

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2B2249/08

***INQUIRY HELD UNDER
THE FATAL ACCIDENTS
AND
SUDDEN DEATHS
INQUIRY (SCOTLAND)
ACT 1976,
SECTION 1(1)(b)***

INTERLOCUTOR

of

IAN HARPER LAWSON MILLER,
Esquire Advocate, Sheriff of the Sheriffdom
of Glasgow and Strathkelvin

in respect of

the hearing on expenses

in

the Fatal Accident Inquiry into the
circumstances of the death of **MARGARET
WESTWATER GILL**

Act: Stephenson, Advocate, for the Health
Boards

Alt: O'Mahony, Procurator Fiscal Depute,
for the Crown

GLASGOW, 23rd December 2009

The Sheriff, having heard Counsel for the National Waiting Times Centre Board and the Greater Glasgow Health Board and the procurator fiscal depute for the Crown on the motion of both Boards for an award of expenses in their favour from the Crown, **Refuses** the motion.

NOTE/

NOTE

[1] In my determination in this Fatal Accident Inquiry which I issued on 30th September 2009 I pronounced an interlocutor continuing to a hearing consideration of the motion made on behalf of both the National Waiting Times Centre Board and the Greater Glasgow Health Board, opposed by the Crown, to find the Crown liable to both Boards in the expenses of the Inquiry and assigned that hearing to take place on 28th October 2009. At that hearing the Boards were represented by Mr Stephenson, Queen's Counsel, who, as junior counsel, had represented the Boards at the Inquiry, and the Crown by Mr O'Mahony, acting principal procurator fiscal depute, who had not represented the Crown at the Inquiry but who was a senior depute in the deaths unit within the office of the Procurator Fiscal, Glasgow.

[2] At the hearing counsel tendered written submissions and then read them through, on occasions adding observations not in the text. In reply the depute presented his submissions orally to which counsel replied.

The motion

[3] As it was expressed in the written submissions the motion for the Boards was in the following terms.

“That the conduct of the Fatal Accident Inquiry by the Crown having been vexatious the Lord Advocate should be found liable to pay to (i) the National Waiting Times Centre Board and (ii) Greater Glasgow Health Board their respective judicial expenses in connection with their preparation for and appearances at the Fatal Accident Inquiry, as taxed on a party and party basis; which failing should be found liable for such part or proportion of their respective expenses as Your Lordship deems appropriate, again as taxed on a party and party basis; the case should be certified as suitable for the employment of junior counsel.”

The submissions on behalf of the Boards

[4] In support of the motion he advanced six propositions.

- (1) The Sheriff in a Fatal Accident Inquiry has the power to award expenses in favour of a party appearing at an FAI against another party appearing, at least where the latter has been guilty of vexatious conduct
- (2) Conduct on the part of the Crown that may be classified as vexatious includes failure to prepare and present evidence appropriately, so as to cause another party to incur unnecessary and unjustified expense.
- (3) The Boards have justifiably incurred substantial costs in connection with the Inquiry which raised potentially very serious matters.
- (4) The conduct of the Inquiry by the Crown has been vexatious resulting in unnecessary and unjustified expense for the Boards.
- (5) Apart from the absence in the present case of a previous prosecution the conduct of this case is similar to that in the **Global Santa Fe** case
- (6) Should the whole expenses be awarded or only a part or proportion?

He supported each proposition with detailed submissions.

The first proposition

[5] Counsel grounded his first proposition in the decision of the Inner House of the Court of Session in the case of **Global Santa Fe Drilling (North Sea) Limited & Ors v The Lord Advocate**, 2009 SLT IH 597. This case arose out of a decision by a sheriff in the context of a Fatal Accident Inquiry whereby she made a finding of expenses against the Lord Advocate and in favour of the interested parties for part of the expenses they had incurred during the Inquiry on the ground that the Crown was unjustified in holding the Inquiry and that as a consequence the Crown's position could properly be regarded as vexatious. The Lord Advocate raised proceedings for judicial review of that finding. The Lord Ordinary reduced the finding. The interested parties reclaimed and the First Division allowed the reclaiming motion.

[6] From the report counsel traced the procedural history, the remedy sought, the circumstances that led to the motion for expenses being made and the learned sheriff's reasons for deciding that the holding and conduct of the Inquiry was oppressive and vexatious. This related to the prolongation of the Inquiry

by reason of the failure to properly and timeously instruct a Mr Beale, an inspector with the Health and Safety Inspectorate, apparently intended to be an expert and the motion for expenses related only to the period during which Mr Beale was involved. He pointed out that the principal issue before the Inner House was whether the finding of expenses was competent and that the reasonableness of the finding and the sheriff's characterisation of the Crown's behaviour as oppressive and vexatious was accepted by the Crown, at least for the purposes of the reclaiming motion. For present purposes it was sufficient to look at paragraphs [33] to [35] of the Opinion of the Court delivered by the Lord President, Lord Hamilton, for the conclusions of the Court which culminated with the words of paragraph [35]: "In the whole circumstances we are of opinion that a sheriff may award expenses against a party to a fatal accident inquiry whose conduct before him has, as the sheriff here found, been vexatious." Counsel submitted that so far as the competency of an award of expenses in a Fatal Accident Inquiry was concerned, where there had been vexatious conduct the decision was binding upon me.

The second proposition

[7] This proposition was concerned with what was meant by vexatious for present purposes. Counsel began by saying that presumably something was vexatious if it tended to vex, ie. to worry or concern. The idea conveyed in the context of a legal action was that the action was vexatious if instituted and conducted without sufficient grounds. What the sheriff was concerned with in the **Global Santa Fe** case appeared to have been an Inquiry which might or might not of itself have been vexatious but which was in any event then conducted in a manner that proved to be vexatious. In the case the sheriff had founded upon the following factors:

- (a) The Inquiry had canvassed only matters already dealt with at the criminal trial.
- (b) The Inquiry had been unnecessary.
- (c) The Inquiry had served no public interest.
- (d) The expenses sought were occasioned entirely by avoidable actings of the Crown and "could have been avoided had the Crown prepared and presented the evidence appropriately and in accordance with the traditionally fair and even-handed approach to be expected of the Crown."
- (e) The purpose of an award of expenses is "to redress the balance between the party causing unnecessary and unjustified expense and the party incurring it"

[8] Counsel then intimated that the word “vexatious” and the phrase “vexatious legal proceedings” in a statutory context had been considered very recently by the Inner House in the case of **The Lord Advocate v McNamara** [2009] CSIH 45, 4 June 2009. That case was an application by the Lord Advocate under section 1 of the Vexatious Actions (Scotland) Act 1898 for an order to be made in respect of the respondent. Counsel directed attention to paragraphs [31] to [35] inclusive of the Opinion of the Court delivered by Lord Reed and observed that in **McNamara** the focus of attention was on the institution of proceedings. He also drew attention to the observations of the Court at paragraph [34] drawing a distinction between vexatious conduct of an action and the bringing of an action which is in itself vexatious.

The third proposition

[9] Counsel began by submitting that Fatal Accident Inquiries were generally expensive and time-consuming. They were taken very seriously by Health Boards, who had an obvious interest in preventing avoidable patient deaths: whether due to individual casual failures by staff, or to systemic failures. In the present case the suggestion was that medical staff may have caused or contributed to Mrs Gill’s death in circumstances in which they could not have then avoided serious censure, giving rise to the need for the employing Boards to take action. Whereas the function of an Inquiry was not to find or to apportion “fault” as a basis for attributing civil responsibility for damages, it was accepted by all the medical witnesses, except perhaps Dr Hatter, that puncturing the abdominal aorta during an angiogram was completely unknown in practice and could not happen if the procedure were undertaken appropriately. Moreover the evidence was that this could not happen without the operator realising what had happened. If the Court had accepted that a tear to the aorta had been caused by the procedure then the position of Dr Oldroyd and of Dr MacDonald would have been very serious indeed and Dr Baxter’s evidence would also have put his position in doubt.

[10] Counsel then said that it was not evident to him that the Crown during the Inquiry fully appreciated the extremely serious potential ramifications for at least Dr Oldroyd and Dr McDonald, of the position they advanced based upon Dr Hatter’s pathology report.

[11] In advance of the hearing of the Inquiry Counsel was instructed to represent at it the interests of both Boards who were interested parties. The discrepancy between the post mortem report and the CT

scan was immediately identified, having been highlighted by Dr Oldroyd in a letter to the Greater Glasgow Health Board Head of Nursing dated 13 March 2006. Fifteen potential witnesses were identified. A statement was taken from Dr Baxter. Statements from Dr Oldroyd and Dr McDonald were obtained via their Defence Union. A statement was taken from the admitting Western Infirmary doctor, Dr Walker, and from a doctor who saw Mrs Gill there, Dr Mackay. A statement was taken from Ward Sister McCandless who was present when Mrs Gill collapsed and throughout the attempts to resuscitate her. Reports were obtained from independent experts, namely, a Professor of Pathology, a Consultant Vascular Surgeon and a Consultant Cardiologist. Consultations to discuss the case were held with each expert. Medical articles and anatomical diagrams were obtained and produced. An angioseal device was tested to destruction at a consultation and the manufacturers of it were involved.

[12] There were a number of procedural hearings, attended by solicitors. Counsel and a solicitor from the Central Legal Office attended throughout the Inquiry. The extended notes of evidence had to be read and a written Submission drafted. The cost of this has to be met by the Boards from their budgets, and money spent on Fatal Accident Inquiries reduced the money available to be spent on other things, including patient care. The legal expenses of the Central Legal Office and of counsel and the fees of experts paid to the date of the conclusion of the hearing of the Inquiry totalled £42,677.83 and further costs would be incurred in connection with the consideration of the Determination and the motion. There was also the hidden cost of diversion of staff as a consequence of those staff attending court and giving evidence.

The fourth proposition

[13] In this part of his submissions Counsel set out the reasons why the conduct of the Crown had been vexatious and as a result the Boards had been obliged to incur unnecessary and unjustified expense. He began with the statutory provisions for convening a Fatal Accident Inquiry set out in section 1 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (“the Act”). For present purposes the provisions as to mandatory Inquiries in Section 1(a) were irrelevant. Section 1(b) gave the Lord Advocate a discretion to seek an Inquiry where it appeared to her “expedient in the public interest” on the grounds that the death was “sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern.” During the Inquiry the depute conducting it intimated that the Crown had convened the Inquiry because the death of Mrs Gill had been sudden and

unexpected, and not because it had been suspicious or had occurred in circumstances such as to give rise to serious public concern as recorded in paragraph [94] of the Note appended to the Determination (“the Note”). Counsel questioned in passing whether that concession should have been made. He then said that the procedure whereby the Crown decide whether to seek a discretionary Inquiry includes an investigation of the death by the procurator fiscal service, which reports its findings to Crown Office. The procurator fiscal then applies to the Sheriff Court for the holding of a Fatal Accident Inquiry if so instructed by Crown counsel acting on behalf of the Lord Advocate. The procedural steps which lead to the decision are all steps taken by the Crown, at different organisational levels. For present purposes the Crown are responsible for all parts of the process. Section 1 of the Act obliges the local procurator fiscal to investigate the circumstances of the death. It is expected that the procurator fiscal will obtain precognitions and expert reports. The process is summarised in Lord Cullen’s consultation paper, “Review of Fatal Accident Inquiry Legislation” issued in 2008 and in particular at paragraphs 2.10, 3.13, 3.17 and 3.18.

[14] The exercise of the Lord Advocate’s discretion required a factual basis, which basis could only be the consequence of an investigative process. The process had to be sufficient to allow the proper exercise of that discretion. Investigation would have to demonstrate at least a *prima facie* reason for concluding that it was expedient in the public interest that a sudden or unexplained death should be made the subject of investigation by the state. The need for adequate investigation by the Crown before an order for an Inquiry was sought from the sheriff was underlined by the absence of procedural mechanisms (a) whereby the sheriff might refuse an order, or review the adequacy of the basis upon which it is sought, or limit or restrict the scope of the Inquiry, and (b) whereby an Inquiry might be abandoned after the sheriff had ordered that it take place.

[15] Further investigation might be required between the Crown seeking an order for an Inquiry and subsequently presenting evidence to the Inquiry. This would be a normal expectation in any court action. Factual evidence might need to be reviewed in the light of other evidence. Experts would normally be asked to review, comment upon and revise their own opinions in the light of developments, including new factual material and expert opinions.

“Preparation for the proof always entails the precognition of witnesses and the examination of all documentary or real evidence which may be relevant, and decisions as to which witnesses are to

be cited, which documents or objects are to be lodged in court as productions, ..." [Macphail, Sheriff Court Practice, 3rd edition, 16.01]

The need for investigation and full consideration of the results of investigation were even more acute when the subject matter was a death and the consequences for those who might be held to have caused the death were, as here, of potentially great seriousness.

[16] Unfortunately it appeared that this Inquiry had not been one at which after appropriate investigation evidence had been led. Rather the Inquiry in crucial respects appeared to form part of the Crown's investigative efforts. This conclusion was a justifiable inference from the manner in which the Inquiry was conducted, the content of the reports lodged, and the evidence given by witnesses to the Inquiry.

[17] The Boards could know what precisely the Crown did, or did not do, to prepare for the Inquiry. The Crown undertook, at the conclusion of the hearing on submissions on 10 July 2009, to produce a chronology. As Counsel had noted it the crown agreed to lodge a "Chronology [of] events after [the] Determination, well in advance of [the Hearing]". The Crown sent a document to those instructing Counsel the day before the hearing on expenses. It was headed "FAI MARGARET GILL – TIMELINE" ("the Timeline"). It was not very illuminating. If the purpose were to set out the investigations made by the Crown then it did not appear do that. It might be incomplete. Taking it at face value Counsel made a considerable number of comments on its shortcomings.

[18] He began by saying that there was no mention at all of Dr Hatter, although the Crown had disclosed they had contact with him prior to the hearing of the Inquiry and he himself spoke during his evidence to having asked for a copy of his post mortem report, recorded at paragraph [50] of the Note. It was not known whether, as he suggested in evidence, Dr Hatter prepared and sent to the Crown a preliminary post-mortem report, nor was it known what the contents of that report, if sent, were and how it compared to his final report, as produced. The date of receipt by the Crown of the produced report was not disclosed. Any communications taking place between the Crown and Dr Hatter (at any time) were not divulged.

[19] Between December 2005 and 30 August 2006 the Crown's focus of attention appeared to have been on obtaining medical records and a response from Glasgow Royal Infirmary as to concerns the family had in respect of Mrs Gill's care at the Western Infirmary. Glasgow Royal Infirmary was involved presumably because, although it did not have its own legal department staffed by solicitors, that was where the Greater Glasgow Health Board employees who collated medical records and reports for the procurator fiscal service were based. The procurator fiscal was corresponding with the GGHB Divisional Clinical Risk Manager. There is no mention in the document of the Golden Jubilee Hospital. It is not apparent when Mrs Gill's medical records from the Golden Jubilee were sought. So far as appeared from the Timeline very little happened between August 2006 and November 2007. It gave no indication of when a precognition was taken by the Crown from Dr Oldroyd, although from the evidence it was known that a statement from him was available to the Crown and it was referred to in Dr Jennings' report. Nothing was known about the content of the statement and whether or not in its preparation Dr Oldroyd was asked about pertinent matters. From the comments in Dr Jennings' report the statement may not have dealt fully with matters.

[20] The Timeline gave no indication that any precognitions were ever taken from any other member of medical or nursing staff and in particular Dr McDonald, Dr Baxter or any of the medical, surgical or nursing staff responsible for Mrs Gill's care at the Western Infirmary. The latter would have included those who made clinical decisions over the crucial last two days of Mrs Gill's life and those who witnessed and who sought to deal with the final catastrophic event on 17 November 2005.

[21] From the Timeline it appears that Dr Jennings was not instructed until 22 November 2007, slightly over two years after the death of Mrs Gill. His report, Production C3, is dated 6 December 2007 on its last page. The information recorded by Dr Jennings as available for the preparation of his report is set out on the front cover of the report and comprised a statement from Dr Oldroyd, "the post-mortem report" and notes from the Western Infirmary. It seemed fair to assume that these three sources of information represented the sum and substance of the Crown investigations undertaken by 22 November 2007. The chronology of the Timeline might indicate receipt of Dr Jennings' report by the Crown on 6 January 2008, which could be an error, or the entry may record a follow-up letter which was not seen. There was no suggestion in the chronology that any matter raised in his report by Dr Jennings was ever investigated.

[22] At some point between late February and late April 2008 a report was sent to Crown Office. On 30 April 2008 Crown Office instructed that an application be made to hold an Inquiry but no application was made until 17 November 2008. There is no suggestion that either Health Board was informed that there was to be a FAI until about the time the application was made. The Central Legal Office were advised of the imminence of an Inquiry by solicitors acting for the family. No further inquiries are disclosed in the chronology. As far as the Timeline discloses, the decision to seek an Inquiry rested upon Dr Jennings's report and the three sources of information referred to in it

[23] The dates on which Dr Baxter was first contacted about the CT Scan, or on which he gave a statement to the Crown, are not indicated. The chronology makes no reference to any enquiry made by the Crown of Dr Jennings after he issued his December 2007 report, but Production C3A is a letter from him dated 25 March 2009 commenting on the angiogram images and referring to a letter sent by the procurator fiscal to him on 25 February 2009. Unsurprisingly Dr Jennings as a Cardiologist felt unable to express any opinion as to what the CT Scan images showed.

[24] Counsel moved on to deal with other criticisms of the Crown preparation for and presentation of the Inquiry. He said that it was reasonable to suppose that the major single factor determining the Crown's decision to seek an Inquiry was the post mortem report issued by the then Crown Pathologist, Dr Tobias Hatter and in particular his claim made in it that the death was caused by a tear in the abdominal aorta due to the cardiac angiogram. The report obtained by the Crown from Dr Jennings in December 2007 proceeds in large part on the basis that an aortic tear was found and was due to the angiogram. The report tries to explain how such an injury could have been caused. However the report also identifies a variance between Dr Hatter's finding of an aortic tear and the CT Scan imaging. In the report Dr Jennings noted:

“The post-mortem finding that the cause of Mrs Gill's death was a tear in the abdominal aorta is at variance with the CT evidence of a leak at the level of the right external iliac artery (a branch of the aorta).” [p 2]

“I have a concern that if the post-mortem and the CT findings are correct that there were two separate bleeding points resulting from cardiac catheterisation in this patient.” [P 3]

These comments clearly indicate a level of doubt as to the accuracy of both recorded findings and a need to investigate the apparent “variance”. No attempt appears to have been made by the Crown to investigate this or to attempt to resolve the apparent inconsistency, until evidence was being given in the course of the Inquiry. When giving evidence Dr Jennings considered (as one would expect from his 2007 report) that the apparent discrepancy between the post mortem finding and the CT Scan was an important issue for the court to resolve.

[25] Dr Baxter’s evidence about the CT scan and its interpretation was on any view always likely to be key evidence. This should have been realised no later than upon proper consideration of Dr Jennings December 2007 report. Dr Baxter’s evidence precludes the existence of damage to the abdominal aorta at the time of the CT scan, which was undertaken shortly after completion of the angiogram. Moreover Dr Baxter’s radiological diagnosis of haemorrhage only from the right external iliac artery informed the decisions taken as to the deceased’s clinical care at the Western Infirmary. The importance of the CT Scan is a matter of contemporary record. In his letter to the deceased’s GP dated 28 November 2005 (Production C4A) Dr Oldroyd stated:

“We made a diagnosis of retroperitoneal haemorrhage and initiated volume resuscitation. The diagnosis was confirmed by CT scan which suggested the bleeding point was in the distal part of the right external iliac artery.”

The CT scan and what it showed was referred to in the admission entry made by Dr Walker shortly after the deceased’s arrival at the Western Infirmary. The Crown had a precognition from Dr Oldroyd prior to December 2007, the precognition being referred to in Dr Jennings’ report. If it dealt adequately with the issues raised by Mrs Gill’s treatment and care and the post mortem report then the Crown should also have been aware from this source that the CT scan and what it showed were crucial matters requiring investigation. All that notwithstanding, solicitors acting for the Boards and for Dr Oldroyd and Dr McDonald had to draw the attention of the Crown to the CT scan in early 2009. Dr Baxter’s uncontested evidence at the Inquiry was that he had not been contacted at all by the Crown in connection with the deceased’s death until some two-three months before he gave evidence to the Inquiry, which he did on 11 May 2009. The Crown did not obtain a copy of Dr Baxter’s Radiological Report, Production C8, until shortly before the Inquiry began. The Crown did not take a statement from Dr Baxter until within a month of him giving evidence, as he disclosed in the course of his evidence. This suggested that the Crown might not have taken the statement until after the Inquiry had begun and evidence had

been led and the chronology in the Timeline did not give enlightenment. There was nothing in the chronology to suggest that having spoken to Dr Baxter the Crown took any steps to check his interpretation of the imaging with an independent expert. Indeed the Crown led Dr Baxter and did not challenge his opinion that the CT scan excluded the possibility of a tear to the abdominal aorta at the time of the imaging. Even after Dr Baxter had given his evidence the Crown appeared to have taken no steps to discuss with Dr Jennings its ramifications, or those of Dr Hatter's evidence, for Dr Jennings obviously had the evidence put to him for the first time in the course of giving his evidence on 14 May.

[26] Counsel submitted that proper consideration of this case required that investigation be carried out by the Crown of what he described as the "variance" between their pathologist's report and the radiological imaging before a decision was made to seek an Inquiry. Had this been done there was no reason to believe that the Crown would not have become aware of the position of Dr Baxter. Presumably the Crown would then have accepted Dr Baxter's opinions since in the event they led him in evidence at the Inquiry and did not challenge him on any part of his evidence. In any event on the other side of the "variance" was Dr Hatter who at the Inquiry withdrew his opinion that any aortic tear seen by him at post mortem was caused by the angiogram or had contributed to the death and accepted that it was most likely a post mortem artefact. He did so when confronted with reports from Cardiologists and a summary of what was expected to be Dr Baxter's evidence about the CT Scan. He was not re-examined. Even then the Crown was reluctant to give-up the causal theory set out in Dr Hatter's report. Despite Dr Hatter's own retraction, the absence of re-examination and the Crown's failure to put to Dr Oldroyd or Dr McDonald that they had caused, or may have caused, a tear in the aorta during the angiogram the Crown refused to make its position clear. The Crown went so far as to seek an adjournment, which if granted would have further prolonged its untenable position, with a view to obtaining a report from another pathologist, based upon what in the absence of any known retained pathology material, and to what purpose, was obscure.

[27] Counsel concluded that it is inescapable that if this matter had been properly investigated with Dr Hatter before an Inquiry was sought, or at any time before he gave evidence, the Crown would have had his position then. In that event it is difficult to see on what basis there could possibly have been a need for the Crown to seek an Inquiry, or to pursue the line that it did at the Inquiry.

[28] Moreover, Dr Hatter's treatment at the hands of the Crown was demonstrably unfair. He had not worked due to ill-health since June 2006. He had since then had no access to his former Department. He had no access to his notes, or his report. He had had to ask the Crown for a copy of his post-mortem report. No statement was taken from him by the Crown. There was no discussion with him as to what his evidence might or might not be. He had not been provided with copies of the three Cardiology reports or of Dr Baxter's Radiological Report. Therefore he was not properly in a position to give either his factual evidence of his findings at post mortem or opinion evidence as to their significance. He was shown the reports only while he was giving evidence and expected to assimilate them while in the witness box and to review and revise his opinions in the light of them. Given his period out of practice Dr Hatter no longer considered he was in a position to proffer evidence as an expert as recorded in the Note at paragraph [50].

[29] Dr Jennings was treated similarly by the Crown. Initially he was asked to deal with matters on the premise that there had been an aortic tear caused by the angiogram procedure despite the Crown by this point having no evidence that this was the case. The differential factual matters and opposing opinions were then sprung on him while he was giving evidence; with the result that all his potential criticisms fell away. Had Dr Jennings been made aware of the facts following upon an adequate investigation by the Crown it was reasonable to assume that he would not have made such criticisms as he made in his December 2007 report.

[30] The manner in which Dr Hatter was presented by the Crown to the Inquiry as an expert witness was also unfair to the other parties and to the Court. The nature of the illnesses from which he was already under treatment in December 2005 were such as to be capable of impacting materially upon his credibility and upon the reliability of his findings. The Crown did not disclose the nature of Dr Hatter's medical problems to parties before the Inquiry. Nor was he asked about them by the Crown. An impression was created that he had a cardiac problem – which he appeared to have developed since June 2006. If the Crown were aware of Dr Hatter's medical problems as at December 2005 then there was a lack of candour and of even-handedness in the failure to disclose them or bring them out in evidence. A similar point arose in respect of Dr Hatter's professional status and the restrictions placed on his right to practice by the General Medical Council.

[31] The Crown had a week's notice of the Boards' intention to move for expenses but was not prepared to argue the motion at the hearing on submissions. Instead they sought a further specific diet after the issue of the Determination. There was no good reason why the Crown should not have been in a position to argue the motion on 10 July 2009. The Crown's failure was a further and separate instance of vexatious conduct for which an award of expenses could and should be made. The result was the need for the present diet.

The fifth proposition

[32] Counsel drew the following comparisons with the **Global Santa Fe** case: the Inquiry was unnecessary; it had served no public interest; the expenses of the Inquiry were occasioned entirely by avoidable actings of the Crown and could have been avoided had the Crown prepared and presented the evidence appropriately and in accordance with the traditionally fair and even-handed approach to be expected of the Crown; and the conduct of the Crown caused unnecessary and unjustified expense to the Boards. He concluded that if anything the conduct complained of in the present case was worse than that in **Global Santa Fe**.

The sixth proposition

[33] The primary position of the Boards was that the whole expenses of the Inquiry should be awarded on the basis of judicial expenses on the ordinary cause scale on a party and party basis and as taxed. In respect that the Inquiry was not sought until November 2008 and the Boards were not aware of the intention to seek an Inquiry until about that time the judicial expenses of the Boards would not pre-date the date of the Order and Warrant. By that date any reasonable investigation undertaken by the Crown into Mrs Gill's death would have made clear that there was no proper basis upon which the Lord Advocate could exercise her discretion to seek an Inquiry. In addition counsel sought sanction for the employment of junior counsel and said in that regard that it was largely a matter of impression whether the subject matter of the Inquiry was such as to justify the instruction of counsel.

[34] His secondary position was that if I considered that there should be an award of expense but not of the whole expenses then I should make an award in respect of whatever period of time or overall proportion of the Inquiry that I considered appropriate. In that regard he submitted that the Inquiry could have been dealt with in the space of two court days and possibly without the need to have the

notes of evidence extended or for written submissions. The Crown could have taken the decision to lead no further evidence after Dr Hatter had concluded his. In that event the determination would not have differed significantly from what it eventually was.

The submissions on behalf of the Crown

[35] The procurator fiscal depute began his submissions by formally opposing the motion. He followed that immediately by observing that it was not he who had represented the Crown at the Inquiry. He then conceded under reference to **Global Santa Fe** that it was competent for a sheriff to make an award of expenses in a Fatal Accident Inquiry and that the test to apply in deciding whether that was appropriate was set out in paragraph [35] of the Opinion of the Court. He observed that what he described as the anomaly of **Global Santa Fe** was that the question of vexatiousness was heard only by the Sheriff Court because the Crown conceded that issue before the Inner House.

[36] He then proceeded to explore the definition of vexatious. He founded upon the definition of that word in the 1993 edition of The Chambers Dictionary. That gave it as “vexing, troublesome, (of a law action) brought on insufficient grounds, with the intention merely of annoying the defendant.” Moreover, he referred to the same dictionary’s definition of the verb to annoy which was given as “to trouble, to vex, to aggravate, irritate, to tease, to harm or injure.” He said that there was nothing in the **Global Santa Fe** decision to say that the court should depart from the dictionary definition of vexatious that he founded upon, that the dictionary definition should be treated as authoritative and building on that, before the court could grant the motion for expenses, it required to conclude that the Crown had instituted and conducted the Fatal Accident Inquiry into the death of Mrs Gill simply with the intention of irritating or annoying those who were moving the motion.

[37] The depute then said that he could distinguish the **Global Santa Fe** case from the present case in three respects. The first was that that case was concerned with a mandatory Inquiry under section 1(1)(a) of the Act where the Lord Advocate had not exercised her waiver and the facts of the case had been aired in the course of a preceding criminal trial which had led to an acquittal of the company. This differed from the present case in which there had been no such proceedings and no such airing. The second was that in that case the impression was given that the Crown were having a second bite at the cherry by not accepting the result of the criminal trial. The third was that at the preliminary hearing

stage in that case when the Crown were asked what additional matters would be analysed over those already given at the trial, the Crown gave a three pronged answer but did not adhere to them at the Fatal Accident Inquiry. He observed that in the **Global Santa Fe** case the Crown were very close to misleading the court and said that there was no suggestion of that in the present case.

[38] The depute then considered the decision in the case of **The Lord Advocate v McNamara** and concentrated upon the contents of paragraph [31] of the Opinion of the Court, and in particular the quotation from the opinion of Lord Bingham of Cornhill CJ in **Attorney-General v Barker** [2000] 1 FLR 759 at p 764, paragraph 19, where His Lordship had set out the three characteristic hallmarks of “a vexatious proceeding”. The depute submitted that this was not an attempt to define the word “vexatious” but was designed only to give examples of characteristics which could amount to vexatious proceedings. In any event the present case did not have any of these three characteristics.

[39] He said that the crux of the motion related to the failure on the part on the Crown to display to Dr Hatter in advance of the Inquiry the reports provided for both the Boards and Drs Oldroyd and McDonald. He said he would deal with this matter “head on”. On 24 March 2009, the date of the second preliminary hearing in the Inquiry, the Crown were provided with the reports of Dr Spratt and Dr Nolan. On receipt of them, Miss Hilley, the depute who represented the Crown at the Inquiry, consulted with a colleague in the Deaths Unit in the office of the Procurator Fiscal at Glasgow. That colleague, a procurator fiscal depute, said that she would deal with those reports. Within 24 hours Dr Jennings was asked for a supplementary opinion and he gave that opinion within a further 24 hours. As to why Dr Hatter was not provided with the various medical reports then available, the depute (unnamed) who had said that she would deal with the matter was off work on sick leave at the time of the hearing on expenses, and had been so for a number of weeks, all post-dating 10 July 2009. This restricted the information that could be obtained from her, but her response was that she had given consideration to allowing Dr Hatter sight of these various reports but was of the view that it would have been inappropriate to exhibit these reports because he would not be in a position to comment upon them.

[40] The depute presenting this submission accepted immediately that the court, and he, could be expected to have a lot of questions to ask of this decision and conceded that with the benefit of hindsight it was a wrong decision to take. Dr Hatter was called by the Crown as an expert in Forensic Pathology.

At the time when the Crown called him the Crown were unaware that he was not still working. The Crown made a conscious decision not to show the reports to Dr Hatter. That decision was not arrived at through ignorance or oversight. There was nothing to suggest that failing to show those reports was motivated by a deliberate intention to hold a Fatal Accident Inquiry which did not need to be held. It was not unusual to have a Fatal Accident Inquiry offering an alternative scenario from that established by Crown investigations. When it was put to him that what Dr Hatter had done in the course of his evidence could be construed as being not the presentation of an alternative scenario but a retraction of the principal ground of his position in his post mortem report, the depute said that that was one interpretation that could be placed upon what Dr Hatter had done. He had given a position that was directly contrary to his report. However, was it reasonably foreseeable that Dr Hatter would do this? At the time of carrying out the post-mortem on Mrs Gill he was a qualified practitioner, and the Crown were unaware of any other Fatal Accident Inquiry where Dr Hatter had changed his position materially. Against that background the Crown were perfectly entitled to expect that he would maintain his position. The depute then said that he had conducted hundreds of Fatal Accident Inquiries and had never in his experience encountered the situation where a pathologist “pulled the rug” out from under an Inquiry in the way and to the extent that Dr Hatter had. In the preparation of the present Inquiry that mind set apply to the Crown.

[41] The depute then moved on to making several responses to the submissions of Counsel on behalf of the Boards. He utterly refuted the suggestion (recounted in paragraph [10] above) that in the Inquiry the Crown did not appreciate fully the extremely serious potential ramifications of the Crown position based upon Dr Hatter’s pathology report for at least Dr Oldroyd and Dr McDonald. The Crown would not and did not conduct Fatal Accident Inquiries with the intention of causing difficulties to clinicians but conversely if a clinician were to be criticised by a Fatal Accident Inquiry that was not a good reason for not holding a Fatal Accident Inquiry.

[42] Moving on to the submissions in support of the fourth proposition, he said that this exemplary study of the *minutiae* of the case failed to demonstrate that any of the matters there referred to amounted to conduct that was vexatious. If there were any impression that the Crown had been incompetent or shoddy in its presentation of the Inquiry, and if the court agreed with that impression, that did not amount to vexatiousness. There had to be a marked difference between incompetence and

vexatiousness. Under reference to paragraph [31] and the third of the hallmarks described by Lord Bingham, namely, that the court process had been used “for a purpose or in a way...significantly different from the ordinary and proper use of the court process”, he submitted that the Boards had not demonstrated an abuse of process of the kind that Lord Bingham was referring to. In petitioning the court to hold a Fatal Accident Inquiry into the circumstances of the death of Mrs Gill, the Crown had a *prima facie* basis for doing so, arrived at entirely in good faith, namely, that her death was clearly one in which it was appropriate to hold an Inquiry because the Crown held evidence to suggest that the circumstances surrounding her death in terms of both the procedure and the post-operative management had been the subject of criticism by expert opinion. The sources for that criticism were the reports of Dr Hatter and Dr Jennings. Their conclusions gave rise to the Inquiry. It was not the statement of Dr Oldroyd which had never been put before the Inquiry but had been referred to obliquely on occasions in the course of it.

[43] Under reference to the criticism that in crucial respects the Inquiry appeared to form part of the Crown’s investigative efforts, (at paragraph [16] above) he said that nothing supported this assertion. When it was put to him that in the course of the Inquiry the depute conducting the Inquiry requested an adjournment in order to obtain a report from another forensic pathologist, and after being acquainted with what had happened at that stage of the Inquiry (for which see paragraphs [88] to [92] of the Note) he responded by saying that this did not amount to the point in time at which the conduct of the Crown became vexatious and that the crucial point in the Inquiry was the point of recantation by Dr Hatter. At that point the Crown had two options. The first was to proceed and that was what the Crown did. The second was to “close the Crown case” there and then. If they had chosen the second option the Crown would be open to the criticism that they had failed to lead all relevant material evidence before the Inquiry. In choosing the first option they were open to the criticism of failing to take full cognizance of what Dr Hatter had said. This dilemma placed the Crown as he put it “between a rock and hard place”. The Act gave no scope for anyone to seek dismissal of an Inquiry. The option taken by Miss Hilley was the best of two bad options and the option chosen allowed the court to make a full and detailed determination. On being requested to consider a third option, which was to seek leave to adjourn for the express purpose of considering the Crown’s then position, the depute accepted that that had also been an available option.

[44] Turning to the Timeline, he began by disassociating himself from it to the extent of saying that it was not his document although it was sent out in his name. He offered his apologies for it not being as full as it might have been. Had any specific issue been raised with him in advance of the hearing on expenses he would have sought to deal with it. On being asked why it was that the Timeline was not intimated and lodged until the day before the hearing on expenses, he said that this was due to pressure of business on his part and also annual leave and that he was happy to provide additional material and information if required by the court or by Counsel for the Boards.

[45] With regard to the criticism made of the Timeline that it did not disclose the nature of Dr Hatter's medical problems to parties before the Inquiry nor was he asked about them by the Crown, the depute submitted that Miss Hilley did not have any knowledge of Dr Hatter's background and accordingly could not be held liable for wanton withholding of information. She knew nothing of the circumstances of his departure from work or anything that would cast doubt on the integrity of his work or his findings other than the way matters turned out in the present Inquiry. With regard to the criticism that the Crown were unable to oppose the motion for expenses on 10 July 2009 (for which see paragraph [31] above), he said that the motion to adjourn was granted unopposed and that it would have been premature to rule on expenses in advance of the Court making its determination. If the Court did make an award of expenses then this present diet should be disregarded in any assessment of the amount.

[46] In conclusion he submitted that if the Court followed the dictionary definition on which he founded then in order to make an award of expenses the court had to conclude that the following two part test had been satisfied: (1) that the Crown had deliberately withheld information from Dr Hatter in the knowledge that if that information were disclosed to him he would recant his position or at the very least the Crown would have had to suspect he would recant it; and (2) that, thereafter, the Crown had initiated the Inquiry with the sole intention of causing annoyance to the Boards. Neither test had been satisfied. There was nothing to say the Crown acted other than in good faith. To grant the motion would have the effect of setting a precedent, namely, where a Crown witness did not give evidence as it was understood he would, then this would amount to the Crown acting vexatiously. He then observed that between April 2007 and March 2008 there were 13,457 reports to Procurators Fiscal throughout Scotland in relation to fatal accident or sudden deaths. That resulted in 43 Fatal Accident Inquiries, less than one-third of one per cent. The Crown took seriously their obligation to inquire into such deaths and

would not submit an application to hold an Inquiry on a whim or on the insistence of next of kin or to cause annoyance to any prospective interested party. For all these reasons the court should refuse the motion.

The reply on behalf of the Boards

[47] Counsel on behalf of the Boards said he wished to respond on three matters but before addressing those agreed that the depute in court was at a disadvantage since he had not conducted the Inquiry and was at a double disadvantage in regard to investigating the preparations for the Inquiry.

[48] On the matter of the definition of vexatious, he submitted that the Crown focused on the reference to intention but they were wrong to do so. Lord Bingham made it clear that it was not the intention that mattered but the effect. In any event, it was difficult to see how any Health Board could be described as being annoyed. On the submission that the motion for adjournment on 10 July 2009 was not opposed, the events of day showed that the depute now in court had appeared in court for the first time in the Inquiry on 10 July 2009 and clearly did not expect to argue the motion for expenses that day. The Crown's request for an adjournment was opposed but it was overtaken by discussions regarding an undertaking to provide the Timeline and once that was made was granted. The third feature related to a submission which the depute withdrew on hearing what Counsel said.

Discussion

[49] In reaching my decision on the motion I have found great assistance in the structure adopted by Counsel in his submissions. In light of that and the submissions for the Crown, I have concluded that the motion can be said to raise the following questions that I have to answer.

- (1) Is it competent for me to grant the motion?
- (2) If it is competent to do that, what is meant by the word vexatious in the present context?
- (3) Did the Crown institute the present Inquiry vexatiously?
- (4) If they did not, did the Crown conduct the present Inquiry vexatiously?
- (5) If they did conduct the proceedings vexatiously, at what point did they become vexatious?
- (6) If I am satisfied that the Crown has acted vexatiously, am I then required to grant the motion?
- (7) If I grant the motion, what part or parts of process should it cover?

- (8) If I grant the motion, should I sanction the employment of junior counsel instructed on behalf of the Boards?

Question (1)

[50] I can answer this question very simply and conclusively in the affirmative. Both Counsel and the depute submitted that the decision of the Inner House in **Global Santa Fe** is in point and binding on me. I agree. The ratio of that decision is expressed at paragraph [35] of the Opinion of the Court delivered by the Lord President, that a sheriff may award expenses against a party to a fatal accident inquiry in circumstances where the conduct of that party before the sheriff has been vexatious.

[51] There are three features of this proposition that are worth emphasising. The first is that the Court has set the bar at a high level by directing that the test is the conduct complained of be vexatious. The second is that even if the sheriff is satisfied that the conduct of the party complained against amounts to vexatious, he is not obliged to grant a motion for expenses against that party because the sheriff retains a discretion which has to be exercised in light of the whole circumstances of the case. The third is that although the Court states that the conduct complained of is that “before” the sheriff that must be construed as meaning the conduct of the inquiry beginning with the application for the holding of an inquiry, which is the earliest point in procedure at which the sheriff becomes involved by the act of placing the application before him to grant the first warrant, and not restricted to the inquiry hearing or any preliminary hearing that precedes it. To construe it otherwise would risk excluding from the ratio an application that might be challenged as vexatious *ab initio* and that cannot have been the intention of the Court.

Question (2)

[52] What in the present context is meant by vexatious? Neither the Act nor the Rules help for both are silent on the whole issue of expenses. So is **Global Santa Fe** because the Crown conceded the issue before the Inner House and the Court did not question the correctness of the learned sheriff’s conclusion. The choice before me from the submissions is between a definition that is judicial and one that is taken from a standard dictionary. I prefer to be guided by the former. In **Lord Advocate v McNamara** Lord Reed, delivering the Opinion of the Court discussed the meaning of the word vexatious. He did so in the

context of a case brought under the Vexatious Actions (Scotland) Act 1898 and it is worth repeating here that passage of his Opinion, being paragraphs [31] to [34] inclusive.

[31] We consider next the requirement that the person against whom the order is sought must have instituted "vexatious legal proceedings without any reasonable ground." The word "vexatious" was not defined in the 1896 or 1898 Acts. As we have explained, however, it was (and remains) a familiar term in practice relating to abuses of process, and it has been understood as bearing the same meaning in the 1896 and 1898 Acts. The meaning of the term was considered by Lord Phillips of Worth Matravers MR, delivering the judgment of the court, in *Bhamjee v Forsdick* [2004] 1 WLR 88 at paragraph 7:

"The courts have traditionally described the bringing of hopeless actions and applications as 'vexatious', although this adjective no longer appears in the Civil Procedure Rules: compare RSC Ord 18, r 19(1)(b) with CPR r 3.4(2). In *Attorney-General v Barker* [2000] 1 FLR 759 Lord Bingham of Cornhill CJ, with whom Klevan J agreed, said, at p 764, para 19 that 'vexatious' was a familiar term in legal parlance. He added:

"The hallmark of a vexatious proceeding is in my judgment that it has little or no basis in law (or at least no discernible basis); that whatever the intention of the proceeding may be, its effect is to subject the defendant to inconvenience, harassment and expense out of all proportion to any gain likely to accrue to the claimant; and that it involves an abuse of the process of the court, meaning by that a use of the court process for a purpose or in a way which is significantly different from the ordinary and proper use of the court process."

As Toohey J observed in *Jones v Skyring* (at paragraph 33), "there is perhaps some tautology" in a provision which requires that proceedings be vexatious and without any reasonable ground. We respectfully agree with the view expressed in the case of *Frost* (at paragraph 30) that "legal proceedings may be properly seen as 'vexatious' if they are devoid of reasonable grounds for their institution".

[32] Characteristic features of vexatious proceedings were identified by the High Court of New Zealand in *Attorney-General v Collier* at paragraph 36:

"Vexatious litigation is frequently accompanied by complex pleadings, a widening circle of defendants as litigation proceeds, frequency of striking out of part or all of the statements of claim, inability to accept unfavourable decisions, escalating extravagant or scandalous claims (frequently involving allegations of conspiracy or fraud) and failure to pursue proceedings once instituted. The authorities cited to us from other jurisdictions demonstrate the consistency with which characteristics such as these are present in vexatious litigation."

[33] This approach is consistent with the Scottish authorities. In *Lord Advocate v Cooney*, for example, the court referred to:

"... the nature of the actions the respondent has raised, the persons he has convened as defenders, his purpose in using or rather abusing the legal processes to carry on a war of attrition, the hopelessness of his actions yet his persistence in pursuing them to the limits which the law allows, and the damaging effects of this conduct on his victims."

[34] We note, however, that an important distinction has been drawn in England and elsewhere, for the purposes of the legislation concerned with vexatious litigants, between an action which is vexatious and an action which is conducted vexatiously. In *Re Langton* [1966] 1 WLR 1575 Lord Parker LCJ said at page 1578:

"Despite the fact that it may be said that the manner in which that action was conducted was vexatious, it must be remembered that the respondent acted in person, and, not only that, but that the action itself could not be said to be a vexatious action; it was one which the respondent was fully entitled to litigate and did litigate and accordingly, so far as these proceedings are concerned, I ignore that action except as a matter of history."

That approach has been followed in Australia (e.g. in *Attorney-General v Wentworth* at page 496) and New Zealand. In *Attorney-General v Collier*, for example, the court said (at paragraph 31):

"It is therefore not the manner in which proceedings are conducted which is in issue in considering the Crown's application, but whether the nature and substance of the proceedings themselves can be characterised as vexatious."

We are content to follow that approach in the present case.

[53] The Court in **McNamara** approved of what Lord Bingham said about the meaning of the word vexatious, and also followed the approach that drew a distinction between an action which was vexatious and an action that was conducted vexatiously. I consider that the approved formulation of the meaning of the word vexatious in paragraph [31] is phrased in terms that are wide enough in scope and general enough in application to encompass the circumstances of the present motion. Accordingly I consider myself bound by them. In addition I take full note of the distinction drawn.

[54] It is worth stressing that the focus of attention is on the concept of abuse of process. That directs attention at the function of the court to do justice between the parties in respect of the issue that parties choose to place before the court for the purpose of obtaining a judicial determination of that issue. For conduct to be characterised as vexatious the fundamental consideration must be whether its effect amounts to an abuse of the court process and, if it possess that character, the degree of vexatiousness must take account of the ways and extent to which it permeates and distorts the ordinary and proper use of the court process. In making that assessment the court can be expected to take into account all relevant features, but a limiting factor must be that any inconvenience or harassment or expense must be such as is demonstrated to be out of all proportion to any gain likely to accrue. This must place a substantial limitation on the occasions on which a motion for expenses could be made in a fatal accident inquiry with any realistic chance of success.

Question (3)

[55] The answer to this question is no. Prior to making the application to the court for the holding of an inquiry into the death of Mrs Gill, the Crown had received the post-mortem report of Dr Hatter, taken

a precognition from Dr Oldroyd and sought and obtained the opinion of Dr Jennings, a senior and respected consultant interventional cardiologist. I have narrated the information they gave to the Crown in the Note and in particular at paragraphs [6] and [7] for Dr Hatter and [15] to [20] inclusive for Dr Jennings. As for Dr Oldroyd's precognition, when the Crown took it and what it contained was unknown to the Inquiry but known to Dr Jennings. The medical reports raised various concerns about the treatment and care that Mrs Gill received over the entire period from her admission to the Jubilee on 9 November 2005 until her death on 17 November 2005. The Lord Advocate, or her representatives acting on her behalf, must be held to have been aware of those various concerns and taken them into account when exercising the discretion given by section 1(1)(b) of the Act which resulted in the conclusion that it was expedient in the public interest to apply for the holding of the Inquiry into her death. That decision cannot be faulted on the ground that it was made or taken vexatiously.

Question (4)

[56] I have concluded that the answer to this question is also no. In reaching my conclusion I have to say that I derived no assistance at all from the Timeline. For the whole period in question there were twenty two entries. Ten of them stated the start and progress of the Inquiry, all in bald terms. The remaining twelve listed the passage of documents or letters or e-mails without giving the least indication of their terms let alone their content that was of any assistance to the hearing. The entries read like an index of events. The depute, who did not draft it, was aware of its manifest and manifold shortcomings. He made very little use of it in his submissions. Counsel was being generous to it when he described it as being not very illuminating. With regret I have to say that it was a disappointing document. It was of no practical value to the hearing unless explained and interpreted for practically every entry which was a task that the depute did not embark upon. In consequence I put the Timeline to one side and made use of it only where it coincided with the submission.

[57] There is no doubt in my mind that the way in which the Crown prepared for the Inquiry was flawed. This was so in a number of respects but two in particular stand out: the failure to appreciate the importance of the CT scan performed by Dr Baxter until an advanced stage; and the failure to accord to Dr Hatter the status that he deserved as their expert pathological witness. For Dr Baxter they ought to have precognosced him much earlier than they did. For Dr Hatter they ought to have precognosced him well in advance of the Inquiry, obtained from him a copy of his curriculum vitae and supplied him with

copies of the various medical reports obtained on behalf of the other interested parties as and when they became available and sought his comments on them in advance of requiring him to give evidence. Had they done all that they ought to have had the information about his professional difficulties and the fact that he had not worked since June 2006. Moreover, and crucially, in light of the straightforward honest and candid way that he gave his evidence I can easily infer that in all probability he would have indicated his retraction before rather than in the course of the Inquiry. The decision by an unnamed depute that it would be inappropriate to exhibit the various medical reports to Dr Hatter was the wrong one to make and its consequences became all too clear when Dr Hatter gave his evidence.

[58] The failure of the Crown to prepare properly undoubtedly affected the way that the Inquiry was presented. The Crown were simply not prepared to the standard that undoubtedly the Crown would have wished. When the evidence came out as it did from Dr Hatter the Crown were clearly in some difficulties. What followed could be characterised as an attempt to retrieve the situation in whatever way could be achieved. Unlike a civil action there is no mechanism for abandoning the cause. An Inquiry once commenced has to be seen through to its conclusion by issuing a determination. The Crown therefore had to do something. The depute presenting the Crown case chose to persevere with the evidence. She led the evidence of Dr Oldroyd and then Dr MacDonald. It is difficult to fault her in doing that at that stage. Similarly it is easy to understand her diffidence on 16 April about conceding at that stage that the Crown would not rely on the evidence of Dr Hatter. Doubtless she wanted to consider the Crown position during the adjournment of the Inquiry. However, when the Inquiry reconvened on 11 May the actions of the Crown suggested a degree of desperation when after leading the evidence of Dr Baxter they moved to adjourn to obtain the services of another pathologist who had no prior professional experience of the facts before the Inquiry. I refused that application. They then on 14 May led Dr Jennings as their last witness.

[59] At the heart of the reason for the motion is the Crown's treatment of Dr Hatter before the Inquiry and their response to his retraction in the course of it. In dealing with this it is necessary to recall that the Inquiry would still have had to take place, because once commenced there is no procedural mechanism whereby it can be halted before the sheriff issues his determination. So the Crown would have had to present evidence. The question is what that would have amounted to, and what effect that would have had on the way the Inquiry was conducted in terms of both content and duration, with a

consequent effect on the level of expenses. The answer to that ought to pave the way to a decision on whether what actually happened amounted to the vexatious conduct of the Inquiry.

[60] Let me proceed on the premise that Dr Hatter did indicate to the Crown before the Inquiry that he would no longer stand by his conclusion on the provenance of the aortic tear. Absent that, the report from Dr Jennings, taken in conjunction with the other medical reports available to the Inquiry still left open for discussion questions over whether the entry site in the groin was too high or the arterial closure device failed post procedurally and also whether a covered stent should have been placed across the bleeding point in her groin area. These are the issues that I refer to at paragraph [35] of the Note. The difficulty for me is assessing what would have been the effect on the Inquiry if it had proceeded on those matters only. It is an insuperable difficulty on the information before me and that is so despite the meticulous and detailed analysis of counsel in support of his fourth proposition. I cannot tease out from the wealth of evidence that was led what would have happened and I certainly could not substitute any view of my own. It follows from this that I cannot draw any conclusion on how long the Inquiry might have taken if only those issues had been canvassed or on how long the Inquiry would then have taken.

[61] Does the Crown presentation amount to vexatious conduct? Undoubtedly it was a flawed presentation and that flows directly from errors in preparation that could be characterised, without indulging in hindsight, as material. But applying that analysis to the judicial interpretation of the word vexatious I do not see that it amounts to conduct that constitutes an abuse of process. The use of the court process was not so significantly different from its ordinary and proper use to take it into that exceptional and serious category of vexatiousness. Nor was it established in submission that such inconvenience and expense as the Boards have suffered in connection with this Inquiry, and there is no doubt that they have suffered inconvenience and expense as a result of the way in which the Crown presented it, was out of all proportion to any gain likely to accrue to them.

[62] In support of his submission counsel at one point sought to persuade me that the facts and circumstances of **Global Santa Fe** were broadly similar to the present case, amounted to vexatious conduct and therefore it could be inferred by analogy that the present case fell into the same category. I am not prepared to go as far as counsel wishes me to go. I consider that every case must of necessity be decided on its own facts and circumstances. In any event I would distinguish **Global Santa Fe** on the

ground that in **Global** the prior procedure of the criminal trial, referred to in paragraph [5] of the Opinion of the Court, evidently weighed heavily in the mind of the sheriff when she said what she is quoted as saying at paragraph [9] of the Opinion. There is no such prior procedure in the present case.

[63] As for the fact that the hearing on expenses did not take place on 10 July, while in large part this was due to the lack of preparation of the Crown to oppose it, the subsequent procedure whereby it took place on 28 October 2009 does not amount to vexatious conduct albeit it incurred additional expense.

Question (5)

[64] I do not need to answer this question.

Question (6)

[65] If I had been satisfied that the Crown had acted vexatiously, I would not then have granted the motion to whatever extent I had concluded the Crown had so acted. I consider that before doing that I would have had to exercise the discretion conferred by the decision in **Global Santa Fe**, as already discussed in answering question (1) at paragraphs [50] and [51] above. That involves an assessment of the whole circumstances. One feature that could be expected to figure in that task is the fact that all Fatal Accident Inquiries are brought and pursued in the public interest under statutory powers that either obliges the Crown to institute proceedings or requires the Crown to exercise a discretion on whether to institute them. This distinguishes them from those civil actions where there is no statutory obligation to bring proceedings and that in practice is the vast majority. Another feature that might have to be weighed in this regard is whether the Inquiry in question fell under section 1(1)(a) or 1(1)(b) of the Act: namely, whether in relation to the holding of the Inquiry under consideration the Crown had been obliged to apply for it or had chosen to do so because it appeared to the Lord Advocate to be expedient in the public interest. I do not need to reach any conclusion on these observations at present.

Question (7)

[66] I do not need to answer this question.

Question (8)

[67] If I had found the Boards entitled to an award of expenses and that had included an element which involved the services of counsel, I would have sanctioned the employment of junior counsel and that for throughout the case. As I observed in paragraph [8] of the Note the finding and conclusions that prompted the Crown to request the Inquiry proposed a cause of death that could be attributed to the conduct of the procedure and therefore raised immediately the question of the clinical competence of the two cardiologists involved: Dr McDonald as the operator and Dr Oldroyd as the supervisor. By inference it also raised questions about what should have been done post-procedurally to diagnose and then treat that cause of death between 9 and 17 November, and this introduced consideration of the actions and decisions of Dr Oldroyd made at both the Jubilee and the Western, and the management regime of Mrs Gill at the Western that was decided upon jointly by Dr Oldroyd, Mr McKay and Dr Moss and then implemented throughout her time there as an in-patient by and large by medical staff at a more junior level than consultants and by the nursing staff. A determination that was critical of the actions of either Dr Oldroyd or Dr MacDonald, or of the management regime at the Jubilee or the Western had the potential to involve serious and expensive consequences for the Boards that were of sufficient importance to merit the employment of counsel to represent their interests at the Inquiry. Beyond that the Inquiry raised questions of a complexity that also merited the employment of counsel, in particular the dispute between the various medical witnesses over the finding that Mrs Gill's aorta had suffered a tear and the conclusion that Dr Hatter drew from that. Not the least of the considerable benefits that the presence of counsel brought to the Inquiry came from his questioning of Dr Hatter which elicited the professional difficulties that he was experiencing in 2006 and their consequences for his career. I précised these in paragraph [50] of the Note. That gave me the material to form my conclusion on how I should make use of Dr Hatter's evidence, as recorded in paragraphs [110] to [112] of the Note. In the whole circumstances I would have had no hesitation in granting sanction. It was sought only for junior counsel.

Postscript on the procedure adopted for hearing the motion

[68] I heard the motion for expenses after issuing my determination. That was in furtherance of my interlocutor dated 30 September 2009 which formed part of the determination. There is no express sanction for proceeding in this way. It was at the hearing on evidence held on 10 July 2009 that counsel intimated his intention to move the motion, but Mr O'Mahony, who appeared for this purpose instead of

the depute who had conducted the Inquiry, intimated that the Crown, while wishing to oppose the motion, was not ready to present its opposition at that hearing. The ensuing discussion resulted in an understanding that the motion should be heard after I had issued my determination. Both counsel and Mr O'Mahony were alive to the possibility that proceeding in this way could run the risk of a challenge on the ground of competency because once a sheriff has issued his determination it is generally accepted that he is thereafter *functus*, but understandably neither wished to take the point, and I am in complete sympathy with them on that. However, any question of competency cannot be ignored. All I would wish to say in support of the procedure that I adopted and followed is that it was the procedure followed by Sheriff Cowan, as recorded by Lord Kinclaven in paragraph [19] of his Opinion in **Global Santa Fe** at the stage of the Outer House proceedings. They are reported at 2007 SLT 849 and paragraph [19] is at page 854A-B. Lord Kinclaven did not criticise the procedure and neither did the Inner House when it considered the reclaiming motion. Neither counsel nor O'Mahony were able to point to any other proceedings in which such a motion had been entertained, and it may be that the present case is the first occasion on which that has happened. At least the adopted procedure has the benefit of being a practical and pragmatic way of dealing with a feature of the procedure of fatal accident inquiries that has only recently received the express approval of the Inner House and has yet to be reflected in any rule of court, if it be considered appropriate to do that.