OUTER HOUSE,
COURT OF SESSION

OPINION OF LORD MACKAY OF DRUMADOON

in the Petition

of

MARJORIE HELEN LEIGHTON and E MOSS LIMITED, trading as MOSS PHARMACY

P753/02

Petitioners;

for

Judicial Review of a Determination of William Dunlop, Advocate, Sheriff of North Strathclyde at Campbeltown, in the Inquiry into the death of the late Catherine Middleton

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Act: Jamieson ; Drummond Miller

Alt: Sheldon : Richard Henderson, Scottish Executive.

24 April 2003

Introduction

[1]These proceedings for judicial review relate to a Fatal Accident Inquiry, which was held following the death of Mrs Catherine Middleton ('deceased'). The deceased was born on 13 January 1924. She died on 16 February 2001. Prior to her death, the deceased resided with her husband, George Middleton, in Campbeltown.

[2]The deceased's general practitioner in Campbeltown was Dr Robert Rae. Towards the end of October 2000 the deceased consulted Dr Rae. She complained of having been unwell for several weeks. Her complaints included that she felt tired and lethargic and had been suffering from persistent chest infections. On 25 October 2000, Dr Rae referred the deceased to Dr Alan Henderson, a consultant physician at the Lorn and Islands District General Hospital, Oban. On 1 November 2000 the deceased attended for a bronchoscopy examination at the Lorn and Islands District General Hospital. Following that examination Dr Henderson advised Dr Rae that the deceased was suffering from lung cancer and that lung function tests had indicated that the deceased also had a moderately severe obstructive ventilatory defect. The deceased had previously been diagnosed as suffering from chronic obstructive pulmonary disorder.

[3]The deceased was referred to the lung clinic at the Beatson Oncology Centre in Glasgow. She attended there for assessment on 22 December 2000. On account of her ongoing chronic obstructive pulmonary disorder, the deceased was not regarded as a suitable candidate for surgery. She declined the option of chemotherapy. She did, however, return to the Beatson Oncology Centre on 8 January 2001, when she underwent a short course of palliative radiotherapy. The deceased was seen again by a colleague of Dr Henderson, at a clinic held at Campbeltown Hospital on 18 January 2001. In January 2001, Dr Rae's assessment was that the deceased would survive for 'some weeks to some months'.

[4]On the morning of 31 January 2001 Dr Rae called at the deceased's home on a routine visit. He learnt that that the deceased had been experiencing nausea and vomiting. Dr Rae considered it possible that her symptoms might have been caused by her cancer having spread to other parts of her body. He thought she might now be suffering from metastatic disease, involving secondary and possibly cerebral tumours. Dr Rae decided to prescribe the drug Dexamethasone, in an effort to alleviate the deceased's symptoms. He wrote the necessary prescription and gave it to the deceased's husband.

[5]Later on 31 January 2001 the deceased's husband took the prescription to Moss Chemists in Campbeltown, which is a pharmacy operated by the second petitioners. The first petitioner, who is a qualified pharmacist employed by the second petitioners, worked in those premises. She was on duty on 31 January 2001. When the first petitioner gave evidence she said that she had no recollection of the prescription having brought into the second petitioners' shop by the deceased's husband. Before the Sheriff, however, (and in the present proceedings), it was accepted by both petitioners that, on 31 January 2001, the first petitioner dispensed the prescription for the deceased. In error, the first petitioner dispensed tablets of the drug Methotrexate, instead of Dexamethasone. The drugs the first petitioner dispensed were in a yellow and white box, in which the drugs had been packaged by the manufacturers. Although the petitioner dispensed the wrong drugs, the computer generated label she printed out, and attached to the box containing the Methotrexate, stated that the drugs being dispensed were Dexamethasone. That label also gave details of how frequently the drugs were to be taken by the deceased.

[6]On 31 January 2001, the prescription could not be dispensed in full. That was because the first petitioner did not have available to her a sufficient quantity of what she mistakenly thought were the drugs that the deceased required. The first petitioner informed the deceased's husband that she did not have sufficient drugs to fulfil the whole prescription. It was arranged that he would return for the balance of the prescription at a later date.

[7]On returning home with the drugs he had been given by the first petitioner, the deceased's husband began administering the drugs to the deceased. That was around lunchtime on 31 January 2001. He continued to do so over the following days. On 5 February 2001, District Nurses, who were visiting the deceased, were concerned that her condition was deteriorating. Dr Rae was contacted. That day the deceased was admitted to Campbeltown Hospital. On her admission to hospital all the medication she had been taking was stopped. Although her husband took the wrongly dispensed drugs to the hospital, shortly after the deceased had been admitted, no further tablets of Methotrexate were ingested by her.

[8]Dr Rae saw the deceased on 6 February 2001. On 8 February 2001 she was transferred by air ambulance to Lorn and Islands District Hospital in Oban. There she came under the care of Dr Henderson and Dr Campion. She died in that hospital on 16 February 2001. Following her death the deceased's body was taken to Vale of Leven Hospital to enable a post mortem examination to be carried out. The remaining tablets of Methotrexate, which had been wrongly dispensed by the first petitioner, had been sent from Campbeltown Hospital to the hospital in Oban. They were sent with the body of the deceased to Vale of Leven Hospital. At the time of the post mortem examination on the deceased, a mortuary technician noticed that although the computer generated label generated by the first petitioner bore to describe those drugs as being Dexamethasone, the drugs were in fact Methotrexate.

[9]That matter was immediately reported to the police and the Procurator Fiscal. Further enquiries suggested that the first petitioner had become aware of her mistake on 5 February 2001, the day the deceased was admitted to Campbeltown Hospital. That morning the deceased's husband had called at the second petitioner's premises, to uplift the balance of the prescription. He was informed by the first petitioner that she still did not have the drugs necessary to complete the prescription. The following day, the first petitioner went to the deceased's family home where she saw the deceased's husband. She said that she had brought the balance of the prescription with her and also said something to the effect that the tablets he had been given on 31 January 2001 had been the wrong strength. She did not, according to Mr Middleton's evidence, disclose that the drugs dispensed on 31 January 2001 had been the wrong drugs. The first petitioner was advised that

the deceased had been admitted to Campbeltown Hospital. She retained the drugs she had brought with her. She took no steps to inform her employers, the second petitioners, staff at Campbeltown Hospital or Dr Rae of the mistake that she had made.

The Fatal Accident Inquiry

[10]A Fatal Accident Inquiry, held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ('the 1976 Act'), took place before the Sheriff at Campbeltown on 6, 7 and 8 February 2002. The procurator fiscal led all of the evidence that the Sheriff heard. The petitioners were represented at that inquiry by Mr Jamieson, the junior counsel who appeared for them in these proceedings. The Argyll & Clyde Acute Hospitals NHS Trust and Lomond & Argyll Primary Care NHS Trust were represented by Mrs Murray, Solicitor and Dr Henderson and Dr Campion were represented by Mrs Robertson, Solicitor.

[11]The Sheriff heard evidence from George Middleton the husband of the deceased; Douglas Hooker, a nephew of the deceased; Mrs Mary McCallum, a sister of the deceased; Dr Robert Rae, the deceased's general practitioner; Dr Eleanor Murray, who carried out a post mortem examination of the deceased the first petitioner; John Mathieson, a staff nurse at Campbeltown Hospital; Victoria Middleton, an auxiliary nurse at Campbeltown Hospital; Dr Alan Henderson, a consultant physician at Lorn and Islands District General Hospital, Oban; Annie Howe, a nursing auxiliary at the Lorn and Islands District General Hospital; Margaret McLean, an enrolled nurse at the Lorn and Islands District General Hospital; Jennifer McIntyre, a ward sister at the Lorn and Islands District General Hospital; Dr Thomas Campion, who was, in February 2001, a junior house officer at the Lorn and Islands District General Hospital; Ian Cavanagh, the second petitioners' area manager for the area including Campbeltown; John Liddell, a registered pharmacist who is employed as an inspector by the Royal Pharmaceutical Society and Detective Inspector David Hardie of Strathclyde Police. In addition the Sheriff had before him affidavits from three individuals, Raymond Benjamin, Lynn Alison Jones and Dawn Burns. None of these affidavits were lodged in the present proceedings and none of them are referred to in the Sheriff's Determination and Note.

The Law

Section 6 of the 1976 Act provides as follows:

"**Sheriff's determination, etc.**

6.-(1)At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction -

(a)where and when the death and any accident resulting in the death took place;

(b)the cause or causes of such death and any accident resulting in the death;

(c)the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

(d)the defects, 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.

(2)The sheriff shall be entitled to be satisfied that any circumstances referred to in subsection (1) above have been established by evidence, notwithstanding that that evidence is not corroborated.

(3)The determination of the sheriff shall not be admissible in evidence or be founded on in any judicial proceedings, of whatever nature, arising out of the death or out of any accident from which the death resulted.

The Sheriff's Determination

[12]Following the Fatal Accident Inquiry, the Sheriff issued a Determination in the following terms:

"The Sheriff, having heard evidence and submissions thereon, finds the following facts established and **DETERMINES**:-

(1)in terms of section 6(1)(a) of the Act,

That Catherine Middleton, (13/01/24), late of 64 Ralston Road, Campbeltown, died at or about 09:20 hrs. On 16th February 2001 within the Lorn and Islands District General Hospital, Oban. She died as the result of an accident which occurred when she ingested Methotrexate wrongly dispensed for her by Marjorie Helen Leighton, pharmacist acting in the course of her employment with Moss Chemists at 16 Main Street, Campbeltown, on 31st January 2001;

(2)in terms of section 6(1)(b) of the Act,

(a)the cause of death was acute tracheobronchitis which Mrs Middleton's immune system was unable to resist;

(b)that the cause of the accident was (i) a dispensing error by the said Marjorie Helen Leighton, and (ii) the failure of Moss Chemists to have any system for checking whether any dispensing errors had been made.

(3)in terms of section 6(1)(c) of the Act,

that reasonable precautions whereby the accident resulting in the death might have been avoided would have been;

(a)for Ms Leighton to have observed the prescription checking procedures demanded by her employers.

(b)for Moss Chemists to have had in place a system for reconciling at the end of each working day the record of those drugs for which they had received prescriptions, and therefore had purported to have dispensed, and the record of those which they had actually dispensed.

(4)in terms of section 6(1)(d) of the Act,

the system of working within Moss Chemists was defective in that there was no procedure for carrying out the sort of check as is mentioned in (3)(b) above."

Submissions for petitioners

[13]The petitioners sought reduction of certain parts of the Determination namely (i) the second sentence in Determination 1, (ii) Determination 2(b), (iii) Determination 3 and (iv) Determination 4. The respondent in these proceedings is the Lord Advocate. Counsel appearing on his behalf resisted reduction of any part of the Determination.

[14]The submissions of counsel for the petitioners fell into two chapters. In the first place he argued that the Sheriff had not been entitled to draw the conclusions he had reached, from the medical evidence he heard. Secondly, counsel argued that the Sheriff had not been entitled to reach the conclusions he had about the

system of working of the second petitioners and, in particular, as to the absence of any system for checking whether dispensing errors had been made.

[15]Counsel for the petitioners made clear that there was no dispute that the first petitioner had made a serious error, when she dealt with the prescription written by Dr Rae. Nor was there any dispute that the first petitioner's error had led to the deceased ingesting drugs, that would have had some adverse impact on the deceased's health and, in particular, upon her immune system. During the course of his submissions, counsel for the petitioner accepted that the ingestion of Methotrexate had played some part in the death of the deceased on the day when her death took place. He argued, however, that the evidence the Sheriff had heard had not been such as to enable him to reach any conclusions, as to the precise effects of the toxic assault upon the deceased's immune system nor as to the contribution of those effects to the mechanics of her death. Counsel submitted that the Sheriff had treated the ingestion of the wrong drugs as being the "proximate cause" of the deceased's death. The Sheriff had not been entitled to do so. Counsel for the petitioners submitted that when one looked at the totality of the medical evidence, it was impossible to say that the ingestion of the wrong drugs had 'resulted' in the deceased's death. Even if the ingestion of the wrong drugs increased the risk of death that did not mean, so he argued, that the accidental ingestion of the wrongly prescribed drugs, had 'resulted' in the deceased's death. He submitted that where there had been factors, other than the ingestion of the wrongly prescribed drugs, that had affected the deceased's health, any finding about the ingestion of the wrongly prescribed drugs, or the consequences of such ingestion, could only have been made in terms of a Determination under Section 6(1)(e) of the 1976 Act. Where other factors were in play, as had clearly been the position in relation to Mrs Middleton's death, the Sheriff had not been entitled to discount all those other factors and make findings under Section 6(1)(a) and 6(1)(b). He should have restricted himself to a finding under Section 6(1)(e).

[16]As far as the second chapter of his submissions was concerned, counsel for the petitioners accepted that the Sheriff had been perfectly entitled to examine the evidence before him to see whether or not Determinations could be made relating to a system for checking for dispensing errors. What counsel argued, however, was that the Sheriff had not heard evidence that entitled him to make Determinations 2(b)(ii), 3(b) and 4.

Submissions for the Lord Advocate

[17]In replying to those submissions, counsel for the Lord Advocate accepted that it was competent to review the Determinations of a sheriff following upon a Fatal Accident Inquiry. Reference was made to *Lothian Regional Council* v *Lord Advocate* 1993 S.L.T. 1133. Counsel argued that there had been ample evidence before the Sheriff to entitle him to make the Determinations that he had. It was also argued that the Court should be slow to overturn those Determinations, having regard to the nature of a Fatal Accident Inquiry, held under the provisions of the 1976 Act and the relevant Rules of Court. In developing his submissions counsel stressed that it was appropriate to view the "accident" as having been the ingestion of the wrongly prescribed drugs by the deceased, rather than the dispensing error made by the petitioner. The ingestion of those wrongly prescribed drugs, which had taken place from 31 January 2001, the date the drugs were wrongly dispensed, until 5 February 2001, the date of the deceased's admission to Campbeltown Hospital, had compromised the defender's immune system. The ingestion of those drugs had adversely affected the deceased's ability to fight the infection involved in the acute tracheobronchitis, which had been certified as having been the medical cause of death.

Decision

[18]In my opinion, the sheriff was perfectly entitled to make Determinations in the terms that he did. I deal with those Determinations one by one. As far as Determination 1 is concerned there is, of course, no dispute as to when or where Mrs Middleton died. In my opinion, however, the date of the deceased's death is of importance when addressing the issue of whether her death occurred "as a result of an accident". The Fatal Accident Inquiry was not just an investigation into the fact that Mrs Middleton had died. It was an

investigation into the circumstances of her death (Section 1(1) of the 1976 Act). From the language employed by the parliamentary draftsman in Section 6 of the 1976 Act, it is clear that those circumstances include the date when the death occurred. On the basis that the accident was the deceased's ingestion of the wrongly dispensed drugs, one issue that the Sheriff required to address, under reference to Section 6(1)(a), was whether her death occurred, on the date that it did, as a result of the ingestion of those drugs.

[19]In my opinion, it is also clear from the language of Section 6(1)(a) of the 1976 Act that the sub-section is not dealing with the cause of death, but rather with the issue of whether there is any connection between any accident and the death, in the sense that the accident 'resulted' in the death of the deceased occurring at the particular time that it did. In my opinion, the language of Section 6(1)(a) is such as can admit the possibility of an accident resulting in a death on one date, with the death having been caused by a specified medical condition, even where, in the absence of any accident, that same medical condition might have caused the deceased's death on a later date. Determinations as to the cause or causes of death are matters for determination under the provisions of Section 6(1)(b). In my opinion, the provisions of Section 6(1)(a) are concerned with different, albeit not totally unrelated, issues, including that of whether any accident that took place resulted in the death of the deceased at the place and at the time that death occurred. Putting it another way, 'Did the accident have as one of its consequences, the death of the deceased at the place and the time that death occurred?'

[20]In my opinion, there was ample evidence before the Sheriff to entitle him to hold that the ingestion of the wrongly dispensed drugs resulted in the deceased's death. That evidence was given by the deceased's husband and her sister, Mary McCallum, and, more importantly, by Dr Murray, Dr Rae, Dr Henderson and Dr Campion.

[21]The deceased's husband noticed a significant deterioration in his wife's condition during the days following Thursday 1 February. So did the deceased's sister, Mrs MacCallum. Dr Rae did not see the deceased between 31 January and 5 February. He saw her again, however, following upon her admission to Campbeltown Hospital. He described her condition at that time as having been 'largely unchanged', although certain additional symptoms suggested to him that her malignancy was spreading. Although he did not claim any great expertise in chemotherapy, Dr Rae gave evidence that one of the possible side effects of the drug Methotrexate, which is used to treat patients with cancer, is the suppression of the patient's bone marrow.

[22]Dr Henderson gave evidence that upon her admission to hospital in Oban, the deceased's blood count was reduced. Both the white cells and the platelets were reduced. At that time Dr Henderson understood that the deceased had only received a single palliative dose of radiotherapy. He gave evidence that the commonest cause of reduced blood counts in cancer patients is the invasion of the bone marrow by cancer. His impression was that was what had occurred. After the deceased's death, Dr Henderson learnt about her ingestion of Methotrexate. He explained that had that been known at the time of the deceased's admission to hospital in Oban, her treatment would probably have been different. He stated that there was little doubt that the deceased's death occurred in the week it did in part, but maybe not entirely, due to the influence of Methotrexate. That particular opinion was expressed by him, in full knowledge of the deceased's medical history and the findings at post-mortem. It was also expressed against the background of his view that had the deceased not died on the date she did, she 'would have been dead within a fairly short number of weeks - a couple of months or so'.

[23]When the deceased was admitted to the Lorn and Islands District General Hospital, Dr Campion was serving as a house officer. He admitted her. He arranged the blood tests, which within hours of her admission disclosed the low blood counts. At that time, Dr Campion had no knowledge that the deceased's had accidentally ingested Methotrexate. He gave evidence, however, that at that time he was aware of the possible side effects of that drug, including the presentation of blood results such as those of the deceased. On 13 February 2001, Dr Campion carried out further blood tests on the deceased. He was alarmed to discover that the white cell count and the platelet count had gone down further. He discussed these further results with a haematologist, Dr Clark, and a senior house officer, Dr Ahmed. He explained that one question

raised in those discussions had been whether the deceased might have sustained a toxic insult to her bone marrow.

[24]Dr Murray, who, with a colleague, carried out the post-mortem examination on the deceased, found that the deceased's bone marrow had been markedly depressed by chemotherapy, but was showing early regenerative changes. The chemotherapy she was referring to was the deceased's ingestion of Methotrexate. Dr Murray indicated that those features agreed with findings on examination of blood samples, taken from the deceased, both before and after death. In the body of the post-mortem report, Dr Murray, and her colleague stated that '(the) deceased has died due to acute tracheobronchitis following developing pancytopenia due to a chemotherapeutic agent'. Pancytopenia is the medical term for a reduction of the white cell count, accompanied by an adverse effect on the body's immune system to fight infection.

[25] When asked by the Procurator Fiscal, if she was able to say whether the deceased's death was directly the result of ingestion of Methotrexate, Dr Murray responded 'I cannot say that death was definitely the total result of ingesting Methotrexate. I do think, however, that it is likely that the fact that the patient had been inadvertently given Methotrexate, (which) had depressed her cells in the bone marrow which naturally fight infection, must have contributed to the acute tracheal bronchitis which caused death, but I cannot say that it is the only precipitating cause.' Dr Murray adhered to those views in cross-examination. When the deceased's full medical history was put to Dr Murray, together with her own finding at post-mortem that the deceased had also been suffering from metastic cancer in her adrenal glands, Dr Murray expressed the opinion that the deceased's chances of dying of acute tracheal bronchitis, at the particular moment she did die, had been enhanced by the fact that the deceased did not have her protective white cells to fight her infection. That deficiency had existed, of course, as a consequence of the ingestion of the Methotrexate. Dr Murray was not prepared to accept that the ingestion of the wrong drugs had made no contribution to the deceased's death occurring at the time it did.

[26]In my opinion, having regard to the evidence he had heard, it was perfectly open to the Sheriff to determine that the deceased's ingestion of Methotrexate had resulted in her death. It had given rise to a toxic insult on her bone marrow. It had led to a deterioration in the deceased's immune system, which affected her ability to fight infections, such as the infection which was the medical cause of her death. In my Opinion, the Sheriff had ample evidence before him that the ingestion of the Methotrexate had a one of its consequences the death of the death occurring on the date that it did.

[27]The averments in the Article 4 of the petition assert that the evidence at the Inquiry indicated that at the time of the deceased's death four factors were involved in the mechanics of death. They were averred to be (i) the deceased's chronic obstructive pulmonary disorder; (ii) the use of palliative therapy in treating the deceased for lung cancer; (iii) the presence of secondary tumours in the adrenal glands and (iv) the ingestion of the wrong drugs. It was averred in the pleadings, suggested in cross-examination and argued by way of submissions before me, that it was impossible to say (a) what had been the relationship between these factors, (b) what had been the relationship between individual factors and the primary cause of death, namely acute tracheobronchitis, and (c) whether only one factor had resulted in the primary cause of death. In my opinion, that whole line of argument proceeds on a failure to appreciate that the provisions of Section 6(1)(a) are not concerned with determining the cause or causes of death. Determination 1 is not a finding that the wrongful ingestion of Methotrexate was the, let alone the only, cause of death. It was directed to the separate issue of whether the accident resulted in the death on the deceased occurring on the day that it did. For all these reasons, I am quite satisfied that the Sheriff was entitled to make Determination 1, in the terms that he did.

[28]Turning to Determination 2, there was no challenge as to the making or the terms of Determination 2(a). As far as Determination 2(b)(i) was concerned, counsel for the petitioners accepted that one cause of the accident had been the dispensing error by the first petitioner. It is clear from the evidence led before the Sheriff that it was open to him to hold that error occurred when the petitioner dispensed the prescription on her own and failed to follow the procedures laid down in the second petitioners' Company Procedures

Manual. Those procedures require that, in the second petitioners' shops, computer generated labels should be attached to the containers of the drugs, which are being dispensed. Those labels have two boxes printed on them. The second petitioners employ dispensers and pharmacists. When a dispenser dispenses drugs, she is required to sign 'the dispensed by' box. The procedures require that a pharmacist check the drugs dispensed, against the prescription, and sign the 'checked by box'. The Sheriff heard evidence that when a pharmacist, such as the first petitioner, dispenses drugs, the pharmacist is expected, having made up the prescription, to step back from what she has done for a minute or so and then go back and check the drugs dispensed. She is expected to sign both boxes. There was no evidence that the first petitioner had checked the drugs she had dispensed. On the contrary, the Sheriff heard evidence that neither box, printed on the label attached to the box containing the Methotrexate, had been initialled or signed by her.

[29]Turing to Determination 2(b)(ii), I have reached the conclusion that it was open to the Sheriff to find that the second petitioners did not have in place any system for checking whether any dispensing errors had been made by their employees. For reasons I shall elaborate upon later, I have also reached the conclusion that it was open to the Sheriff to find that it would have been possible for the second petitioners to have had such a system in place. Standing those conclusions, it was, in my opinion, also open to the Sheriff to hold that the absence of such a system constituted a failure on the part of the second petitioners that was a cause of the accident, which occurred when the deceased ingested the wrongly dispensed drugs.

[30]Turning to Determination 3, counsel for petitioners did not dispute that a reasonable precaution whereby the accident resulting in the deceased's death might have been avoided would have been for the first petitioner to have observed the checking the procedures laid down in the second petitioners' Manual. In these circumstances, his submission in relation to Determination 3(a) was a technical one, linked to his submissions in relation to Determination 1. He argued that if I accepted his submissions in relation to Determination 1, Determination 3(a) could not survive. He accepted, however, that if I were to be against him in relation to Determination 1, I would be entitled to hold that the sheriff had evidence before him warranting his making Determination 3(a). Standing the view I have reached in respect of Determination 1, it follows that I also hold that the Sheriff was entitled to make Determination 3(a).

[31]As far as Determination 3(b) is concerned, counsel's submissions were that the evidence before the Sheriff was not such as to entitle him to hold that a computer based system for checking on dispensing errors could be designed and successfully implemented. He argued that a number of stages of development would have to be gone through, before any such computer based system could be operated effectively. This argument he sought to support by reference to two reports, which had not been before the Sheriff. These were a Report of the Inquiry into the London Ambulance Service, dated February 1993, and a Report on Electronic Prescribing, dated January 2002, which had been prepared by the All Party Pharmacy Group in the Westminster Parliament. Counsel for the petitioners submitted that upon the basis of the evidence before the Sheriff, it was unclear that such a system would be entirely free from problems. Counsel did recognise, however, that had such a system been in place and had it picked up the first petitioner's error later in the day on 31 January 2001, that might have prevented the deceased ingesting more than an initial dose of the wrongly prescribed pills and might have avoided the consequences of that accident and her death occurring, on the date when it did occur.

[32]In dealing with these submissions, I should refer first to the two reports, about the lodging of which I have more to say later in this Opinion. In my opinion, there is nothing in either report that is of any assistance in addressing the issue of whether on the basis of the evidence the Sheriff heard he was entitled to make Determination 3(b). As I have indicated the report about the London Ambulance Service is dated February 1993. A great deal has happened in the field of information technology over the last ten years. Whilst the second report is more recent, from my reading of it the report provides no basis for judicially reviewing the Sheriff's Determination.

[33]Counsel for the petitioners acknowledged that, having regard to the error that had been made by the first petitioner, it had been open to the Sheriff to consider the checking of stock as a possible method for

identifying any dispensing errors that had been made.

[34]On this issue, the Sheriff heard evidence from Ian Cavanagh, the second petitioners' area manager, and from John Liddell of the Royal Pharmaceutical Society. Ian Cavanagh gave evidence that dispensing errors occur from time to time. The second petitioners' Manual lays down how and to whom they should be reported. The possibility of such errors occurring is regularly discussed with the second petitioners' pharmacists. When the Sheriff put to Ian Cavanagh the possibility of a computer based system for checking the drugs dispensed by a shop, against the drugs still held within the shop, Ian Cavanagh gave evidence that there was no software or technical expertise in that area that has developed anything like that.

[35]In the event, however, John Liddell gave evidence to contrary effect. He stated that it would be possible, albeit time-consuming and a burden, for a shop with a stock control system on computer, to employ a computer based system for checking for the occurrence of dispensing errors. He indicated that the software is available to allow such an exercise to be carried out. He also explained that such software is tied in with the software used by the wholesalers of drugs who supply community pharmacists, such as the second petitioners' premises in Campbeltown.

[36]Having regard to that evidence, it was, in my opinion, open to the Sheriff to make Determination 3(b). That was a Determination made in terms of Section 6(1)(c). As such, it was a Determination to the effect that it had been established to the Sheriff's satisfaction that such a precaution might have avoided the death and the accident resulting in the death and that the precaution was a reasonable one.

[37]Here again, the Sheriff was concerned with the death of the deceased on the date when it occurred. In my opinion, it cannot be said that the conclusions he reached were not open to him on the evidence he heard. Having regard to the terms of Determination 3(a), it cannot be argued that the Sheriff took no account of the first petitioner's failure to follow the correct procedures, when dispensing the prescription. Nor were the conclusions the Sheriff reached not open to him, merely because those procedures, set out in the second petitioners' Manual, were not themselves the subject of any criticism or because John Liddell stated that the available software was not foolproof.

[38]It is, in my opinion, important to bear in mind the provisions of Section 6(3). They provide that the determination of the Sheriff shall not be admissible in evidence or founded on in any judicial proceedings, of whatever nature, arising out of the death or any accident from which the death resulted. When a Sheriff makes a determination under the provisions of Section 6(1)(c), it is perfectly possible that the reasonable precaution, which he identifies and holds as having been established on the evidence before him, may, on subsequent consideration or investigation, not amount to what the Sheriff considered it to be. But that is not the test against which such a determination falls to be assessed in judicial review proceedings. On the contrary, such a Determination falls to be assessed against the evidence the Sheriff heard and on the basis of whether he was entitled to reach the conclusions he did, having regard to that evidence.

[39]Another factor to bear in mind is that the deceased's accident occurred over several days, from 31 January 2001, the date when she first ingested the wrong drugs, until 5 February 2001, the date on which she was admitted to Campbeltown Hospital. There can be little doubt, therefore, that had the second petitioners had in place a system of the nature referred to in Determination 3(b), it might have been possible to have prevented the deceased from ingesting at least some of the drugs that she did. Equally, had it become known, within a day or so of the first petitioner's error, that the deceased had ingested the wrong drugs, that information could have been communicated to the doctors who were treating her.

[40]Turning finally to Determination 4, counsel for the petitioners accepted that his submission in relation to this Determination to some extent duplicated his position in relation to Determination 3(b), although he stressed that a distinction had to be drawn between the language used in Sections 6(1)(c) and 6(1)(d). Having due regard to that difference in language, I am satisfied that it was open to the Sheriff to hold that the absence of any system for picking up dispensing errors made by the first petitioners constituted a defect in the second

petitioners' system of working, which contributed to the deceased's accidental ingestion of Methotrexate and her death on 16 February 2001.

[41]In the whole matter, therefore, I sustain the second plea-in-law for the Lord Advocate and dismiss the petition.

Postscript

[42]Before I conclude this Opinion I ought to mention two other matters. The first relates to the state of the productions at the start of the First Hearing before me. Although the petitioners had lodged a number of productions, in anticipation of the First Hearing, their productions did not include the Determination which I was being invited to review. That omission was immediately acknowledged and a copy of the Determination was made available. However, it was also clear that the petitioners had failed to lodge various important documentary productions that had been before the Sheriff. These included the post-mortem report on the deceased, the medical records relating to the deceased, the medical certificate of cause of death signed by a pathologist and the intimation of death to the Procurator Fiscal at Campbeltown by the Registrar of Birth, Deaths and Marriages. Another document that had not been lodged was the second defender's "Company Procedures Manual". It was clear from the Notes of Evidence relating to the hearing before the Sheriff, which had been lodged as productions in the present proceedings, that certain sections of the post-mortem report, the medical records of the deceased and the second petitioner's Company Procedures Manual had been referred to in evidence. Despite that, those documents were only produced and lodged as the hearing before me progressed. That was unsatisfactory. It resulted in my being referred to passages in the transcript of the evidence that contained quotations from documents that were not before me. The petitioners, having been represented at the Fatal Accident Inquiry, had copies of all the documents that were referred to during that Inquiry. Such documents ought to have been lodged in the present proceedings, in anticipation of the start of the First Hearing.

[43]The other matter I should mention is that the petitioners lodged as productions in the present proceedings, certain documents that had not been before the Sheriff. These were a medical report by Dr Chris Twelves dated 24 October 2002, an affidavit by Dr Twelves dated 14 February 2003, the Report of the Inquiry into the London Ambulance Service, dated February 1993 and the Report on Electronic Prescribing, dated January 2002, which had been prepared by the All Party Pharmacy Group in the Westminster Parliament.

[44]At the start of the First Hearing, counsel for the Lord Advocate intimated that he intended to object to any reference being made to those documents, because they had not been before the sheriff. During the course of the debate on that objection, counsel for the petitioners stated that he would not insist on referring to the report and affidavit of Dr Twelves. During that debate, I indicated that I was inclined to allow counsel for the petitioners to make reference to the two reports, entirely without prejudice to any questions of relevancy and competency that might arise. In the event, as I have indicated, I reached the view that there was nothing in those reports that assists the petitioners in the submissions that were advanced on their behalf. For the avoidance of any doubt, however, I should also indicate that I am far from satisfied that those two reports were competently before me, notwithstanding the fact that the second of the reports was mentioned in the petitioners' pleadings.