

FATAL ACCIDENT INQUIRY
Under the
Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976
Case Reference B231/12
Determination by Sheriff Derek J. Hamilton, Esquire,
Sheriff of North Strathclyde
following an Inquiry held at Greenock
into the death of Judith Laing, born 17th November 1943

GREENOCK: 7th January 2013

The Sheriff, having resumed consideration of the cause, DETERMINES that in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that –

- (a) Judith Laing, born 17th November 1943, residing formerly at 10 Slaemuir Avenue, Port Glasgow, died at Inverclyde Royal Hospital, Greenock on 29 January 2009. Mrs Laing was pronounced dead at 13.55hrs on that date.
- (b) The cause of Judith Laing's death was;
 - (i) Adult Respiratory Distress Syndrome,
due to
 - (ii) Intra-Abdominal Infection,
due to
 - (iii) small bowel resection for strangulated femoral hernia.
- (c) The death of Judith Laing might have been avoided had the following reasonable precautions been taken;
 - (i) Arrangements made for Judith Laing to have been admitted to Inverclyde Royal Hospital for an immediate surgical review on 1st December 2008.

(ii) Arrangements made for Judith Laing to have been admitted to Inverclyde Royal Hospital for an immediate surgical review on either 2nd or 4th December 2008.

(iii) The senior reviewer within the medical receiving unit (J North Ward) of Inverclyde Royal Hospital on 4th December 2008, to have noted the presence of a right sided groin swelling on her examination of Judith Laing, and to have discussed her findings with a senior colleague or obtained a surgical opinion as to the cause of the swelling. Alternatively, to have discussed any findings which were inconsistent with findings on earlier examinations of Judith Laing, with a senior colleague.

(iv) The consultant on duty within the medical receiving unit (J North Ward) of Inverclyde Royal Hospital on 4th December 2008, to have;

(1) Read the referral letter from Judith Laing's general practitioner which made reference to a swelling in Judith Laing's groin.

(2) Read the admission notes prepared by Dr Briffa which made reference to a swelling in Judith Laing's groin and to Judith Laing not having passed wind.

(3) Not initialed the admission records of Judith Laing until he had fully read them.

(4) Read the examination notes prepared by Dr Erskine, and noted the conflict between them and the admission notes prepared by Dr Briffa, in their findings relative to right sided groin swelling.

(5) Examined Judith Laing prior to her being passed on to a colleague.

(v) Judith Laing to have been thoroughly examined by an experienced doctor prior to her being transferred from the medical receiving ward on 5th December 2008.

(vi) A senior doctor to have considered, earlier than 8th December 2008, the note by Dr Smith of a groin swelling, and the differential diagnosis by Dr Briffa of an obstructed bowel.

(vii) The earlier ordering of a CT scan to investigate the location and extent of infection within Judith Laing.

- (d) There was a defect in the system of clerking in patients within the medical receiving unit (J North Ward) at Inverclyde Royal Hospital, their subsequent examination and assessment, and the passing on of their care, which contributed to the death of Judith Laing. There was no effective system within J North Ward of identifying a person with initial overall charge of the care of a patient, and of identifying what measures had been taken for a patient. There is a need for a review of procedure within J North Ward at Inverclyde Royal Hospital for clerking in and examining patients, and the noting of same, to ensure, that after admission a patient is comprehensively examined by an appropriately experienced doctor, that when a patient is passed on, those taking over the patient can rely on the medical notes for that patient and have a clear understanding of what procedure has been undertaken, at what level and by whom.
- (e) There are other factors relevant to the circumstances of Judith Laing's death:
 - (i) The need for a review of procedure at Inverclyde Royal Hospital on how amended reports/results/findings are introduced into a patient's medical records, how the existence of an amended report/result/finding or opinion is highlighted in the patient's medical records, and how any amendments are brought to the immediate attention of those treating a patient.

Finds in Fact –

Personal Circumstances

- (1) Judith Laing was born on 17th November 1943, and was resident at 10 Slaemuir Avenue, Port Glasgow. She was married to and lived with Alexander (known as Alistair) McCallum Laing. They had been married since 18 November 1963 and had three adult children: Alison, Alistair and Kenneth.
- (2) Mrs Laing worked as a Cleaning Supervisor for Inverclyde Council in a local Primary School. She was in good health. In the past she had suffered from breast cancer and had a lumpectomy in 1992. She had a re-occurrence in 1999 and following treatment, she appeared to have been well and free of any symptoms since.

- (3) Mrs Laing and her husband had been out together socially on 29th November 2008. They returned home at approximately midnight and at that time Mrs Laing had no signs of illness or of being unwell. Not long after retiring to bed, Mrs Laing experienced pain in her stomach. Mrs Laing began vomiting, and after returning to bed she and her husband noted a small lump about the size of a ten pence piece in her right groin area, and swelling of her abdomen. Mrs Laing asked her husband, Alistair Laing, to call a doctor.

Pre admission to hospital: 30th November 2008 to 4th December 2008

- (4) Mrs Laing's husband first called NHS 24 Out Of Hours Service at 05.40hrs on Sunday 30 November 2008. Mrs Laing spoke to the call handler and told her that she had been vomiting, that her vomit was a terrible colour, and that she had pain in her abdomen and a lump in her groin. Mrs Laing was advised to take paracetamol, which she did.
- (5) At 10.40hrs on Sunday 30th November 2008, a further telephone call was made to NHS 24 Out Of Hours Service. Mrs Laing advised that she was not improving, that she had stomach pain and had been vomiting for approximately ten hours. She advised her vomit was green in colour. Mrs Laing was advised to attend at Greenock Health Centre that morning.
- (6) At approximately 12.00hrs on Sunday 30th November 2008, Mrs Laing attended the NHS Greater Glasgow and Clyde Out Of Hours Service at Port Glasgow Health Centre with her husband. Mrs Laing was examined by Dr Alan Dickson. Mrs Laing gave a history of having been unwell for the previous twelve to eighteen hours and, other than the previous three hours, to have been vomiting. Mrs Laing made no complaint of abdominal pain, but said she was aware of a swelling in her groin area. On examination, Mrs Laing was noted to not be in discomfort, to have a soft and non tender abdomen, and a swelling, questionably in the right inguinal area. Dr Dickson made a diagnosis of probable viral gastritis with an unexplained right inguinal swelling. Mrs Laing was advised re her fluid intake, prescribed Buccastem, (an anti sickness medication) and asked to make an appointment with her General Practitioner regarding the inguinal swelling. At approximately 08.00hrs on Monday 1st December 2008, an electronic copy of the Out Of Hours Service entries relating to Mrs Laing

was sent to Mrs Laing's GP practice, Drs Jeffries, McCartney & Smith, The Health Centre, 2 Bay Street, Port Glasgow. That entry would have been looked at and filed in Mrs Laing's electronic GP records.

- (7) Dr Dickson failed to diagnose that Mrs Laing was suffering from a femoral hernia.
- (8) Mrs Laing continued to vomit. On Monday 1st December 2008 at approximately 08.30hrs to 8.45hrs, there having been no improvement in Mrs Laing's condition, Mrs Laing's husband telephoned her GP Practice. Mr Laing requested that a doctor attend to see his wife. At about 13.00hrs on 1st December 2008, Dr Annabel Shepherd, at that time a locum with Mrs Laing's GP practice, attended Mrs Laing's home to examine her.
- (9) Dr Shepherd attended Mrs Laing's home, having perused a summary taken from Mrs Laing's GP records. That summary did not contain a copy of the Out Of Hours entry which had arrived earlier that morning. Dr Shepherd noted from Mrs Laing that she had already attended the Out Of Hours Service and that she had been vomiting over the weekend. She noted that despite having been prescribed Buccastem, there had been no improvement (other than there had been no vomiting that day), and that Mrs Laing was worried about the very dark fluid she was vomiting. On examination Dr Shepherd found Mrs Laing's abdomen to be soft, slightly tender all over with bowel sounds normal. On examination Dr Shepherd found a lump in the groin area, but failed to note that fact in her entry in Mrs Laing's GP records, and noted '*no masses*'. Mrs Laing was prescribed medication and was to be reviewed as needed.
- (10) Dr Shepherd failed to diagnose that Mrs Laing was suffering from a femoral hernia.
- (11) Had Dr Shepherd diagnosed the presence of a femoral hernia she would have referred Mrs Laing for a surgical review.
- (12) On 2nd December 2008 Mr Laing contacted Mrs Laing's GP practice reporting that Mrs Laing had worsening pain and dark vomit. He took a sample of her vomit to the surgery early that morning. He met with Dr Maureen Smith, who advised that the sample of vomit appeared to have blood in it, and provisionally arranged for Mrs

Laing to be admitted to Inverclyde Royal Infirmary. On returning to the GP surgery at approximately 11.00hrs, Mr and Mrs Laing were advised that the sample had tested negative for blood and that Mrs Laing was not to be admitted to hospital.

- (13) Dr Smith examined Mrs Laing. She noted that Mrs Laing had stopped vomiting the previous evening. Her abdomen was soft and non tender. She noted a groin swelling and diagnosed it as a swollen gland. Blood was taken and sent for testing.
- (14) By 4th December 2008 Mrs Laing was still vomiting. Her blood results showed a slightly raised white cell count, and readings which indicated Mrs Laing's kidney function was possibly compromised. Dr Smith called Dr Graham Currie, Consultant in general medicine at Inverclyde Royal Hospital, to advise him of Mrs Laing's circumstances and to arrange for her admission to Inverclyde Royal Hospital for investigation. Dr Smith did not mention the presence of a swelling in Mrs Laing's groin area. A referral letter for Mrs Laing was prepared by Dr Smith. That letter did not initially mention a swelling in the groin area, but at the request of Mr Laing, Dr Smith added a handwritten post script "*Large inguinal swelling noted- ? gland*".
- (15) Dr Smith failed to diagnose that Mrs Laing was suffering from a femoral hernia.
- (16) Had Dr Smith diagnosed the presence of a femoral hernia she would have referred Mrs Laing for a surgical review.
- (17) Had Mrs Laing been referred for a surgical review on 1st, 2nd or 4th December 2008, it is likely that Mrs Laing would have been taken to theatre and undergone surgery on the day of her referral.
- (18) Had Mrs Laing undergone surgery on 1st, 2nd or 4th December 2008, the chances of a leak or breakdown of an anastomosis would have been lessened, and might have been prevented.
- (19) Had there been no leak of the anastomosis, it is likely Mrs Laing would have survived.
- (20) Earlier surgery might have prevented Judith Laing's death.

Post admission to hospital:

4th December 2008 – 8th December 2008

- (21) Judith Laing was admitted to Inverclyde Royal Infirmary on 4th December 2008. There was no time of admission noted in the hospital records. Mrs Laing was clerked in to J North Ward by Dr Amy Briffa, an FY1 (Foundation Year 1) doctor. Dr Briffa noted Mrs Laing's presenting complaint as abdominal pain and vomiting, and noted a detailed history which included; *"has not moved bowels since Saturday, no wind passed either"*. On examination, she noted Mrs Laing's abdomen to be slightly distended, and the presence of a right sided inguinal node. Her impression of the situation was *"? Obstruction constipation"*. Her plan for Mrs Laing included chest and abdomen X-rays and a senior review. As an FY1 doctor, all of Dr Briffa's actions would be reviewed by a more senior doctor.
- (22) On 4th December 2008, Dr Gillian Erskine was the doctor on duty next in seniority to Dr Briffa. The consultant in charge of J North Ward on that date was Dr Graham Currie. Part of Dr Erskine's duties was to review Dr Briffa's work. Dr Erskine was aware when reviewing Mrs Laing's case that Mrs Laing's GP and Dr Briffa had noted right sided groin swelling. Dr Erskine examined Mrs Laing on 4th December 2008. Again the time is not noted. Dr Erskine did not note the presence of any swelling in the groin, and in her differential diagnosis did not include the possibility of an obstruction.
- (23) J North Ward is a medical receiving ward. Ward rounds in J North Ward are conducted twice per day, and are led by a senior doctor or consultant.
- (24) On 5th December 2008, Dr Davanand Sharma, Associate Specialist, conducted a ward round. Again the time is not noted. He did not examine Mrs Laing.
- (25) On 5th December 2008 at 1500hrs, Mrs Laing was transferred to the Cove Unit on K Ward. The consultant in charge of that ward was Dr Graham Currie.

- (26) K Ward is an orthopaedic rehabilitation ward which had a significant number of medical patients, of which Mrs Laing was one. Ward rounds in K Ward are conducted under the supervision of a doctor, Monday to Friday each week, with a consultant attending the ward rounds perhaps two to three times during that period. Ward rounds at weekends are nurse led with no doctor present.
- (27) Mrs Laing was monitored on K Ward by Dr Catriona Thomson, an FY1 doctor. She noted Mrs Laing's blood results on Friday 5th December 2008, and over the weekend of 6th and 7th December 2008. Further blood results were reviewed on Monday 8th December 2008. Dr Thomson noted the blood results over that period showed a degree of renal impairment. Mrs Laing was treated with intravenous fluids to correct the imbalance in the results. Markers for inflammation/infection had fallen over that period.
- (28) On 8th December 2008, Mrs Laing was seen as part of a ward round, with Dr Graham Currie, Consultant, in attendance. Mrs Laing's kidney function was still compromised and there was evidence of bacterial infection within her body. Further tests, including an ultrasound scan, were ordered.
- (29) An ultrasound scan was carried out on Mrs Laing on 8th December 2008, and was reported by Dr Patrick Walsh, Consultant Radiologist, on the same date. It stated inter alia; "*Stomach and bowel loops distended*" and concluded; "*I suspect GI obstruction*". Dr Thomson then carried out her first examination of Mrs Laing. She concluded that Mrs Laing had an obstruction, and the 3/4cm mass she found was most likely a hernia, noting "+ ? *R inguinal hernia*". Dr Thomson called for a surgical review. Dr Thomson acted appropriately and swiftly.
- (30) A surgical review was carried out by the Out Of Hours Staff Grade Surgeon, Mr Faisal Ramadan, on 8th December 2008. He diagnosed an obstructed femoral hernia, which required surgery. Mrs Laing was transferred to H South surgical ward at 18.00hrs on 8th December 2008.
- (31) At approximately 21.30hrs on 8th December 2008, Mr Faisal Ramadan operated on Mrs Laing. Mr Ramadan found Mrs Laing's bowel to be severely strangulated, (which

was restricting the blood supply) and a small area of necrosis. A midline laparotomy was carried out, a length of the small bowel was removed (resected), and the bowel ends were joined end to side (an anastomosis). Mr Ramadan carried out the operation appropriately and correctly.

9th December 2008 – 20th December 2008

- (32) Post operatively Mrs Laing clinically presented very well. Mrs Laing's blood and biochemical results showed signs of an ongoing non specific inflammatory process, and of possible infection. A urine test for a urinary tract infection was clear on 12th December 2008, and a vaginal discharge swab taken on 14th December 2008 was also negative.
- (33) On 14 December 2008, Mrs Laing's urea and creatinine levels were noted to be high, indicating renal failure. She had a high CRP (C-Reactive Protein) reading which indicated possible inflammation. This could have been caused by surgical trauma, infection or simply as a result of the low volume of urine being passed. Mrs Laing appeared well on examination.
- (34) Mrs Laing's hospital medical notes for the period 15th – 17th December 2008 were missing from Crown Production 2, and were not available to the Inquiry. The nursing notes for that period were however available.
- (35) By 16th December 2008, Mrs Laing's blood and biochemistry results indicated that she had an infection which was causing concern.
- (36) By 19th December 2008, Mrs Laing clinically still presented well. At approximately 20.30hrs, Mrs Laing had a sudden onset of right sided chest pain. She was examined at around 21.30hrs and was found to be in respiratory distress. She was diagnosed with having lower lobe pneumonia on her right side, and a possible pulmonary embolism. A CT scan was requested for 20th December 2008.
- (37) On 20th December 2008 at around 02.00hrs, Mrs Laing was examined by an anaesthetist who arranged for a chest X-ray. She was again examined at 05.45hrs,

when it was noted that there had been a significant deterioration in Mrs Laing's breathing and blood pressure. The impression of the anaesthetist was that Mrs Laing had sepsis in her abdomen or chest, and/or a secondary pulmonary embolism.

- (38) A CTPA (CT Pulmonary Angiogram) was undertaken for a suspected pulmonary embolism. Mrs Laing became very unstable after the scan and her heart rate increased significantly. A CT scan carried out on 20th December 2008 diagnosed a tension pneumothorax (i.e. air out-with the lung in the chest cavity putting pressure on the lung, causing the lung to collapse) Steps were taken to stabilize Mrs Laing. The scan also revealed a collection of fluid in Mrs Laing's abdomen. Sepsis was also suspected, but it was unclear whether it was in the abdomen, chest or both.
- (39) The change in Mrs Laing's condition from 19th December 2008 to 20th December 2008 was dramatic. By 20th December 2008 Mrs Laing was very unwell and extremely unstable.
- (40) On 20th December 2008 at around 20.00hrs, a second laparotomy was performed on Mrs Laing. Mrs Laing was then returned to the ITU at around 01.00hrs on 21st December 2008.

21st December 2008 – 29th January 2009

- (41) Between 21st December 2008 and 29th December 2008, Mrs Laing experienced a number of unexplained pneumothoraces, requiring the insertion of chest drains to remove excess air/fluid from her chest cavity.
- (42) On 29th December 2008, Mrs Laing was extubated (i.e. removal of tube assisting breathing) and taken off the ventilator. She was reintubated on 31st December 2008. From 31st December 2008 to 14th January 2009 there was no dramatic change in Mrs Laing's condition.
- (43) On 14th January 2009, Mrs Laing was believed to have had a gastrointestinal bleed, and blood transfusions were carried out over the following seven days. Endoscopies were carried out on 16th and 22nd January 2009.

- (44) On 26th and 27th January 2009, Mrs Laing's condition deteriorated significantly.
- (45) At 13.55hrs on 29th January 2009, Mr Duncan Thomson, Consultant Anaesthetist, pronounced Mrs Laing dead.

NOTE

Introduction

- (1) This inquiry was held in terms of section 1 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ('the Act'), in respect that the Lord Advocate considered it in the public interest that an inquiry be held into the death of Judith Laing (born 17th November 1943) on 29 January 2009, at Inverclyde Royal Hospital, Greenock. Although the application for the holding of the inquiry does not specify it, it seems that the inquiry was sought under section 1(1)(b) because the Lord Advocate considered it expedient in the public interest in the cause of the death that an inquiry under the Act should be held into the circumstances of the death on the ground that the death had occurred in circumstances such as to give rise to serious public concern.
- (2) Section 6(1) of the Act requires 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 causing the death took place;
 - b) the cause or causes of death and any accident resulting in the death;
 - c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
 - d) the defect, if any, in any system of working which contributed to the death or any accident resulting in the death; and
 - e) any other facts which are relevant to the circumstances of the death.
- (3) The only method of establishing those circumstances is by the assessment of the evidence led by the Procurator Fiscal and by any other interested party represented at

and participating in the inquiry. In addition it has often been said, correctly, that a fatal accident inquiry is concerned with fact-finding, not fault-finding. That is a statement which should be borne in mind at all times. The purpose of the Inquiry is not to attach fault to any person. Rather, it is to inquire into all the circumstances of the death in order to discover the truth, identify any reasonable precautions which might have been taken and ascertain if any lessons can be learnt which might serve to prevent the re-occurrence of any similar death.

- (4) I have been asked by parties to identify and, in terms of Section 6(1)(c), set out in my determination any reasonable precautions that might have been taken. I am reminded of the comments made by Sheriff Stephen at Edinburgh following upon the Fatal Accident Inquiry into the death of Lynsy Myles (27 February 2004) in which her Ladyship made the following observation;

“Again lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is clear appropriate testimony which challenges the treatment a patient receives. The view I take of this matter is that for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff. Before I can find a precaution to be reasonable in the context of a medical issue, there must either be an admission by the treating doctor that he failed to take a precaution or course of action which he clearly ought to have taken, or took the course of action which, in the exercise of ordinary care, ought not to have been taken. Failing that there would require to be established by independent evidence the matter in which the doctor in a particular area of expertise, and with the particular experience, ought to have acted. This clearly requires there to be a standard by which the actions of doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification...”

- (5) Further, the test to be applied in considering reasonable precautions is whether or not as a result of taking such precautions, death “**might**” have been avoided. ‘Carmichael – Sudden Deaths and Fatal Accident Inquiries, 3rd Edition’, the most recent edition of

the standard text book on the subject matter, at page 174, paragraph 5-75 states (with my emphasis);

*“What is required is not a finding as to a reasonable precaution whereby the death or accident resulting in the death “would” have been avoided, but whereby the death or accident “**might**” have been avoided...Certainty that the accident or the death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a “probability” but a real or lively possibility that the death **might** have been avoided by the reasonable precaution.”*

- (6) Sheriff Kearney, in his determination in relation to the death of James McAlpine, issued on 17th January 1986 and referred to by ‘Carmichael’ at paragraph 8-99 states;

“In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death be satisfied that the precaution was a reasonable one.....The phrase “might have been avoided” is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than “would, on the probabilities have been avoided” and rather directs one’s mind in the direction of lively possibilities.”

The Inquiry

- (7) The Inquiry heard evidence on 17th, 18th, 20th, 21st, 24th, 25th and 28th September 2012. The Inquiry was then adjourned for written submissions to be lodged, and these were read out to the Inquiry on 8th October 2012. The evidence in this Inquiry was detailed and complex, and there were competing views on appropriate treatment. I am therefore particularly grateful to parties for their helpful and detailed submissions.

(8) At this Inquiry, parties were ably represented as follows:

- The Lord Advocate: Linda Martin, Procurator Fiscal Depute
- Mrs Judith Laing's family: Mr Rodgers, Solicitor, Drummond Miller, Glasgow
- Dr Annabel Shepherd and Dr Maureen Smith: Mr Mawby, Solicitor, Brechin Tindal Oatts, Solicitors, Edinburgh
- Greater Glasgow Health Board: Miss Helen Watts, Advocate, instructed by Central Legal Office, Edinburgh

(9) I heard evidence from the following witnesses and in the following order, all led by the Procurator Fiscal Depute:

- Alistair Laing, 10 Slaemuir Avenue, Port Glasgow
- Dr Alan Dickson, General Practitioner, Ardgowan Medical Centre, 2 Finnart Street, Greenock
- Dr Annabel Shepherd, General Practitioner, Possilpark Health Centre, 85 Denmark Street, Glasgow
- Dr Maureen Smith, General Practitioner, The Health Centre, 2 Bay Street, Port Glasgow
- Dr Amy Jean Briffa, General Practitioner, formerly Inverclyde Royal Hospital, Greenock
- Dr Gillian Erskine, General Practitioner, formerly Inverclyde Royal Hospital, now Mount Pleasant Practice, Station View Health Centre, 84 Holmscroft Street, Greenock PA15 4DG
- Dr Catriona Thomson, General Practitioner, formerly Inverclyde Royal Hospital, now at Holdenhurst Road Surgery, 199 Holdenhurst Road, Bournemouth BH8 8DE
- Dr Graham Currie, Consultant, General Medicine, Inverclyde Royal Hospital, Greenock
- Dr Davanand Sharma, Associate Specialist, Inverclyde Royal Hospital, Greenock
- Mr Faisal Ramadan, Surgeon, Inverclyde Royal Hospital, Greenock

- Mr Douglas Morran, doctor, formerly Inverclyde Royal Hospital, Greenock, now at The Beatson Institute, University of Glasgow
- Gerald Anthony Gahan, Advanced Nurse Practitioner, formerly Inverclyde Royal Hospital, Greenock, now at Royal Alexandra Hospital, Paisley
- Dr Lynn McCracken, formerly Inverclyde Royal Hospital, Greenock, now at Royal Alexandra Infirmary, Paisley
- Mr John Joseph Reidy, Consultant Surgeon, Inverclyde Royal Hospital, Greenock
- Mr Iain Watt, former Consultant General Surgeon, Inverclyde Royal Hospital, Greenock
- Mr James Thornton Holmes, former Consultant General and Colorectal Surgeon, Peterborough
- Dr John Clark, Consultant Forensic Pathologist, Department of Forensic Medicine and Science, Glasgow University

(10) In addition, evidence from the following witnesses was given by way of sworn affidavits which were read out at the hearing:

- Mr Gerrit Denys, Consultant General Surgeon, Inverclyde Royal Hospital, Greenock
- Dr Duncan Thomson, Consultant Anaesthetist, Inverclyde Royal Hospital, Greenock
- Dr Norman Wallace, former Principal and Trainer in General Practice, Edinburgh
- Dr Patrick Walsh, Consultant Radiologist, Inverclyde Royal Hospital, Greenock

(11) In addition, a Joint Minute dealing with the lodging of Crown productions (1) to (5), and signed by all parties, was lodged and was read out at the Inquiry

(12) The Crown productions comprised:

- (1) GP records of Judith Laing
- (2) Inverclyde Royal Hospital Records – Judith Laing – three volumes
- (3) Report by Dr Norman Wallace, dated 3rd May 2012
- (4) Report by Mr James Thornton Holmes, dated 8th February 2010
- (5) Post Mortem report by Mr John Clark, Forensic Pathologist, dated 18th March 2009
- (6) Report by Mr James Thornton Holmes, dated 3rd March 2012

The Evidence

General

- (13) As with any Inquiry into a death in a hospital, there was a substantial amount of evidence of a detailed and complex nature. I heard detailed evidence about the causes and symptoms of herniae and the significance of readings in blood and biochemistry results. I think it may be helpful to set out some of the relevant medical issues which came out, and to explain the significance of some abnormal blood readings.
- (14) It was explained that a **hernia** is where an organ in the body protrudes through the sac or wall surrounding that organ. A hernia of the bowel can lead to obstruction of the bowel, which is a significant issue for an individual. Herniae can be classed as reducible or irreducible. A reducible hernia is a hernia which can disappear back in through the hole from where it came. This can be done by gravity, for example when an individual lies down, or it can be pushed, or manipulated back through the hole. A non-reducible hernia is one which does not disappear when an individual lies down, or where there would be a difficulty in pushing it back into place. A hernia which is not reducible is called an **incarcerated hernia**. A hernia which is incarcerated can become **obstructed**. A hernia which is incarcerated can also become **strangulated**, i.e. twisted, and therefore is more serious. An obstruction can result in the blood supply to the organ being compromised. A strangulation, which will also cause an obstruction, will result in the blood supply to the organ being compromised. Loss of blood to the tissues of an organ results in the tissues dying, a process called **necrosis**.
- (15) A hernia in the groin area can either be an **inguinal hernia** or a **femoral hernia**. An inguinal hernia lies slightly higher up in the groin than a femoral hernia. Inguinal

herniae are much more common in males, and femoral herniae are much more common in females, particularly in older females. I was shown statistics, which were not disputed, which stated that femoral herniae account for only around seven per cent of all herniae in the groin. In elderly women, the incidence of femoral herniae for them approaches that of inguinal herniae. Because femoral herniae involve the protrusion through a smaller sac, they are less likely to reduce than inguinal herniae, and therefore more likely to be incarcerated. As I have said, a hernia which is incarcerated can become strangulated, and therefore the risk of strangulation in a femoral hernia is very much greater than for an inguinal hernia. A femoral hernia involves part of the bowel containing the abdominal contents protruding through the sac. If it becomes obstructed, the blood supply to the small bowel is compromised which can lead to necrosis. Femoral herniae therefore pose a greater risk to the bowel and to the patient.

(16) When blood is tested, a number of readings can be taken from the various products within the blood. The following were some of the more significant blood readings which were being monitored by those involved in Mrs Laing's care:

- CRP - C-Reactive Protein. This protein is produced by the liver and an increased reading can be a sign of inflammation in the body.
- Creatinine - This is an indicator of kidney function.
- eGFR - Estimated glomerular filtration rate. This is the rate at which creatinine is cleared from the body. A reduced reading can be an indication that kidney function is compromised.
- Urea - This is an indicator of kidney function. An increase can show kidney function is compromised. This can increase with dehydration.
- WCC / WBC - (white cell count / white blood count) -
A raised level can be a sign of infection in the body. It can also indicate inflammation.

- Neutrophils - (This is expressed as a percentage of the white cell count)
 - An inflated reading can indicate bacterial infection. A reduced reading can indicate viral infection.

(17) I heard evidence from a number of doctors who treated Mrs Laing. I also had the benefit of evidence from Mr James Thornton Holmes, Consultant Colorectal Surgeon, and from Dr Norman Wallace, former Principal and Trainer in General Practice.

(18) The following were described in evidence as symptoms of a hernia in the groin, and of an obstructed hernia.

- (i) The hernia would present as a swollen area. The actual swelling or lump, in itself, may not be painful. It may be tender, but not always. It can become more tender if it becomes inflamed and, if there is necrosis in the late stage, the area may well become red on the surface.
- (ii) Inguinal and femoral herniae present fairly similarly, but in slightly different areas. Mr Thornton Holmes said that inguinal herniae usually would show a slightly larger lump.
- (iii) Bowel sounds were important. An obstruction might be identified by what are described as “tinkling” sounds.
- (iv) Mr Thornton Holmes stated in evidence that the signs of an obstruction caused by a hernia usually include abdominal pain. That pain may come in waves as the bowel tries to push against an obstruction. That can be described as colicky pain.
- (v) Vomiting could be a sign that the bowel was obstructed. As vomiting persists, the vomit would usually change in colour from clear (which is a sign of bile) to dark brown or black (which is a sign of blood or faeces).
- (vi) Other signs of an obstruction could include abdominal pain (as the abdomen becomes distended), bowels not opening and the patient not passing wind.
- (vii) Mr Ramadan said that dilated loops in the bowel, which were noted on the X-ray taken on 4th December 2008, could indicate an obstruction, especially if the patient was experiencing colicky pain. Colicky pain is spasmodic pain which can occur when there is a tubular obstruction and the body is trying to push things through the obstruction.

- (19) It was explained by various experts however, that some of these symptoms may well be absent, even where there is an obstruction. I heard evidence that when looking for a strangulated femoral hernia one would normally look for a lump with associated pain. Dr Graham Currie, Consultant gastroenterologist in J North Ward explained that if a bowel became obstructed for some time it can become paralysed. The bowel works in continuing waves, and where the bowel does not move it can become paralysed; that is described as ileus. If nothing is passing through the bowel the pain can be less than might be expected, and the bowel may well have quiet sounds. Mr Reidy also explained that a degree of ileus was normal after a bowel operation, particularly where the bowel had been handled. Further, a patient who had experienced obstruction of the bowel could expect the period of ileus after an operation to last a bit longer than normal.
- (20) It was clear from the evidence I heard that the symptoms for inguinal and femoral hernia can be similar, and differentiating between an inguinal and femoral hernia is often not easy. Dr Currie stated that femoral herniae were very rare on medical wards and, due to a lack of comment on them in medical textbooks, a medical doctor's knowledge of them was somewhat different from that of a surgeon.
- (21) In Mrs Laing's case the swelling in her groin was initially diagnosed as a swollen lymph gland/node. It was explained that an inflamed lymph node was the body's reaction to fighting infection. There are lymph nodes throughout the body, and that includes in the groin area.
- (22) Mr Thornton Holmes said that with a lump in the groin area, the most important issue was to ascertain whether or not it was a hernia. If it was an inguinal hernia and not obstructed, it may well be reducible. He said that if in doubt, he would explore the lump surgically. Mr Thornton Holmes explained that a femoral hernia was much more dangerous than an inguinal hernia and had to be dealt with as an emergency. To him, vomiting would be a sign that the hernia was blocked and therefore required to be dealt with as an emergency. Mr Ramadan, who gave evidence, was a Staff Grade Surgeon experienced in inguinal and femoral hernia. Mr Ramadan's view was that an irreducible hernia should be referred for treatment immediately as it can become

strangulated, which leads to a loss of blood supply which in turn leads to necrosis (death of tissue and vessel). Once tissue dies sepsis can develop, and bacteria from the dead tissue can travel around the rest of the body. Irreducible hernia can on occasion be popped back in by an application of pressure without the requirement for surgery. If, however, matters are left and the viability of the tissue becomes compromised then a resection, i.e. a cutting of the bowel, and an anastomosis i.e. a rejoining of the bowel, often become necessary. Mr Ramadan said that classic symptoms of a strangulated hernia would include a lump in the groin which does not disappear when pressed, vomiting, and pain and swelling in the abdomen. Mr Ramadan's view was that if these symptoms were presented to a General Practitioner, a patient should be referred to a surgeon or an accident and emergency department as an emergency.

Mr Alistair Laing

- (23) Mr Alistair Laing described how he met his wife when she was age 15. They became engaged in 1962 and married on 18th November 1963. Together they had three children: Alison, Alistair and Kenneth. Mr Laing described his wife as someone who took pride in her appearance, and generally kept in good health. She had suffered from breast cancer some years ago. His wife was employed initially as a machinist, and latterly as a Cleaning Supervisor with Inverclyde Council, employed at a local primary school. She worked there until her illness, which sadly resulted in her death.
- (24) Mr Laing described that after a night out with his wife on 29th November 2008, his wife felt unwell in the early hours of 30th November 2008. Mrs Laing began to experience terrible pain in her stomach and began vomiting. On returning to bed she and Mr Laing noted a hard lump about the size of a ten pence piece on the right side of her groin. There was no evidence to suggest whether or not the lump had been there prior to Mrs Laing beginning to vomit, as until that time she had been sleeping. Mr Laing described his wife's vomit as a dirty brown colour and which had a "*not normal*" smell. Mrs Laing asked her husband to call a doctor. Mrs Laing was instructed by the call handler to take paracetamol. This did not help, and a few hours later she continued to vomit. Mr Laing again contacted NHS 24 who advised him to take his wife to a local Out Of Hours clinic. Mr Laing took Mrs Laing there, where she was seen by Dr Alan Dickson. Mr Laing said that on coming out of the

consultation with Dr Dickson, his wife commented that her symptoms were not the result of a hernia as the lump was too low down. Mrs Laing was given a prescription for medication to prevent sickness.

- (25) The following day, Monday 1st December 2008, matters had not improved for Mrs Laing, and first thing in the morning Mr Laing called Port Glasgow Health Centre requesting a house call. Dr Annabel Shepherd, the locum with the practice, visited Mrs Laing around 13.00hrs. Mr Laing said that he asked Dr Shepherd about the lump in his wife's groin area and that Dr Shepherd replied that it was the gland working against the infection. Again Mrs Laing's condition failed to improve, and at about 04.00 hrs on Tuesday 2nd December 2008 Mr Laing collected a sample of her vomit. He took this to his surgery first thing that morning. At that time Mrs Laing's condition had not improved. She was still vomiting, still had the lump in her groin area and still had pain from her stomach.
- (26) Mrs Laing was seen at the surgery by Dr Maureen Smith. Dr Smith arranged for Mrs Laing to be admitted to Inverclyde Royal Hospital. She said she would check the sample of vomit given to her. Later that morning Mr Laing was told that no blood had been found in the sample and therefore Mrs Laing did not require to go to hospital. Mrs Laing was again examined by Dr Smith. She was told that her lump was not the result of a hernia as it was too low down. Mrs Laing was advised to return to the surgery the following week for the lump to be investigated.
- (27) Matters did not improve for Mrs Laing. Mr Laing received no communication from the surgery regarding the results of her blood test. On 4th December 2008, Mr Laing again took his wife to the surgery. At that stage Dr Smith arranged for Mrs Laing to be admitted to Inverclyde Royal Hospital. Dr Smith advised that Mrs Laing had a slight urine and kidney infection. A letter of referral was prepared for the hospital. On being given the letter of referral Mr Laing asked Dr Smith if she had mentioned the fact that his wife was vomiting continually. Dr Smith acknowledged that she had not mentioned that. She took the letter from Mr Laing and wrote something further on it. During that final consultation with Dr Smith no mention had been made of Mrs Laing's vomiting or of the lump in her groin.

- (28) Mr Laing went on to describe his wife's treatment in hospital. Mrs Laing continued to be sick and was placed on a drip. By 8th December 2008 a conclusion was made that Mrs Laing was suffering from a hernia and that it was to be operated on. Mr Laing said that from around 10th to 18th December 2008 his wife felt better and looked quite well. Her bowels, however, had not moved from 29th November 2008 until her admission to hospital, and again following her operation. On 19th December 2008 Mrs Laing developed pain in her right side. A further operation was carried out and thereafter Mr Laing felt that his wife looked well again. Her condition, however, deteriorated rapidly and Mrs Laing was moved into a High Dependency Unit. Sadly Mrs Laing's condition continued to deteriorate, and she was placed on a ventilator. Mr Laing was advised that Mrs Laing's bowel had been leaking and the contents of her bowel were within her stomach. Eventually after consultation with Mr Laing, the medical staff switched off Mrs Laing's ventilator on 29th January 2009, and Mrs Laing passed away.
- (29) I found Mr Laing to be extremely measured in his evidence. Clearly this was a shocking episode for Mr and Mrs Laing. There was no hint however in Mr Laing's evidence of exaggeration of his wife's condition, and there was no attempt to focus blame on anyone for his wife's death. He spoke fondly of his wife when giving evidence, at times raising some smiles from his family who listened intently.

Medical Evidence

30th November 2008 – 4th December 2008

Dr Alan Dickson

- (30) In November 2008, Dr Dickson was employed by Greater Glasgow and Clyde Out Of Hours Service. He described how when on call within Port Glasgow Health Centre he would receive details of patients he was to see via a message from Greater Glasgow Out Of Hours Service.
- (31) Dr Dickson explained that the Out Of Hours Service computer system extracted limited information from the caller's own GP records. This was then available to the out of hours doctor. Dr Dickson explained that at 08.00hrs on each day all the previous day's contacts with the Out Of Hours Service are e-mailed to patients' own

practices. Within Dr Dickson's own practice all such e-mails are then printed off and reviewed, and then placed within the patients' records. Dr Dickson sensed that this was not a uniform practice however.

(32) Dr Dickson examined Mrs Laing on 30th November 2008. He had certain information in relation to this matter from Mrs Laing's earlier contact with the Out Of Hours Service. Dr Dickson noted that Mrs Laing had no major abdominal pain, her temperature, blood pressure and pulse were all normal, and she did not appear to be in any discomfort. He examined her abdomen which he found to be soft. He noted that Mrs Laing had swelling in her right inguinal area. Dr Dickson diagnosed Mrs Laing's vomiting as a result of viral gastroenteritis. Having noted the right inguinal swelling, he did not connect that to Mrs Laing's symptoms of vomiting. Dr Dickson was aware that Mrs Laing had had a previous diagnosis of breast cancer. He thought the swelling might have been related to swollen lymph glands.

(33) Dr Dickson explained that if the lump had been a strangulated hernia he would have expected the site of the hernia to have been painful. Dr Dickson noted that Mrs Laing had no significant pain and had stopped vomiting approximately three hours prior to consultation. Dr Dickson accepted that he failed to recognise the association between the lump in the right groin area and Mrs Laing's other symptoms, and that in doing so he failed to make a correct diagnosis.

Dr Annabel Shepherd

(34) In November 2008, Dr Shepherd was employed as a locum GP within Mrs Laing's general practice at Port Glasgow Health Centre. On 1st December 2008 Dr Shepherd was tasked to carry out a house call to Mrs Laing, and she visited Mrs Laing around 13.00hrs. Dr Shepherd explained that it would be normal practice for a summary of the patient's records to be provided to her prior to her making the house visit. That summary would be taken with her to the visit. The fact that the patient had been seen by the Out Of Hours Service would not however be in the summary sheet, but would be in the full records. Dr Shepherd explained that the procedure in her own practice now was to triage all house call patients by telephoning them in advance of the visit. By doing so she would learn, for example, that the patient had been seen by the Out Of Hours Service.

- (35) Dr Shepherd had little recollection of her visit to Mrs Laing, which is perhaps understandable given that it was almost four years ago, and Dr Shepherd had not learned of Mrs Laing's death until approximately six months after the event. Dr Shepherd was referred to her notes of the consultation, Crown Production number 1, at page 2. Dr Shepherd conceded almost immediately that there was no record of any lump within her notes. She said that she probably should have asked about a lump in the groin area and should then have considered the possibility of an obstruction. Dr Shepherd felt that she had inappropriately diagnosed Mrs Laing as suffering from viral gastroenteritis. She believed that she had either examined Mrs Laing's abdomen and had failed to record in her notes the presence of a lump in the groin area, or had not examined the abdomen at all. Dr Shepherd considered it highly improbable that if she had examined Mrs Laing's abdomen she would not have seen the lump in the groin area. Mr Laing said that he asked Dr Shepherd about the lump in his wife's groin area, and that Dr Shepherd replied that it was the gland working against the infection. I am satisfied therefore that the more likely explanation for there being no note by Dr Shepherd of any swelling, was that she examined Mrs Laing, saw the swelling, but failed to note it in her record.
- (36) Dr Shepherd said that on reflection she should have been worried about the possibility of an obstruction in the bowel because of Mrs Laing's level of vomiting, and her call to NHS 24. She said she should have examined Mrs Laing specifically to make sure that she did not have a strangulated femoral hernia. In a similar situation now she would have a strong suspicion of a femoral hernia, would examine the groin area closely and, if suspicious of a strangulated femoral hernia, would refer for surgical intervention. Dr Shepherd had not seen a patient with femoral hernia before this case.
- (37) Following Dr Shepherd being advised of Mrs Laing's death some six months after the event, Dr Shepherd took the opportunity to review her notes by meeting with Mrs Laing's practice doctor to carry out a significant event analysis. She also discussed the issue with her appraiser. She accepted at that early stage that she had mis-diagnosed Mrs Laing's symptoms.

Dr Maureen Smith

- (38) Dr Smith was Mrs Laing's General Practitioner. When Dr Smith first examined Mrs Laing on 2nd December 2008 she was conscious of the fact that Mrs Laing was not someone who sought much medical attention. Dr Smith examined Mrs Laing and did note the presence of a lump in the right groin area. She thought it was more likely to be a lymph node rather than a femoral hernia. Having considered the history of vomiting and abdominal pain, Dr Smith thought it likely that Mrs Laing had viral gastroenteritis. She was surprised however by how well Mrs Laing looked. Dr Smith had earlier arranged for Mrs Laing to be admitted to hospital, but had cancelled that admission to the hospital because she thought that Mrs Laing was improving. She stated that it was not unusual for vomiting to last a number of days. There was no evidence of blood in her vomit and Mrs Laing was otherwise presenting well. She was not dehydrated and her blood pressure and pulse were relatively normal. There were no visible signs of infection and Dr Smith made a diagnosis of probable gastroenteritis. Dr Smith arranged for a blood test to be carried out and saw Mrs Laing two days later on 4th December 2008.
- (39) By 4th December 2008 Mrs. Laing was still vomiting. Mrs. Laing was acutely unwell with vomiting, and Dr Smith accessed the blood results electronically rather than waiting on them being sent to her surgery. She noted that Mrs Laing had a degree of renal failure, which possibly indicated some infection. Mrs Laing had no recent blood records to compare the current records with, and therefore could not report whether the renal failure was acute or long-standing. Dr Smith was concerned principally in dealing with the vomiting and possible renal failure. In her own mind, Dr Smith separated the vomiting and abdominal pain experienced by Mrs Laing from the lump which she found in the groin area. She questioned whether the lump in the groin was a swollen lymph node which had occurred as a result of the lymph node reacting to the infection.
- (40) Dr Smith arranged for Mrs Laing to be admitted to hospital. She telephoned the hospital specifically to arrange admission because she felt that Mrs Laing was not presenting very much for the hospital medical team to see.
- (41) It was clear to Dr Smith that by 4th December 2008, Mrs Laing's kidneys were not functioning well. Dr Smith was alert to that because she did not have a history of

kidney results to compare with. She discussed the matter with Dr Currie at Inverclyde Royal Hospital and arranged for Mrs Laing to be admitted. She noted the lump in the groin area was still present and was still irreducible. She did not consider the lump to be a strangulated femoral hernia, and for that reason did not refer Mrs Laing to a surgical team. Dr Smith prepared a referral letter to Inverclyde Royal Hospital, and that was shown at Crown Production number 1, page 7. There was a post-script to the letter which stated "*large inguinal swelling noted - ? gland*". This post-script was hand-written by Dr Smith and was added at the request of Mr Laing.

- (42) Dr Smith stated, that on examination Mrs Laing did not complain of any pain at the site of the swelling. On that basis Dr Smith did not think that it was a strangulated hernia. Dr Smith accepted in evidence that this sent her in a wrong direction in her diagnosis. Dr Smith said in evidence that even on reflection, the absence of pain would lead her to conclude that whilst there may have been an obstructed and incarcerated hernia, she would not consider it to have been strangulated.
- (43) Dr Smith gave evidence that, prior to Mrs Laing's case, she only had experience of two femoral herniae, both of which involved reducible groin swelling with no other symptoms. Both of those cases had been referred for urgent outpatient assessment. She had experience of one case of a femoral hernia subsequent to Mrs Laing's case, and on that occasion the hernia could not be fully reduced, and again the patient was referred for surgery. Prior to dealing with Mrs Laing, Dr Smith would have expected a femoral hernia to present quite differently from a swollen lymph node. She said that following Mrs Laing's case when she did not diagnose a femoral hernia, she was much more alert to the possibility of similarities in their presentation. Dr Smith had, since Mrs Laing's case, carried out a significant event analysis, had done further reading on the issue, and now taught students in her practice to be alert to the symptoms of herniae.
- (44) Dr Smith accepted that if she had made the link between the groin swelling and the other symptoms she would have referred Mrs Laing for a surgical review. She said that had she made the correct diagnosis two days earlier, there may well have been a different outcome for Mrs Laing.

Medical Evidence

4th December 2008 – 8th December 2008

Dr Amy Briffa

- (45) Mrs Laing was admitted to J North Ward (a medical receiving ward) on 4th December 2008. Dr Briffa was a foundation year 1 (FY1) doctor in J North Ward at Inverclyde Royal Hospital during Mrs Laing's time there. Dr Briffa had never before seen a femoral hernia. Dr Briffa explained that she would have been supervised by another doctor. As an FY1 on ward she would report to a Senior House Officer, who might be anyone from one to four years ahead of her in experience. That doctor would change on a weekly basis. The consultant in charge also changed every week because the ward was a receiving ward. Dr Briffa's duties involved looking after patients who had been admitted to the ward, checking their bloods etc, and helping clerk in patients who had been referred by their GPs. It was part of Dr Briffa's duties to take a medical history and a note of the presenting complaints, and to start any procedures she could, e.g. to take blood.
- (46) Dr Briffa examined Mrs Laing and noted the following: a right sided inguinal node (she explained that by writing "node" on the notes she would have considered the swelling to be have been a lymph gland); the patient had a slightly distended abdomen; bowel sounds were quiet (she explained this did not suggest any adverse finding). Her impression of the presentation was noted as possible obstruction of the bowel, or constipation. Mrs Laing's blood test results showed some abnormal findings which indicated that Mrs Laing's kidneys were not functioning normally. Dr Briffa also noted "*MSU grew coliforms*" (bacteria) which indicated the mid stream urine sample which had been sent to the lab by Mrs Laing's GP had grown cultures, suggesting possible infection.
- (47) Dr Briffa did not require to consider obtaining a second opinion as there was a set procedure in place whereby all work of FY1s should always be reviewed by a more senior doctor.

Dr Gillian Erskine

- (48) At the time of Mrs Laing's stay in Inverclyde Royal Hospital, Dr Erskine was a relatively junior doctor in J North Ward undergoing specialized training part I. Dr Briffa, as the FY1, would raise any concerns with her and she in turn would raise any concerns with the consultant, Dr Currie. Dr Erskine was the senior reviewer of Dr Briffa. Dr Erskine was referred to Crown Production 2 Volume 1, at page 13. She would have been aware of a referral letter from the GP, and of Dr Briffa's admission notes. The past history taken by her would have been a combination of those and the patient's own words. Dr Erskine said that she would have followed her normal practice of examining the patient and noting anything odd. She said she would have examined Mrs Laing's groin area. Her notes made no mention of Mrs Laing's groin lump or swelling. She said that was something she would have checked, and as there was no note of it, notwithstanding the previous mention of the lump, her position was that she had found no swelling on examination. At the time of Mrs Laing's examination by Dr Erskine, Mrs Laing was still to have an abdominal X-ray carried out. When questioned on whether she considered the possibility of a bowel obstruction, Dr Erskine stated that having read back the notes she could only imagine that a bowel obstruction would have been in her differential diagnosis, but that her findings on examination went against such a diagnosis. Although the history suggested an obstruction, Dr Erskine said if there had been an obstruction she would have expected swelling of the abdomen, a tinkling noise of the bowel sounding, and tenderness to confirm such a diagnosis. When considering Mrs Laing's symptoms, Dr Erskine's differential diagnosis included a urine infection, a viral illness, dehydration, active renal failure and constipation.

Dr Davanand Sharma

- (49) Dr Sharma was the Associate Specialist in J North Ward on 5th December 2008. He was the senior doctor that day. Dr Sharma confirmed that he had no recollection of Mrs Laing's case. He conducted a ward round on 5th December 2008 and saw Mrs Laing. Dr Sharma confirmed that on the medical receiving ward, ward rounds were conducted by a senior doctor twice per day, seven days per week. Once a patient was referred to another ward, ward rounds would be carried out Monday to Friday, but only with a consultant present two to three times per week. As J North Ward was a receiving unit, if the patient had arrived within the previous twenty four hours, the patient would require a full assessment. If the patient had already been on the ward,

then a review of the patient would be sufficient. It would not be necessary to look at the previous records; he would simply be interested in any new information. He would look at the conclusion of the receiving team to see if their conclusions on management had been effective. He would look to see if the working diagnosis and treatment were effective. In his entry of 5th December 2008, Dr Sharma recapped Mrs Laing's diagnosis. He did not believe that he had examined Mrs Laing and saw no indicator to require this. As well as the previous notes, he would be able to see that the patient was better and would receive reports from staff that she was generally well. Mrs Laing's results were generally in keeping with the diagnosis. Dr Sharma said that he had reviewed Mrs Laing's X-rays taken on 4th December 2008, and he did not believe that they showed an obstruction of her bowel. The X-ray showed a dilated bowel. Obstruction was a possible cause; however there were many other possible causes, for example infection and vomiting. Evidence of fluid levels on an X-ray would be more in keeping with an obstruction, but there were no fluid levels apparent. In Dr Sharma's opinion, the X-ray did not seem to show an obstruction, Mrs Laing had been treated, and by 5th December 2008 Mrs Laing appeared to be getting better.

Dr Graham Currie

- (50) Dr Currie was the Consultant on call in J North Ward on 4th December 2008. He is a consultant gastroenterologist. Dr Currie explained that patients would normally be clerked in by a junior doctor, and during ward rounds any significant abnormality would be brought to his attention. Dr Currie specifically remembers Mrs Laing as he had, unusually, prior to her admission spoken to her GP, Dr Smith. The GP had thought something was not right and had properly sent Mrs Laing for evaluation. Mrs Laing had been vomiting excessively. Excessive vomiting often affects a patient's electrolytes and depletes their fluids. These factors could result in kidney failure, with toxins going in to a patient's system. This appeared to be the case with Mrs Laing. Dr Currie said that he had not seen the referral letter from Mrs Laing's GP and could not be sure if her GP had mentioned a lump in Mrs Laing's groin. The GP had been concerned about possible kidney failure. Dr Currie explained further that if the MSU (mid-stream urine) showed bacteria at certain levels, and showed a lot of white blood cells, that was a sign of a Urinary Tract Infection. Mrs Laing had a Urinary Tract Infection, which was a very common occurrence, and Dr Currie assumed that was related to Mrs Laing's vomiting.

- (51) Dr Currie accepted that Mrs Laing's admission records (Crown Production 2, Volume 1, page 11 and 12) as completed by Dr Briffa, had been available to him and that he had initialed them as he was the Consultant in charge. He said, however, that he had not read the notes. Dr Currie was referred to an entry in the medical records made by him on 4th December 2008, (Crown Production 2, Volume 1, page 15). Although that was an entry written by him, and appeared to be a note from an examination, he said he had not at that stage examined Mrs Laing. Dr Currie explained that normally he would see a patient the morning following the patient being clerked in. To see a patient earlier may result in him seeing a patient without the full clerking in notes.
- (52) Dr Currie explained that he was not on the ward on 5th December 2008, the day following Mrs Laing's admission. Dr Sharma was the doctor who performed the ward round that day. Dr Currie did not see Mrs Laing on a ward round until Monday 8th December 2008. He explained that the cause of Mrs Laing's vomiting was the main issue for him at that stage. Vomiting was a symptom associated with several hundred possible causes. Vomiting led to fluid depletion, which in turn led to kidney failure. Vomiting can be caused by a urinary tract infection, and in Mrs Laing's case there was evidence of such an infection. Dr Currie explained that when he saw Mrs Laing on 8th December 2008 he did not examine her, as he would have been told that all her results showed that she was improving.
- (53) Dr Currie said he had not seen Mrs Laing's X-ray of 4th December 2008. Even if he had seen the X-ray, that would not have changed his approach to matters. Dr Briffa had questioned whether there was an obstruction, and Dr Walsh, the consultant radiologist, had looked for an obstruction and found none. The X-ray suggested that local irritation of the pancreas might have been the cause of the problem. Dr Currie said that when a bowel is obstructed it can become filled with fluid. He would have expected an X-ray of an obstructed bowel to show fluid levels pooling. The nursing notes at Crown Production 1, page 540, note that the X-ray result was '*constipation, no obstruction*'.
- (54) Dr Currie said that in any event, Mrs Laing's results seemed to indicate she was improving. Her CRP levels were dropping and she had not vomited from admission

on 4th December 2008 until 6th December 2008, and then there had been only intermittent vomiting. There had been no further vomiting on 7th or 8th December 2008. Mrs Laing appeared to no longer be showing signs of sepsis and it was believed that she would be returned home shortly. Because there had been some vomiting on 6th December 2008 however, further investigations were commenced and these included an ultrasound scan. Once the scan results were obtained and an obstruction noted, Mrs Laing was referred for surgery, and Dr Currie took no further part in her care.

Dr Catriona Thomson

- (55) Mrs Laing was transferred to K Ward (Cove unit) on 5th December 2008 at 15.00hrs. Dr Thomson was working as an FY1 on 'K' Ward (Cove unit). Dr Thomson noted various blood test results over the period 4th to 8th December 2008. She said the results indicated a degree of renal impairment and she arranged management of this by intravenous drips. Generally the blood test results indicated that kidney function was improving over the period 5th to 8th December 2008. The results indicated that there may also have been some bacterial infection, although the indicators were very unspecific. Dr Thomson said, however, that she received a hand-written result of Mrs Laing's ultrasound, and that was shown at Crown Production 1, Volume 1, page 18. The ultrasound scan result showed, *inter alia* a suspected gastro-intestinal obstruction. Dr Thomson found the ultrasound scan result unexpected. Mrs Laing had appeared to be improving in health. She therefore examined Mrs Laing and concluded that it was most likely Mrs Laing had a hernia. Dr Thomson explained that often it was not easy to interpret an abdomen X-ray on its own. With the X-ray, the ultrasound scan, and the detailed history, she had a much clearer picture of the position.

Mr Faisal Ramadan

- (56) Mr Ramadan was a Staff Grade Surgeon experienced in inguinal and femoral herniae. Mr Ramadan's view was that an irreducible hernia should be referred for treatment immediately as it can become strangulated, which leads to a loss of blood supply which in turn leads to necrosis. Once tissue dies sepsis can develop, and bacteria from the dead tissue can travel around the rest of the body. If matters are left and the viability of the tissue becomes compromised then a resection, i.e a cutting of the bowel, and an anastomosis i.e a rejoining of the bowel, often become necessary.

When Mrs Laing was presented to Mr Ramadan he considered her to be in a high risk category. Her blood results over the period of 4th to 8th December 2008 were deranged, and her kidney function was not optimal. She had been vomiting and had been ill for some time, and also had a possible prolonged obstruction. He considered Mrs Laing had possible sepsis and necrosis, and therefore toxins would have been passing into her blood stream. On operating on Mrs Laing, Mr Ramadan found her femoral canal to be enlarged with fluid. The bowel was severely strangulated, which was restricting the blood vessels, and which had led to a small area of necrosis. The bowel above the obstruction was dilated because of the pressure being put on it as a result of the obstruction. Mr Ramadan said that at the stage Mrs Laing was referred to him he would estimate that the strangulated femoral hernia would have been present for approximately the previous twenty four to forty eight hours. At that stage it was not possible to put the hernia back in without surgery. An earlier referral may have resulted in the hernia being reducible without surgery, or perhaps the surgery not being to the same intrusive level. Post-operatively, Mrs Laing was transferred to the High Dependency Unit under the care of Mr Watt.

Medical Evidence

9th December 2008 – 20th December 2008

Mr Douglas Morran

- (57) In December 2008 Mr Morran was an ST2 in general surgery, on K Ward. Mr Morran noted blood results over several days. Although raised white blood count on 11th December 2008 indicated both infection and inflammation, that was deemed not significant at that stage, and on 12th December 2008 the white blood count was moving downwards. From 13th to 15th December 2008, however, the white blood count remained elevated, which was abnormal and gave concern that there was ongoing infection. I was advised that was not particularly unusual three to four days post-operatively. During this period Mrs Laing also had increased CRP levels which indicated an ongoing inflammatory process. I was advised that might be expected to peak two to three days post-operatively.
- (58) Up to this point a number of issues were being looked at. Mrs Laing was suffering increased pain from the 11th to 12th December 2008 . It was explained, however, that

at that time she was being moved from intravenous pain killers to oral pain killers which would have been less effective, thereby increasing her pain. She had pain on urinating and that was being investigated. Mr Morran said that post-operatively, the most common areas for infection were in the urinary tract and in the chest. The mid stream urine (MSU) results however on 12th and 14th December 2008 gave no evidence of a Urinary Tract Infection. A vaginal swab was also negative. In view of the operative procedure in this case, he said he would have also considered abdominal infection. Mrs Laing's abdomen was distended but there was no obstruction. She was passing flatus, which was a good sign. A urine sample taken on 12th December 2008, and reported on 14th December 2008, showed no significant growth and no evidence of a UTI. A wound swab was also negative.

- (59) An X-ray carried out on 12th December 2008 showed dilated small bowel loops. That indicated that Mrs Laing was not absorbing food and water and therefore her small bowel was not back to normal. She was noted to be dehydrated. It was explained that because of the earlier obstruction in her bowel and because of the surgery, her bowel wall may well have become thickened. That could have resulted in the bowel wall absorbing more fluid, giving the appearance of Mrs Laing being dehydrated with insufficient fluid in her vascular system. After review of the X-ray, Mrs Laing was put back onto intravenous fluids. The X-ray also showed that Mrs Laing had gas in her rectum, which was described as a good sign as it indicated that there was movement all the way through the bowel.
- (60) Mr Morran noted that the ward round notes for the 15th, 16th and 17th December 2008 were missing from the records. Information, however, could be obtained from the nursing notes over that period. The white blood count remained elevated on 18th December 2008, yet confusingly Mrs Laing still clinically presented very well.
- (61) On 19 December 2008 Mrs Laing became extremely unwell. She had right sided chest pain. Mrs Laing by that stage had pneumonia. It was explained that pneumonia can occur in a number of ways. For example, pneumonia can be contracted in the community. In Mrs Laing case, she had undergone surgery and she had had a tube inserted into her windpipe. Mrs Laing was believed to have basal atelectasis, a condition which led to collapse of the small airways in the lung, which led to a

gathering of mucus, which in turn led to growth of bacteria. As a result she had respiratory distress, raised temperature and raised pulse. A diagnosis was made of lower lobe pneumonia or a possible pulmonary embolus. A lung CT scan was ordered and Mrs Laing was transferred to the High Dependency Unit. Mr Morran explained that basal atelectasis was a common occurrence post-operatively, that it was a common cause of a raised white cell count and temperature, and that treatment was prompt mobilisation to open up the airways, rather than simple administration of antibiotics.

- (62) Mr Morran explained that pneumonia did not suddenly occur, and therefore pneumonia would not have caused the sudden change in Mrs Laing's condition on 19 December 2008. He thought therefore that her condition might have been as a result of a pulmonary embolism or mucus plugging the large airways. Such sudden blockage could result in the loss of part of the lung.
- (63) Investigations to determine the source of any infection were ongoing. Mrs Laing's abdomen was pain free, which indicated no sepsis. MSU was clear, as was a vaginal swab. It was Mr Morran's impression that Mrs Laing clinically appeared well. He said that Mrs Laing's change on 19th December 2008 was striking, as he expected Mrs Laing to shortly be going home.

Mr Gerald Gahan

- (64) Mr Gahan was an Advanced Nurse Practitioner working on night teams. He could not recollect this case. He was on H South Surgical Ward on 14 December 2008. He made an entry at 01.40 am. Mrs Laing's urea and creatinine levels were noted to be high, indicating renal failure. She had a high CRP reading, which indicated possible inflammation. That could have been caused by surgical trauma, infection or simply as a result of the low volume of urine being passed. She appeared well on examination. Her oxygen levels however were low, and it was explained that there could be many reasons for that. Mrs Laing did not show any signs of wheeze or dullness in her chest. Her chest had a good sound all over. There was no suggestion of fluid or infection in her chest. She had no cough and no sputum. She did, however, have crackles at the bases of both lungs. Mr Gahan did not think that was an indicator of a chest infection. The crackling was an indicator that the bottoms of the lungs were not fully inflating.

That was not uncommon post-operatively. Post-operatively, a patient does not, perhaps, breathe as deeply as normal. Also, post-operatively, a patient would be expected to be lying flat on a bed, which is not conducive to taking big breaths. Mr Morran had stated the treatment for this was mobilisation rather than antibiotics.

- (65) Mr Gahan noted a worsening of Mrs Laing's U and E (Urea and Electrolytes) results. He believed that was due to Mrs Laing not getting enough fluids. Her urine output was improved. He said he would have expected the U and E results to improve.
- (66) Despite Mrs Laing looking well, Mr Gahan was considering the possibility of infection because of the raised CRP and WCC levels, the slightly raised temperature, a vaginal discharge, and the fact that Mrs Laing had been through an operation and had had a catheter and drips inserted. He discussed the matter with the surgical SHO and continued to provide fluids via an intravenous drip, carried out another blood test, and arranged a sepsis screen.

Dr Lynn McCracken

- (67) Dr McCracken was an FY1 on H South Surgical Team. When Mrs Laing was seen on 11th December 2008, the neutrophils in the white blood count were slightly further raised. Slightly raised neutrophils indicated a possible bilateral infection. On 12th December 2008, it was noted that Mrs Laing had increased pain on urinating. This could have been explained, however, by a change from intravenous to oral painkillers, to less effect, and to her catheter being removed. On 13th December 2008, Mr Laing's heart rate was raised and it was noted that this was secondary to dehydration, rather than infection. Dr McCracken had made an entry related to the X-ray taken on 12th December 2008. She had noted that there was an element of ileus, but was unable to exclude obstructive pathology. Results on the same day showed that there was no Urinary Tract Infection, and therefore it was likely that there was an infection in Mrs Laing's chest.
- (68) Dr McCracken also explained that bi-basal crackles could be an indicator of infection, but equally might simply be as a result of a patient lying down for a period and not mobilising. Dr McCracken was suspicious of infection, but excluded an upper Urinary Tract Infection. Mrs Laing's chest also appeared to be clear, she had no

cough or sputum, which all suggested the absence of chest infection. She had an increased pulse rate, a rise in markers and a higher temperature. She said she would therefore consider that recent surgery had been the source of the inflammation/infection. The fact that Mrs Laing was oxygen-depleted was also a possible sign of infection.

Mr John Reidy

- (69) Mr Reidy was the on-call consultant over the weekend 13th and 14th December 2008. He only vaguely recalled Mrs Laing's case, and his evidence was based on the medical records before him. Mr Reidy said that anastomosis procedures tend to be very successful. They can, however, break down very quickly. The most common time for that would be four to six days post-operatively. Part of the bowel loses the blood supply and breakdown can happen very quickly. The failure or leaking of the anastomosis could also be caused by undue tension on the bowel ends, e.g. a bad piece of bowel being used in the anastomosis. If the breakdown is caused by a failure of the body to heal, the breakdown would take longer. The procedure relies on the body's own healing process. If a patient is unwell, then there is the risk of poor wound healing. A patient who had been obstructed for nine days would be compromised in their wound healing.
- (70) Mr Reidy said that a patient with a small leak in the bowel may not look unwell on the outside. There would be a rise in inflammatory markers, in temperature, etc. There may be signs of clinical change, e.g. abdomen tender and distended. Mr Reidy explained that the bowel worked with continuing waves closing it. If there was ileus in the bowel, the bowel became paralysed. Ileus was normal after a bowel operation. In a patient who had had an obstruction, and who had a bowel being handled during an operation, it would be expected that there would be a period of ileus which might last a bit longer.
- (71) Over the period 11th – 14th December 2008, Mrs Laing's white blood count was mildly elevated. This gave an indication of inflammation. Mr Reidy said that at that stage, he would have been looking for infection in the chest or in the catheter, as the chest and abdomen were the most common areas for infection. All infection investigations were, however, clear. Mrs Laing had loose stools but this would not

have been a concern for Mr Reidy, as he would have been happy simply that the bowels were moving.

- (72) Mr Reidy was referred to page 956 of Crown Production 2, which was a report of the X-ray carried out on 12th December 2008. Mr Reidy did not consider the report gave a classic picture of a bowel obstruction. He said it was corroborative evidence that Mrs Laing had a degree of ileus.
- (73) Mr Reidy described how a patient such as Mrs Laing would be treated globally. He rejected the criticisms of Mr Thornton Holmes in his report. Mr Reidy's notes suggested that there were concerns about something going on in Mrs Laing's abdomen, but initially they had no hard facts on which to base any diagnosis. On that basis, his practice was to wait to see how matters developed. His main concern was that Mrs Laing was dehydrated. She had been in acute renal failure, and if her dehydration was not treated she could again lapse into renal failure. By 14th December 2008, Mrs Laing was noted to be improving. She looked better and had passed flatus, and her abdomen was softer. On the basis that all of the signs were of improvement, he would not have thought of returning Mrs Laing to theatre to have her abdomen re-opened. There was no suggestion that that would have been the appropriate course of action. It would have been possible to give Mrs Laing a contrast CT scan. That would have involved giving her intravenous contrast fluid. It was not considered the best course of action for Mrs Laing because her renal function was already impaired and the contrast fluid could further damage her kidneys.
- (74) Mr Reidy refuted the allegation by Mr Thornton Holmes that nothing was done for Mrs Laing. It was suggested that Mrs Laing could have been put on antibiotics to try and control the infection. Mr Reidy explained, however, that if antibiotics were introduced too early in an unguarded fashion, then early signs of the infection, which might provide a guide to the source of the infection, may well be masked. It was also good practice not to use antibiotics in a haphazard manner. Mr Reidy accepted that if there was an anastomotic leak, or evidence of widespread peritonitis, then surgery was the best option. It was explained that some anastomotic leaks however resolve on their own.

- (75) Mr Reidy was asked what might have happened if a CT scan had been carried out on 13th or 14th December 2008. He replied that on the basis that the scan which was done on 19th December 2008 showed a sizeable collection of fluid in the pelvis, he speculated that there might have been evidence of a smaller scale collection. Equally, there may have been nothing to see. If a small collection of fluid had been seen, then that may not have resulted in Mrs Laing being taken for surgery. Small bowel anastomoses normally heal well. There was no sign of peritonitis or widespread infection, and Mrs Laing appeared to be improving. If there had been a small collection, they may well have given Mrs Laing antibiotics and observed her. An advantage of conservative management was that the condition might well heal itself, and in fact most small leaks would heal themselves. A localised infection could be dealt with by other tissue wrapping itself around the leak and forming an abscess. Such an abscess could often dissipate itself. An abscess could also be drained, but if inaccessible then treated by surgery. Mr Reidy said that, on reflection, he probably would not have managed Mrs Laing any differently, but had she been deteriorating, he would have considered instructing a scan earlier.

Mr Ian Watt

- (76) Mr Watt was the doctor responsible for Mrs Laing's care following her first operation. Mr Watt explained that a hernia by itself would not always cause an obstruction. Whilst the presence of an obstruction of a hernia could be diagnosed, only surgery could confirm if a hernia was strangulated. Strangulation referred to the blood supply to the bowel being compromised. Mr Watt explained that an obstruction could develop symptoms, such as vomiting, which could be intermittent because of the bowel's need to re-fill. As an obstruction develops, the capacity of the bowel also increases. Mr Watt also gave reasons for the breakdown of an anastomosis. A number of factors contributed to tissue not healing and breaking down. It could be a technical/mechanical issue, for example the sutures giving way. It could be as a result of the bowel not healing because the patient was unwell. Where a patient had a bowel obstruction for some time, then the risk of breakdown would be higher than someone with an unobstructed bowel. It was uncommon, however, for the small bowel anastomosis to fail. He put the failure rate at about one per cent, with increased risk factors only taking that risk up to about one-and-a-half to two per cent. If there was a serious concern on the part of the surgeon carrying out the operation that the

anastomosis might fail, then the ends of the bowel would be brought out to the surface and retained there for a period. That, however, was very unusual in the small bowel. Mr Watt said that the normal recovery period for a small bowel anastomosis might be in the region of three to four days. However, that period could increase to ten to fifteen days if the bowel had been obstructed for a prolonged period. Such a period would not necessarily give him cause for concern. He did not consider there was much of a disadvantage of waiting and observing a patient post-operatively. He thought there was more risk to a patient by intervening on a second occasion by way of surgery too soon. Mr Watt was reasonably satisfied with Mrs Laing's progress. The X-ray on 12 December 2008, in his opinion, was reassuring as it showed gas in the rectum. He believed the X-ray report showed post-operative paralytic ileus, which would be quite normal.

- (77) Although various markers gave an indication of infection, there was nothing specific to explain the rise in the markers. Mrs Laing's abdomen was soft and non-tender, therefore the problem did not seem to relate to the abdomen. Mr Watt believed that an important part of the assessment of a patient was to look at her clinical appearance. In Mrs Laing's case, she generally always appeared well. She looked well; her abdomen was soft; and she was passing flatus. Mr Watt said that so long as a patient was clinically improving, then in the absence, say, of a particular abdominal tenderness or pain, he would continue with conservative management of the patient. With a small leak, he would expect some abdominal tenderness. He would only carry out a CT scan if he thought it would change his proposed management of the patient. In Mrs Laing's case, he was satisfied with her being managed conservatively.
- (78) On 19 December 2008, Mrs Laing deteriorated dramatically. There was concern that she may have had a pulmonary embolism. Prior to that day, her chest had not given any real cause for concern.
- (79) Mr Watt was asked if an earlier diagnosis of the breakdown of the anastomosis would have altered his management of Mrs Laing. He said that he would still have managed Mrs Laing conservatively. He would have been reluctant to carry out a second operation. Even operating at an earlier stage might not have altered the outcome. Most infections were self-limiting, and the site of infection would not necessarily

mean surgical intervention was the appropriate course. Mr Watt said that it was likely he would not have done anything any differently even if he had been aware of the breakdown in the anastomosis.

- (80) Mr Thornton Holmes' report was put to Mr Watt. Mr Watt said that Mr Thornton Holmes had chosen isolated episodes and results to interpret. He, Mr Watt, had seen the patient over a number of days and had developed a clinical picture of her improving.
- (81) Mr Watt gave two possible reasons for not proceeding with a CT scan. Firstly, the exposure to radiation would have been significant, being in the magnitude of 20 or more X-rays. He explained there is a greater reluctance on the part of radiologists now to subject patients to CT scans. Secondly, a CT scan would involve contrast fluid being introduced into the patient which might also damage already compromised kidneys.
- (82) Mr Watt described the process of pneumonia. He explained how a small abscess could lead to pneumonia. If the bacteria in the abscess was contained, and remained there, then that would not be a significant problem. However, if the bacteria spilled into the blood stream and was taken round the body that would have a secondary effect. The body's inflammatory process kicking in could cause damage to other organs.
- (83) Pneumonia can develop over a short period of time. That can be the result of a direct bacterial infection. It can also be the result of an inflammatory response which causes damage to the blood vessels and tissues within the lung. The damaged tissues in the lung then become flooded. That process can happen over a very short period.

Mr Thornton Holmes

- (84) Mr Thornton Holmes' view was that had Mrs Laing's obstructed hernia been recognised by the General Practitioners between 30th November 2008 and 4th December 2008, and that if she had been admitted urgently to hospital and an operation performed, then, on the balance of probabilities, Mrs Laing's bowel would have been viable; resection would not have been necessary; and Mrs Laing would

undoubtedly have survived. He also believed that if the obstructed hernia had been recognised on 4th December 2008 when Mrs Laing was admitted to hospital, it was likely the bowel would still have been viable and would not have required a resection. Under those circumstances, Mrs Laing, he said, would clearly have survived. Had a resection been performed on 4th December 2008, it was believed by Mr Thornton Holmes that on the balance of probabilities, the anastomosis would not have leaked. Although it was difficult to be sure of the cause of the leakage of the anastomosis (which is relatively unusual in small bowel anastomoses), it could be said that by 8th December 2008, Mrs Laing's bowel had been obstructed for nine days and her general condition would therefore have deteriorated. For much of that time, she had had an electrolyte disturbance. Mr Thornton Holmes believed that those factors were the main cause of the anastomotic disruption. Again, if the anastomosis had not leaked then, according to Mr Thornton Holmes, it is virtually certain that Mrs Laing would have survived.

- (85) Mr Thornton Holmes is a retired Consultant General and Colorectal Surgeon, having retired in 2008. Mr Thornton Holmes had no criticism to make of the surgical procedure carried out on 9th December 2008. He acknowledged that post-operatively, Mrs Laing initially did well. He noted Mrs Laing's observations from 9th December 2008. Mr Thornton Holmes believed that between 12th and 14th December 2008, suspicion should have been aroused that there was an abdominal problem, with an effort made to investigate that. His view was that an ileus could not have caused the rise in the white cells which was observed, but that an obstruction and leakage of the anastomosis could have done so. He believed that, on the balance of probabilities, further investigation would have revealed the anastomotic leak at an earlier stage. Mr Thornton Holmes' view was that by not carrying out further investigations at an earlier stage post-operatively, this was a factor which contributed to Mrs Laing's death.
- (86) Mr Thornton Holmes stated that had the second operation been undertaken by 14th December 2008, he believed on the balance of probabilities that Mrs Laing would have survived.

- (87) Mr Thornton Holmes in his report was critical of the failure of those who had examined Mrs Laing prior to admission to hospital on 4th December 2008 to correctly diagnose the existence of a femoral hernia. He was also critical of the failure to diagnose a femoral hernia by some of those treating Mrs Laing between 4th and 8th December 2008. Finally, he was critical of the failure to identify the leak of the anastomosis prior to further surgery being carried out on 21 December 2008.

Mr Duncan Thomson

- (88) I received affidavit evidence from Mr Duncan Thomson, Consultant Anaesthetist. Mr Thomson was the on call consultant anaesthetist when Mrs Laing was admitted to ITU on 20th December 2008. At that time Mrs Laing was critically unwell. The cause of her right sided chest pain was not clear and the probable cause was thought to have been pneumonia or pulmonary embolism (i.e. a clot in the lung). A chest X-ray and CT scan were arranged. There was no reference in the medical records for 19th and 20th December 2008 of Mrs Laing complaining of pain in her abdomen. The only pain referred to was noted in the medical records as pain in her chest. When Mr Thomson was called to see Mrs Laing, she was in extremis (i.e. at the point of death). The CT scan diagnosed a tension pneumothorax (i.e. air out-with the lung chest cavity putting pressure on the lung causing the lung to collapse). This was a life threatening condition which required emergency treatment. The CT scan revealed a collection of fluid in Mrs Laing's abdomen. Sepsis was also suspected, but it was unclear whether it was in the abdomen or chest or both. Mr Thomson described the change in Mrs Laing's condition from 19th December 2008 to 20th December 2008 as dramatic. Mrs Laing was treated throughout the day of 20th December 2008.

Medical Evidence

21st December 2008 – 29th January 2009

Gerryt Denys

- (89) On 21st December 2008 Mr Gerrit Denys, Consultant Surgeon performed a second laparotomy on Mrs Laing. He noted that the anastomosis from 8th December 2008 was inflamed and had disrupted. There was a large pelvic abscess present, located in the pouch of Douglas (i.e. area between the rectum and back part of the uterus). There was a quantity of free liquid (i.e. bowel contents, blood and pus) in her abdomen. A

further anastomosis was carried out. Mr Denys said that in his opinion the first anastomosis had possibly been leaking for a couple of days. The medical records prior to 21st December 2008 did not record the common symptoms of a leaking anastomosis that he would have been looking for.

- (90) Mr Thomson, in his affidavit, noted Mrs Laing's progress from 21st December 2008 to the time of her death on 29th January 2009. Mrs Laing experienced a number of unexplained pneumothoraxes. On 14th January 2009 Mrs Laing had a large amount of melaena (i.e. blood in faeces) possibly from a gastrointestinal bleed. This required multiple transfusions over a seven day period. Mrs Laing thereafter continued to decline. She developed multi-organ failure and died on 29th January 2009.

Cause of Death

- (91) As to the actual cause of Mrs Laing's death, the Crown principally relied on Crown Production Number 5, the post-mortem report by Dr John Clark, dated 18 March 2009. In that report, Dr Clark concluded that Mrs Laing had died from Adult Respiratory Distress Syndrome in the lungs. He stated it was a progressive pneumonia-like condition in which the lungs become full of fluid and fresh scar tissue. He stated in his conclusion;

"This is a well-recognised complication in anybody who has suffered major trauma, shock or severe infection, the last of these being the cause in this lady, probably largely stemming from the breakdown of the original bowel anastomosis from the first operation."

- (92) Dr Clark was called to give evidence to the Inquiry, and to clarify the source of any infection that might have caused the Adult Respiratory Distress Syndrome. Dr Clark in evidence explained that ARDS was a progressive condition, typically found in people with major trauma or severe infection anywhere in the body. The condition was effectively the lungs' response to major illness.
- (93) Dr Clark explained that when he examined Mrs Laing's body, there was no infection remaining in it, it having cleared up by the time the post-mortem was carried out. Dr Clark was aware that an infection in the form of an abscess in Mrs Laing's pelvis had

been found after her death. He stated that this may have started off the chain of events which caused problems in Mrs Laing's lungs. Dr Clark said that he did not find any other obvious cause. He said that, on examining Mrs Laing's lungs, he found fine scar tissue. He explained that the lungs can become filled with fluid and cells from blood. The lungs attempt to heal themselves by scarring. The condition probably developed over a number of weeks. Dr Clark explained that pneumonia in the form of a pure infection in the lungs is a form of bacteria in the lungs which responds to fluids and antibiotics. ARDS, however, was quite different, as it is much more widespread and progressive and it is not something which antibiotics are likely to be able to clear up. Dr Clark said that sepsis caused pneumonia, and it was his view that sepsis was most likely what had caused the ARDS which he found. Dr Clark said it was not likely that pneumonia in itself would develop into ARDS, but that it was more likely to result from generalised infection in the body, and the lungs reacting to that generalised infection. On examining the clinical record of Mrs Laing's treatment, he found the evidence of infection in the abdomen to be an acceptable explanation for the ARDS. He did not find any other obvious cause.

DISCUSSION

- (94) On 30th November 2008, Dr Dickson noted a swelling in Judith Laing's right inguinal area and questioned possibly lymphadenopathy. Dr Dickson explained how a patient's information was given to him by the Out Of Hours Service. The messages to him were in electronic format on the Out Of Hours Service computer system. An initial screen gave a patient's details and something about the time and nature of the call. Another screen gave more detailed information. A separate screen gave detail of recent contacts with the Out Of Hours Service, for example previous calls relating to the same matter. Dr Dickson explained that he would not routinely look at the previous contacts screen unless prompted to do so. Often there was information within the first screen which led him to look at the previous contacts screen. The main screen, however, gave no indication whether the call he was dealing with was a first contact or otherwise. What became clear during this inquiry was that medical practitioners constantly build up a clinical picture of a patient's illness from information they are able to gather during the period of an illness. The fact that Dr Dickson said he did not routinely look at the entries for a patient's previous contact with the Out Of Hours Service, leaves the possibility of useful information from

earlier contacts being missed due to the existence of those earlier contacts not being highlighted. I would have thought that it would have been helpful in reaching an informed diagnosis, for the Out Of Hours Service doctor to be alerted by a message/prompt on the first screen indicating whether or not the matter he or she was dealing with was the patient's first contact with the service relating to that matter. This would avoid the practitioner speculating as to the position and having to search on other tabs within the system.

- (95) The out-of-hours entries are emailed to patients' GP surgeries at 08.00hrs each morning. Dr Shepherd said that in 2008, prior to undertaking a home visit it was not a routine practice to examine patients' records, but often simply the summary which was given. The out-of-hours entry in respect of Mrs Laing was not contained within the summary sheet seen by Dr Shepherd. Dr Shepherd said that when doing a house visit in response to a request following out-of-hours contact, routinely she would not see the out-of-hours entries prior to going out to the house visit. Dr Smith however, said that her practice was to look at a patient's recent record, and the out-of-hours record of patients if they were available, prior to visiting a patient at home
- (96) I would have thought that a doctor carrying out a house visit in respect of an event which necessitated contact with the Out Of Hours Service should have all the information available to, and received from, the Out Of Hours Service. Dr Shepherd said she would receive details of the out-of-hours contact from the patient. According to Dr Shepherd, there did not seem to be any system in place at Mrs Laing's GP practice whereby doctors conducting house visits were advised that those visits were in response to a call following an out-of-hours contact. I consider there should be a system in place to include, as part of the information given to the doctor conducting a house visit, a note of the patient's most recent prior contact with the surgery, or with the Out Of Hours Service. That would alert that practitioner to the existence of information possibly relating to the current problem requiring the house visit. As Dr Smith said that the out-of-hours entry would be looked at by her, and in this case the absence of the out-of-hours e-mailed entry apparently made no difference to Dr Shepherd's stated position, (that notwithstanding the absence of the Out Of Hours Service notes, she examined Mrs Laing and found a swelling (notwithstanding she did not note it)), I make no recommendation in respect of this issue.

- (97) Dr Smith noted that Mrs Laing appeared to be clinically well, and because of that was apprehensive that Mrs Laing might not be admitted to hospital. She therefore made a call to Dr Currie at Inverclyde Royal Hospital to arrange for Mrs Laing's admission. Dr Smith, therefore, had seen Mrs Laing twice in three days, had arranged for blood tests to be carried out and had been pro-active in seeking out the results. Having done that, she then made arrangements on two occasions for Mrs Laing to be admitted to hospital. Dr Smith appears to have acted diligently. Dr Smith's failing, however, was in not associating Mrs Laing's groin swelling with Mrs Laing's other symptoms. Dr Smith was very candid in accepting that in not doing so, she made a serious error. She said she should have associated the two matters, and if she had done so she would have concluded that Mrs Laing possibly had a femoral hernia with an obstruction. Had she made that connection, she would have referred Mrs Laing immediately to hospital for intervention. Both Dr Shepherd and Dr Smith recognised the significance of a femoral hernia and the serious implications if the condition was not treated urgently.
- (98) Crown Production Number 3, was an expert report from Dr Norman Wallace dated May 2012. Dr Wallace had been a principal in general practice for thirty one years and was a trainer in general practice for twenty seven years. Dr Wallace said that general practitioners would be very familiar with herniae and might see several patients presenting with such every year. He said obstructed herniae were much less common, and a general practitioner might be expected to deal with such a presentation only once every few years. If a hernia was diagnosed by a GP, patients would be advised to look out for signs of strangulation, these being pain and tenderness over the hernia site with increasing abdominal pain and possible vomiting.
- (99) Dr Wallace concluded in his report that Mrs Laing's presentation to Dr Shepherd and to Dr Smith (and subsequently to the hospital doctors) was due to an undiagnosed obstructed femoral hernia. He appreciated how easily an incorrect diagnosis could be made as patients are rarely seen with symptoms and signs following an acute obstruction. Dr Wallace said that matters were further complicated for Dr Shepherd and Dr Smith because Mrs Laing did not present with a full classical picture of a

strangulated hernia, such as pain and tenderness over the hernia site. Dr Wallace also commented that Dr Smith had been attentive in her assessment of Mrs Laing.

- (100) Dr Wallace's phraseology alternates between "obstructed" and "strangulated", and it is not clear which he means. For the reasons given above however, it is clear that an obstructed bowel can lead, with or without it becoming strangulated, to a compromise of the blood supply, and to potentially serious problems for the organ and for the patient. I do not think it is essential therefore to be able to say whether Mrs Laing's hernia was simply obstructed, or obstructed and strangulated, up to 4th December 2008.
- (101) Mr Thornton Holmes provided a written report for the Inquiry dated 8 February 2010, and that formed Crown Production Number 4. He also gave evidence to the Inquiry. Although Mr Thornton Holmes had initially been instructed by the Crown, it became apparent during his evidence that he had also been instructed by Mrs Laing's family in respect of potential civil proceedings. It was acknowledged that Mr Thornton Holmes' duty was to the Court and not to any one party, but care had to be taken to ensure that his evidence did not focus on the fault of individuals. Unfortunately, Mr Thornton Holmes' CV contained within his report was no longer up-to-date. Mr Thornton Holmes said that between 1961 and 2002 he had seen emergency cases for herniae on a regular basis. He would regularly see between one and two inguinal herniae per week, and would see several femoral herniae per annum. Of those, one or two might be strangulated. Mr Thornton Holmes was therefore well qualified to provide expert evidence on the symptoms and treatment of femoral herniae.
- (102) Mr Thornton Holmes' opinion was that as a general principle, a patient with abdominal pain and vomiting should always be admitted to a surgical department, unless there were very good reasons for being certain that the abdominal pain and vomiting did not have a surgical cause. As a retired consultant colorectal surgeon, Mr Thornton Holmes was able to give expert opinion on what he considered were the classical symptoms of a strangulated femoral hernia. Mr Thornton Holmes' expertise however did not extend to him being able to provide expert opinion on acceptable practice of General Practitioners when faced with particular symptoms, or on the level of care provided by General Practitioners.

- (103) Whilst Mr Thornton Holmes' opinion was that Mrs Laing presented with classical symptoms of a strangulated hernia, Dr Wallace's opinion was somewhat different. Dr Wallace did not consider Mrs Laing presented from the outset with classical symptoms of a strangulated femoral hernia. That divergence of opinion perhaps highlights the difficulty facing practitioners when presented with symptoms such as those shown by Mrs Laing. At paragraph 4.1.1, of Dr Wallace's report however, Dr Wallace said that the only appropriate action for a patient suspected of having an obstructed hernia was for that patient to be admitted to hospital.
- (104) As I have emphasised already, this is a fact finding and not a fault finding inquiry. However I do not understand Dr Wallace's report and its conclusion to be disputed by Dr Shepherd or by Dr Smith, who both accepted that their failings in making an incorrect diagnosis resulted in a delay in Mrs Laing being referred to hospital for treatment.
- (105) Both Dr Shepherd and Dr Smith accepted that if they had made a diagnosis of an obstructed hernia, they would have referred Mrs Laing immediately for a surgical opinion. Dr Smith said she felt that may well have resulted in a different outcome for Mrs Laing. I do not therefore require to reconcile the differences in opinion between Dr Wallace and Mr Thornton Holmes as to whether or not Mrs Laing was displaying classical symptoms of an obstructed/strangulated hernia.
- (106) Dr Wallace's evidence was that had Mrs Laing been admitted to hospital when seen initially on 30 November 2008 or 1 December 2008, she probably would not have developed the subsequent complications that led to her death. He accepted however that such a conclusion was not within his particular area of expertise. I heard other evidence that the earlier a diagnosis is made of a femoral hernia, the earlier the intervention would be. Obstruction of a femoral hernia can easily lead to a loss of blood to the organ, and an obstruction can easily lead to a strangulation. That, in turn, leads to a loss of blood to the organ, resulting in necrosis. Had Mrs Laing been referred to the hospital earlier, it may well have been the case that she would not have required surgical intervention at all, or would not have required surgery as significant as a resection and anastomosis of the bowel.

- (107) I heard evidence that there were a number of factors which could lead to a breakdown of an anastomosis, and those included the length of time the bowel had been obstructed, the state of the tissue which was used to rejoin the bowel, and the general health of the patient in aiding the healing process. The longer a patient had an obstruction, and therefore the greater the period of general illness, the greater were the chances of a breakdown of the anastomosis. It is clear that had Mrs Laing had surgical intervention sooner, the chances of a breakdown in the anastomosis would have been lessened. There would therefore have been a lessening of the risk of infection. Given Mr Clark's opinion as to the contribution that infection had to Mrs Laing's death, it follows that the chances of Mrs Laing dying were likely to have been lessened if her obstructed bowel had been diagnosed sooner.
- (108) It was accepted by Mr Mawby on behalf of Dr Shepherd and Dr Smith, that a correct diagnosis by them might have prevented Mrs Laing's death. It was accepted by Mr Mawby on behalf of Dr Shepherd and Dr Smith, and his view was not challenged by the other parties, that in terms of Section 6(1) of the Act, reasonable precautions which might have prevented Mrs Laing's death, were as follows;
- **A reasonable precaution which might have prevented Judith Laing's death would have been for arrangements to have been made for Judith Laing to have been admitted to Inverclyde Royal Hospital for an immediate surgical review on 1st December 2008.**
 - **A reasonable precaution which might have prevented Judith Laing's death would have been for arrangements to have been made for Judith Laing to have been admitted to Inverclyde Royal Hospital for an immediate surgical review on either 2nd or 4th December 2008.**
- (109) The failure to diagnose Mrs Laing's obstructed bowel, however, was not confined to the General Practitioners. A major issue in this Inquiry was whether or not once in hospital, Mrs Laing should have had a surgical referral earlier than 8th December 2008.

- (110) On 4th December 2008, there were a number of signs which indicated a possible bowel obstruction. Again, I think it is important to distinguish between a strangulated hernia and a bowel obstruction. Again, it seemed to me that some witnesses found the terms interchangeable. There was evidence from some of the witnesses that the absence of pain in Mrs Laing's abdomen was an indication that she was not suffering from a strangulated hernia. I understood from the evidence that the absence of pain, although it might indicate that the bowel was not strangulated, did not necessarily mean that there was no obstruction. Mr Ramadan was of the view that the strangulation which he observed on 8th December 2008 had been there for possibly between twenty four and forty eight hours. It is therefore quite possible that as at 4th December 2008, and for a few days thereafter, Mrs Laing's bowel was simply obstructed and not strangulated. Mr Denys however said that according to Mrs Laing's records which he reviewed, the resection and anastomosis could not be done end to end, but had to be done end to side, and that was because one side of the bowel was large and inflamed, with the other narrow. He said that was due to Mrs Laing having a strangulated femoral hernia since on or around 29th November 2008. It is therefore impossible to say with any certainty how long the bowel had been strangulated prior to surgery on 8th December 2008.
- (111) In evidence, there was no criticism of Dr Briffa, who clerked in Mrs Laing, took a full history and conducted a full examination. Having done so, she noted her impression was of a possible obstruction or constipation, and that was her preferential diagnosis. She set out a treatment plan which included repeating the blood tests, arranging X-rays and a senior review. She explained that a senior review would, in any event, be automatic, as all of her decisions as an FY1 doctor would be reviewed by a more senior doctor. On 4th December 2008, Mrs Laing gave a history of having had colicky abdomen pain, black vomit, no bowel movement since 29th November 2008, and not having passed wind since 29th November 2008. Mrs Laing's abdomen was distended and there was a swelling in her groin. These were all signs of possible obstruction. I heard evidence that a common sign of an obstruction in the bowel was bowel sounds which were "tinkling" in nature. On examination, however, Mrs Laing had quiet bowel sounds and little abdominal pain. Dr Currie, though, explained that if a bowel was obstructed for some time, it could become paralysed, a term called ileus. If nothing was then passing through the bowel, pain in the bowel might be less than

expected, and the bowel may have quiet sounds. It appears, therefore, that quiet bowel sounds and the absence of pain in Mrs Laing on 4th December 2008 were not inconsistent with the possibility of an obstruction.

- (112) There were a number of symptoms and signs, therefore, which were consistent with Mrs Laing having an obstruction as at 4th December 2008. Dr Briffa set in motion procedures to investigate that possible obstruction, and those investigations included the taking of an abdominal X-ray. Many of the symptoms, however, were also consistent with a Urinary Tract Infection, and Mrs Laing's blood results had confirmed that Mrs Laing had such an infection.
- (113) Dr Erskine accepted that Mrs Laing's history was consistent with an obstruction. Dr Erskine's evidence was based on her notes of her examination, as she quite understandably could not recollect her examination of Mrs Laing, which occurred almost four years ago. Dr Erskine said that in considering her note, she must have veered away from a conclusion of an obstruction based on her examination of Mrs Laing, as she said she had not made a note of any swelling in the groin area. Dr Erskine said that she would have followed her normal practice and examined Mrs Laing for any swelling in the groin area, and the absence of a note of any swelling would mean that she did not find a swelling. It is perhaps unfortunate that given Dr Smith's letter of referral and the previous note by Dr Briffa, both of which mentioned a swelling, a specific comment regarding the absence of such a swelling and her conclusion from that, was not made by Dr Erskine. It is difficult to reconcile Dr Erskine's findings with Dr Briffa's, as I heard other evidence that it was unlikely the hernia would reduce and then reappear. Mr Thornton Holmes' opinion was that Mrs Laing presented with absolute characteristics of an obstructed femoral hernia. His view was that by 4th December 2008, Mrs Laing's hernia was undoubtedly strangulated. By that time, Mrs Laing had had an obstruction for four days, abdominal pain, vomit which had been clear and then dark, and had not opened her bowels during that period. Mr Thornton Holmes was of the view that there was no doubt the swelling in Mrs Laing's groin area would have been there from 29th November 2008 to 8th December 2008, notwithstanding that Dr Erskine's notes of her examination on 4th December 2008 did not disclose the presence of a swelling. I am therefore led to the conclusion that the swelling in Mrs Laing's groin was on balance likely to have

been present both when she was examined by Dr Briffa and by Dr Erskine. Although Mrs Laing's abdomen was noted as not distended, nor tender, for the reasons already given by Dr Currie, the absence of pain in the abdomen did not necessarily exclude an obstruction. Mr Thornton Holmes said that if there had been any doubt as to whether or not a lump was present, then the opinion of a consultant should have been sought. His view was that a review by a consultant may well have resulted in a referral to a surgical registrar to investigate.

- (114) I find that in terms of Section 6(1) of the Act, a reasonable precaution which might have prevented Mrs Laing's death, was as follows;

The senior reviewer within the medical receiving unit (J North Ward) of Inverclyde Royal Hospital on 4th December 2008, to have noted the presence of a right sided groin swelling on her examination of Judith Laing, and to have discussed her findings with a senior colleague or obtained a surgical opinion as to the cause of the swelling. Alternatively to have discussed any findings which were inconsistent with findings on earlier examinations of Judith Laing, with a senior colleague.

- (115) An X-ray of Mrs Laing's abdomen was taken on 4th December 2008. Dr Walsh said in his affidavit that the abdominal X-ray taken on 4th December 2008 should have been available immediately thereafter on the hospital computer system. The image could have been viewed by the medical ward staff. X-rays are also viewed by radiologists who have particular expertise in analysing them. Mrs Laing's X-ray of 4th December 2008 was viewed by a locum consultant radiologist, Dr H Dhliwayo, on Friday 5th December 2008 at 11.27hrs. It was explained that if a radiologist considered an X-ray image demonstrated something which required urgent treatment, he would record the report as a "Category 5 report". Best practice would say that the radiologist would then telephone the ward team to alert them to the problem. Alternatively, a hard copy typed report could be sent to the ward. Dr Dhliwayo did not categorise his report as a Category 5 report. His report was not typed until 8th December 2008 at 12.05hrs. After being typed, a report is then verified by a consultant radiologist. Dr Dhliwayo was not available on 8th December 2008 and the X-ray was examined, and the report verified by Dr Walsh at 13.06hrs on 8th

December 2008. Dr Walsh said in his affidavit that he agreed with the content of that report. He said he did not consider that the X-ray “*clearly demonstrated an obstructed bowel*”. Dr Walsh went on to say that notwithstanding what he subsequently came to know about Mrs Laing’s condition, he remained of the view today (and notwithstanding the amendments to the report - see below) that the X-ray was “*not immediately suggestive of bowel obstruction*”.

(116) There was a disturbing piece of evidence to emerge. Dr Walsh said in his affidavit that, in preparing to give evidence for this Inquiry, he checked the hospital computer system to once again view the X-ray report of 4th December 2008. He noted that a second version of the report had been created and verified by Dr Dhliwayo on Monday 15th December 2008 at 10.28hrs. There were three changes in the later report. The most significant of these he considered was the addition of the words “*Consider ultrasound for further evaluation*”. Having made enquiries, Dr Walsh was advised by the hospital IT Department that changes had been made on other occasions to X-ray reports, and that the method adopted by Dr Dhliwayo was seen as an acceptable way to make changes. The fact that the original report (pre alteration) appeared in the records before this Inquiry, and in the records sent to the experts for their comments, suggests that there is a significant flaw in the system of having amended reports included within patients’ records.

(117) The presence of an amended radiology report was not known until Dr Walsh went into the hospital computer system prior to this Inquiry. The amendment to the report made no difference to the investigations being carried out, as an ultrasound was in fact carried out on 8th December 2008. I consider though, that how the report was amended, and how that amendment failed to find its way into Mrs Laing’s medical records is a relevant factor in terms of Section 6(1)(e). I consider there requires to be a review of procedure dealing with;

(i) how amended reports are introduced into a patient’s medical records,

(ii) how the existence of an amended report/result or opinion is highlighted in a patient’s medical records,

(iii) how any amendments are brought to the immediate attention of those treating the patient.

- (118) It was the case therefore that by 8th December 2008, although the X-ray report did not exclude the possibility of an obstruction (contrary to what was suggested by Dr Currie), there was nothing within Mrs Laing's records to alert the medical team that there were any adverse findings from the X-ray. Over the period 4th to 8th December 2008, Mrs Laing's blood results were being monitored. Dr Thomson, duty doctor in the Cove Unit, monitored Mrs Laing's condition over that period. Mrs Laing continued to show signs of compromised kidney function and some infection, but the results showed a general overall improvement. It came as a surprise to Dr Thomson, therefore, that the ultrasound scan on 8th December 2008 showed signs of obstruction. Dr Thomson said that the obstruction was not part of the working diagnosis, and she referred in evidence to the ward round note of Dr Sharma dated 5 December 2008, where a Urinary Tract Infection was noted. When Dr Thomson took a further history from Mrs Laing on 8th December 2008, she noted that Mrs Laing's bowels had still not moved and that she had only passed wind that day. It was accepted in evidence that no bowel movement for a number of days might simply be the result of constipation and not obstruction. Mrs Laing had an empty rectum which was also suggestive of a bowel obstruction. Dr Thomson said that having reviewed the X-ray taken on 4th December 2008, she was of the view that it may have led her to look for an obstruction.
- (119) Dr Currie said that even with hindsight, he would not have arranged for a surgical referral prior to the ultrasound scan result being available. It was only at that stage there was a clear suggestion of an obstruction. He did not consider that the X-ray taken on 4th December 2008 demonstrated a bowel obstruction. He said that was also the view of Dr Walsh, Consultant Radiologist.
- (120) Interpretation of X-ray images is a specialised field. There will be differences of opinion among those who attempt to do so. Dr Walsh's evidence did not exclude the possibility of a bowel obstruction, but simply stated that it was "*not immediately suggestive of bowel obstruction*". Dr Thomson's view now of the X-ray was that it may have led her to look for an obstruction. As was clear throughout the Inquiry, diagnosis is not an exact science, and in reaching a diagnosis a clinician has to build up a picture of the patient with information drawn from many sources. The X-ray

report would be only one such source. Indeed, it is not even clear in this case that the X-ray report was available by the time the ultrasound scan report raised the suspicion of an obstruction.

(121) Dr Currie said it was unusual for a GP to call him ahead of a referral of a patient. He knew Dr Smith had concerns with Mrs Laing. Dr Currie however did not read Dr Smith's letter of referral. Dr Currie initialed Dr Briffa's admission notes. He accepted that he had not read them. He then made an entry in the records, dated 4th December 2008, again without examining Mrs Laing. Dr Currie said that it was not his practice to examine a patient who had just been admitted, until the full clerking-in procedure had been completed. That sometimes meant he examined a patient in detail the following day. In this case, Mrs Laing was not examined by Dr Currie on 4th December 2008. Dr Currie was not on duty on Friday 5th December 2008. The ward round on 5th December 2008 was carried out by Dr Sharma. Dr Sharma said that his practice was that if a patient had been admitted within the previous twenty-four hours, he would make a full assessment. With patients who had already been on the ward, however, he would only conduct a review and would look at how the patient had felt/progressed since the last review. His practice was to look at the conclusions of the receiving team to see if its conclusion on management had been effective. Dr Sharma was referred to his entry in respect of his ward round visit to Mrs Laing on 5th December 2008. His note was very brief. He did not believe he had examined Mrs Laing as he saw no reason to do so. He could not recollect if he had examined the X-ray which would have been available but, looking at it now, he was of the view that although it showed a dilated bowel and that was a possible cause of obstruction, as there was no fluid shown, that would not fit with the diagnosis of an obstruction.

(122) Dr Sharma did not examine Mrs Laing, as he assumed he was simply carrying out a review, as Dr Currie had initialed the admission notes and had made an entry in the records. Without having examined Mrs Laing, Dr Currie however had arranged for Mrs Laing to be transferred to the Cove Unit in K Ward. The significance of that was that there were no doctor-led ward rounds in the Cove Unit at weekends, and therefore over the weekend of 6th and 7th December 2008 Mrs Laing was not seen by a senior doctor as part of a ward round. On 8th December 2008, Dr Currie carried out a ward round in the Cove Unit and again did not examine Mrs Laing. He considered Mrs

Laing was improving and she was being considered for discharge. Mrs Laing was therefore not fully examined by a senior physician from the time she was admitted to hospital on 4th December 2008 until the surgical review on 8th December 2008. Dr Sharma thought that he was simply carrying out a review when he saw Mrs Laing during the ward round on 5th December 2008. It seems to me that the initialing of the admission notes by Dr Currie, and a further entry by Dr Currie, should have been an indication that Dr Currie had examined Mrs Laing and had considered her case. It seems to me to be fundamental that if a doctor initials an admission record, it can be taken that that person has read and considered that record. That clearly was not the case here.

- (123) I am satisfied that there was a defect in the system of working which contributed to Judith Laing's death. Dr Currie presumably assumed that as the clerking in procedures had not been completed whilst he was still on the ward, someone else would fully assess Mrs Laing. Dr Sharma did not know that Dr Currie had not fully assessed Mrs Laing's condition. There requires to be a more robust procedure for clerking in and examining patients, and the noting of same, to ensure that when a patient is passed on, those taking over the patient can rely on the medical notes, and have a clear understanding of what procedure has been undertaken, at what level and by whom.
- (124) Dr Currie was asked to comment on the clerking in notes which he had not read at the time of Mrs Laing's admission. He said that the black colour of vomit was a sign of possible gastro-intestinal bleed. He stated that there was no evidence of any faecal vomit, the presence of which would have indicated an obstruction. The symptom of no movement of the bowel was difficult to interpret, but that no passing of wind was more significant and was a feature of a bowel obstruction. He did, however, say that if the obstruction had been there for some time he would have expected Mrs Laing to be experiencing pain. He explained that if a hernia was irreducible there may be no symptoms. If irreducible and obstructed however then symptoms would develop.
- (125) Dr Currie noted that Mrs Laing had been referred by her GP to a medical rather than a surgical ward. She had undergone treatment from 4th to 8th December 2008 and her condition appeared to be improving. He said that if there had been an obstruction he

would have expected her condition to have deteriorated. In all the circumstances Dr Currie did not consider that a referral to a surgical department should have been made sooner. Mr Denys is a consultant surgeon specializing in colorectal surgery. He said that strangulated femoral hernias were generally more commonly found in middle aged women. He would expect the lump would be non reducible, painful when touched, and as the bowel would be trapped, he would expect to find bowel contents in the vomit. He said he would expect a patient presenting with such symptoms to be admitted to a surgical ward. I have some difficulty in understanding how Dr Currie was able to say in evidence, that even in hindsight he would not have taken a different approach now as he did then. My concern is that his view at the time appears to have been based on limited information. He had not seen the X-ray and had not examined the patient. His view now, even with the benefit of hindsight, was given without an examination of the patient. Interestingly, Dr Currie said in evidence that it was significant that Mrs Laing not passing wind, as that was a feature of bowel obstruction. He said in evidence that Mrs Laing not passing wind had not been realised at the time. That was not entirely accurate as it had of course been noted by Dr Briffa.

- (126) Clearly Mrs Laing's case was unusual. Dr Currie accepted it was unusual for a GP to telephone him in advance of him receiving a patient. Clearly Dr Smith was unsure of the cause of Mrs Laing's symptoms and wished them further investigated. That I would have thought, would have been good reason for a senior doctor to have examined Mrs Laing at an early stage. Had Dr Currie reviewed the admission records and examined Mrs Laing, he would however have been aware of the presence of a swelling in Mrs Laing's groin, and of a number of symptoms which indicated a possible bowel obstruction. Significantly, I believe, he would have been aware of Mrs Laing not having passed wind for some time. He would also have seen that there was a discrepancy in the differential diagnosis of Dr Briffa and Dr Erskine. Dr Currie's experience was such that he knew a bowel which had been obstructed for some time could become paralysed, and that could lead to symptoms such as the absence of pain and quiet bowel sounds, which others might consider were symptoms pointing away from a bowel obstruction. A number of doctors had felt the lump in Mrs Laing's groin area and all had considered that it was a lymph node. Dr Currie, however, when making his decision to transfer Mrs Laing had not even been aware of the lump, as he

had not read the admission notes nor examined Mrs Laing on 4th December 2008, (as Mrs Laing had at that stage not been fully clerked in). He had not examined her on 8th December 2008, (as she appeared to have been improving). Dr Currie could not therefore say if the obstruction noted to be there on the 8th December 2008 had been there for some time.

(127) The X-ray taken on 4th December 2008 was available on the hospital computer system, and would have been available to anyone carrying out a full review of Mrs Laing on 5th December 2008. It may well be that looking at the X-ray in isolation, the conclusion could be reached that it was *“not immediately suggestive of bowel obstruction”*. Had Dr Currie, however, reviewed the admission records, and had he examined Mrs Laing and seen the swelling in her groin, then he may well have been able to build up a much fuller picture of Mrs Laing.

(128) In terms of Section 6(1) of the Act, a reasonable precaution which might have prevented Mrs Laing’s death, was as follows;

(i) The consultant on duty within the medical receiving unit (J North Ward) of Inverclyde Royal Hospital on 4th December 2008 to have;

(1) Read the referral letter from Dr Smith which made reference to a swelling in Judith Laing’s groin.

(2) Read the admission notes prepared by Dr Briffa which made reference to a swelling in Judith Laing’s groin and to Judith Laing not having passed wind.

(3) Read the examination notes prepared by Dr Erskine, and noted the conflict between them and the admission notes prepared by Dr Briffa, in their findings relative to right sided groin swelling

(4) Not initialed the admission records of Judith Laing until he had fully read them.

(5) To have examined Judith Laing prior to her being passed on to a colleague.

(129) I have concerns that whilst Mrs Laing was admitted to Inverclyde Royal Hospital on 4th December 2008, she was not fully examined by a senior doctor over the period 4th to 8th December 2008, and, that only once a surgical review was called for, was she

examined by a senior physician. It seems that effectively no senior doctor took charge of Mrs Laing's care on her admission. Dr Currie at no time properly examined her, and Dr Sharma believed he was only carrying out a review.

- (130) It is clear that Mrs Laing's presentation led to a number of possible diagnoses. It is not for this Inquiry to second-guess decisions made by doctors when assessing patients. There was a clear failure to have Mrs Laing examined at an early stage by a senior physician. There seemed to be no effective system in place to deal with a situation where the findings of an FY1 and an FY2 were inconsistent. Had there been such a system, and had there been a system in place for Mrs Laing to be seen by a senior physician within twenty-four hours of her admission, she may well have been referred earlier for a surgical opinion and her situation may have resulted in less extensive surgery. I consider, that the decision to transfer Mrs Laing from a medical receiving ward, where doctor-led ward rounds were conducted twice daily, to a general ward, at a weekend when there were no doctor led ward rounds, and to have been transferred there prior to being examined by a senior physician, was a decision that resulted in Mrs Laing's presentation not being properly assessed by a senior physician at an early stage. Had Mrs Laing's presentation been assessed, and had she been examined by a senior physician on 4th or 5th December 2008, a decision might well have been taken to seek a surgical opinion on the possibility of an obstruction. Dr Currie said he was not able to conclude there was an obstruction until the ultrasound scan results were available. I heard evidence that obstructions of the bowel should be treated urgently, and a surgical review should be obtained at the earliest opportunity. Waiting for conclusive evidence of an obstruction in this case may have resulted in more extensive surgery having to be carried out, or may have lessened the chances of the anastomosis succeeding. Considering Mr Ramadan's view that when he saw Mrs Laing on 8th December 2008, he thought her bowel had been strangulated for between twenty four and forty eight hours, an earlier surgical referral may well have found the obstruction before it became strangulated, which would have resulted in a less extensive surgical procedure. Whilst much of this is speculation, I cannot help but wonder in view of the evidence of a number of doctors regarding the symptoms of bowel obstruction, and despite Dr Currie's view that even with the benefit of hindsight his management of Mrs Laing would have been no different, that a thorough consideration of the GP's letter of referral, the inconsistent findings of the FY1 and

FY2 doctors, consideration of the X-ray, and an examination, all carried out by a senior doctor, may well have led to an earlier conclusion that Mrs Laing possibly had an obstructed bowel. It seems that the swelling in Mrs Laing's groin was not the subject of much focus after it was reported by Dr Briffa.

(131) In terms of Section 6(1) of the Act, a reasonable precaution which might have prevented Mrs Laing's death, was as follows;

(1) Judith Laing to have been thoroughly examined by an experienced doctor prior to her being transferred from the medical receiving ward on 5th December 2008.

(132) It is clear that the symptoms displayed by Mrs Laing on admission to hospital could have been caused by a number of factors. A number of investigations were initially carried out. Various observations were taken and various tests were carried out on samples which were taken. Those tests ultimately resulted on 8th December 2008 in the conclusion that Mrs Laing had a femoral hernia and that she was suffering from an obstructed bowel. Appropriate and swift surgical treatment was then carried out. It was found during surgery that not only was Mrs Laing's bowel obstructed but that it was also strangulated. There was no criticism in any of the evidence of the surgical treatments which were provided. There was no suggestion that there was anything surgically which could have been done, other than a resection and anastomosis.

(133) There were competing views on the most appropriate method of treatment of Mrs Laing after her first operation on 9 December 2008. Post-operatively, Mrs Laing was closely observed and a number of tests were again carried out. Various markers indicated the possibility of an infection. It should be noted that the existence of an infection within Mrs Laing's body was not something which was out of the ordinary for someone who had undergone surgery. There was a difference of opinion between Mr Thornton Holmes and some of the other witnesses as to what exactly should have been done to identify the source of the ongoing infection. Mr Thornton Holmes, it could be said, was much more in favour of an interventionist approach. He said that based on the results which he observed, he would have investigated matters more vigorously. He said he would have had a standing chest X-ray carried out. Mr Watt,

however, said that taking such X-rays, even in 2008, was no longer standard practice and that it had not been standard practice to carry out standing chest X-rays for some years. Mr Thornton Holmes also said that he would have carried out a contrast CT scan, believing that that would have shown the existence of a leak at a much earlier stage. Mr Denys said that in looking at Mrs Laing's post operative readings he would not automatically think that the surgical procedure had gone wrong, and thus perform a second laparotomy to check for leaks. He said it would be a last option to open someone up again, as further surgery had risks. As a surgeon, he would be thinking the worst and, in looking to find out what had gone wrong, would request a CT scan. Mr Watt, however, said that a CT scan carried an increased radiation risk. That was dismissed by Mr Thornton Holmes as slight. Mr Watt also said he would not have been happy carrying out a contrast CT scan because of the need to introduce contrast fluid to Mrs Laing's body. Mrs Laing's renal function was, by that stage, already compromised. Mr Thomson, the consultant anaesthetist, having reviewed Mrs Laing's notes, said it appeared that after her first laparotomy Mrs Laing was eating, drinking and pain free. The notes did not suggest that Mrs Laing was experiencing significant abdominal pain. He believed the doctors caring for Mrs Laing had good reason to treat the chest infection, rather than think there was a problem with Mrs Laing's abdomen after the first operation.

- (134) Post-operatively, Mrs Laing's blood results indicated ongoing inflammation. That was considered not to be unusual. Her white cell count, which had been elevated slightly, was again showing an improvement. When that was found to have risen again, around 13 December 2008, there was concern about an ongoing infection. A number of things were being done - various tests were being run; consideration was being given to the possibility of an abdominal infection, a vaginal infection and a chest infection. I was advised that it is difficult to interpret biochemistry and blood results in isolation, and that a patient had to be considered in an overall clinical context. Notwithstanding the ongoing infection, even as at 18 December 2008, Mrs Laing clinically presented very well.
- (135) Investigations to trace the source of the infection were undertaken in the common areas to be considered, namely; the urinary tract, the chest and the abdomen. Urinary tract tests proved negative for infection. Mrs Laing's chest appeared to be clear. She

had no cough or sputum. She had a vaginal discharge, but the swab from that also proved negative for infection. It is clear that a number of possibilities were being considered, one of which was an abdominal infection. Although Mr Thornton Holmes' view was quite clear, and that was that more intrusive investigation should have been carried out at an earlier stage, that approach was criticised by some of the witnesses. Firstly, they pointed to the fact that Mr Thornton Holmes was basing his view simply on a snapshot from the records of results at various points in Mrs Laing's treatment. The evidence from those who were treating Mrs Laing was that she was presenting a complicated picture and that was, in large part, due to the fact that she clinically appeared very well, notwithstanding the various markers which were being recorded. There was, perhaps, then, an understandable reluctance on the part of the medical team to take invasive and aggressive measures with a patient who had been weakened by her illness to date and who, on the face of it, appeared to be looking well.

- (136) Two sources of sepsis in Mrs Laing were ultimately identified. Firstly, pneumonia, and secondly, an abdominal infection. It was thought that there must have been a leak of some sort as an abscess was found in the abdomen. It was explained that abdominal infection can be caused by a breakdown of the original anastomosis. An anastomosis break-down can be caused by a leak. A leak can be caused by a lack of a blood supply to the organ which compromises the organ's healing, but as the small bowel is very vascular (this aiding its healing) that possibility was considered unlikely. I heard evidence that it was uncommon for an anastomosis of the small bowel to break down. Other causes of a breakdown could be as the result of undue tension on the bowel ends, for example, a bad piece of bowel being used in the anastomosis. As the procedure relies on the body's own healing process, the general ill-health of a patient also plays a part. From the investigations carried out, there was no suggestion that there had been a mechanical breakdown of the surgery. As part of the investigations, an X-ray was carried out on 12 December 2008. Again, there were conflicting views about whether or not that X-ray showed a bowel obstruction. Mr Morran advised, however, that the acute deterioration in Mrs Laing's condition was not because of that sepsis, but because of the pneumonia in her chest.

- (137) Mr Thornton Holmes' view was that where there was a small bowel leak, the only treatment was to re-open the patient. He said it was very difficult to re-sew the bowel, and that normally a further resection would be required. Although the body's own defence mechanism would start to work and fight against an infection, only if a patient was very lucky would a collection of the infected abscess remove itself from the body by bursting through the wound. If a patient was unlucky, the abscess would burst within the body, causing peritonitis and often death.
- (138) Mr Thornton Holmes was asked for his view on the cause of Mrs Laing's death. His view was that the adult respiratory distress syndrome was due to intra-abdominal infection caused by the leakage from the anastomosis. He said the primary source of infection was in the abdomen, and that ultimately led to the adult respiratory distress syndrome. That view was consistent with the evidence of Dr Clark.
- (139) I was asked to treat Mr Thornton Holmes' evidence with some caution. By the time of the Inquiry he had been instructed by Mrs Laing's family, and I have already commented on that. It became clear in evidence that Mr Thornton Holmes either did not have all of Mrs Laing's medical records when he prepared his report, or that he omitted to note some matters. He appeared not to have access to the temperature charts. He believed that Mrs Laing, after her first operation, may have been treated in a medical ward and his views on Mrs Laing's treatment post-operatively may have been coloured by that view. It was, however, the case that Mrs Laing had been treated on a surgical ward.
- (140) It is not for this Inquiry to decide what the preferred course of treatment for Mrs Laing was. Clearly, there were differing views on how the various observations should have been acted upon. Mr Watt said that even if he had evidence from a CT scan of possible infection in the abdomen, he might not, in any event, have treated Mrs Laing any differently. His preference was to treat the symptoms conservatively. He said that many anastomotic leaks resolved themselves. His approach was always to try and allow that to happen. That being the case, he saw no real value in carrying out various intrusive procedures if their outcomes would have made no difference to his decision to conservatively manage Mrs Laing. Mr Watt said that it was his preference to conservatively manage Mrs Laing, rather than subject her to a second operation

unless it was necessary. That approach was to some extent supported by the evidence of Mr Denys who said that it was a last option to open a patient again after major surgery. Mr Denys did however say that he would have considered obtaining a CT scan. When the CT scan was eventually carried out it showed a sizeable collection of fluid in the abdomen. Clearly, what an earlier scan would have shown is simply speculation. All that Mr Watt could say in evidence was that he may not have dealt with Mrs Laing any differently. An earlier CT scan however may well have shown significant fluid in the abdomen, which may well have led Mr Watt to adopt a different course of action. In view of the evidence of Mr Thornton Holmes and Mr Denys, I find that an earlier CT scan was a reasonable precaution which might have been taken and which might have avoided Mrs Laing's death. In stating this, I do not criticize the decisions which were made, but simply state that obtaining the CT scan earlier is a decision which it would have been reasonable to take.

- (141) There is no doubt that this is an extremely tragic case. Had Mrs Laing's symptoms been correctly interpreted at an earlier stage, it is unlikely she would have required such extensive surgery and her general wellbeing would have been better, thereby aiding her recovery. Mr Morran explained that the longer a patient had a strangulated femoral hernia the more likely it was the organ would be non-viable, and therefore an operation would be required. Mrs Laing had nine days of her bowel not functioning properly before she underwent surgery. She had dilation of the small loops and therefore required a longer post-operative recovery. Mr Morran accepted that if the first operation had been carried out earlier there may not have been any need for a resection to have been done, and therefore Mrs Laing may not have required such lengthy post-operative recovery. She therefore might not have developed pneumonia.
- (142) Counsel for the Health Board asked me to find, on the basis of Dr Clark's evidence, that the cause of Mrs Laing's sudden deterioration was her right-sided lower lobe pneumonia. What I considered to be the significant issue was what caused the right-sided lower lobe pneumonia which led to Mrs Laing's sudden deterioration. Dr Clark accepted that the symptoms shown by Mrs Laing could appear quite suddenly, but said that such symptoms had to appear at some point. Dr Clark stated that the abscess in Mrs Laing's abdomen may have started off the chain of events which caused problems in the lungs. Dr Clark could not find any other obvious cause. Dr Clark

found fine scar tissue in Mrs Laing's lungs. He explained that when lungs become filled with fluid and cells from blood, the lungs attempt to heal themselves by scarring, a condition in Mrs Laing which probably developed over a number of weeks. Dr Clark explained that pneumonia in the form of a pure infection in the lungs is a form of bacteria in the lungs which responds to fluids and antibiotics. ARDS, however, was quite different, as it is much more widespread and progressive and it is not something which antibiotics are likely to be able to clear up. Dr Clark said that sepsis caused pneumonia, and it was his view that sepsis was most likely what had caused the ARDS which he found. Dr Clark accepted that patients who were in hospital post-operatively sometimes would get pneumonia because they were not moving and breathing as they normally would. Dr Clark said that it was not likely that pneumonia in itself would develop into ARDS, but that it was more likely to result from generalised infection in the body, and the lungs reacting to that generalised infection. Mr Watt accepted the pneumonia could be linked to the infection in the pelvis. Mr Gerryt's evidence was that there was a large abscess present, located in the pouch of Douglas and there was a quantity of free liquid (i.e. bowel contents, blood and puss) in Mrs Laing's abdomen. Mr Laing gave evidence that he was been told that Mrs Laing's bowel had been leaking and that the contents of her bowel were within her stomach. In the absence of any persuasive expert evidence to the contrary, I am satisfied, on the balance of probability that the Adult Respiratory Distress Syndrome found within Mrs Laing was likely to have been caused by generalised infection, rather than localised infection within the lungs caused by pneumonia. I am satisfied that the pneumonia was the result of inter alia the generalised infection, and that this ultimately resulted in Mrs Laing's death.

- (143) What was clear throughout this Inquiry was that femoral herniae are extremely uncommon. Dr Smith said that in thirty years of practice, she had only experienced two or three. Dr Currie said that there was very little written material in medical texts. Mr Thornton Holmes said that notwithstanding the lack of literature, doctors should still be aware of femoral herniae and the potential dangers caused by them. Significantly however, Mr Thornton Holmes said in evidence that although he would see inguinal herniae once or twice per week, he, despite being a consultant colorectal surgeon, would only see "several femoral herniae per annum" and only one or two of those would be strangulated.

- (144) It was also clear that there are different approaches to managing a particular set of circumstances, and the approach to be taken by a clinician is for that clinician's professional judgment. Mr Watt and Mr Reidy preferred a conservative approach to matters, whereas Mr Holmes preferred more direct intervention. It is not for this Inquiry to prefer one approach over another.
- (145) Clearly, Mrs Laing's death could have been avoided if her symptoms had been correctly diagnosed earlier. Her death could have been avoided if the anastomosis leak had been identified sooner. It is clear, however, that those treating Mrs Laing were dealing initially with a condition which was unusual, and thereafter with a confusing and conflicting range of results. It can be of no comfort to Mrs Laing's family that had different decisions been made, Mrs Laing may well have survived. That is not to apportion blame to any one individual, but is simply to state what I understood to be agreed by almost all who gave evidence; that if certain things had been done differently, the outcome would undoubtedly have been different.
- (146) I wish to express my condolences to Mrs Laing's family and, in particular, to her husband, Mr Laing. I have already stated that I was extremely impressed by the manner in which Mr Laing gave his evidence. I hope that by having this Inquiry many, even if not all, of the questions which the family undoubtedly would have had about the death of Mrs Laing have now been answered.

Sheriff Derek J. Hamilton
Sheriff of North Strathclyde