INQUIRY INTO THE DEATH OF MRS EILEEN PETERSON

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT LERWICK

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Inquiry into the circumstances of the death of Mrs Eileen Peterson

Determination

by

Sheriff Principal Sir Stephen S T Young Bt QC

Lerwick, 10th July 2006

The sheriff principal, having resumed consideration of the evidence and submissions thereon, determines as follows:-

1. The late Mrs Eileen Henrietta Peterson (date of birth 28 March 1920), latterly residing at Taing House, Seafield, Lerwick, died there on 9 March 2005 some time between about 10.30 pm and 11.20 pm.

2. The cause of Mrs Peterson's death was pneumonia.

Note

[1] At the outset of this note it may be of assistance to set out the terms of sub-section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 which prescribes the matters which should be the subject of the sheriff's determination following an inquiry such as this. The sub-section reads:

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.

It will be seen that in this case I have confined my determination to the matters referred to in sub-sections 6(1)(a) and (b).

[2] I have not thought it necessary or appropriate to make detailed findings in fact about the circumstances which led up to Mrs Peterson's death. The evidence has all been recorded and this and the documents which were referred to by the witnesses during the inquiry all speak for themselves. I am happy to record that, judging by their respective demeanours, I saw no reason to doubt the credibility or the reliability of any of these witnesses. Following Mrs Peterson's death Dr Donald Newnham MD, a consultant physician at Woodend Hospital, Aberdeen, prepared a report (no. 5 of process) in which he was critical of the treatment given to Mrs Peterson at the Gilbert Bain Hospital, Lerwick, and the decision to discharge her back to Taing House. He spoke to his report at the inquiry and I also heard evidence from Dr Kenneth Graham FRCP who was the consultant physician in charge of Mrs Peterson's care while she was a patient in the hospital. For present purposes I do not find it necessary to reach any conclusion on whether or not any of Dr Newnham's criticisms were justified. I will only say that I think that I think that I should have been very slow to prefer the evidence of Dr Newnham to that of Dr Graham who actually saw and examined Mrs Peterson and was familiar to an extent that Dr Newnham could not be with the arrangements that might be made for Mrs Peterson's care outwith the hospital at local establishments such as Taing House.

[3] Mrs Peterson was admitted to the Gilbert Bain Hospital in Lerwick at about 4.10 pm on 8 March 2005. She was discharged from the hospital and returned to Taing House at about 5.00 pm on 9 March 2005. In the course of the inquiry I heard evidence from Dr I M Lightbody FRCP who is a very experienced consultant physician in geriatric medicine at Perth Royal Infirmary. His uncontradicted evidence was to the effect that there was nothing that the staff of the hospital could have done to save Mrs Peterson's life following her admission to the hospital. It was not suggested that anything might have been done to save her life in the few hours that elapsed between her return to Taing House and her death.

[4] Mrs Peterson's son, Mr Michael Peterson, represented the family at the inquiry. He had evidently prepared for the inquiry with considerable care. He was called as a witness by the Crown and, after he had answered all the questions that were put to him by the procurator fiscal and the other parties' solicitors, I offered him an opportunity to give evidence about any other matters that he wished to raise about which he had not already spoken. In the event, he added nothing to his earlier evidence. Nor did he call any other witnesses to give evidence.

[5] At the conclusion of the evidence he presented extensive and detailed submissions which he had helpfully typed out and copied for the benefit of the court. But it has to be said that a very great deal of the content of these submissions consisted of matters, including references to documents and assertions of fact, which had not been spoken to during the evidence itself or were at odds with what the witnesses had actually said.

[6] In the course of his submissions he suggested, as I understood him, that the staff of Taing House had been at fault in two respects in particular, namely that they had not obtained a urine sample from Mrs Peterson before her admission to hospital on 8 March 2005 and that they had allowed her to become dehydrated. He was also critical of the NHS 24 out-of-hours medical service and the Lerwick Health Centre. I do not consider that any of these criticisms was borne out by the evidence adduced during the course of the inquiry. Besides, I am not persuaded that, even if it had been demonstrated that the staff of Taing House had been at fault in one or other or both of the respects claimed by Mr Peterson, this would have caused or materially contributed to Mrs Peterson's death. In short, nothing that he said came anywhere near satisfying me in light of the evidence which was actually led that there were any reasonable precautions which might have been taken before Mrs Peterson's admission to hospital on 8 March 2005 whereby her death might have been avoided or that there had been any defects in any system of working which had contributed to her death. And in light of the evidence of Dr Lightbody I think it is plain that no findings may properly be made under sub-sections 6(1)(c) or (d) of the Act in relation to the events following Mrs Peterson's admission to hospital.

[7] I have not thought it appropriate to make any finding under sub-section 6(1)(e) of the Act. In summary, the sad but simple fact is that Mrs Peterson was a frail old lady who was overwhelmed by a disease, namely pneumonia, which in her case proved fatal. As already indicated, various criticisms were made of members of the staff of the hospital (in particular Dr Graham) but I have not thought it necessary to express any opinion on these since, even if they had been well founded and staff of the hospital had done what it was suggested they should have done, there would have been no difference to the eventual outcome, namely Mrs Peterson's death.

[8] On a final note, I may perhaps refer to sub-section 1(1) of the Act which, in a case such as the present, provides *inter alia* that, where it appears to the Lord Advocate to be expedient in the public interest that an inquiry under the Act should be held into the circumstances of the death on the ground that it was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern, the procurator fiscal shall investigate those circumstances and apply to the sheriff for the holding of an inquiry under the Act into those circumstances. In terms of sub-section 3(1), on such an application being made to him, the sheriff is required to make an order fixing a time and place for the holding by him of an inquiry under the Act. He has no discretion in the matter.

[9] In light of sub-section 1(1) I acknowledge that it is for the Lord Advocate alone to decide if it is expedient in the public interest that a fatal accident inquiry should be held in a case such as this. At the same time it is I think right to record that it did occur to me several times during this inquiry to wonder whether it really was in the public interest that this particular inquiry should have taken place at all. I do not doubt that, where for example there have been serious failings in the systems or practices of a hospital or its staff or instances of gross incompetence or neglect, it may be right that these should be made the subject of scrutiny in public. But in the present case, even if it had been demonstrated for example that there was a causal connection between any failing on the part of a member of the hospital staff and Mrs Peterson's death, it is far from clear to me how the public interest would have been served by the holding of this inquiry. At worst in this case it might have been said

that errors of judgement had been made (and I do not say that there were). In such a situation, if the matter has been properly investigated by the procurator fiscal and thereafter been the subject of discussion among him, the hospital staff and the deceased's family and if it can be seen that appropriate steps have been taken to avoid a recurrence of any errors that were made, it may be said that this is all that the public interest requires and that the public interest does not also demand that any such errors should be brought to light in the public glare of a fatal accident inquiry. Here it should be recalled in particular that the doctors and nurses whose actions are likely to be under scrutiny at an inquiry such as this have to continue working and caring for their patients and it cannot be in the interest of these patients that these doctors and nurses should be subject to the strain inevitably associated with the prospect of having to give evidence at a fatal accident inquiry and perhaps being made the subject of any public criticism at the end of the day. Moreover it has to be said that a fatal accident inquiry necessarily involves the expenditure of a good deal of time and money which some might say would be better spent in other directions including the care of patients. I can readily understand that the family of a deceased person might want a fatal accident inquiry into the death of their relative. But what may be in the interest of a particular family does not necessarily coincide with the public interest.