EXTRA DIVISION, INNER HOUSE, COURT OF SESSION

[2011] CSIH 7

P1007/07

OPINION OF THE COURT

delivered by LORD CLARKE

in the Reclaiming Motion

by

ALICE EMMS (AP)

Petitioner and Reclaimer;

against

THE LORD ADVOCATE

Respondent:

_____

Lord Clarke

Lord Emslie

Lord Wheatley

Act: Bovey, Q.C., Pirie; Thompsons

Alt: Lake, Q.C., S Smith; SGLD Group B Directorate, Solicitors

28 January 2011

[1] In this reclaiming motion the reclaimer reclaims against an interlocutor of the Lord Ordinary (Lady Smith), whereby her Ladyship dismissed the reclaimer's petition for judicial review of a decision by the respondent to refuse to order an inquiry under section 1(1)(b) of the Fatal Accident and Sudden Death Inquiries (Scotland) Act 1976 and *separatim* to review the failure of the respondent to hold an inquiry, compatible with the requirements of Article 2 of the European Convention on Human Rights, into the death of her late son George Emms (hereinafter referred to as "the deceased").

[2] The background to the reclaimer seeking to have the respondent carry out an inquiry of the sort desiderated on her behalf is set out, very fully, in the Lord Ordinary's Opinion, at pages 53-61 of the reclaiming print, which we gratefully adopt. We would simply endeavour to summarise the position as follows.

[3] As at 25 August 2004 the deceased was 49 years of age. The deceased had had a longstanding complicated medical history. He suffered from pre-existing brain damage, diabetes mellitus, hepatitis C and epilepsy. During childhood he had had encephalitis and he suffered a stroke in 1993. He had learning difficulties and was an adult to whom the provisions of the Adults with Incapacity (Scotland) Act 2000 applied. On 25 August 2004 the deceased was admitted to St John's Hospital, Livingston as a result of a GP referral, which stated that he was suffering from breathlessness. He was diagnosed as having a "urinary tract infection - chest infection". His diabetes was poorly controlled and he had difficulty in swallowing. He was clearly a very unwell man. On his admission to hospital, because of the difficulties he was experiencing with swallowing, the decision was taken that it would be necessary for him to be fed artificially. On 1 September

2004 a percutaneous endoscopic gastrostomy (hereinafter referred to as "PEG") was inserted through his abdomen into his stomach. The PEG device consisted of a flexible valve through which a patient having swallowing difficulties could be fed, hydrated and have liquid medicine administered.

[4] The deceased died in hospital on 8 September 2004. Acting on behalf of the respondent, the procurator fiscal ordered a post mortem examination to be carried out to ascertain the cause of the deceased's death. That examination was carried out on 13 September 2004 by Professor Anthony Busuttil of Edinburgh University. It resulted in a report to the procurator fiscal (6/5 in the appendix), which was received by the procurator fiscal on 24 September 2004. In setting out the deceased's medical history, Professor Busuttil noted that on "1 September he had a PEG tube fitted to his stomach to allow food and drugs to be administered directly to his stomach. This procedure apparently passed without complication." On the final page of the report the following was written:

"OPINION AS TO CAUSE OF DEATH

I(a) Septicaemia

(b) Combined effects of inhalation of gastric contents and peritonitis

(c) Insertion of a gastric feeding tube

(d) Encephalitis and strokes

II Diabetes mellitus

Hepatitis C

Chronic pancreatitis and cholelithiasis."

Professor Busuttil went on to note:

"This man had swallowing difficulties brought on by brain changes resulting from encephalitis and strokes. To deal with this a PEG was passed into his stomach under a local anaesthetic. He had required surgery to his upper abdomen in the past and an upper abdominal scar was present as well as nylon sutures within the tissues. As such, the local anatomy was distorted due to the presence of the adhesions and other changes consequent on his surgery. The tube, although appropriately sited, has leaked and as a consequence there was an inflammation of the lining of the abdominal cavity (a peritonitis). This in turn led to systemic infection, i.e. blood poisoning (a septicaemia).

He was also a diabetic and as such his immunity would have been deficient and thus he would have been less able to deal with any intra abdominal infection."

Perhaps Professor Busuttil's reference to, as a cause of death, the insertion of a gastric feeding tube may have unwittingly caused the deceased's family concern that something untoward had occurred in the treatment of the deceased. For whatever reason, as the Lord Ordinary notes, the deceased's family evidently had a concern about the use of the PEG. Professor Busuttil was invited by the procurator fiscal to provide a supplementary report. This he did by means of a supplementary report dated 23 November 2004 (6/6 of the appendix). After setting out the deceased's medical history again, Professor Busuttil wrote:

"COMMENTARY

This handicapped 49 year old man had problems with swallowing and given his diabetic state and his requirement to have his dietary intake monitored, a PEG was inserted into his stomach. This tube was inserted on 1 September after informed consent for this problem was obtained from the parents. This

procedure was not perhaps as straightforward as usual, given the presence of previous upper abdominal surgery, which would have caused local scarring and anatomical distortion. He was given antibiotics for one day after this procedure, but developed a temperature over the 3-5th September during which period no insulin was apparently given to him. Dr Middleton, the duty physician, instructed blood cultures and he was started on broad-spectrum antibiotics.

On 8th September, as his abdomen became tense and distended, a diagnosis of peritonitis was made. The suggestion from the autopsy is that there was leakage from the site where the PEG was placed in the stomach. If this leak had been diagnosed earlier the only treatment was surgery to enable identification and closure of this leak and a cleaning out procedure of his abdominal (peritoneal) cavity. This appears to have been contemplated close to the time of his death.

I am not personally familiar with the procedure by which a PEG is inserted. In retrospect, however, the fever, which developed a few days after its insertion may have suggested a leak therefrom. This man had a large number of other medical conditions which have predisposed him to infection and to poor healing - not least his diabetes, and as such the complication of his PEG insertion have to be viewed in that context."

[5] The consultant gastroenterologist at the hospital, Dr AJK Williams apparently, on sight of Professor Busuttil's reports, discussed them with Professor Busuttil. As a result of these discussions Professor Busuttil, in a letter dated 11 January 2004 to Dr Williams (No.6/8 in the appendix) wrote, *inter alia*, as follows:

"I have no doubt whatsoever from what you told me that:

(a) the PEG tube was essential for this man

(b) It was appropriately inserted

(c) The family knew what it was required for and they understood fully the complications inherent in this procedure.

This 49 year old man was a person whose immunity and perhaps also his repair processes were impaired due to the large number of concomitant serious conditions that he also suffered from not least his post pancreatitic (presumably) diabetes.

The family still have a number of questions, which they want answered and in particular in relation to the PEG insertion and I am sure that Mr Stott, the local Procurator Fiscal will be seeking advice from experts in this field to attempt to answer them as I do not feel that I can respond from personal knowledge or experience of the procedure."

[6] As it happens, another patient had died in September 2004 in St John's Hospital, Livingston after undergoing insertion of a PEG. The National Health Service Lothian Trust instructed an internal investigation into the death of the deceased and the other person "to determine if any lessons are to be learned from these incidents that should affect the future care of patients in St John's Hospital". The result of that investigation in relation to the deceased is to be found in a document described as "Critical Incident Report" (6/9 of the appendix). Unfortunately that document is not dated, but it appears that it was likely to have been completed towards the end of 2004 or, at the latest, the beginning of 2005. The report sets out the history of the medical care provided to the deceased. It is noted that he was known to have had progressive swallowing problems for at least five months prior to his admission to hospital. They key findings, in this report, relating to the deceased's case were as follows:

"(1) Mr Emms' assessment and the decision to insert a PEG tube followed existing guidelines of care for patients with dysphagia (difficulty swallowing).

(2) This decision was discussed with his family and the principles set out in the Adults with Incapacity (Scotland) Act 2000 (AWIA) were followed. However the appropriate documentation was not completed. This did not affect the clinical treatment received by Mr Emms.

(3) The insertion of the tube was technically successful. Difficulty was encountered with the connection between the PEG and the bag containing the feed, but this was readily addressed.

(4) The documentation of Mr Emms' care was incomplete at weekends when ward staff were under most pressure.

(5) The prescription of his insulin was complicated by the use of different prescribing regimes at different times. This may have contributed to Mr Emms not receiving insulin on 4th September, although his blood sugar was continuously monitored and was not excessively high."

Under a section headed "Background" it is noted that "PEG feeding is a common procedure in patients who develop swallowing difficulties where there are problems that prevent the use of a naso-gastric tube. In the case of Mr Emms, he repeatedly removed the naso-gastric tube inserted on 28 August. In St John's Hospital 32 PEG tubes were inserted during 2004. There is a recognised 30 day mortality rate associated with the procedure of 20%. The mortality rate at St John's is 22%".

[7] The procurator fiscal, having considered the terms of Professor Busuttil's reports, and the report just referred to, reached the view that it appeared that any concerns about the PEG were not well-founded. He did however indicate to the reclaimer's then solicitor that he was prepared to instruct a report by an independent expert, not associated with Lothian National Health Service, to consider the circumstances of the deceased's death. He invited the deceased's family to nominate any such expert if they so wished. There was then a change of solicitors to those who presently represent the reclaimer. On 6 October 2005 the procurator fiscal wrote to the reclaimer's now solicitors (6/13 of the appendix) in the following terms:

"I refer to previous correspondence and note that I have not yet heard from you regarding the question of an expert witness in this case.

You may be aware from your clients that, on the advice I had received from consultants at St John's Hospital and information from the pathologist, I had no particular concerns as to the procedures carried out at St John's Hospital prior to George Emms' death. I did, however, agree that I would contact an independent expert to ensure that the family's concerns were addressed by a person not associated with Lothian NHS.

Following the discussion with the hospital's medical managers, I am aware that there are concerns at St John's at the length of time this investigation has taken and the fact that the matter is still 'hanging over' the medical team involved there (in their view unnecessarily).

In these circumstances, if I do not hear from you by the end of October it would be my intention to report this death to Crown Office on the basis of the knowledge I have to hand with a view to closing my investigation."

The reply to that letter (6/14 of the appendix) from the reclaimer's solicitors was in the following terms:

"We are still having difficulty with the Legal Aid Board, although that is not a direct concern of yours.

The expert whom you wish to instruct is of course entirely a matter for you.

In so far as you consider it necessary, our clients have no objection.

In more detail we will be raising with you the question of a fatal accident inquiry and look forward to hearing from you confirming that such an inquiry will be held."

The reference to the Legal Aid Board is a reference to an application made on behalf of the reclaimer to pursue a claim of negligence. This was the first time, it seems, at least as far as written correspondence discloses, that the possibility of a fatal accident inquiry was raised in relation to the circumstances of the deceased's death. Faced with the terms of that letter, the procurator fiscal replied in a letter dated 9 November 2005 (6/15 of the appendix) in the following terms:

"I refer to previous correspondence and write to advise you that I have reviewed my investigation into the circumstances of the death of George Emms.

As you are aware it was agreed with Messrs Balfour & Manson (petitioner's previous solicitors) that a particular expert opinion would be sought. Since that agreement took place I have received the critical care review from St John's Hospital and also had an opportunity of fully discussing this matter with the pathologist who carried out the post mortem examination. From that review and from the discussions with the pathologist I am convinced that the PEG procedure was essential and that it was carried out appropriately in this case.

In these circumstances I do not now feel it appropriate to seek an expert opinion.

If you have been able to obtain legal aid to act on behalf of Mrs Emms I would be more than happy to forward to you relevant documentation."

On 22 November 2005 the reclaimer's agents wrote to the procurator fiscal (6/16 of the appendix) advising "the legal aid position has now been sorted out and we have legal advice and assistance". The writer then made certain requests about the production of certain documents to them. In conclusion he wrote: "I meanwhile refer to the last paragraph of our letter of 17 October 2005 and look forward to hearing from you that a fatal accident inquiry will be held." The procurator fiscal responded in a letter dated 25 November 2005 (6/17 in the appendix) in which he said:

"In the light of information contained in the critical incident report, and further discussion with Professor Busuttil, Dr Williams and others which led to Professor Busuttil's letter of 11 January, I do not feel it is appropriate to hold a fatal accident inquiry into the circumstances of Mr Emms' death".

On 9 February 2006 the reclaimer's solicitors wrote (6/18 of the appendix) to the procurator fiscal *inter alia* saying:

"I also note the conclusion that you do not regard this case as appropriate to hold a fatal accident inquiry. Please specify more detailed reasons for that conclusion. It is also our position that an inquiry should be held into the circumstances of the death of Mr Emms. He was under the care of the NHS and we consider that the Lord Advocate is obliged to hold an inquiry having regard to Article 2 of the European Convention of Human Rights."

That was the first reference to Article 2 of the ECHR that had been made in terms of correspondence between the parties' representatives before this Court. It should be noted, also, that up until this point the only specific concern that the reclaimer and family of the deceased had raised, was focused on the procedures relating to the insertion of the PEG. On 14 February 2006 the procurator fiscal wrote (6/19 of the appendix) to the reclaimer's solicitors in *inter alia* the following terms:

"There is little I can add to the contents of Professor Busuttil's letter of 11 January 2005 regarding the conversation I had with Professor Busuttil and enclose for your information a copy of letter received from Dr Williams which covers all the points that I discussed with him. Should you wish to establish the content of any conversation between Professor Busuttil and Dr Williams I would, of course, have no objection to you approaching either of those individuals.

Having examined the documentation obtained in the course of this inquiry, it does not appear to me to be in the public interest to hold a fatal accident inquiry into the circumstances of this death."

The reclaimer's solicitor, on 27 February 2006, in a letter to the procurator fiscal (6/20 of the appendix) having again asked "please advise us why you do not consider it in the public interest to hold a fatal accident inquiry", the procurator fiscal replied on 6 March 2006 (6/21 of the appendix) setting out again his reasons for considering that a fatal accident inquiry was not appropriate in the circumstances of the case.

[8] The reclaimer's solicitor, apparently, continued to press the procurator fiscal to instruct a fatal accident inquiry without giving any specific detail as to what it was that required such an inquiry to be instructed. On 15 May 2006 the procurator fiscal in a letter to the agents (6/24 of the appendix) specifically enquired "If, however, you are able to clarify in what respect you think there has been a breach of Article 2 of the European Convention of Human Rights, I would be more than happy to address the point further". That enquiry does not appear to have received a reply.

[9] In or about November 2006, there was intimation to the procurator fiscal of an application for legal aid on behalf of the reclaimer to bring proceedings for judicial review of the decision not to hold a fatal accident inquiry. That application was notified to the respondent. On 22 November 2006 a letter was sent on behalf of the Deputy Crown Agent to the reclaimer's solicitor advising them that:

"Further to your correspondence with the procurator fiscal in Linlithgow in relation to the above death, I write to advise you that Crown counsel have instructed that an independent expert's report be prepared in relation to the treatment provided to Mr Emms prior to his death.

I have today written to the Legal Aid Board to advise them of the position."

In a letter to the Scottish Legal Aid Board of the same date (6/35 of the appendix) advising of the decision to instruct an independent expert report, the Deputy Crown Agent informed the Board that:

"Once that expert report has been received, a final decision will be taken in relation to whether a fatal accident inquiry should be held.

In light of the ongoing investigation, it may be appropriate to delay reaching any decision in relation to the granting of legal aid for a petition for judicial review."

[10] The instructions to provide a further report were given to Dr David A Johnston, consultant gastroenterologist at Ninewells Hospital Dundee. In due course Dr Johnston produced a report (6/37 of the appendix). He commenced his report in the following terms:

"Further to your letter of 21 November 2006 I have prepared the report below. As requested in your letter I have focused on the appropriate care, clinical decision making, and professional actions carried out during the treatment of Mr Emms whilst in St John's Hospital. I have taken as evidence for my report the patient's case notes, the post-mortem report, and the statements available from the staff at St John's Hospital."

As will be seen from the terms of the report, read as a whole, it concentrated, to a significant extent, on the question of the insertion of the PEG into the patient and the procedures associated therewith. That was totally in line with the fact, as previously noted, that up until the time of his instructions to prepare a report the only specific concern that had been raised relating to the deceased's treatment was in relation to the PEG insertion. The conclusion of the report was "Overall, having reviewed the notes, I can find no problem with either the care given to Mr Emms, the clinical decision making or the professional action of PEG insertion." After receipt of that report the procurator fiscal wrote to the deceased's mother and brother (6/40 of the appendix) in the following terms:

"I understand that you were advised that the Crown was seeking an independent expert report into the circumstances of your son's death. A report has now been obtained and has been considered by Crown counsel. Taking account of all the circumstances including the expert report, Crown counsel have reached the view that the circumstances surrounding your son's death do not meet the appropriate criteria for a fatal accident inquiry and accordingly have decided that a fatal accident inquiry should not be held."

Noting that this decision would be disappointing to them, the procurator fiscal went on to say:

"I would welcome the opportunity to meet with you to discuss the terms of the expert report and explain the reasoning behind the decision not to hold a fatal accident inquiry."

It appears, from the papers before us, that a meeting did in fact take place, as proposed, between members of the deceased's family and the procurator fiscal on 22 June 2007 (see 36/38 of the appendix). The reclaimer and her family, however, apparently remained unhappy at the decision not to proceed with a fatal accident inquiry and the present petition for judicial review was brought.

[11] It should be noted that in Article 6.1 of the petition it is averred:

"The documentation referred to in the proceeding paragraphs gives rise to a substantial number of important and obvious unanswered questions that should be answered by a fatal accident inquiry or other inquiry that complies with the requirements of Article 2 ECHR, in respect of the circumstances that lead (*sic*) to the death of the late George Emms. These questions may be gathered into five chapters. Those chapters are: (i) the Decision to Insert a PEG; (ii) Informed Consent; (iii) Insertion of the PEG; and (iv) Post Insertion Materials (v) antibiotics".

As previously observed, prior to the raising of the judicial review proceedings the only specific concern which emerges from the materials before the Court which was brough to the attention of the respondent on behalf of the deceased's family was in relation to the PEG.

[12] Before this court Mr Bovey QC was, from the outset of his submissions, at pains to stress that the reclaimer's case was based on a possible systemic failure on the part of St John's Hospital employees which had caused or contributed to the deceased's death. Invited to specify the features on which the reclaimer now relied as demonstrating failures in any system, senior counsel stated that these were as follows:

"1. The failure of any specialist staff to attend during the weekend of 4/5 September 2004.

2. The absence of any demonstrable nursing on 4 September.

3. The failure of the hospital to develop procedures which would allow the deceased to overcome the limitations in his ability to express himself with a view to improving his situation; and

4. The failure, as a consequence of the foregoing, to take on the Friday, Saturday or Sunday, the steps initiated by expert staff on Monday 6th September including the administration of antibiotics;

5. The lack of any record to demonstrate what happened between 11 pm on Friday 3rd September and the expression of concern by relatives on the morning of Sunday 5th September."

These "features", senior counsel submitted, related to the issue of infection and might have contributed to the death of the deceased from infection. Having regard to the history of the matter which we have just set out the absence from those "features" of any reference to the PEG insertion and associated procedures is conspicuous and remarkable.

[13] The Lord Ordinary, in dismissing the petition, at paragraph 53 of her opinion stated:

"I am satisfied from the terms of the Article itself (Article 2 of the ECHR) and a reading of the authorities that the obligation to hold a public inquiry does not arise in every case where a person dies whilst under medical care."

That proposition was accepted as being correct by senior counsel for the reclaimer before this court. It is appropriate to set out, at this point, the relevant terms of Article 2. They are:

"1. Everyone's right to life should be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a Court following his conviction of a crime for which this penalty is provided by law."

At paragraph 55 of her opinion the Lord Ordinary referred to the following passages in the judgment of the Grand Chamber of the ECHR in *Calvelli* and *Siglio* (2002) ECHR 32967/96 at paras 48 to 49 where the court stated:

"...The first sentence of Article 2,...ranks as one of the most fundamental provisions in the Convention and also enshrines one of the most basic values of democratic societies making up the Council of Europe (references omitted). Those principles apply in the public health sphere too. The aforementioned positive obligations therefore require States to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of patients' lives. They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or in the private sector, can be determined and those responsible made accountable (references omitted)"

That statement, the Lord Ordinary, suggested:

"envisages the State taking a number of administrative measures as regards putting systems in place which have as their objective the provision of medical care that has the protection of patients' lives as their objective."

There are a number of such measures in Scotland and, indeed, in the United Kingdom, as a whole, and it was not suggested by the reclaimer that there was any general failure in that regard in this case. In a footnote to her opinion at this point the Lord Ordinary stated, under reference to authority:

"Where a State has made adequate provision for securing high professional standards among health professionals and the protection of patients' lives, it is liable to be very difficult to call it to account from the standpoint of the positive aspect of its Article 2 obligation where a patient dies even if due to matters which could be characterised as negligence." (references omitted)

Her Ladyship having recognised the nature of the substantive obligation arising under Article 2 in the field of medical negligence, then turned to consider the procedural obligation that has been held to arise therefrom in the following terms at para 58:

"It (Article 2) goes on and refers to the need for there to be an independent effective judicial system. Again it is not suggested that such a system is not available in this case".

Her Ladyship, nevertheless, remarked:

"It is important to note, rather, that the above narrative then indicates when it is that the system requires to be accessed and brought into play. That is in circumstances where there is a need for those responsible for the death to be made accountable. That can arise only in circumstances where there is a reasonable possibility that the death has been caused by an act or omission for which some person or persons ought, by means of such an inquiry, to be held to account."

At paragraph 59 of her judgment the Lord Ordinary, under reference to the case of *Silih* v *Slovenia* (2009) 49 E.H.R.R. 37 opined that:

"I take it from that that it means that the requirement to hold an effective public judicial inquiry into the death of a patient in medical care does not arise in the absence of at least some reasonable possibility of a person or persons responsible for the care of that patient being found in breach of duty".

Her Ladyship then referred to a passage in the decision in the case of *Banks* v *UK* (2007) 45 EHRR SE15, (which was a case involving a putative suicide in prison) at page 84 which is to the following effect:

"It is not however apparent that such an inquiry would be a means of identifying and bringing to account the perpetrator(s) of any unlawful violence where the police investigations and inquest have been unable to do so. There is, in the court's opinion, no general requirement under Article 2 of the Convention to provide a public inquiry into the general background to a suspicious death, where, as was the case in the current application, the ordinary mechanisms have provided for an adequate scrutiny of the incident itself."

Her Ladyship also made reference to the Court of Appeal decision in the case of *R (Takoushis)* v *Inner North London Coroner* (2006) 1 WLR 461 and a passage from the judgment of the Master of the Rolls at paragraph 85. Those authorities clearly established, the Lord Ordinary held, that it was not every case of death in a hospital that required a public inquiry such as a Fatal Accident Inquiry a proposition regularly accepted, as has been seen as being correct by the petitioner's counsel. On the hypothesis, however, that Article 2 procedural requirements had been triggered, in the instant case, the Lord Ordinary then addressed the ways in which the obligation to inquire may, if it arises, be discharged where a patient had died in hospital. Her response to that question was, at para 65 of her opinion, that:

"It seems clear that performance of the Article 2 obligation need not involve a public judicial inquiry. The adoption of other forms of procedure may suffice. In particular the availability of civil litigation may be enough."

She noted that in the case of *Powell* v *United Kingdom* (2000) 30 E.H.R.R. CD 362 the European Court had stated that where the parents of a deceased child had settled civil litigation in relation to the death of that child they had:

"...by withdrawing their appeal, ...closed one of the options which may have uncovered the extent of the lack of coordination among the doctors concerned at the relevant time. Of greater significance for the court is the fact that the applicants settled their civil action in negligence against the doctors. In the court's opinion, the applicants by their decision closed another and crucially important avenue for shedding light on the extent of the doctors responsibility for their son's death. Had the civil action proceeded the applicants would have been entitled to a full adversarial hearing on their allegations of negligence, to subject the doctors concerned to cross-examination under oath and obtain discovery of all documents relevant to their claim...Having regard to the above considerations the court finds that it is not open to the applicants to complain under Article 2 of the Convention that there was no effective investigation into their son's death..."

Referring to other cases including *Cavelli supra* her Ladyship, at para 67 of her opinion, concluded:

"Thus, it seems to me that the clear current view is that it is liable to be fatal to a claim of breach of Article 2 in circumstances such as those of the present case that the claimant has either not made use of a civil litigation avenue that is available to him or has used it but settled his claim out of court. The petitioner here has chosen not to go down the civil litigation route."

The Lord Ordinary noted, however, that the reclaimer's argument was that she should not be regarded as someone in the same position as a person who had failed to make use of civil litigation when it was available. What was contended on her behalf was that she could not properly commence civil litigation because "She has no basis upon which to allege negligence on the part of any person responsible for the deceased's care."

In that situation, however, she was calling upon the State to afford her an inquiry of the sort she desiderated. The Lord Ordinary remarked that the problem with that approach was that it sought to place a greater burden on the State in a case where it was frankly accepted that there is no arguable case of negligence than where there is such a case. What the reclaimer was, it seemed, seeking to rely upon was some general public interest. The purpose of Article 2 was not, however, to be held to oblige States to investigate and inquire into all matters relating to a death in which the public may have an interest. Moreover, the Lord Ordinary noted that no claim for a violation of Article 2 arose unless the claimant could show that he or she was a "victim" of the alleged breach of the Article. There was a problem here for the reclaimer because any aspect of public interest justifying an inquiry was, as yet, unidentified despite certain references made by the reclaimer's counsel to the deceased's medical notes and the possibility of a need for improvement in certain procedures. What was being sought was, in essence, an inquiry in the hope that something might emerge of concern which none of those who had examined the case thus far had noticed. For the foregoing reasons the petition was dismissed by the Lord Ordinary.

[14] In opening his submissions, on behalf of the reclaimer before this court, Mr Bovey emphasised that the error in the Lord Ordinary's approach had been that she had failed to appreciate properly that the petitioner was seeking to advance a "systemic" case. By that he said that what was meant was the inquiry sought was to address possible deficiencies in the system operated by the health authority at the hospital in question at the time of the deceased's death. The Lord Ordinary had decided the case against the reclaimer in part, at least, because of the reclaimer's failure to take up a negligence claim in the civil courts. But that was neither necessary nor appropriate where the reclaimer's interest was to allay concerns about systemic failures. In that respect reliance was placed on what Lord Bingham said in *Savage* v *South Essex NHS Trust* (2009) 1 AC at para 69:

"In the first place, the duty to protect the lives of patients requires health authorities to ensure that the hospitals for which they are responsible employ competent staff and that they are trained to a high professional standard. In addition, the authorities must ensure that the hospitals adopt systems of work which will protect the lives of patients. Failure to perform these general obligations may result in a violation of Article 2."

When asked by the court, however, if the reclaimer was able to suggest the precise basis whereby the death of the deceased had been caused, to any extent, by any systemic breach by the health authority, he said he could not do so and there are no relevant averments in the petition to that effect. Senior counsel went on to submit that the Lord Ordinary had adopted, wrongly, it was said, what was described as a "remedy based approach" which was understood to mean that because there was a possible remedy in civil law open to the reclaimer, which she had not pursued, she was therefore precluded from seeking any other method of inquiry into the circumstances of the deceased's death. It was accepted, however, by senior counsel for the reclaimer that the Lord Ordinary was justified in saying, as she did, at para 53 of her opinion:

"I am satisfied from the terms of the Article itself and a reading of the authorities that the obligation to hold a public inquiry does not arise in every case where a person dies whilst under medical care nor will the satisfaction of the obligation necessarily require there to be a judicial inquiry."

[15] The reclaimer relies in her case, it was said, to some extent on the absence of nursing notes for 4 September 2004 relating to the deceased. When further pressed by this court to spell out what were the systemic failures relied upon by the reclaimer senior counsel set out the items referred to at para 12 above. As previously noted these features, it was submitted, related to "the issue of infection" and may have contributed to the death of the deceased from infection. Moreover we repeat that it is noteworthy that nowhere in that list of matters is the use of the PEG as part of the procedures adopted in addressing the deceased's condition.

[16] In developing his submissions in this respect, senior counsel for the reclaimer reminded the court that the PEG was inserted on 1 September 2004. The medical records relating to the deceased which had been recovered, and which were before the court, indicated that on 2 and 3 September the deceased's condition

was, as senior counsel put it, "authoritatively" reviewed by medical staff. He then, however, went on to contend that there was no such authoritative review thereafter of the deceased until 6 September. He, thereby, painted a picture almost of the deceased being left, unattended, by medical and nursing staff for two or three days. Any proper consideration, however, of the detailed medical notes, as was in due course carried out by senior counsel for the respondents, would have demonstrated that that was factually totally inaccurate and senior counsel for the reclaimer had subsequently to accept this was so and to apologise to the court. We will return to this matter in due course, but suffice it to say that this misunderstanding of the true position under which senior counsel for the reclaimer appeared to labour had, it seemed to us, led him to seek to advance a case for which there was simply no support in the relevant medical records. Once he accepted that the reclaimer's case to that extent was fatally undermined. To a large extent this case it seemed had been built up on the basis of the absence of a nursing note or nursing notes for 4 September from which certain inferences were suggested, which a full and careful reading of the medical records did not justify. Another remarkable feature of the position, advanced by counsel for the reclaimer, was that it was said that he could not point under reference to any material, apart from his own contention, to any of these alleged systemic failures having caused or contributed to the deceased's death. They had not been raised with Dr Johnston who had said that the nursing care was satisfactory. Senior counsel for the reclaimer asked how it could be that Dr Johnston said that when there were no nursing notes for 4 September. It was sufficient, it was submitted, for the reclaimer to raise the possibility of a causal link between these matters and the deceased's death due to the proximity in time between them and the death itself. These remaining concerns justified the holding of a further and fuller inquiry into the deceased's death, the requirements of which would be met by a fatal accident inquiry. The inquiries, to date, into the deceased's death were inadequate because they were neither independent nor public. Under reference to various decisions of the House of Lords, the Supreme Court and the European Court of Human Rights, which were concerned with the suicides of persons in custody, or detained as mental patients, or the deaths of soldiers when on active service, senior counsel for the reclaimer contended that there were sufficient parallels to be drawn between the present case and those cases, where a public inquiry to fulfil the requirements of Article 2 was considered necessary. The deceased had been a vulnerable person in the care and control of the health authority in question. The Lord Advocate, or those acting on her behalf, when asked to hold a fatal accident inquiry should have considered whether or not there was an arguable case for holding one and she should have concluded that there was. Having regard to the authorities, all that was required was that there was a possibility of a violation of the Article 2 substantive obligation to preserve life, to trigger the need for the kind of inquiry that the reclaimer sought. Reference was made to the recent decision of the Supreme Court in the case of *Smith* v *Secretary of State for Defence* (2010) UK SC 29 in which a particular form of public inquiry was considered necessary into the death of a young soldier who died in active service. It should be noted that in that case, as Lady Hale put it, at paragraph 137, the Supreme Court were of the view that:

"We already know enough to raise the serious possibility that the UK may in some way have been in breach of its obligation under Article 2. So the scope of the inquiry must be wide enough to look into this..."

[17] It is worthwhile noting also, at this stage, how Lord Mance expressed himself in his judgment at para 210 where he said:

"Certain categories of case in which the substantive right contained in Article 2 has been held to be potentially engaged with the result that the procedural obligation has been held to exist are clearly recognised."

His Lordship then went on to set out the categories of case to which he had just referred. They were as follows:

1. Killing by State agents

2. Death in custody.

3. Conscripts.

4. Mental health detainees.

5. Other situations where the State has a positive substantive obligation to take steps to safe guard life.

As Lord Mance observed at para 211:

"The procedural obligation incumbent on the state to investigate deaths which, either of their inherent nature or in their particular circumstances, involve the state's potential responsibility under Article 2 may be distinguished from the general substantive obligation under Article 2 to establish an appropriate regulatory, investigatory and judicial system."

[18] Senior counsel, under reference to Professor Busuttil's report (6/5 of the appendix), somewhat remarkably, in our opinion, submitted that the finding that the deceased died of infection and diabetes complications gave rise to the possibility of the State having violated the substantive Article 2 obligation. That was compounded, it was said, by the apparent lack of care provided to the deceased over the weekend 4/5 September - an assertion, as already noted, the pursuer's counsel had to depart from in due course. Those contentions were fortified from time to time by oblique and general references to the position of persons like the deceased not being able to communicate as easily as others about their concerns and requirements. But these references, in our judgment, were never formulated in such a way as to amount to fact based allegations of systemic failure which could have been causative of death. Senior counsel pointed out that Dr Johnston made no reference in his report to the Critical Incident Report nor the absence of nursing notes for 4 September. His report was, accordingly, it was said, unsatisfactory and incomplete. Nevertheless senior counsel accepted that he had no material available to him which would form the basis of any criticism of the findings which Dr Johnston did in fact make. The complaint was rather that he did not, apparently, have the fullest information regarding the deceased.

[19] Senior counsel then turned to address the question as to whether, in the circumstances, what had been done in the present case with regard to investigation satisfied any obligation on the State to investigate the death of the deceased. In that respect it was contended that Dr Johnston's inquiry into the deceased's death was deficient because it had insufficient participation from the family of the deceased and lacked the sufficient degree of public scrutiny. The Critical Incident Report was deficient because it did not appear to be independent. The post-mortem examination carried out by Professor Busuttil was said not to be "effective" and did not involve participation by the family of the deceased.

[20] The case of *Kennedy* v *The Lord Advocate* 2008 SLT 195 was cited. In that case the daughter and widow of persons who had died following infection with hepatitis C during the course of receiving blood products and blood transfusions brought petitions for judicial review of the refusal by the Lord Advocate to hold a fatal accident inquiry into the deaths. The context in which the petitions were brought has to be noted. It was this. At paragraph 8 of his opinion as the Lord Ordinary noted:

"it is a matter of public record that over a period of years from around 1980 a large number of individuals, who had been under the medical care of and receiving treatment from the National Health Service in Scotland, received blood transfusions, blood products and tissue transfer, which infected them with the hepatitis C virus. Over 4000 individuals were infected."

He then continued at para 9:

"It is also a matter of agreement that the circumstances in which those individuals came to be infected with hepatitis C virus, the consequences of their infection and the National Health Service's handling of the public health issues involved have given rise to public concern, including continuing calls in the Westminster Parliament, in the Scottish Parliament and in the media for the holding of a public inquiry in Scotland."

The Lord Ordinary held that the Lord Advocate's decision not to hold a fatal accident inquiry involved a breach of the procedural obligation under Article 2. He did so because (a) there were reasonable grounds for

taking the view that the deaths might have resulted from wrongful acts on the part of those responsible for providing the relevant supplies of blood, (b) that while the jurisprudence of the European Court of Human Rights did not require a State to initiate an investigation into every case in which an individual had died, after having been treated and cared for in hospital, a State did however require to put in place a system that provided for the practical and effective investigation of the facts of such a death and the determination of civil liability and (c) that any investigation carried out in the instant case, and relied upon by the Lord Advocate, did not constitute an effective investigation of the facts relating to the deaths. In the absence of the holding of such an inquiry or other form of independent public inquiry initiated by the Lord Advocate there were no options available to the petitioners which offered any realistic prospects of an effective investigation of the full facts relating to the deceased's or the holding to account those responsible or of a determination of civil liability. The reasoning of the Lord Ordinary in that case in requiring a fatal accident inquiry, or other equivalent public inquiry, to be held, it was submitted, should be applied to the present case. In particular his Lordship's dismissal of the adequacy of civil litigation as meeting the requirement of an effective investigation was relevant. In the present case the petitioner was raising a question over the system that had been in place at the hospital at the time of the deceased's death where, perhaps, there was no-one to be found liable and negligent. She simply did not know if that was the case or not. The practical obstacles in the way of bringing an action of negligence as recognised by the Lord Ordinary at paragraph 105 of his opinion in *Kennedy* also arose in the present case.

[21] In reply senior counsel for the respondent drew the court's attention to the nature of the decision which was the subject of attack in the present case, and under reference to the case of *Bloggs* (2003) 1 WLR 2724 and the dicta of Auld LJ at para 63, it was submitted some deference may be required to be given by the court towards such a decision. As Lord Walker had said in *Pro Life Alliance* (2003) 2 WLR 1403 at para 139:

"The court's task is not to substitute its own view for those of the (decision maker) but to review their decision with an intensity appropriate to all the circumstances of the case."

Senior counsel for the respondent reminded us of the established systems, in Scotland, for the investigation of deaths. He referred to the provisions of section 24 of the Registration of Births, Deaths, Marriages (Scotland) 1965 and the Registration of Births, Still Births, Death and Marriages (Prescription of Forms) (Scotland) Regulations 1965 SI No 1839 which provide for the notification of causes of death by registered medical practitioners. In addition there is the long established role of the procurator fiscal acting on behalf of the Lord Advocate of investigating sudden deaths and the circumstances surrounding these. The procurator fiscal's functions are, to some extent, similar to those of the coroner in England and Wales but there are important material distinctions of function and powers. In *Bell's Dictionary and Digest of the Law of Scotland* 7th Edition 1890 under the heading "Procurator Fiscal" appears the following:

"...It is the duty of the sheriff and his procurator fiscal in cases where there is reason to suggest that any individual has met his death by violence, or from other than natural causes immediately to have the body examined by medical men and to take a precognition regarding the circumstances of the case."

This was the practice at common law. In *Carmichael "Sudden Death and Fatal Accident Inquiries"* (3rd Edition), the writer, after having noted the legislative measures which were subsequently enacted commencing with the Fatal Accidents Inquiry (Scotland) Act 1895 and culminating in the Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976 states at para 1-07:

"The present position is, therefore, that the procurator fiscal, appointed by and responsible to, the Lord Advocate has a right and duty at common law to inquire into certain cases of death, violent, unnatural, suspicious or unexplained. He does so in the public interest. The purposes of such inquiry are at least to minimise, but of course, preferably and as far as possible to eliminate, the risk that homicide and other crimes should go undetected, and secondly, to expose and eradicate dangers to life and the health and safety of the public, to allay, when necessary, public anxiety, to assist in the maintenance of accurate statistics, and where, appropriate and relevant, to secure and preserve evidence."

That statement of the position reflects the provisions of section 1(1) of the 1976 Act. By section 1(1)(b) the Lord Advocate is required to exercise a judgment as to whether the case of any death makes it expedient in the public interest to have a fatal accident inquiry under the Act. To enable the Lord Advocate to execute such a judgment she has, obviously, to be provided with relevant information that would at least raise the possibility that the cause of the death is such as to give rise to some public concern. The gathering of any such material may come about by virtue of the death being reported to the procurator fiscal and his carrying out an investigation in respect thereof. In the present case the death of the deceased, it seems, was reported immediately by the hospital to the procurator fiscal who, in turn, immediately instructed a post-mortem examination to be carried out by an independent medical expert in the shape of Professor Busuttil. The procurator fiscal also requested and obtained a report from the deceased's treating physician. As previously noted the treating physician attended a meeting with Professor Busuttil to explain certain matters to him. That resulted in the suggestion by Professor Busuttil that an expert should be consulted in relation to the PEG insertion (which was the apparent area of concern of the relatives at that time). The Hospital Trust itself carried out a further inquiry which resulted in the Critical Incident Report. It was submitted by senior counsel for the respondent that it required to be noted that the PEG procedure, as was made clear in the critical incident report and in Dr Johnston's report**,** was not risk free. The mortality rate was referred to in the Critical Incident Review. Dr Johnston in his report states:

"Unfortunately the patient developed a recognised complication (peritonitis) of PEG tube insertion which can occur in up to 1% of cases. When it does occur it has a significant mortality which unfortunately has been the outcome in this case."

Senior counsel took the court over the medical notes relating to the deceased (6/4 of the appendix). While it was true that there were no nursing notes relating to 4 September, and that had been explained as due to pressure of work at that time, the medical notes, it was submitted, clearly demonstrated, contrary to what was suggested by senior counsel for the reclaimer, that throughout the period the deceased was being treated in hospital, in particular over the period of 3 to 6 September, he was being regularly examined and assessed and being treated by both medical and nursing staff. Vital signs were checked and there was taking of samples. There was administration of antibiotics. There did appear to have been a failure to adjust the insulin to be taken by the deceased over the weekend of 3 September, but the level of his blood sugars would not appear to have contributed to his death. This all, it was submitted, presented a picture very different from that sought to be painted on behalf of the reclaimer of the deceased being left virtually unattended and uncared for over the weekend in question. There was no indication given to the medical staff or nursing staff over the period of any deterioration of the deceased's condition such as to cause alarm and to require immediate action which was not taken.

[22] Against that background, senior counsel for the respondent submitted that there was in place a system of investigation which was available for the purposes of investigating any possible breach of the State's obligation under Article 2 of the Convention in connection with the deceased's death. In the case of a death in hospital there existed a range of possibilities; the carrying out of a post-mortem investigation instructed by the procurator fiscal, disciplinary procedures, the instruction of reports from independent experts, prosecutions in cases where criminal conduct was involved and fatal accident inquiries. There were also available, in our system, independent courts where claims for negligence resulting in death in hospital could be brought. What was appropriate, if anything, by way of inquiry, in any particular case depended on the facts and circumstances of the case in question. All of this was summed up recently by the European Court of Human Rights in the case of *Silih* v *Slovenia* (2009) 49 EHRR 37 at paras 155 and 156 where the following is stated:

"In the sphere of medical negligence, the procedural obligation under Art 2 has been interpreted by the court as imposing an obligation on the state to set up an effective judicial system for establishing both the cause of death of an individual under the care and responsibility of health professionals and any responsibility on the part of the latter.

The court observes that the procedural obligation has not been considered dependent on whether the State is ultimately found to be responsible for the death. Where the intentional taking of life is alleged, the mere fact that the authorities are informed that the death has taken place gives rise *ipso facto* to an obligation under Art. 2 to carry out an effective official investigation. In cases where the death was caused unintentionally and in which the procedural obligation is applicable, this obligation may come into play upon the institution of proceedings by the deceased's relatives."

There was however, it was submitted, a prior question and that was whether any obligation on the State to investigate went beyond what was done in this case. The petitioner, it was submitted, had placed before the court nothing to suggest that the State had failed in its substantive responsibilities under Article 2. As had been pointed out by the House of Lords in *R (Middleton)* v *West Somerset Coroner* (2004) 2 AC 182 at paras 2 and 3:

"2. The European Court of Human Rights has repeatedly interpreted Article 2 of the European Convention as imposing on member states substantive obligations not to take life without justification and also to establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life... (citations omitted)

3. The European Court has also interpreted Article 2 as imposing on member states a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or other of the foregoing substantive obligations has been, or may have been, violated and it appears that agents of the State are, or may be, in some way implicated."

The fact of the deceased's death in hospital did not, *per se*, amount to circumstances in which it appeared that one or other of the foregoing substantive obligations had been or may have been violated and it appeared that agents of the State were or might have been in some way implicated. Moreover there was no inference to be drawn from the fact of a death in hospital that something had gone wrong in the sense of there having been a breach of Article 2 obligations. The position may be quite different in cases involving, for example, prisoners who are found dead in their prison cells where they have apparently committed suicide. As had been accepted by the petitioner's counsel it was not the position that every death in hospital required a public inquiry of the kind desiderated by the petitioner. In the case of *Savage* v *South Essex Partnership NHS Foundation Trust* (2009) 1 AC 681, Lord Scott at paragraph 8 under reference to *Powell* cited *supra* said:

"Powell's case was a case of alleged medical negligence in which a young boy had died in a National Health Hospital. His parents said that his death had been caused by the negligence of the hospital and that therefore it must be considered that there was a breach of the State's obligation to protect life. The Strasbourg Court rejected that conclusion, at page 364:

"It cannot accept that matters such as error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life".

Powell's case, therefore, is authority for the proposition that, in the context of care of patients in hospitals, something more will be required to establish a breach of the Article 2(1) positive obligation to protect life than, simply, a failure on the part of the hospital to meet the standard of care of the patient required by the common law duty of care".

[23] In the present case, at the highest, what was apparently relied upon was potential negligence involving a systemic failure in the treatment of the deceased. But there was complete absence of identification as to what these alleged failures were which were said to be causative of death. All that was done by the petitioner was to raise a number of questions in relation to the treatment of the deceased. In *Savage*, which was a case involving an attempted suicide by a mental patient while in hospital, the distinction between death arising from systemic failures and those arising from personal negligence was discussed by Lord Rodger at

paragraphs 69 to 71. Reference was also made, in this connection, to the judgment of Richard J, as he then was, in *R (Goodson)* v *Bedfordshire and Luton Coroner* (2006) 1 WLR 432 and *R (Takoushis)* v *Inner North London Coroner* (2006) 1 WLR 461. In the present case the death had been found to have been caused by a complication arising from a proper and recognised procedure in circumstances where the deceased had been suffering from a number of serious conditions. There was no material available to the court which challenged that finding. If any remedy was available to the reclaimer it lay in a claim of negligence if she could obtain the evidence to support that. Simply, however, to raise the possibility of systemic failures was not good enough. That case appeared to be based on a single sentence in the reclaimer's pleadings in the petition. The questions raised by senior counsel for the reclaimer in submission did not in themselves identify any systemic failures. The various specific issues raised in the pleadings in the petition at pages 17 to 31 provided no proper basis for seeking the kind of inquiry she did. The decision to insert a PEG was consented to on the deceased's behalf and there was now really no suggestion that it should not have been done. As regards the actual insertion of the PEG the averments do not even suggest a causal connection between the way in which the PEG was inserted and death, far less a systemic failure in that respect. Some play had been made of the absence of nursing notes for part of the last weekend of the deceased's life but, quite apart from the fact that no causal connection between whatever that was said to demonstrate and the deceased's death had been suggested, a careful perusal of the medical records showed that nursing care was being administered throughout, though not necessarily recorded in appropriate places. Questions were raised about the appropriate administration of drugs, but again examination of the medical records show that that was attended to, and in any event, no causal connection was made out, far less any systemic failure in that respect. Something was made of the possibility that infection could have developed in the deceased prior to when it was first detected and treated but the records showed no symptoms of infection, such as fever, until the evening of Sunday 5 September. No mention was made in the pleadings of the matters which were advanced by senior counsel as being suggestive of possible problems arising from the deceased's learning disabilities which caused or materially contributed to his death. The remarks made by senior counsel for the reclaimer in that respect were no more than broad suggestions which were left completely in the air.

[24] Senior counsel for the respondent then sought to address points, which in the submissions of counsel for the reclaimer were said to form the basis of an alleged systemic failure on the part of the hospital. The first of these was an alleged failure of any specialist staff to attend the deceased on the weekend of 4 September. That was not borne out by the medical records but, in any event, if it could be made out and could be shown to have caused or contributed to the deceased's death that would simply be indicative of possible negligence. The second factor was lack of nursing on 4 September. This matter was now shown to be factually untrue. The third factor, namely failure on the part of the hospital to develop procedures which would allow the deceased to overcome the limitations in his ability to express himself with a view to improving his situation was based on pure speculation and again nothing was said about how any such failure had contributed to or caused the death. The fourth factor relied upon was that as a consequence of the foregoing factors there was a failure over the weekend of 4 September by expert staff to take the steps which were carried out on 6 September which included the administration of antibiotics. This appeared to raise either a matter of clinical judgment regarding treatment or at worst a one-off piece of personal negligence. No suggestion was given as to the indicators that should have required the treatment given on 6 September given prior to that time. The last factor relied upon was said to be the lack of any record to demonstrate what had happened between 11 pm on Friday 3 September and expressions of concern by relatives on the morning of Sunday 5 September. This was again factually untrue as the medical records demonstrated.

[25] The reclaimer, in the present case, had simply failed to present any material which began to point to systemic failure on the part of the hospital, never mind one which had occasioned the deceased's death. In that respect the circumstances of the case were clearly distinguishable from the position in the case of *Kennedy*.

[26] In any event, even if the court were to reach the conclusion that there were circumstances in the present case which desiderated an inquiry under the procedural requirements of Article 2, what was done in the present case was clearly sufficient in the circumstances. The authorities were clear that there was no single

"off the shelf" model which required to be used in every case when an obligation to investigate arose. In *R (L)* at paragraph 78 Lord Rodger had observed that the principal hallmark of an Article 2 compliant inquiry is that it is "effective" and independent. He then continued however:

"But, beyond that, what matters is that the investigator should take all reasonable steps to secure the evidence concerning the incident and to find out, if possible, what happened and what, if anything, went wrong. The steps which the investigator needs to take to fulfil these requirements will inevitably depend on the circumstances of the particular case. There neither is, nor can be, any single off-the-peg model which is suitable for use in all cases."

In the present case, the matter was considered and investigated by the procurator fiscal, the pathologist Professor Busuttil and by Dr Johnston - these persons were all independent of the hospital authority. The reclaimer and her representatives were given access to all the relevant papers. She was invited to choose the independent specialist expert who was to be instructed to review the case - an offer she did not take up. There was nothing to suggest that any further investigation was required which would have been any more effective than what was done in the circumstances of this case. For all the foregoing reasons it was submitted that the Lord Ordinary had been correct in dismissing the petition and the reclaiming motion should be refused.

Decision

[27] In *Savage* at para 10, Lord Scott said:

"Every patient who enters hospital knows that he or she may be at risk of medical error. We know that these things happen. Sometimes the error constitutes medical negligence, sometimes it does not. *Powell's* case...shows that provided that there is no serious systemic fault and provided, in the event of death, that there is a proper investigation of the causes, a negligent medical error will not necessarily be enough to constitute a breach of the Article 2(1) positive obligation. The case would, in my opinion, be no different if the patient who had died were an inmate in a prison hospital or a mentally ill patient who had been sectioned under section 3 and transferred to the hospital wing of the mental hospital on account of some medical condition. If, however, the conditions in the prison hospital or the hospital wing had been markedly inferior to those in an ordinary hospital and had contributed to the patient's death, the Article 2(1) positive obligation might well be engaged."

Medical staff in the hospitals of this country have as their primary aim the proper care of patients so that their health may improve. They are not in the business of killing people. Sometimes things go wrong, as Lord Scott observed, because hospitals are institutions staffed by human beings, however well trained and competent the staff may be. If such mistakes are made, the person, or persons, responsible may be sued in a civil litigation. But such occurrences, however understandably distressing they may be to the relatives of the persons who die as a result, do not raise questions of public concern unless something has apparently gone quite seriously wrong, which is indicative of not just a one-off situation, or a single example of error of judgment, or carelessness, but is of such a nature that gives concern that the system and procedures in operation at the hospital were so deficient that there may have been a number of deaths attributable to them or, that if these deficiencies are not addressed, there may be more deaths in the future. Such situations do arise but they are mercifully rare. When they do arise they no doubt engage the procedural requirement under Article 2 in all its vigour but, as senior counsel for the petitioner accepted, not every death in a hospital engages Article 2. How then does one identify such a case? Clearly simply to assert that a death in hospital has occurred through a systemic failure or failures on the part of those responsible for the system can never be enough. What the authorities reveal, in our judgment, is that persons seeking to assert that Article 2 has been engaged in the field of medical care have to provide material which shows that there is "a serious possibility" that a serious systemic failure has arisen which has caused, or contributed to, the death or deaths in question. While it is, no doubt, understandable that relatives and friends of deceased persons will be anxious to know why their loved one has died while in hospital, that anxiety must be converted into, at the very least, a reasonable suspicion, or belief, based normally on some kind of relevant evidence, that

something has seriously gone wrong for which the State is responsible and which may have caused or contributed to the deceased's death, before Article 2 is engaged. The authorities have also made it clear, on several occasions, that where the circumstances that are known demonstrate that the death may have been caused by medical negligence any obligation as to inquiry may be met by the availability of a civil litigation raised by the relatives of the deceased in the ordinary courts (see *Calvelli* and *Powell* cited *supra*). These two features are drawn together by Richard J (as he then was) in the *Goodson* case cited *supra*, at para 63, where he stated:

"On the material before the coroner and before this court, there was no question of any actual or possible breach of the State's positive obligation under Article 2. There was at most a possibility of simple negligence which even if established would not amount to a breach of Article 2."

On the second point his Lordship at paragraph 59(iv) said:

"...The Strasbourg cases on death resulting from alleged medical negligence show that, if the procedural obligation does apply, the range of remedies available under the judicial system (criminal, civil and possibly disciplinary) can be sufficient to discharge it."

As regards the first feature, the position in the present case can be quite shortly stated. Nothing, in our judgment, emerges from the pleadings in this case, or the supporting material, which goes anywhere near persuading us that there were or are grounds for genuine concern about the circumstances surrounding the deceased's death. As already noted the initial concern on behalf of the deceased's family focused entirely on the use of the PEG procedure and the way it had been carried out, but this has been departed from. In submission before us no reference was made to any evidence that could form the basis of serious concern that something had gone wrong in the treatment of the deceased attributable to more than personal negligence and which caused or materially contributed to his death. If it were sufficient to demand and obtain a fatal accident inquiry into the death of a hospital patient simply on the basis of the kind of expression of concern as has been made in this case, without reference to a proper basis for these concerns then there would, in our judgment, be no acceptable limit to numbers of such inquiries. It was not suggested that our legal system is deficient in the range of types of investigation which are available to be instituted on the occasion of the death of a patient in the hospital. Senior counsel for the reclaimer appeared to accept the distinction required to be drawn between a case where there were genuinely held concerns that the death of a patient in hospital had arisen through something having gone seriously wrong in his care and treatment on the one hand, and on the other hand, cases where concerns are of a wider nature in the sense that there is some basis for believing that the death of a deceased may have arisen by virtue of a systemic failure in the procedures and treatment provided generally in the hospital in question. The latter kind clearly may raise general and genuine public concerns because of the fact that if these failures are not identified and addressed further deaths may follow. What type of inquiry, if any, is required in any particular case will depend on its facts and circumstances and into what category of case it falls - the individual piece of personal negligence type of case or the systemic failure type of case. But the starting point, in any event, is for the person seeking to invoke Article 2 to present material that is supportive of serious concern that there has been a breach of the substantive obligation under Article 2 (reference is made to the passage from the judgment of the House of Lords in *Middleton* cited *supra*). It goes without saying that in the present case there was no question of life having been taken deliberately nor is there anything before us to suggest that the deceased's death was caused by any recklessness on the part of persons for whom the State bears responsibility. We think in this connection that the dictum of Lord Rodger in *Savage* at para 45 is directly in point:

"A State is under an obligation to adopt appropriate (general) measures for protecting the lives of patients in hospitals. This will involve, for example, ensuring that competent staff are recruited, that high professional standards are maintained and that suitable systems of working are put in place. If the hospital authorities have performed these obligations, casual acts of negligence by members of staff will not give rise to a breach of Article 2."

Nothing in the material placed before this court raises the serious possibility of any breach of the obligation just described in the passage cited. Even if there had been material before us as to raise such a possibility of a breach of the substantive obligation under Article 2, we would have had no hesitation in considering that what has been done in this case amounted to an effective public independent investigation into the deceased's death. From very shortly after the death of the deceased there was commenced an independent investigatory process into the circumstances of the death. It was triggered by the procurator fiscal who is independent from the hospital authority. He instructed an independent post-mortem examination by Professor Busuttil who is not connected with the hospital in question. He obtained written reports from Professor Busuttil. Although those investigations did not, in our judgment, reveal any serious concern about failures of a systemic nature, nevertheless matters were not left there because, in due course, as has been seen, the procurator fiscal instructed a report from an independent specialist who had access to the deceased's medical records and who addressed, in particular, what appeared to be the area of concern of the deceased's relatives at that time. The procurator fiscal also had a report from the consultant physician in charge of the deceased's care at the time of his death. The Critical Incident Report from the hospital was also made available to the procurator fiscal. Cumulatively, all of that material, in our judgment, entitled the procurator fiscal, acting on behalf of the respondent, to come to the conclusion that the public interest requires no further investigation. The deceased's family were given the opportunity to have input into the selection of the person who reviewed the deceased's medical history but they did not take up that invitation. They were also informed that they could have complete access to all the relevant records. There has, of course been available to the petitioner the possibility of the bringing of a civil law claim of negligence if there were grounds for doing so. To date she has chosen not to.

[28] Those representing her simply made a demand for a fatal accident inquiry. They did so as if that arose as a matter of right, and without the need of presenting any of the kind of material that might suggest there was serious cause for concern of systemic failures in this case. In *Smith* Lord Philips at para 87, Lord Rodger at para 126 and Lady Hale at para 137 indicated that what triggered the need for a public inquiry was when there was material showing a real serious possibility that there had been a breach of Article 2. In the absence of any such material in the present case there is no doubt, in our view, that what was done by way of investigation was amply sufficient and effective in relation to the circumstances of the case and the decision not to instruct a fatal accident inquiry involved no breach of any obligation owed to the petitioner under Article 2. In *VO* v *France* (2005) EHRR 259 the European Court expressly held that if the alleged violation of Article 2 was not intentional then remedies including civil claims or disciplinary measures may be adequate to meet any obligation of investigation under Article 2. But even without such remedy being pursued, we are satisfied that the inquiry carried out in the present case in any event, is enough to satisfy the Article 2 obligation.

[29] For all the foregoing reasons the reclaiming motion falls to be refused. We should add this. We can well understand the deep concern and sorrow which the reclaimer and her family have felt had about the death of no doubt a beloved and valued member of their family. Nevertheless we cannot forebear to say that it is regrettable that the bringing of these proceedings has resulted in matters hanging over both the reclaimer and her family and also those persons involved in the care of the deceased for a very considerable period of time. The decision as to whether to hold a Fatal Accident Inquiry is one for the discretion of the Lord Advocate. A decision in that respect is not readily to be interfered with. Fatal accident inquiries are designed for particular situations where the public interest is engaged. They can be costly and lengthy. The situation in the present case is that since the court has not been provided with any good basis for thinking that there was some properly reasoned concern about the death of the deceased which was indicative of significant malfunction in the systems and procedures in place in the hospital at the time, there never was any proper basis for seeking to attack the decisions taken on behalf of the respondent in this case.