

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

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

Court reference number: 2B260/06

DETERMINATION

by

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

following

an Inquiry held at Glasgow on the 22, 23,
24, days of May, the 13, 14, 15 and 17 days
of November all in the year Two Thousand
and Six and the 24th day of January in the
year Two Thousand and Seven into the
death of **ALAN PEACOCK**, aged 58, who
resided latterly at Flat 19/5, 54 Kirkton
Avenue, Glasgow.

GLASGOW, 25 May 2007

The Sheriff, having resumed consideration of the cause,

FINDS and DETERMINES

that

(1) In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Allan Peacock, who was born on 24 July 1942 and who resided latterly at Flat 19/5, 54 Kirkton Avenue, Glasgow G13 died within the Western Infirmary, Dumbarton Road, Glasgow at noon on 22 March 2001.

(2) In terms of section 6(1)(b) of the said Act that the causes of his death were bronchopneumonia and septicaemia due to infection of the right groin due to coronary artery angiography procedure.

(3) In terms of section 6(1)(c) of the said Act (i) that the death of Allan Peacock might have been avoided if the ultrasound scan requested by Dr McAllister on 13 February 2001 had been carried out either on 14 or on 15 February 2001 rather than cancelled by an unknown doctor on 15 February prior to it being carried out; and (ii) that it was reasonable to have carried out the ultrasound scan on 15 February 2001.

(4) In terms of section 6(1)(d) of the said Act that there is neither need nor justification for making any determination.

(5) In terms of section 6(1)(e) of the said Act that there is neither need nor justification for making any determination.

NOTE

Introduction

[1] This Inquiry has been convened under section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (“the Act”) to inquire into the circumstances of the death of Allan Peacock (Mr Peacock). Mr Peacock died on 22 March 2001 in the Western Infirmary, Glasgow. He was then 58 years of age having been born on 24 July 1942. He had resided latterly at Flat 19/5, 54 Kirkton Avenue, Glasgow. The cause of death of Mr Peacock given in his death certificate was bronchopneumonia and septicaemia due to infection of the right groin due to coronary artery angiography procedure. He had undergone that procedure on 8 February 2001. The Inquiry concentrated upon an investigation of his care and

management from his initial referral to hospital on 5 February 2001 until his death some six weeks later.

[2] At the Inquiry the Crown was represented by Mr O'Mahoney, procurator fiscal depute. Six of the doctors involved in the care of Mr Peacock were represented: Dr John Byrne, Mr David Chong, Dr Kenneth McAllister and Mr Stuart Moir by Mr Jessiman, solicitor; Mr Andrew Seaton and Dr Neena Bodasing by Mr Mawby, solicitor. In addition the Greater Glasgow Health Board was represented by Miss Craik, solicitor. I was informed that the family of the deceased were aware that they could take part in the Inquiry and if appropriate be represented at it but had elected to take no active part in it. Mrs Ellen Peacock, the widow of the deceased, attended the whole Inquiry in company with other members of her family.

[3] In the course of the Inquiry I heard evidence from Mrs Peacock and from thirteen doctors of whom ten had been involved in the care of Mr Peacock throughout the period under investigation. As at February and March 2001 they, and the posts they held, were:

- Doctor Lisa Clampitt (now Gibbons): a Senior House Officer at the Western Infirmary working in the Cardiology Unit.
- Doctor John Byrne: a Specialist Registrar and acting consultant in Cardiology at the Western Infirmary.
- Dr Neena Bodasing: a Specialist Registrar in Infectious Diseases and General Medicine at both the Western Infirmary and Gartnavel Hospital.
- Mr Dominic Byrne: a consultant in General and Vascular Surgery at Gartnavel Hospital.
- Dr David Chong: a Specialist Registrar in General Surgery at Gartnavel Hospital.
- Mr Andrew Seaton: a consultant in Infectious Diseases and General Medicine at Gartnavel Hospital.
- Dr James Bidwell: a Specialist Registrar in Orthopaedics and Trauma.
- Dr Kenneth McAllister: a General Surgical House Officer at Gartnavel Hospital.
- Mr Stuart Moir: a consultant Orthopaedic Surgeon at the Western Infirmary.

- Dr Roshan Weerackody: a Senior House Officer in Medicine at The Brownlee Centre, Gartnavel Hospital.

The other three doctors were Mr John Clark, Mr Michael Wyatt and Mr Peter Bloomfield. Mr Clark, a Consultant Forensic Pathologist and Senior Lecturer in Forensic Pathology at Glasgow University, carried out the post mortem on Mr Peacock and subsequently prepared a Report on his findings which is Crown Production number 2. Mr Wyatt, a Consultant Vascular Surgeon at the Nuffield Hospital, Newcastle upon Tyne prepared a Report on the care of Mr Peacock which is Crown Production number 4. Mr Bloomfield, a Consultant Cardiologist at Edinburgh Royal Infirmary was the only witness not led by the Crown. He was called on behalf of Dr John Byrne and prepared a Report on the care of Mr Peacock which was production number 1 for Dr Byrne.

[4] During the Inquiry the parties presented a Joint Minute agreeing that Crown Production number 3 was a Report prepared by Mr Hugh Miller, Consultant Cardiologist, and that it accurately reflected his views. The reason for proceeding in this way was that illness prevented Mr Miller from giving his evidence to the Inquiry. The Minute formed number 6 of process. The evidence concluded on the seventh day of the Inquiry. The representatives thereafter prepared written submissions which each tendered on the eighth day and then glossed as considered appropriate in oral submission. Before hearing those submissions Mr O'Mahoney intimated that the members of Mr Peacock's family present wanted on behalf of the family permission to read out a statement about him. All representatives, having perused the statement, indicated that they had no objection to the request. I granted it subject to the qualification, which the family accepted, that I could not take its contents into account in my determination. One of Mr Peacock's sons then read out the statement.

[5] All parties wanted the evidence transcribed and this was done. For that reason I do not propose to précis the evidence in this determination except in so far as it is necessary to explain how I have arrived at my determination of the circumstances of Mr Peacock's death as required by section 6(1) of the Act. Moreover, since parties prepared written submissions I do not propose to rehearse them either except where similarly required. Where I have thought it necessary to refer to a page reference

from the medical records for Mr Peacock, Crown production number 1, (“the notes”) I have given the page number in italic script. A page reference in roman script is to the page of the transcribed notes of evidence (“the transcript”).

[6] There was no dispute about Mr Peacock’s medical condition on admission, or the progress in general of his care and management and the order in which it occurred or the nature of the angiographic procedures he underwent. For that reason it is possible to narrate them without having to weigh the evidence led in that regard.

Mr Peacock’s relevant medical condition

[7] In February 2001 Mr Peacock was a 58 year old man employed as a security guard. He lived with his wife whom he had married in August 1961. He was slightly overweight. He had smoked in the past but had given up successfully some years before. He was no more than a social drinker. He suffered from angina and hardening of the arteries in one leg. His angina had been diagnosed when he was aged 48 or 49 and the hardening of the arteries some two years before his death. There was a family history of ischaemic heart disease. He took medication to regulate his angina and blood pressure. He also suffered from diabetes. His medical condition did not prevent him from indulging in golf and fishing with his sons or from going out regularly with his wife.

[8] On Sunday 4 February he suffered angina pains. They were sufficiently severe for him to attend his medical general practitioner on 5 February. As a result the general practitioner arranged an appointment for him at the Western Infirmary for 2.00 pm on 6 February for the assessment and potential management of his unstable angina. That referral set in train the sequence of events that ended tragically with his death some six weeks later.

The progress of his care and management

[9] On Tuesday 6 February Mr Peacock attended for his outpatient appointment. On returning home he was informed that he should attend hospital the following day for an angiogram. On 7 February he underwent that procedure, performed by Dr Lindsay a specialist registrar in cardiology. In order to facilitate the procedure Dr Lindsay had to gain entry to Mr Peacock’s heart and did so by opening his femoral

artery in the region of his right groin and inserting a sheath in the incision. Following the angiogram Mr Peacock was informed that an angioplasty was required and he was kept in hospital overnight to facilitate that. On 8 February he underwent that procedure. The surgeon in charge was Dr John Byrne. He made use of the same point of entry as had been used in the preceding angiogram. As part of the operation Dr Byrne inserted a sheath into a vein in Mr Peacock's left hand. After this operation Mr Peacock remained in the ward overnight. During the course of that evening Dr Clampitt removed the sheath implanted in Mr Peacock's groin to facilitate entry to the femoral artery for the purposes of both the angioplasty and the angiogram. During the following day, 9 February, he was discharged home.

[10] His physical condition deteriorated over the ensuing weekend. On Tuesday 13, Mr Peacock was unable to get out of bed and was not eating or drinking anything. Mrs Peacock telephoned Dr Robertson, his medical general practitioner who came out immediately, saw Mr Peacock and phoned for an ambulance to take him to the Accident and Emergency Department of the Western Infirmary.

[11] Once there he was admitted to the Acute Medical Receiving Ward under the care of Mr Seaton. On admission Dr Bodasing carried out an initial review. Mr Seaton carried out a review of Mr Peacock's condition in the course of that evening as a result of which he sought a senior surgical opinion. This led to the attendance of both Mr Bidwell and Dr McAllister. Both examined Mr Peacock. As a result Dr McAllister requested that Mr Peacock undergo an ultrasound scan. That request was submitted the following day but subsequently and unbeknown to Mr Seaton or those of his team of physicians who gave evidence, cancelled on 15 February. Meanwhile, Mr Seaton and his team continued to treat Mr Peacock for his infection by use of clinical responses. On 16 February Mr Peacock was reviewed by Mr Byrne.

[12] On 18 February he was referred to The Brownlee Centre, Gartnavel Hospital, still under the care of Mr Seaton. One of Mr Seaton's registrars, Dr Erica Peters, requested the Radiology Department at Gartnavel Hospital, with whom they worked closely, to carry out an ultrasound scan on 19 February. Mr Seaton received the results of that scan during the morning of 19 February. It revealed the presence of a

pseudo aneurysm in Mr Peacock's right leg. Mr Seaton thereupon requested an opinion from a vascular surgeon in relation to that leg. Dr Weerackody sought it from Dr Chong who did not feel that immediate intervention was necessary and suggested referral to a vascular clinic.

[13] On 21 February Mr Dominic Byrne, assisted by Dr Chong, operated on Mr Peacock in an attempt to isolate the infected aneurysm so that it could no longer infect the rest of Mr Peacock's body and also if possible to repair the aneurysm. He found that the lateral wall of the femoral artery was beyond repair. It had disintegrated completely and there was a large amount of infected tissue surrounding it. He had to ligate three arteries, the external iliac, the superficial femoral and the profunda. He operated again on 24 February because of a concern about the possible presence of necrotising fasciitis but he found none. As a consequence of the ligation Mr Peacock's right leg had to be amputated above the knee because it was dying due to a lack of blood. This was done on 27 February.

[14] He never recovered fully after this procedure. He was transferred to the renal unit. Subsequently he developed atrial fibrillation, renal failure and diarrhoea. Despite supportive treatment his condition steadily deteriorated over the following weeks and he died on 22 March.

[15] On 26 March Mr Clark carried out a post mortem examination on the body of Mr Peacock. He completed a death certificate for Mr Peacock and prepared a Post Mortem Report dated 3 April 2001 which is lodged as Crown Production number 2. Neither the death certificate itself nor an extract copy of it was introduced into the Inquiry.

The angiography procedures

[16] The purpose of a coronary angiogram is to evaluate and define coronary heart disease. It is a diagnostic procedure. The procedure is performed by a cardiologist and is designed to reveal the extent and severity of any coronary arterial narrowing or blockage. The procedure is invasive because it requires the cardiologist gaining access to the patient's body. It involves tracing a wire from the point of entry into the heart and injecting a dye so that the arteries can be visualised on an X-ray screen. The

images thus produced are the angiogram. At the time when Mr Peacock underwent the procedure the practice was to use as the point of entry the femoral artery in the area of the groin, that being the main artery to the heart into which a plastic tube was inserted to facilitate the passage of the wire to the heart.

[17] An angioplasty is a clinical procedure that can be adopted following an angiogram. It involves placing a stent into a coronary artery whose blood supply is compromised by ischaemic heart disease. The stent holds open the artery thereby increasing its diameter and allowing the passage of more blood than could be achieved without the presence of the stent. It is an interventionist procedure because the cardiologist conducting the procedure has to gain access to the affected artery, open it by using what is in effect a balloon and then release the balloon once the stent is in place and thereby able to hold open the artery after the conclusion of the procedure. At the time when Mr Peacock underwent the procedure it involved gaining access by way of the femoral artery. The decision whether to perform an angioplasty is one of clinical judgement in light of the results of the angiogram and in only a minority of cases will it need to be performed.

[18] The removal of the sheath was a normal consequence of the preceding procedures. On removal there was the potential for ongoing bleeding from the artery and the longer that bleeding went on the greater was the risk of a bruise forming at the site of the sheath. That bruising could in certain circumstances turn into a false aneurysm, a known potential complication of the procedures. To avoid that the doctor removing the sheath has to press on the groin at the site of the entry wound for a period of time until haemostasis is achieved.

The areas of controversy

[19] As the Inquiry progressed attention focussed on three areas of controversy all raised by Mr Wyatt in his report and spoken to by him in evidence. They were:

- (1) Whether Mr Peacock should have been allowed home on 9 February.
- (2) Whether a diagnosis of a false aneurysm should have been entertained on 13 February on Mr Peacock's re-admission to hospital followed by an immediate vascular review arrangement for an urgent ultrasound and urgent treatment of his infected false aneurysm.

- (3) Whether the advice given on 19 February for clinical review was inappropriate.

Of these by far the greatest time and attention was devoted to the second. Mr Wyatt answered (1) in the negative and (2) and (3) in the affirmative. Mr Bloomfield was asked only about (1) and one aspect of (2) affecting Dr Byrne, namely whether it was reasonable for him to have arranged an echocardiogram and a transoesophageal echocardiogram after Mr Peacock had been re-admitted to hospital. He answered both (1) and that aspect of (2) in the affirmative.

[20] When it came to the hearing on evidence the procurator fiscal depute did not seek to pursue (1) to the point where he asked that it form part of my determination under either section 6(1)(c) or (e) but did request that (2) grounded a finding under (c) and (3) one under (e). As he expressed it (2) grounded a finding that the reasonable precaution whereby Mr Peacock's death might have been avoided was: "[t]he performance of an ultrasound ordered on the 13 of February 2001 to be carried out on 14 February or as early thereafter as reasonably practicable. Appropriate diagnosis and accordant surgical procedures could have been performed at an earlier stage with a view to treating the infected pseudo aneurysm." As for (3) he said it grounded a finding that "[t]he advice given by Dr Chong to Dr Weerackody on 19 February 2001, namely the suggestion to refer Allan Peacock to a Consultant Vascular Surgeon for review at a clinic, was inappropriate."

[21] The procurator fiscal depute and all the representatives were in agreement in their submissions in respect of determinations under section 6(1)(a), (b) and (d). For (a) they said it ought to be that Mr Peacock died on 22 March 2001 at the Western Infirmary, Glasgow, for (b) what is stated in the death certificate signed by Mr Clark and for (d) that no finding could be or should be made. Beyond that Miss Craik and Mr Jessiman urged for (a) a record of the time of death: she as 11.30 am, he as 12.00 noon.

[22] In response to the Crown position on (c) and (e), each representative adopted for (c) the position that there should be no finding in relation to the actings of those whom each represented. Miss Craik and Mr Mawby submitted the same for (e) while

Mr Jessiman said that any comment on the actings of Dr Chong should be dealt with under (e) and not (c).

[23] In a Fatal Accident Inquiry section 6(1) of the Act imposes on the Sheriff a duty to make a determination setting out the circumstances of the death that fall within subsections (1)(a) to (e) inclusive of that section so far as he is satisfied that they have been established on the balance of probabilities from the evidence led at the Inquiry. That statutory provision makes it clear that such an Inquiry is a fact-finding exercise circumscribed by the terms of the section. As Lord President Hope stated in the case of *Black v Scott Lithgow Limited* 1990 S.C. 322; 1990 S.L.T. 612 in the context of examining the powers and duties given by subsection 6(1):

“There is no power in this section to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident...It is plain that the function of the sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, in so far as this can be done to his satisfaction.”

(pages 327; 615H to I)

In fulfilling that duty the Sheriff is greatly assisted, as I have been in the present inquiry, by the submissions of the Crown and the representatives but is not constrained or bound by them because the requirement that the Sheriff be satisfied is declared by the Act to be mandatory. As a consequence it would be open to a Sheriff to make a determination that ran counter to the submissions or was not urged at all if he thought that compliance with the statutory duty required him to do that as a consequence of the evidence presented to the Inquiry. Although the evidence hinted on occasions at certain features of Mr Peacock's care that were outwith the proposed issues, none was followed up to the point that I felt satisfied that I should go beyond the submissions and those issues.

Determinations under section 6(1)(a), (b) and (d)

[24] In the present Inquiry, having analysed the evidence and with the benefit of the very helpful submissions, it seems to me that there is no real dispute over the

determinations under (a), (b) and (d) and I can deal briefly but conclusively with all three.

[25] For (a) I am satisfied that the evidence supports a determination that Mr Peacock died within the Western Infirmary, Dumbarton Road, Glasgow on 22 March 2001. As for the time of death, the medical records for Mr Peacock state at page 303 that he was declared dead at 12 noon that day. Mr Clark was neither asked about the time of death nor invited to look at and comment on the death certificate registered on 26 March 2001 which he had completed as certifying registered medical practitioner or an extract copy thereof. I conclude that in the absence of evidence for the exact time of death I should state it to be when he was declared dead, namely 12 noon. This is in contrast to the death certificate which states 11.30 hours but since it was not put in evidence I feel I cannot use it for the purpose of determining the exact time of death.

[26] For (b) Mr John Clark gave evidence about the cause of death as found in the course of his post mortem examination and contained in his Report, Crown production number 2. He expressed his conclusions as follows:

“Post mortem examination confirmed the various clinical diagnoses and showed that this man died ultimately of bronchopneumonia and infection which had spread around the body ie. septicaemia. This had caused gradual failure of a number of organs including the kidneys and lungs although there was no real evidence of ischaemic colitis.

The source of the infection appeared to be from the tissues of the right groin where the earlier angiography procedure had been carried out and where there was now widespread inflammation of the muscle, fatty tissues and blood vessels. The adjacent femoral artery and vein was completely blocked, the reason for the amputation.

This man’s death can be traced directly back to the angiography procedure which he had had carried out to investigate and dilate up an area of severe narrowing of one of the main coronary arteries. At the site where the cannula had been inserted into the artery at the right groin there had clearly been some leakage of blood following the procedure (pseudo-aneurysm), this having become infected, with

consequent blockage of the blood supply to the rest of the leg. The leg subsequently had to be amputated, while the infection spread locally and then around the body.

The examination confirmed the severe coronary artery disease for which the angiography had been carried out and showed the stent to be functioning well”.

On only one matter was he cross examined and that related to the source of infection. Mr Jessiman asked if the original site of infection could have been the ventralin site in Mr Peacock’s left arm and it had then spread through the body including the right groin. Mr Clark (at page 461) said that it was possible but he did not know how that could be proved. When he conducted the post mortem examination he saw that the infection was focussed in the groin and the arm area had cleared up. It was a possibility that it had started in the arm where entry had been gained by opening a vein but the fact that the groin infection was so florid would suggest that that was where it started. Had the arm been a major focus of infection he might have expected more visible infection on the skin round about (page 463). I am satisfied on balance for the reasons given by Mr Clark that he is correct in concluding that the infection started in the groin and not the arm. Indeed Mr Jessiman commented very fairly at the end of his cross examination that the infection probably originated from the coronary angioplasty procedure (page 464). In conclusion I am satisfied that Mr Clark’s pathological conclusions follow from his findings and justify his stated cause of death which he then incorporated into the Death Certificate he signed and issued and I make that cause my determination under (b).

[27] For (d) there is no evidence that satisfies me that I could or should make a determination that a defect in any system of working in either the Western Infirmary or Gartnavel Hospital contributed to Mr Peacock’s death. The closest that the investigations went in the direction of what might have involved such a consideration was the discussion relating to the treatment of the original request for an ultrasound requested by Dr McAllister on 13 February. The discussion centred on what was meant by “mane” in the request but also probed whether the request ought to have been dealt with as an emergency (which it was not) or as a less urgent matter (which it was) described by Mr Dominic Byrne as not routine but early (page 257) and what that decision involved in the way of active participation by clinical and radiological

staff to secure the priority with which the scan ought to have been carried out and the results thereafter intimated speedily to the ward where Mr Peacock was an in-patient. There was some suggestion that the medical team involved in the care of Mr Peacock might have misunderstood the degree of urgency in obtaining the results of the ultrasound scan that the surgical input required but while the whole discussion raised some pertinent questions there was insufficient evidence as to what was the system of working in place in February 2001 and moreover it did not proceed far enough to satisfy me that I could or should make a determination under (d).

The issues in controversy

[28] The areas of controversy properly relate to determinations under (c) and (e). I think that they should be discussed in terms of the three heads identified by Mr Wyatt and narrated in paragraph [19] above, notwithstanding the Crown's position on the first of these heads at the hearing on evidence, and in addition in terms of the Crown's proposed determination about carrying out an ultrasound scan as narrated in paragraph [20] above. Accordingly I propose to discuss the following four issues and the answers that I give to each will provide the material for any determination under (c) or (e):

- (1) Whether Mr Peacock should have been allowed home on 9 February 2001.
- (2) Whether a diagnosis of a false aneurysm should have been entertained on 13 February when Mr Peacock was re-admitted to the Western Infirmary followed by an immediate vascular review and arrangement for an urgent ultrasound and urgent treatment of his infected false aneurysm.
- (3) Whether the ultrasound scan ordered on 13 February should have been carried out on the 14 February or as soon thereafter as was reasonably practicable.
- (4) Whether the advice given by Dr Chong to Dr Weerackody on 19 February for clinical review of Mr Peacock was inappropriate.

My assessment in general of the evidence

[29] Before I deal with the issues, I consider that I should indicate my approach to the assessment of the evidence of each of the witnesses whose evidence bears on this task.

[30] All of the witnesses to fact were without question doing their best to assist the Inquiry and strove to present their recollection of events as truthfully and accurately as memory permitted. Mrs Peacock gave her evidence in a quiet, firm and commendably dignified way. Her memory was clear and reinforced by referring to the diary of events from 5 February to 22 March 2001 she had started keeping on 12 February 2001. It was Crown production number 5. I have no hesitation in accepting what she said as reliable for the background to her husband's initial referral to hospital and his condition between 9 and 13 February. Beyond that her evidence had little to say about the matters placed in issue that was not reflected in the medical notes or evidence of doctors.

[31] As for the various doctors who had a role in the care and management of Mr Peacock in both the Western Infirmary and Gartnavel Hospital some of them lacked a detailed personal recollection of their involvement. This was particularly so with the more junior doctors. I did not find this surprising. Whatever the level of seniority in the medical profession at the material time, and it ranged from established consultant to senior house officer, each was a busy professional who could expect to be called upon to deal with many patients at the material time and subsequently. There was also the telling consideration that the Inquiry commenced more than five years after Mr Peacock's death and concluded almost six years after it. Where direct recollection was lacking the evidence had to be derived or culled from the medical records for Mr Peacock, Crown production number 1. All parties worked with those extensive records which ran to 596 pages and made no criticism of what was written in them. The focus of discussion concentrated upon the meaning of the records spoken to in evidence and what each doctor was able to say about his or her actings. Where either memory or reference to the medical records or a combination of both was still unable to unlock a recollection of actings I treated that not as a mark of unreliability as a witness but as a perfectly understandable lapse of memory with no sinister connotations. The task facing me in addressing the issues is not really one of assessing reliability as one of assembling the complicated and diverse input by a team of doctors over a total period of about two weeks into a coherent whole in order to assess what treatment Mr Peacock received, when he received it and why.

[32] Mr Clark falls into a different category. He spoke to his post mortem findings and his Report, Crown production number 2. His evidence was given from the standpoint of a consultant forensic pathologist of, then, some fifteen years seniority who had conducted thousands of post mortem examinations. He gave his evidence with great authority. What he said was challenged on only one matter which I have dealt with in paragraph [26] above and no one suggested that I should do other than accept what he said as entirely reliable, which I have no hesitation in doing.

[33] As for the evidence of the skilled witnesses I think that it would be inappropriate to make a general assessment of the evidence of both. Instead I think it right to deal with their different conclusions when addressing the areas of practice and diagnosis on which they reached different conclusions. However, that does not prevent me from making a number of general observations about them.

[34] Neither Mr Wyatt nor Mr Bloomfield had any involvement whether direct or indirect in the care of Mr Peacock. For what had happened they both relied upon the same extensive set of medical records. In all material respects their chronologies are consistent with one another differing only in expression and the occasional point of detail. On that same basis of fact they have reached conclusions described by Mr Wyatt at page 547 of the transcript as “diametrically opposed”.

[35] Mr Wyatt is a consultant vascular surgeon and has been since 1994. He qualified in medicine in 1982 and since then has acquired further professional qualifications: the degrees of Master of Science in Clinical Science and Doctor of Medicine in surgery, and a Fellowship in surgery from the Royal College of Surgeons in England. In addition he is an examiner and an appraiser of examiners for that Royal College, and is the editorial secretary for and a board member of the British Journal of Surgery. He has been a council member of the Vascular Society of Great Britain and Ireland and was for three years the secretary for the Surgical and Academic Research Society and Treasurer of the Endovascular Forum. He has previously prepared many reports most of which were for cases of vibration white finger. He prepared his Report for the Inquiry from a consideration of copies of the medical records for Mr Peacock, a copy of Mr Clark’s post-mortem Report, a copy of

Mr Miller's Report and a copy of diary entries whose author he was at the time unaware of but which were in fact Crown production number 5.

[36] Mr Bloomfield is a consultant cardiologist and has been since 1989. He has worked in cardiology since 1979. In addition to his ordinary medical degrees he has acquired an M.D. degree, and is a Fellow of the Royal College of Physicians and also a Fellow of the American College of Cardiology. He has given evidence in court before in relation to cardiological matters including Fatal Accident Inquiries. He had prepared for giving evidence to this Inquiry by having sight of Mr Peacock's medical records and of the reports prepared by Mr Miller and Mr Wyatt.

[37] Both men were undoubtedly highly skilled and greatly experienced in their own fields of expertise and gave evidence with the benefit of their years of professional work in those fields at consultant level. Both were impressive witnesses in different ways: Mr Bloomfield measured and calm, Mr Wyatt more animated in delivery and assertive in his responses.

[38] In his evidence Mr Bloomfield approved and adopted Mr Miller's account of events and observed that he could find no significant mistake or omission in it. That chronology was culled from Mr Peacock's medical records. Mr Bloomfield supported the conclusion he had expressed in his Report dated 6 November 2006 that Dr Byrne's decision on 9 February to discharge Mr Peacock was reasonable in light of the circumstances then known and without the benefit of hindsight. In addition he considered that Dr Byrne's decision to arrange an echocardiogram and a transoesophageal echocardiogram as a way of investigating the potential source of Mr Peacock's infection was not unreasonable in all the circumstances.

[39] Mr Wyatt adopted his own history of events which was also derived from Mr Peacock's medical records and supported his opinion that a reasonable body of medical opinion (i) would not have allowed Mr Peacock to return home on 9 February (paragraph 2.5) and (ii) would have, at an earlier stage than was done, performed an ultrasound, made the diagnosis of a false aneurysm and allowed Mr Peacock to undergo surgical exploration of that aneurysm which was infected (paragraphs 2.6 and 2.10).

[40] There was one other valuable source of evidence and that was the report prepared by Mr Miller. I have made use of it because of the terms of the Joint Minute and also because of the use made of it in evidence by both Mr Wyatt and Mr Bloomfield. As a consequence where I have had to present a chronology of relevant events I have drawn heavily on all three medical reports.

Issue 1: Whether Mr Peacock should have been allowed home on 9 February 2001

[41] For the purposes of this issue I have worked with the following chronology of relevant events.

Chronology of relevant events

[42] On admission on 7/2/01 the admitting nurse noted his past history of peripheral vascular disease (2 years) and hypertension (5 years). He had been a non-insulin dependent diabetic for 5 years. He was afebrile and had bilateral excoriation of both groins from a “sweat rash”. Dr. John Byrne as Acting Consultant saw Mr Peacock and noted the peripheral vascular disease and the presence of previously documented left superficial artery occlusion with an associated femoral bruit. He contemplated using Reopro (an antiplatelet agent) during the procedure.

[43] The angiography performed by Dr Lindsay demonstrated severe disease in the form of a tight stenosis of the circumflex coronary artery. A size 7 French femoral sheath was left in place overnight with Heparin (a blood thinning agent) anticoagulation. The sheath site was satisfactory on returning to the ward and again the following morning.

[44] The following day Dr Byrne performed a coronary angioplasty procedure and placed two stents in the circumflex artery to maintain the patency of the affected artery. The result was excellent. Mr Peacock was given an eptifibate (antiplatelet) infusion for a total of 18 hours. Heparin was stopped at the end of the procedure and there was a comment that the sheath was to be removed when the APPT (a measure of anticoagulation) was less than 60 seconds. Clopidogrel (an antiplatelet agent) was prescribed for four weeks.

[45] The sheath was removed later that night by Dr Clampitt at a time that is unstated but was from her evidence between 2115 hours and 2135 hours. The procedure was painful and she gave Mr Peacock two measures of Diamorphine 2.5 mg and metochlopramide 10 mg. She managed to achieve haemostasis after 20 minutes of pressure on the site but she noted a slight haematoma measuring 2 cms x 5 cms which was soft and non-expanding.

[46] At 0230 hours on 9 February Mr Peacock, while standing by the side of his bed became disorientated and very sweaty and his heart rate increased to 120 to the minute. Dr Clampitt examined him and performed an ECG but found nothing untoward. The wound site in his groin was noted to be satisfactory.

[47] At 1100 hours that same day his temperature was noted as normal. His white blood count had risen to 20.39. The catheter site was noted to be slightly red and warm. Both groins were noted to have severe intertrigo with an offensive white exudate. Dr Clampitt considered an infected haematoma and arranged swabs of both groins, and culture of the urine and catheter site. Canestan cream was prescribed for the skin.

[48] At 1140 hours Mr Byrne reviewed Mr Peacock on his second, and special, visit to him that morning. He noted the elevated white blood count but normal temperature and advised: "Allow home". The Immediate Discharge Sheet made no mention of any concerns regarding Mr Peacock's leg."

Comment

[49] It is undisputed that treating Mr Peacock for his unstable angina by carrying out an angiogram followed by an angioplasty was appropriate and no criticism is ventured about the way in which either procedure was conducted. The criticism related to the decision to allow Mr Peacock to return home on 9 February.

[50] It was Dr Byrne who took that decision. It was an exercise of his clinical judgement. In making that judgement he had his own experience as a cardiologist, his knowledge of the operation he had performed on Mr Peacock, his own observation of

Mr Peacock during his post-operative visits to him on the ward, the medical notes made subsequent to his return to the ward supplemented by information from Dr Clampitt relating to Mr Peacock's white cell count.

[51] Dr Byrne had been involved in angiographic procedures since 1995, initially assisting at them but latterly performing them himself. From then until the time when he conducted the operation Mr Peacock, he had been involved in approximately 300 angiograms and 100 angioplasties per annum of which roughly half were elective and half acute. I take from this experience that by February 2001 he was very well qualified in the procedure. He was also aware that a false or pseudo aneurysm could occur as a consequence of the way the procedure was then conducted and opined that he could expect it then in only about one per cent of cases. I say "then" because the evidence was that the procedure has been altered subsequently and this has lowered the rate of occurrence.

[52] After performing the angioplasty on Mr Peacock, Dr Byrne saw him once later on 8 February although he has not documented that visit in the notes, and then again twice on 9 February, the first between 8.00 am and 9.00 am as part of a routine ward round and the second a special visit at approximately 11.40 am because he had been appraised by Dr Clampitt of Mr Peacock's raised white cell count. Dr Byrne's entries for 9 February are at pages 577 and 578 of the notes. He was aware of Dr Clampitt's entry at 2.30 am that morning. She had informed him of that raised white cell count at some time between 11.00 am and 11.40 am. He was also aware of readings taken at 11.00 am when Mr Peacock's temperature was 36, which was within normal limits, and his pulse and blood pressure were also within normal limits.

[53] When he examined Mr Peacock he included his leg in that examination. This is the effect of the tick against the word leg in the notes at page 577. What caused him concern at that examination was the elevated white cell count. It had risen from 6.7 to 20.39 which was a large jump. He knew that could be a sign of infection but he also knew that it could be a sign of other things as well because a raised count is a non-specific indicator. That is why he went to see him to assess if there were anything else to suggest that he had an infection. Having examined Mr Peacock he did not feel there was anything suggesting a systemic infection. He concluded that

Mr Peacock had a superficial infection within the skin creases but that there was no sign of septicaemia or anything of that kind. The raised white cell count did not point ineluctably to the conclusion that he was suffering from an infection. There were many other reasons which could have caused that count namely acute inflammation, trauma, bleeding or even a heart attack. At the time he took that decision he was aware of the suggestion that Mr Peacock had been disorientated, had been sweaty and had a raised white cell count. These three factors did not lead him to conclude that Mr Peacock was suffering from an infection. The high white cell count could have been due to the fact that Mr Peacock had undergone two procedures in quick succession, namely the angiogram and the angioplasty, both of which were physiologically stressful for the body. If he had concluded that Mr Peacock was suffering from septicaemia he would not have discharged him from the hospital. Dr Byrne disagreed with Mr Wyatt's assertion that on 9 February Mr Peacock was exhibiting signs and symptoms of septicaemia when he took the decision to discharge him. If there had been early signs of septicaemia at 2.30 pm on 9 February Dr Byrne would have expected Mr Peacock to have got worse and to have felt unwell and in addition he would have expected some rise in temperature from the normal. Instead he found heart rate and blood pressure were normal throughout and no signs at any stage that his temperature was elevated.

[54] Dr Clampitt was at the material time a medical senior house officer working in the cardiology department as part of her training rota. She was in her second year as a senior house officer but that still meant that she was a relatively junior member of the medical staff. She described herself as "the lowest rung on the ladder" (page 54) and "the most junior member of the team" (page 59). She was considerably more junior and far less experienced than Dr Byrne. Her first encounter with Mr Peacock was when she removed the sheath from his right groin. She had been taught how to do it and had had experience of doing it. She was aware of the importance of ensuring that there was no ongoing bleeding. She achieved haemostasis in 20 minutes at about 9.35 pm and noted, as she knew she was required to do, the presence of a slight haematoma around the site Mr Peacock approximately two centimetres by five centimetres in area which she recorded as being "soft not enlarging". It was not tender. She did not construe this bruising at the time as a false aneurysm. She knew what that was because she had been warned by senior colleagues to guard against its occurrence.

Had she had any concerns in that regard she knew to speak to a senior colleague. She did not feel the need to do that. In addition while conducting the removal she administered 5 milligrammes of diamorphine in two lots to counter the pain Mr Peacock was experiencing.

[55] She next saw Mr Peacock at about 2.30 am on Friday 9 February because the nursing staff asked her as the doctor on call to examine him. They had observed that his wound site was satisfactory (page 578). Her notes of that are at page 237 and the record of the ECG tracing of the heart taken at that time is at page 69 of the notes. She did not conclude from his presentation that he was suffering from septicaemia. She accepted that an increased white cell count could be indicative of infection, which she sought to differentiate from septicaemia described by her as systemic sepsis, but could also have been due to other causes. She disagreed with the suggestion that at that time Mr Peacock was exhibiting signs of septicaemia.

[56] She next saw Mr Peacock at 11.00 am that same morning because she had been made aware that his white cell count was elevated and she wanted to see why. She examined his legs and found the wound in his right groin slightly red and warm around the catheter site. She also observed bilateral severe intertrigo in both groins. For that reason she swabbed both groins in case of infection from the intertrigo but not specifically possible infection of the haematoma and they were sent for analysis. She requested a swab of the catheter site but it may not have been done and in any event there is no record of it being sent to the laboratory for culture and analysis. She said that at that time Mr Peacock was not showing signs of septicaemia. She was satisfied that he had a normal pulse, a normal blood pressure and a normal temperature. She agreed with the statement that if he had been suffering from septicaemia he ought not to have been discharged.

[57] On this issue I have preferred the conclusion of Mr Bloomfield to that of Mr Wyatt and that for five reasons. The first is that Mr Bloomfield is a cardiologist while Mr Wyatt is a vascular surgeon. Mr Bloomfield gave his evidence as a cardiologist and Mr Wyatt as in his own words an expert vascular surgeon (p 486). Both consultants were eminently qualified and experienced in their own specialised disciplines with cardiology and vascular surgery presenting as separate specialities

and both provided great assistance to the Inquiry for which I am grateful. I prefer the cardiologist to the vascular surgeon because the angiography procedure which Mr Peacock underwent was conducted by a cardiologist, Dr Byrne, within a care plan that at that stage in treatment was a cardiological one. Mr Wyatt was punctilious in confining himself to working within his own discipline. He was reticent, and very properly so, about trespassing on to areas involved cardiological treatment and expressly confined himself to matters of vascular complications (p 546).

[58] The second is that Mr Bloomfield's conclusion was supported by Mr Miller, a consultant cardiologist, whose report was accepted by all as accurately reflecting his views and in addition was referred to in evidence by both Mr Bloomfield and Mr Wyatt. Mr Wyatt understandably differed in his conclusions but for the same reason as set out above I prefer the approach taken by a specialist in the same discipline as Dr Byrne.

[59] The third is that Mr Wyatt seemed to me present an account of events and interpretation of events that was tinged with the benefits of hindsight in a way and to an extent that I did not take from Mr Bloomfield and which I could not read out of Mr Miller's report. From all the evidence led from not only Mr Bloomfield and Mr Wyatt but also from Dr Byrne, I concluded that the mindset of the disciplines of cardiology and vascular surgery was different. All the evidence was to the effect that where a patient was under the care of a cardiologist or indeed a physician the vascular surgeon was introduced by way of referral or by being asked for a professional opinion as part of an ongoing care plan. That mindset gives the vascular surgeon the opportunity to look at what has gone before by way of treatment and care of a patient and assess it as a necessary prelude to his direct involvement and I think that this may have played some part in how Mr Wyatt viewed treatment of Mr Peacock. I am fortified in this conclusion by his occasional overt admission of his use of hindsight and in this regard I would instance two passages: the reference to subsequent events showing that Mr Peacock presented on re-admission on 13 February with a surgical emergency that required urgent treatment (page 566); and the discussion that took place over the effect that concerns about Mr Peacock's left forearm had clouded the issue of what was the cause of his condition as at 15 February (page 579).

[60] The fourth is that I was impressed by the demeanour and evidence of both Dr Byrne and Dr Clampitt for the events that followed the conclusion of the angioplasty up to the point when Dr Byrne made the decision to allow Mr Peacock to go home on 9 February. The evidence they gave was to my mind reliable and where it was in contrast to the analysis of Mr Wyatt, which I accept, was of necessity an analysis after event, I preferred the evidence of the doctors who were on the ward at the material time.

[61] The fifth is that the evidence of Mr Bloomfield in support his opinion on this issue was unchallenged by any cross-examination at all. There was no issue raised of the reliability of the information with which Mr Bloomfield had to work, the only challenge to his conclusions coming from Mr Wyatt. While Mr Bloomfield was invited to go through his report in the course of his evidence and to support Mr Miller's report, he was not asked to comment upon Mr Wyatt's evidence on the discharge on 9 February beyond a question relating to whether in his opinion Mr Peacock had septicaemia at the time of his discharge. Mr Bloomfield's answer was to disagree with Mr Wyatt. No further features of Mr Wyatt's evidence were put to Mr Bloomfield.

[62] The conclusion to which I have come is that on balance the information before Mr Byrne at 11.40 am entitled him to reach the conclusion that Mr Peacock could return home. There was common agreement that a raised white cell count could be an indicator of the presence of not only infection but the early signs of septicaemia, but on the evidence presented to me I cannot conclude that that is the diagnosis which the presence of such a count should have led to necessarily in the instant case. It was one of a number of conclusions that might have been drawn subject to there being additional information that would support it in the direction of septicaemia. I accept from the evidence of Dr Byrne and the notes which support it that the picture of early septicaemia was not one he was obliged to reach in the exercise of his clinical judgement and that he was entitled to reach the conclusion that it was safe to allow Mr Peacock to return home. His conclusion is supported by Dr Clampitt and although she was a very junior doctor at the time I accept that her contemporaneous clinical judgement is one she was entitled to reach and it is consistent with Dr Bryce's. Furthermore I accept that on balance Dr Byrne could be expected to have followed his

normal practice and informed Mr Peacock to represent early in the event of any complications arising. Accordingly I answer this issue in the affirmative.

Issue 2: The management of Mr Peacock following his readmission

[63] Mr Peacock was re-admitted to the Western Infirmary on 13 February having been referred by his general practitioner. The consultant in charge was Mr Seaton. The chronology of events which followed that re-admission I have used for dealing with this issue is based to a significant extent on Mr Miller's account of events with additions from Mr Wyatt's report where I consider that appropriate and from the evidence of the various doctors who were involved in the care of Mr Peacock. The pages in Mr Peacock's medical records that are of particular importance for this issue are at pages 240 to 268.

Chronology of relevant events

[64] On examination commencing at 1540 hours Mr Peacock was seen by Dr Bodising the specialist registrar in infectious diseases and general medicine. As the registrar on duty she had to see him as a new admission to assess him and carry out his initial management. He gave her a history of being unwell for three days and of complaining of pain in his right leg to such an extent that he was unable to walk. In addition he had pain in both arms. He had experienced no chest pain since the insertion of the stent. He was unwell and sweating and was subsequently fevered. There was extensive bruising in the right leg and groin. She concluded that Mr Peacock required a senior review by her consultant physician, Mr Seaton. She did not formally refer Mr Peacock to him because she knew that he would be doing an early evening ward round.

[65] On review at 2030 hours by Mr Seaton in the company of Dr Bodising Mr Peacock was fevered with a temperature of 39.2deg and he had myalgia, sweating and breathlessness. His left forearm was tender and red with tenderness in the left axilla and his right leg was swollen. Mr Seaton made a differential diagnosis of “? side effect of Simvastatin/” “? Streptococcal pyomyositis or staphylococcal infection” (this last described in his notes as MRSA/MSSA). Cultures were taken and treatment started with antibiotics: Vancomycin, Clindamycin and Ciprofloxacin. Mr Seaton noted that he wanted a senior surgical opinion in respect of Mr Peacock's arm and leg

to be obtained that night. He was noted to have an extremely poor renal function. The renal team were involved in his care-over the next few days. His renal function recovered in due course.

[66] At some time before 2115 hours Mr Bidwell, the orthopaedic senior specialist registrar in orthopaedics and trauma, reviewed Mr Peacock. He noted some induration of the forearm but the muscle bellies were soft. There was a fusiform swelling around the groin puncture site. There was marked intertrigo but no cellulites. He diagnosed Thrombophlebitis of the left forearm secondary to an infected Venflon cannula site and a pseudonaneurysm of the right groin with absent distal pulses but with known peripheral vascular disease. He thought there was no surgically remediable source of infection and that the treatment Mr Peacock was then receiving should be continued.

[67] At 2115 hours Dr McAllister the general surgical senior house officer saw Mr Peacock and noted the groin haematoma and that there had been bleeding for some time postoperatively and since discharge from hospital. His plan requested a Doppler ultrasound examination of Mr Peacock's right femoral region "mane" with vascular surgical review thereafter.

[68] On 14 February cultures of the groin swabs taken on 9 February were reported. They showed the presence of Group G Streptococcus sensitive to Clindamycin. At 1200 hours a blood culture bottle grew Streptococci and at 1750 hours further Gram positive cocci were identified on blood culture. The bacteriologist discussed antibiotics and advised continuing the current treatment regime. That involved Vancomycin, Clindamycin and Ciprofloxacin.

[69] On 15 February Mr Seaton reviewed Mr Peacock at about 0850 hours. He noted the presence of Streptococcal infection and also the possibility of staphylococcal infection. Mr Peacock's left forearm, deltoid and axilla were tender and he remained feverish. Mr Seaton made no comment about the right leg.

[70] At 1535 that day Dr Bodasing reviewed Mr Peacock. She noted that he was feeling better but that his left arm was exquisitely tender. She described his right leg as being "as before swollen++ tender++". His creatinine kinase reading (an indicator

of muscle damage) had risen to greater than 4000 and she expressed concern that there might be pyomyositis or necrotising fasciitis both of which are complications of streptococcal infection. She wrote that Mr Peacock needed a senior surgical review urgently.

[71] At 1615 hours that day Mr Peacock was seen by Mr Stuart Moir, a consultant orthopaedic surgeon, to see if there was a cause for his illness that was remediable orthopaedically. He concluded that there was not a drainable collection in either the left arm or the right thigh. While both areas were certainly tender, neither was grossly swollen or tense and there had probably been bleeding into the quadriceps following catheterisation.

[72] On 16 February Mr Seaton examined Mr Peacock at 0830 hours. He noted that he looked and felt much better and that his leg and arm were less painful. He concluded that his condition was improving and that his treatment plan should be continued.

[73] Later that morning but prior to 1100 hours Mr Moir reviewed Mr Peacock and noted a gradual improvement in his condition, and that he was less tender in both his left arm and thigh. He confirmed that no surgical intervention was advisable at this stage.

[74] On 17/2/01 the notes indicate that he was assessed as continuing to improve. Although his right leg was swollen it was not particularly tender. Moreover, he was moving his toes, had a good pulse and was experiencing normal sensation. His left arm had also improved. The doctor who made the entry on page 263 and the first lines of page 264 of the notes, believed to be a Dr Pereis, recorded that the left arm was improving but the anterior capsule of the left shoulder was tender++. He wondered if this might be the source of sepsis and recommended review of the left shoulder. He also recorded that there was bruising around the groin puncture site with mild tenderness but no clear collection. He recommended transfer to Brownlee Ward.

[75] On 18 February before transfer he was noted as feeling well, eating and drinking. The direction was that he be transferred to Brownlee as being “well” but still infected.

[76] Following that transfer he was further examined by a doctor, believed to be Dr Pereis, who following examination noted that Mr Peacock should undergo a Doppler ultrasound scan on his right leg and groin the following day.

[77] On 19/2/01 Mr Seaton examined Mr Peacock at 1130 hours. He noted that he was very much improved. The right leg was swollen and a new feature was an effusion in the right knee. Mr Seaton had by then received the result of the ultrasound which is found at page 129 of the notes. This had shown a pseudo aneurysm and a haematoma in the right groin. He advised obtaining a vascular opinion on the right leg.

Comment

[78] Undoubtedly, Mr Peacock was seriously unwell when he was re-admitted to hospital on 13 February. He presented with a severe systemic infection and renal problems and accordingly was admitted to a medical ward, not a surgical one. I consider that fact to be significant for present purposes in two respects: for how and why his care plan was drawn up as it was and then carried out over the succeeding days; and for the way in which I should assess Mr Wyatt’s criticism of the plan. I am satisfied that admitting him to a medical ward was the correct procedure to follow in light of the reason for his re-admission and indeed there was no criticism ventured of that decision. Mr Wyatt’s criticism can be presented as requiring the medical team caring for Mr Peacock to engage in a course of treatment that involved three features: firstly, to entertain on 13 February a diagnosis of a false aneurysm; secondly in light of that diagnosis to request both an immediate vascular review and an urgent ultrasound scan; and thirdly to treat Mr Peacock urgently for his infected false aneurysm. Mr Bloomfield was not asked to assist in commenting on these matters. His single observation about Dr Byrne involves a decision that post dates the time under consideration in this issue and accordingly I need not deal further with it.

The first feature

[79] Mr Wyatt, as an expert vascular surgeon, was ideally placed to assist with a definition of a false, or pseudo, aneurysm. He described it as blood outside an artery contained within the tissues (pages 476 and 481) those tissues being adjacent to that blood vessel. It was a ruptured aneurysm like a ruptured aorta (page 566). I adopt that definition. Hardly surprisingly, what was said by those other doctors asked to define this phenomenon was consistent with it.

[80] On 13 February Mr Peacock was examined by four doctors within the first six hours of his re-admission. In order of examination they were a specialist registrar in infectious diseases and general medicine (Dr Bodasing), a consultant physician (Mr Seaton), a senior specialist registrar in orthopaedics and trauma (Mr Bidwell) and a senior house officer in general surgery (Dr McAllister). That in itself is to my mind an obvious indication that Mr Peacock's symptoms did not appear to the physicians to lend themselves to a ready or single diagnosis. It is also indicative of Mr Seaton's resolve as the physician in charge to determine the cause of the infection from which Mr Peacock was then suffering as quickly as circumstances would permit by seeking surgical assistance albeit at that stage not vascular.

[81] Neither of the physicians considered the possibility of a pseudo aneurysm. It was the two surgical colleagues who raised the possibility that Mr Peacock might be suffering from a pseudo aneurysm in his right groin. That is recorded in the notes at page 245 for Mr Bidwell and 246 for Dr McAllister. Indeed Dr McAllister explained that he suspected that the false aneurysm might be infected, although he has not reflected that in his note, and that was why he suggested an ultrasound scan. Mr Wyatt accepted that both doctors had entertained the presence of a false aneurysm but commented that these diagnoses were secondary and not primary. I shall come on to deal with that but for this first feature I am satisfied that the diagnosis of a false aneurysm was entertained on 13 February albeit that was in conjunction with the suggestion by both Mr Seaton as physician and the two surgeons, that the seat of infection might involve the left forearm which was showing signs of cellulitis. It is this dual prognosis that leads into Mr Wyatt's criticism of the care plan.

[82] His criticism is that the team of doctors should have made the diagnosis of a false aneurysm on 13 February as the primary diagnosis and not merely one of several possible diagnoses and that it was possible to make that diagnosis in the absence of the results of an ultrasound scan (page 499). He said that if a vascular surgeon had seen Mr Peacock on his re-admission “that would have been the first diagnosis we would have entertained” (page 499).

[83] Dr Bodasing said that she did not have a false aneurysm in mind because it was not a condition that she had come across prior to this case (page 164) and Mr Seaton that he did not entertain the possibility of it. He gave three reasons for that: he was doing a busy general ward round that evening; he thought Mr Peacock’s condition might have been a complication of vascular procedure in his forearm; and he did not perform these procedures and was not specifically aware of this being a great possibility (pages 280 and 281). In addition he observed that he was aware of the condition that was an infected false aneurysm but had never seen one either prior to or since caring for Mr Peacock (page 283). Mr Bidwell said that his overall impression of Mr Peacock was that he was suffering from a thrombophlebitis secondary to the venflon site on his left forearm, namely from an inflammation of the superficial veins of the forearm. He went on to say that he felt the main problem was in Mr Peacock’s right groin caused by a pseudo aneurysm (page 371). He did not feel that there was an abscess in Mr Peacock’s leg and for that reason that there was nothing he could do within his area of expertise to alleviate his sepsis. For that reason he advised the team caring for him to continue with treatment by intravenous antibiotics (page 373). Dr McAllister began his evidence by saying that he had no recollection of this case and therefore his evidence was dependent entirely upon the notes. By reference to those notes at pages 246 and 247 he said that he had commented upon the infection in the forearm as well as the right groin but had added that neither definitely explained Mr Peacock’s then deteriorating condition (page 247) as it had been explained to him in the course of referral (page 394). The ultrasound scan that he requested be done the following morning, which indicated in his mind a degree of urgency, would have two uses, to confirm the presence of a false aneurysm and to identify whether there was a collection of pus in the tissues (page 395) which would have assisted in identifying the source of infection.

[84] Underlying these medical views was the condition in which Mr Peacock re-presented. It is set out accurately and in detail in Dr Bodising's note at pages 240 to 243. Mr Seaton described him as "extremely unwell" (page 274) and as "a very, very sick man" (page 282). He was generally unwell with signs of infection in his left arm and his axilla as well as his leg and Mr Seaton's position was that he was keeping an open mind on the source of the infection. His top priority that evening was to resuscitate him from his severe sepsis (page 282) which he thought was a consequence of his recent hospitalisation (page 305). That aim is supported by his proposed care plan set out in his note at 2030 hours that evening, recorded at page 244 of the notes. That plan included seeking a senior surgical opinion because, as he said in evidence, in his opinion Mr Peacock was suffering from a life threatening infection but he was not sure where it was coming from (page 278). In fact he obtained surgical opinions that were not of consultant status, Mr Bidwell being a senior registrar and Dr McAllister a senior house officer which, as he himself observed, belied the title because it was a junior position. Nonetheless the opinions were the most senior that Dr Seaton was able to obtain in the time scale to which he was working that evening. He elected to combat Mr Peacock's infection with an aggressive treatment of antibiotics while at the same time keeping an open mind on its source or sources. The problem according to Mr Wyatt was that "the diagnosis had been missed" because attention was focused elsewhere than on a false aneurysm (pages 513 and 514).

[85] I have concluded that I disagree with Mr Wyatt's criticism. It seems to me on the evidence of the team of doctors involved in Mr Peacock's care that evening that it was asking too much of the physicians to identify at that time the actual existence of a false aneurysm, conclude that it was the primary reason for Mr Peacock's condition and proceed accordingly. In the first place, Mr Peacock was being treated in an acute medical receiving unit and was under the care of physicians. It is to be expected that they were likely to resort in the first place to a recognised medical response to severe infection, namely, the use of aggressive antibiotics. Secondly, Mr Peacock's presentation on 13 February was undoubtedly very complex. As it was analysed at the time, it did not point unequivocally in one direction for the source of infection. Thirdly, he was reassured by the advice he got that nothing urgent needed to be done by way of surgical intervention to attack the source of infection so he was able to focus on managing the infection which he did conservatively using antibiotics.

Fourthly, I accept that it was rare for a physician, even one with the seniority of Mr Seaton, to have much experience of being called upon to treat let alone diagnose a false aneurysm. Dr Byrne observed that as at 2001 he would have anticipated finding such a condition in about one per cent of cases where he had performed a coronary angioplasty (page 130). I accept that evidence. Familiarity with false aneurysms is much more obviously the province of the surgeon and in particular the vascular surgeon than the physician. Indeed Mr Wyatt recognised and accepted this. When he was asked if there was a hierarchy of knowledge amongst vascular surgeons, cardiologists and general physicians concerning pseudo aneurysms or infected pseudo aneurysms as possible complications he replied that he disagreed in that he would expect a cardiologist to have as much knowledge of the complications of their interventionist procedures as vascular surgeons but he accepted that both specialities would have a greater knowledge than a general physician (page 540). I accept that assessment. I think that Mr Wyatt speaking as an expert vascular surgeon demanded of Mr Seaton a knowledge of false aneurysms that was greater than could or should reasonably have been attributed to him as a physician. It was asking too much of him or indeed of his specialist registrar Dr Bodising to conclude what he indicated he would have concluded.

[86] The same observation applies to an infected false aneurysm. It was accepted by all as being a much rarer occurrence. Mr Wyatt said in evidence that it was unusual for aneurysms to be infected (page 500) and in his report that it was a rare but recognised complication of coronary artery stenting procedure (at paragraph 2.13). Dr Byrne observed that of the one per cent of cases he referred to where there was a false aneurysm very, very few became infected (page 131) and very tellingly that Mr Peacock's case was the first that he had ever seen and he had not seen any since. I accept that evidence. It seems to me to reinforce from the point of view of both the vascular surgeon and the cardiologist the rarity of the condition and fortifies my conclusion that it was asking too much of the physicians involved to do what Mr Wyatt urges they should have done. The same applies to the surgeons who were called in of whom in any event Mr Wyatt had no criticism (page 576).

The second feature

[87] Mr Seaton did not call in a vascular surgeon on 13 February but I have to say that I think that is not a failing for which he can be criticised. He was still at the stage of investigating the causes of Mr Peacock's infection. He had sought and obtained such surgical opinions as he could that evening. There is no suggestion in this Inquiry that there is any issue arising out of the system of working then in place concerning the availability of an on-call vascular surgeon. I proceed therefore on the basis of the evidence that was led and on that conclude that faced with the condition in which Mr Peacock presented it was not unreasonable for Mr Seaton to shape and commence his care plan without including the requirement for urgent vascular review. To require that of him is to attribute knowledge beyond what he had and also to my mind introduces an element of hindsight which was denied him and the others on duty that evening. As for requesting an urgent ultrasound scan the scan that Dr McAllister requested was intended by him to be conducted the following day and that in itself betokened a degree of urgency, albeit not as pressing as an emergency request. It so happened that that scan was not done in that intended time frame but none of the team members who gave evidence can be held responsible for that.

The third feature

[88] Having concluded that it was not unreasonable for Mr Seaton and his team to have acted as they did I need say no more than that I disagree with this criticism because I do not think that he team could have been expected to have analysed the source of infection as a false aneurysm.

Issue 3: The ultrasound scan

[89] This issue is related to the foregoing one. I can answer it quickly and unhesitatingly in the affirmative.

[90] On 13 February Dr McAllister's examination of Mr Peacock at about 2115 hours led him to request a Doppler ultrasound examination of his right femoral region "mane" with vascular surgical review thereafter. It is unclear from the evidence when that request was delivered to the radiology department but what was clear was that the request was cancelled on 15 February at the behest of an unnamed doctor. The relevant entry is at page 127 of the notes and states simply: "This examination was

cancelled by the referring clinician.” On the evidence led I accept that none of those who gave evidence and were involved in the care of Mr Peacock over those days was responsible for that decision. I also accept that none knew who had made it. It was not until after he was transferred to the Brownlee Ward that a further request was made for an ultrasound scan. I accept that that may be due in part to ignorance of the cancellation of the scan on the part of those caring for Mr Peacock and in part to the fact that it could take several days for the results of such a scan to be delivered to the ward unless the request had been made as an emergency which Dr McAllister’s had not been. Mr Seaton received the result of that scan on 19 February and immediately advised obtaining a vascular opinion on his right leg.

[91] Mr Wyatt observed that the urgency of the situation was not appreciated until the ultrasound scan result showed positive for the presence of a false aneurysm (page 519). At the time of surgery by Mr Byrne the advanced state of maceration and friability of the arterial tissues indicated that the infection that caused that condition had been present for a long time (page 504).

[92] I am satisfied that the medical evidence led entitles me to conclude on balance that on 13 February Mr Peacock had a false aneurysm in his right groin at the site where the sheath had been inserted. To go beyond that is to enter the realms of conjecture. It may be that by that time infection had already set in at that site, but I do not feel confident on the evidence in making a finding in fact to that effect and in any event would be unable to conclude the extent to which that had occurred. However, that does not prevent me from being satisfied that a Doppler ultrasound scan would have been of assistance to Mr Seaton and his team in their efforts to find the source or sources of Mr Peacock’s infection. The ready evidence for that is the response to the results of such a scan that were delivered to Mr Seaton on 19 February and the course of subsequent treatment of Mr Peacock. Had Dr McAllister’s request been acted upon and not cancelled I think that its results would have led to a similar type of response which could be expected to have brought forward by several days the direct involvement of the specialist vascular surgeons. To what extent that would have prevented the death of Mr Peacock I cannot say. It might not have in the event, but what I think I can say from the assistance I received in the evidence, and particularly that of Mr Wyatt, is that it could be expected to have increased his chances of

combating his systemic infection even if only slightly. It would have been reasonable to have carried out that scan on 15 February.

Issue 4: Dr Chong's advice

[93] The Crown criticism, echoing Mr Wyatt's criticism, was that the advice given by Dr Chong on 19 February was inappropriate.

Chronology of events

[94] The sequence of events that led to that advice started with the transfer of Mr Peacock to Brownlee Ward at Gartnavel Hospital on 18 February. That transfer had no effect on Mr Seaton remaining as the consultant in charge. He was assisted by a team of clinicians. One of them was Dr Weerackody, then a senior house officer in medicine.

[95] On 19 February Mr Seaton saw Mr Peacock and assessed his condition. Dr Weerackody was with him. Mr Seaton's note in the records, at page 266, is timed at 11.30 am and includes the direction: "Get VASCULAR opinion re leg." It was Dr Weerackody who carried out that injunction by speaking to the vascular registrar. His personal recollection of events was limited. He was obliged to make much use of entries in the medical records. He said, under reference to the first entry on page 267 of the records that he wrote that entry and that the on call vascular registrar he had spoken to was Dr Chong. The entry reads:

"Spoken to vascular registrar (4058). Does not feel immediate intervention is needed. Suggest referral to Consultant Vascular Surgeon for review at clinic. However, evidence to suggest size of false aneurysm, embolic complications, to contact Vascular Reg again. Letter dictated 19.02.01."

[96] After that discussion and in furtherance of the advice given by Dr Chong, he had dictated a letter to a consultant surgeon within Gartnavel Hospital to request that Mr Peacock be seen at that surgeon's out-patient clinic. That letter appears at page 6 of the medical records. It was only when Dr Weerackody saw that letter that he was able to recall that he had signed it. He had no direct memory of what he discussed with Dr Chong and his entry on page 267 did not state that. In the course of his

evidence he accepted that the issues he discussed were those set out in the first two paragraphs of his letter to the surgeon.

Comment

[97] In February 2001 Dr Chong was a specialist registrar in general surgery at Gartnavel Hospital. He stressed that he was not then a vascular registrar but a general registrar. He recalled being involved in the care of Mr Peacock and, while he had no recollection of speaking to Dr Weerackody, accepted that it was he whom Dr Weerackody had contacted on 19 February for advice and that the number 4058 was his then pager number. He had a very vague recollection of the information Dr Weerackody gave him about Mr Peacock's condition (at page 266), and thought it was that the patient had renal failure with sepsis and a false femoral aneurysm. Subsequently, on 21 February he became directly involved in the care of Mr Peacock and assisted Mr Byrne during the operation carried out that day. Dr Chong admitted that he did not examine Mr Peacock on 19 February to make his own assessment. He was asked what he made of his advice to Dr Weerackody taking into account his subsequent knowledge about Mr Peacock's condition and he replied (p 266): "Having regard to everything I know now in retrospect, I believe it was poor advice." He added that up until that point his experience of false femoral aneurysms was only on an out-patient basis, that he had never seen a septic pseudo aneurysm either before or since (p 268) and that in retrospect he should have seen Mr Peacock and made an assessment of him at that time (p 267). He would then have referred him on to the appropriate vascular surgeon (p 268) and that although he was not a vascular surgeon it was likely that he would have been operated on that same day, the 19 February (p.271).

[98] The procurator fiscal depute, in submitting that I make a determination under (e), qualified his position that the advice given by Dr Chong was inappropriate by saying that it was unclear precisely what had passed between Dr Weerackody and Dr Chong in their conversation. Mr Jessiman's primary submission was that any finding about the actings of Dr Chong should be dealt with under (e) and not (c) for the various reasons he gives in that part of his written submissions devoted to Dr Chong.

[99] I have to decide whether the advice given by Dr Chong was inappropriate and then if it were whether I am satisfied that I should make a determination and if so whether it should be under (c) or (e). He gave evidence with the benefit of hindsight and that hindsight informed what he said and why he concluded that he had given poor advice. Indeed much of the questioning invited that approach, proceeding as it did on the basis that he apply that hindsight. He clearly felt that looking back he ought to have examined Mr Peacock rather than have relied upon whatever information he was given. What he was unable to say with any certainty was what information he was given on the strength of which he gave the criticised advice. I remain unclear about what information he had to work with beyond what he himself recalled: renal failure with sepsis and a false femoral aneurysm. In particular and central to this matter is the fact that he was not asked to consider Dr Weerackody's letter dictated on 19 February following his discussion with Dr Chong or comment upon its terms. Admittedly Dr Weerackody said that the content of the first two paragraphs of the letter, which gave a condensed and selective history of the care of Mr Peacock between his admission on 7 February and the result of the ultrasound scan on 19 February, set out the issues he discussed with Dr Chong over the telephone and would have reflected the terms of that conversation, but I gained the distinct impression when he gave those answers that he was assenting readily to the pointed questions that were put to him rather than volunteering the information from his own knowledge. Moreover, he was not asked if the way he framed the letter accorded with any custom or practice he had adopted, namely of rehearsing the information on which he sought advice. I was not persuaded from the way he gave his evidence that I could conclude he did in fact disclose all the information contained in the first two paragraphs. The only other evidence that bears upon the quality of advice given came from Mr Byrne. He was asked about that advice by reference to Dr Weerackody's entry at page 267. He answered that the entry seemed to him to rest on assumptions made by Dr Chong that the condition of the false aneurysm was stable and not associated with active complications and that treatment on a semi-elective basis would be appropriate (p 246). On that basis Mr Byrne said that the advice was incorrect because of Dr Chong's interpretation of the clinical picture (pp 246-247). Dr Chong was aware of the presence of a false aneurysm and the error crept in because infection of that aneurysm was not listed in the entry as a complication of it. Accepting that the entry does have that omission I return to what Dr Chong himself

said, that Mr Peacock was suffering not only from a false femoral aneurysm but also from renal failure with sepsis. I accept that he did know that at the material time and therefore was aware at least of the presence of sepsis although I cannot conclude that he knew it affected the aneurysm. In short while agreeing that his advice was poor and moreover was incorrect in fact, I am not satisfied that the evidence discloses that at the time he tendered it he was aware of the true picture in sufficient relevant detail to draw the conclusion it was inappropriate. Accordingly I answer this issue in the negative and as a consequence make no determination on Dr Chong's advice. For the sake of completeness I should say that if I am wrong and there is sufficient evidence to draw that conclusion I would have made it as a comment under (e) and not as a finding under (c).

My conclusion for determinations under section 6(1)(c) and (e)

[100] Having answered the four issues as I have I am satisfied that I should make a determination under section 6(1)(c) in the terms that I have set out but that there is neither need nor justification to make any determination under 6(1)(e).

Concluding comment

[101] I made avizandum on 24 January 2007. When in early March I was able to begin drafting this determination I formed the view that I needed to have sight of Mr Peacock's death certificate or a copy of it even although it had not been put in evidence to any witness. Accordingly I asked the Crown then, through my Clerk, to forward a copy, and the Crown in acknowledging that request indicated that they would forward a copy to my Clerk. I concluded writing this determination at the very beginning of May. By then I was still waiting for the copy certificate. I instructed my Clerk to renew my request and again the Crown indicated that they would forward a copy of the certificate. It was not until the afternoon of 24 May that I received the long awaited copy. I have issued my determination as quickly as I could after receiving it and checking its terms and incorporating its contents in this determination where appropriate.