 hrs. The Medicare slip in respect of that visit records that Maureen Smyth was complaining of swollen legs and gout. It further recorded that there was a history of alcoholism (which the patient denied). Dr Carlin prescribed a painkiller and indicated that Maureen Smyth should see her GP when the swelling had settled, for further treatment to prevent recurrence of gout. Dr Carlin was not aware of that Maureen Smyth had been seen by Dr Alagar on 11th July 1999. He had not seen the Medicare slip completed by Dr Alagar, and accordingly was not aware of the blood culture report from the hospital. He did not have access to the clinical notes kept by the GP surgery in respect of Maureen Smyth (even had he had such access it is unlikely that the GP notes would have alerted him to the group B streptococcal infection). It was Dr Carlin's evidence that had he known of the blood culture report he would have arranged for Maureen Smyth to be admitted to hospital. In Dr Carlin's opinion intravenous antibiotic treatment would have been necessary, and that could only have been carried out in hospital. Dr Carlin explained that at Medicare there was no system whereby a doctor had access to records of previous calls in respect of any patient, when a doctor from Medicare had attended. He gave evidence that the deputising service in the Coatbridge/Airdrie area has a computer system in which all calls are logged. The doctor on call has access to all calls during the previous three months. If a patient had been seen recently the doctor on call would be alerted.

Maureen Smyth's daughter, Carol Gage, was present when Dr Carlin attended. She spoke of a doctor's visit on Sunday 18th July. There is, however, no record of any doctor having attended on that date. Mrs Gage was unsure of dates generally (at one point she said that the next time she saw her mother after Dr Carlin's visit was on Monday 18th July). In view of this uncertainty I am unable to conclude that there was any doctor's visit on Sunday 18th July. Mrs Gage saw her mother on the morning of Monday 19th July before going to work. She said that her mother's condition was then about the same as it had been on the 13th July, when her mother's feet were badly swollen, she could not walk very well, and she was being sick. She did not call for a doctor on that day, but did so on Wednesday 21st July.

On that day Dr Park from the GP surgery attended. He treated her for gout. Whilst he was there Maureen Smyth was suddenly sick, and vomited a mouthful of clear fluid. She told Dr Park that her stomach had been upset for the previous three to four days. Dr Park formed the view that her stomach was upset because of the medication previously prescribed for her gout. He prescribed three types of medication. He prescribed Diclofenac, and anti-inflammatory drug, for the gout. He also prescribed Losec and Domperidone, the former being a gastric protector, and the latter being and anti-nauseant. He said that Maureen Smyth was not presenting with symptoms of septicaemia.

There is no record of Dr Park's visit in Maureen Smyth's clinical notes kept by the surgery. Dr Park explained that because the surgery was extremely busy that afternoon he overlooked the noting of his visit to Maureen Smyth. Before going to see Maureen Smyth he had not looked at her clinical notes. He was not aware of the blood tests which had been carried out. He had not seen the report from the laboratory, the Medicare slip in respect of Dr Alagar's visit, or the Medicare slip in respect of Dr Carlin's visit. At the time it was not the practice in his surgery for doctors to take clinical notes with them on house calls. There was no system which ensured that doctors going on house calls saw the clinical notes before doing so, and I comment on this in greater detail below. Even had Dr Park looked into the clinical notes before going to see Maureen Smyth, it is doubtful whether he would have seen the laboratory report or the Medicare slips, given the evidence of Dr Raeburn as to problems with the systems for filing such reports and slips, due to staff shortage. Dr Park explained that certain changes had, by the time of the inquiry, been made. He accepted that it would be reasonable for clinical notes to be stamped "seen by Medicare" on receipt of a Medicare slip, to alert any doctor looking at the notes to the fact, and to cause the doctor to look for the Medicare slip itself. He further accepted that it would be reasonable to have a similar system in respect of bacteriology or haematology reports, and the like. He said that following Maureen Smyth's death a new protocol had been put in place in the surgery, a copy of which formed production No 6. This protocol set out the steps which doctors should take when a significantly abnormal normal report is received from the laboratory. It also requires doctors to check reports on a daily basis.

On Thursday 22nd Jul 1999 Mr McAtasney phoned Mrs Gage to ask how Maureen Smyth was. Mrs Gage told him that she had not been to see her mother that day. Accordingly he phoned Maureen Smyth's house but there was no answer. He then went to her house, arriving at around 13.00 hrs. He knocked at the door, but again there was no answer. He went to Maureen Smyth's bedroom window and knocked at that, again without answer. He then knocked at the door again, and it was opened by Maureen Smyth's son, Kevin Docherty, who had just arisen from bed. He told Mr McAtasney that Maureen Smyth was still in bed. Mr McAtasney went to her room, and found her lying on the floor behind the door. He could feel no pulse and phoned for an ambulance. He telephoned Mrs Gage and Maureen Smyth's mother to tell them what had happened. Two paramedics then attended and confirmed that Maureen Smyth had died.

Dr Park attended at about 13.30 hours and confirmed the death. On 26th July 1999 Dr Marjorie black carried out a post-mortem examination. She found evidence of chronic pancreatitis, consistent with the history of alcohol abuse, and superimposed upon that an abscess in her pancreas. She also found an enlarged nodular pale liver, and evidence of two

duodenal ulcers. In addition there were two large vegetations on her aortic valve, and evidence of meningitis was found in the brain. Bacteriological examination of pus from the abscess and the vegetations on the heart valve both grew a group B Streptococcus. The cause of death had previously been certified as:

"1 Pancreatic sepsis and suspected infective endocarditis;

Conditions contributing to death:

2 Chronic alcoholism."

In view of the findings at post-mortem examination Dr Black amended the cause of death to:

"1 a Streptococcal meningitis and infective endocarditis

due to

1 b Streptococcal septicaemia

2 Chronic alcoholism."

As far as at the determination under section 6 (1) (a) of the Act is concerned, there was no difficulty as to the place of death. It is clear that Maureen Smyth died within her home. On the evidence it is not possible to be precise as to the time of death. However there was clear evidence as to when Maureen Smyth was found dead. Dr Park said that that he was called out to her home at 1:15 pm. It was the evidence of Dr Marjorie Black, the pathologist, that she had been told that at around 22.30 hrs on 21st July 1999 Maureen Smyth had said that she wanted a long lie the following morning, and was left in the living room at 01.00 hrs. I have therefore determined that the death took place between 01.00 hrs and 13.15 hrs on 22nd July 1999.

As far as the determination under section 6 (1) (b) of the Act is concerned, as I was invited to do by the procurator fiscal, Mrs Coull and Mr Griffiths, I have determined that the cause of death was as stated in Dr Marjorie Black's Post Mortem Report of 7th September 1999. There was no dispute or issue regarding this.

Under section 6 (1) (c) of the Act the Sheriff is to determine the reasonable precautions, if any, whereby the death might have been avoided. Whilst I have found under section 6 (1) (e)

that there were precautions which could have been taken and which could be regarded as reasonable, and that such precautions not being taken was a fact relevant to the circumstances of death, in order to make a determination under section 6 (1) (c) I must also be able on the evidence to find that such precautions "might" have resulted in the death being avoided. In my view the use of the word "might" means not that it is probable that the death would have been avoided, but that there was a real possibility that the death might have been avoided. In view of the evidence of Dr Girdwood and Dr Willox I feel unable to conclude that there was such a real possibility. Dr Girdwood gave evidence that, in view of the findings at post-mortem examination, in his opinion admission to hospital, even on 11th July 1999, would not have avoided Maureen Smyth's death. It was possible, he said, that aggressive antibiotic treatment might have prolonged life, but it was unlikely to have avoided the eventual outcome. He explained that with infective endocarditis there is only a 10 percent overall cure rate, and that the condition as found in Maureen Smyth would almost certainly have required heart valve replacement surgery. That, he said, was the only possibility for a radical cure. She was a very poor surgical risk, given that the history of alcoholism, the pancreatitis, the abscess in the pancreas, and the liver disease, and it was unlikely that she would have survived surgery. He explained that aggressive antibiotic treatment itself is not without danger. In his opinion a cure was very unlikely in this case. Dr Willox, whilst expressing the view as an expert general practitioner that there had been various failures in the treatment of Maureen Smyth, and that there were certain deficiencies in systems of working, said that he had formed the conclusion that Maureen Smyth had a serious medical condition, with a background of chronic alcoholism. In his view the heart valve growths had not occurred in the few days before death. In his opinion it was quite possible that Maureen Smyth would have died, whatever action had been taken. He said that any one of the pancreatic abscess, the endocarditis, or the septicaemia (particularly with the involvement of the meninges) could have led to death. Accordingly I have decided to make no determination under section 6 (1) (c).

Turning now to section 6 (1) (d), the Sheriff, in terms of that section, is to determine the defects, if any, in any system of working which contributed to the death. Again, as will be seen from my findings below under section 6 (1) (e), I have determined that there were defects in systems of working which were facts relevant to the circumstances of Maureen Smyth's death. However, to make a determination regarding such defects under section 6 (1) (d) I would also have to find it proved on the evidence that there was a causal link between the defect and the death. Again, in view of the evidence of Dr Girdwood and Dr Willox referred to above, I am unable on the evidence to find it proved that the defects I have founded to exist, or any of them, actually contributed to the death. Accordingly I have made no determination under section 6 (1) (d).

The Sheriff, under section 6 (1) (e), is to set out in his determination any other facts which are relevant to the circumstances of the death, in so far as such facts are established to his satisfaction. It seems to me in this case that such facts include a number of failures on the part of certain persons, and defects in systems of working, upon which I should comment. It further seems to me that there were some reasonable precautions which could have been taken, but were not. This too is a fact which, in my view, is relevant to the circumstances of the death in this case.

The failures upon which I wish to comment are as follows:

It seems to me that there was a failure on the part of Dr Raeburn, despite being advised by Dr Baird that Maureen Smyth had a potentially serious infection which required urgent investigation and a check being made on the patient's condition, in that he did not on 10th July 1999 visit Maureen Smyth and examine her. To Dr Raeburn's credit, he readily accepted during the course of his evidence that this was a failure, which he regretted.

There was also a failure on the part of Dr Raeburn to make an entry in the house call return book, so as to ensure that Maureen Smyth was visited on the following Monday. It was Dr Raeburn's evidence that, having decided not to visit Maureen Smyth on 10th July, he intended that a visit be made to her on the Monday, once the report on the final blood cultures was available.

As I have stated above, I have concluded on the balance of probabilities that Dr Alagar did not see Maureen Smyth and examine her. Having reached that conclusion I feel I must record that there was a failure on his part on 11th July 1999 to visit and examine Maureen Smyth, and in particular to check her temperature.

There was also a failure on the part of Dr Park to make a note in the clinical notes relating to Maureen Smyth kept at his surgery. Had he, on return to the surgery on 21st July 1999, written up the notes, he might well have seen Dr Raeburn's entry for 10th July, and taken additional action.

The following are the reasonable precautions which I conclude could have been taken (although, as stated above, I was not satisfied on the evidence that there was a real possibility that such precautions would have avoided the death):

Having been told by Dr Baird that Maureen Smyth had a potentially serious infection which required urgent investigation, it would have been a reasonable precaution for Dr Raeburn to have visited Maureen Smyth, and to have examined her, on 10th July 1999. On that date Dr Baird had received and passed on the first results of the blood culture, which had grown Gram-negative bacilli. Dr Baird explained that there are different grades of severity of infection involving such bacteria, ranging from, for example, a non-serious urinary tract infection to something life-threatening. Dr Raeburn could find no telephone number for Maureen Smyth in her medical records, and nor could he obtain a number from directory enquiries. He therefore decided not to call on Maureen Smyth that today, but to wait for the results of the final cultures which were to be telephoned the following day, and put her down for a house call on Monday 12th July. Dr Raeburn accepted that with a Gram-negative infection it is necessary to see the patient, with a view to assessing by way of clinical examination whether not admission to hospital is necessary. Whilst I accept that if Dr Raeburn had gone to Maureen Smyth's house that day she would not have been there, it is possible that her son would have been at home and could have told Dr Raeburn that his mother was staying with Mr McAtasney. He could then have called upon her at Mr McAtasney's home. Alternatively, if Maureen Smyth's son was not at home, he could have left a note indicating that it was important that Maureen Smyth contact the surgery immediately. Given the possibility of this being a life-threatening infection, it would also in my view have been reasonable, in the absence of any response to such a note, for further efforts to be made to contact Maureen Smyth, for example through other relatives (if known), or even with the assistance of the police.

Given the conclusion I have reached that Dr Alagar did not see Maureen Smyth when he called at her home on 11th Jul 1999, because she was not there, it seems to me that it would have been a reasonable precaution for Dr Alagar to ascertain from her son where she was, and then to visit her at Mr McAtasney's house to check on her condition, and in particular to take her temperature. It was Dr Girdwood's evidence, which I accepted, that anyone seeing this patient following a report that there was a group B streptococcal infection, should take the patients temperature, and if the patient was pyrexic, should ideally admit the patient to hospital. If for any reason Dr Alagar was unable to ascertain where Maureen Smyth was, it would have been a reasonable precaution for him to ask Maureen Smyth's son to ensure when he was the next in contact with her that she contacted him or the GP surgery, or at least to leave a note for Maureen Smyth indicating that she should immediately do so. Given the very serious nature of a group B streptococcal infection, it would also have been reasonable for Dr Alagar, in the absence of any early response from Maureen Smyth, to ensure that further steps be taken to contact Maureen Smyth, with the assistance of other relatives (if known), or even with the assistance of the police.

It would have been a reasonable precaution for Dr Alagar to arrange to have Maureen Smyth admitted to hospital for intravenous antibiotic treatment. There was a difference in opinion between some of the medical witnesses and others, as to whether intravenous antibiotic treatment in hospital would always be necessary for a patient with a group B streptococcal infection. Drs Baird, Raeburn, McKenna, Park and Carlin were of the view that admission to hospital would always be necessary. On the other hand Drs Alagar, Girdwood, and Willox were of the view in that it would depend upon the condition of the patient on clinical examination whether hospitalisation was necessary. They were all of the view however that careful monitoring would be important. I accepted, as submitted by Mr Griffiths, that these were two respectable bodies of opinion. However, Dr Alagar said in evidence that if Dr Baird had recommended intravenous antibiotic treatment in hospital than he would have followed that recommendation. He would have had no problem in admitting Maureen Smyth to hospital. It was Dr Baird's evidence that he would not have recommended any particular antibiotic to Dr Alagar, because it would not have been possible to treat the infection other than intravenously in hospital. He was clear that he stressed to Dr Alagar that he, Dr Alagar, must make sure that something was done. In cross-examination he said that it was his usual practice to stress that intravenous antibiotic treatment would be required and therefore that admission to hospital would be necessary. On the balance of probabilities I have concluded that Dr Baird followed his usual practice. It therefore it seems to me that, notwithstanding Dr Alagar's opinion that hospitalisation would not always be necessary, it would have been reasonable for him to admit Maureen Smyth to hospital, in accordance with Dr Baird's recommendation.

I was invited by Miss Cameron to find that it would have been a reasonable precaution for Dr Arthur to have admitted Maureen Smyth to hospital when she attended at the accident and emergency department on Friday 9th July 1999, on the basis that Dr Arthur suspected that there was an infection. Dr Arthur, however, was clear in his evidence that his primary diagnosis was gout. Maureen Smyth's symptoms were consistent with gout. Whilst he had ordered blood cultures, that was simply a routine precaution, with a view to excluding the presence of any infection. Whilst he wanted to exclude infective arthritis, he was of the view that it was highly unlikely that there would be septic arthritis in both feet. The elevated white blood cell count was possibly due to the gout, and would, in his view, have been higher if there had been a serious infection. Dr Arthur also said that the pyrexia he noted was consistent with gout, and if it had been due to a bacterial infection it would probably have been higher than it was. There was also evidence that Maureen Smyth wanted to go home. I found Dr Arthur a persuasive and reliable witness. I am quite satisfied that he acted properly

and responsibly, and that in all the circumstances it could not be said that he ought to have admitted Maureen Smyth, as a reasonable precaution.

I turn now to the question of the defects in systems of working. I have concluded that there were certain defects in systems of working, both at the Bruce Medical Centre and at Medicare. In the main these defects seem to me to have led to failures in communication. Clearly, where a medical practice relies upon an organisation such as Medicare for out of hours and weekend cover, there is a potential for a breakdown in communication. It is therefore important that systems are in place to minimise that. I concluded that the evidence established that the following defects in systems of working existed:

There was a lack of any system, whether computerised or manual, at Medicare for recording calls on patients, which would enable a Medicare doctor to know of any recent contact between other Medicare doctors and the patient in question. In this case Dr Carlin attended on 13th July 1999 and did not know of Dr Alagar's attendance on 11th July, and had not seen the slip completed by Dr Alagar, which would have alerted him to the fact that streptococcal bacteria had been grown in Maureen Smyth's blood. It was Dr Carlin's evidence that if he had been in possession of that information he would have arranged for Maureen Smyth to be admitted to hospital. Dr Carlin said that in the Coatbridge/Airdrie area the deputising service has a computer system in which all calls are logged, and the doctor on call has access to all entries in the previous three months. It was Dr Carlin's evidence that the introduction of such a system at Medicare would make it much easier for the Medicare doctors to do their job effectively. I agree with him. Such a system would have enabled Dr Carlin, in this case, to have known of the streptococcal infection found in Maureen Smyth's blood. Dr Carlin was asked about the possibility of centralised access to each patient's medical records. Whilst he agreed that that would be helpful in an ideal world, he recognised that there were considerable practical and financial difficulties with that, and also problems with confidentiality. Dr Willox, who gave evidence as an expert general practitioner, agreed with him. I accept the evidence of Dr Carlin and Dr Willox in this respect, and accordingly do not find that the lack of such centralised access to records constituted a defect in any system of working.

The system of working in the Bruce Medical Centre with regard to laboratory reports was also defective. When such reports were received at the Centre they were passed to the practice manager, who was not medically qualified, to review. The system was that they would be stamped with a box with a number of options for action. This box would be completed by the practice manager. The options included those chosen in this case, namely "Speak to Dr/nurse" and "File". The other options were "Tell normal", "Script" and "Attend". I was informed that the options chosen in this case meant that the report should be filed in the patient's records, and that the patient should speak to a doctor or a nurse. Dr Raeburn told me that this might mean that a receptionist would phone the patient, but the position was far from clear. Dr Raeburn also said that the system was in any event not able to work properly at the time, because the practice manager was on maternity leave and, in due to lack of funding, there were other staff shortages. At the time of the hearing there was still a shortage of staff, particularly for duties such as filing. The options in the stamped box which were not chosen in this case were not explained to me. However, it does not seem right that such reports should be reviewed by an unqualified member of staff, who then decides what action is to be taken. In my view is essential that such reports are promptly filed in the patients medical records, and that a dated entry (perhaps by use of a stamp) indicating receipt of the

report is made in the running clinical notes within the records, so that any doctor looking at the clinical notes will be alerted to the fact that the report has been received, and will be able then to look elsewhere in the records for the report itself. Dr Raeburn explained that that since Maureen Smyth's death a new protocol had been put in place within the surgery in respect of blood tests and the like. A copy of that protocol forms production No 6. In terms of the protocol all patients are to be advised at the time of a blood test or other test to contact the surgery for the report. The patient is to be advised when the result should be available. It also provides that all reports are to be checked by doctors on a daily basis (rather than by the practice manager) and that action is to be taken upon abnormal results. Where there is a significantly abnormal report, the protocol requires that the doctor takes urgent steps to contact the patient, in the first place by telephone, and if that is not successful by home visit. There is also provision for a letter being left if the patient is not at home, and for further action if, following a letter being left, the patient does not contact the surgery by the following day. Dr Park, in his evidence, readily accepted that stamping the running clinical notes within a patient's medical records, to indicate the receipt of a laboratory report or the like, would be a sensible additional measure, and he indicated that he would put that in place immediately.

The system in the Bruce Medical Centre for dealing with Medicare slips was also defective. These are usually received by delivery to the Centre on the Monday following a weekend, or the following day in the event of a visit at night, unless they are particularly urgent, in which case they are also transmitted by fax. Again, they are reviewed by an unqualified practice manager, and ought to be filed in the patients medical records. However, in this case, due to the staff shortages I have mentioned above, there was a delay in filing the Medicare slip completed by Dr Alagar, and it was not seen for 3 1/2 or 4 weeks. It seems to me that that the system should ensure that such Medicare slips are reviewed by a doctor, who should decide upon any action to be taken. They should also be promptly filed, and again there should be an entry, perhaps by stamp, made in the running clinical notes within the patients medical records, to alert any doctor looking at the clinical notes to the fact that there has been out of hours contact with the patient. The doctor will then be able to look for the actual slip elsewhere within the records. Dr Park again readily accepted that the system should be immediately modified to take account of the foregoing. In his view the Medicare slips should be handed in to one of the meetings of the doctors within the Medical Centre.

The system in relation to the making of house calls to patients of the Bruce Medical Centre was also defective. Prior to Maureen Smyth's death a patient's medical records would not be taken by the doctor when he went to call upon the patient. Some doctors looked at the records before going, but some did not. I was informed that by the time of the hearing it was the policy of the Centre that doctors going on house calls would take the medical records of the patients to be visited with them. In this case, if Dr Park had taken the medical records with him when he visited Maureen Smyth on 21st July 1999 it is likely that he would not have omitted to record that visit. He would presumably also have seen the entry made by Dr Raeburn on 10th July 1999, and may well have acted differently than he did.

I acknowledge that some of these defects in working systems may well by now have been attended to and put right. However, to any extent that they have not been attended to, it seems to me that they ought to be, as quickly as possible.

There is another matter which I think I should mention. In his evidence, Dr Baird explained that, when viewed under a microscope, Gram-negative bacteria look very different than group B streptococcal bacteria. He was unable to explain why the final report from the laboratory indicated the existence of bacteria quite different in nature to those reported the

day before, in the telephoned preliminary report of 10th July 1999. Given the lack of evidence on this matter, I do not think I can make any finding that there was any failure in the laboratory.

In conclusion, I would like to extend the sympathy of the Court to Maureen Smyth's family and friends, some of whom attended at the Inquiry. I would further like to thank them for their assistance at the Inquiry.