FIRST DIVISION, INNER HOUSE, COURT OF SESSION

[2025] CSIH 27
P245/24

Lord President
Lady Wise
Lord Clark

OPINION OF THE COURT

delivered by LORD PENTLAND, the LORD PRESIDENT

in the reclaiming motion

in the cause

DR KAREN DUNCAN

Petitioner and Reclaimer

against

THE LORD ADVOCATE

Respondent

Petitioner and Reclaimer: Reid KC; The Medical and Dental Defence Union of Scotland
Respondent: G Anderson KC, R Macpherson; The Scottish Government Legal Directorate

30 October 2025

Introduction

[1] These proceedings for judicial review arise from the tragic death of a young child. The reclaimer (the appellant), a general medical practitioner, seeks reduction of a single finding in a determination issued by the sheriff following a Fatal Accident Inquiry into the circumstances of the child's death. In this opinion we will refer to the child as "J" in order to protect her family's privacy. The challenged finding is that on 1 November 2019 at the Culloden Medical Practice in Inverness the reclaimer could reasonably have taken a

precaution which might realistically have resulted in J's death being avoided. The precaution specified by the sheriff was that the reclaimer could have referred J to the Paediatric Assessment Unit ("PAU") at Raigmore Hospital, Inverness for further assessment. The sheriff made a number of other findings identifying precautions which she considered could have been taken by other doctors. She found that there were two defects in the system of working at Raigmore Hospital which contributed to J's death. None of these other findings is relevant for the purposes of this case.

[2] The reclaimer convened the Lord Advocate as a respondent to represent the public interest. The Lord Advocate opposed the petition for judicial review. Following a substantive hearing, the Lord Ordinary refused the petition. The reclaimer now appeals to this court on the ground that in so doing the Lord Ordinary erred in law.

[3] The reclaiming motion (appeal) raises fundamental issues concerning the correct approach to the scope and purpose of a Fatal Accident Inquiry held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

The facts

[4] The following summary of the pertinent facts is drawn from the sheriff's determination. There is now no dispute about any of the facts.

[5] J was born on 26 March 2018. She died on 25 November 2019 at the Royal Hospital for Children, Glasgow. She lived in Inverness with her parents and two older siblings.

[6] In about July 2019, Mrs M, the child's mother, noticed that J's appetite had deteriorated. She took the child to her local GPs' surgery, the Culloden Medical Practice in Inverness. Mrs M expressed concerns about J's appetite and her high temperature. J was prescribed antibiotics for an ear infection.

[7] In August and September 2019 Mrs M contacted a health visitor with continuing concerns about J's weight and eating habits. The health visitor visited the family and sought advice from a dietician; she passed on the advice to Mrs M. At an appointment with the family on 26 September 2019 the health visitor noted that J was suffering from weight loss.

[8] At the beginning of October 2019 Mrs M noticed a lump protruding from the left side of J's stomach. Her tummy was bloated. Around that time J was frequently crying with what Mrs M believed to be pain.

[9] On 2 October 2019 Mrs M took J to an appointment with a general practitioner at the practice because of her concerns about J's weight and continued high temperature. No abdominal examination was performed at this appointment.

[10] On 3 October 2019 J passed a large blood clot in her nappy; this was about two inches in length. Mrs M photographed it. The same day she took J to the practice and had a consultation with a general practitioner. Mrs M showed the photograph of the blood clot to him. He considered the clot to be unusual. He carried out a limited abdominal examination, but this was difficult because J became distressed and was too active for a deep palpation to be performed. The GP thought J appeared well; he noted the possibility of intussusception, but decided to take no further action, concluding that no further review was necessary.

[11] On 20 October 2019, Mrs M contacted NHS 24 and reported that J had had a lump in her stomach for two days. It seemed painful when touched and the child was presenting with an unusual cry, described as either high-pitched or weak or moaning. An appointment was given for J to be seen by a nurse practitioner in the out-of-hours service at Raigmore Hospital.

[12] The child was seen that evening at Raigmore Hospital by a nurse practitioner. Mrs M told her about the lump on the left side of J's abdomen and that she was in pain. She advised that J had passed a blood clot in her stool following recent antibiotics and that her GP had been made aware of this. Mrs M showed the nurse the photograph and told her that she had concerns about J's weight loss and her reduced food intake. The nurse was informed that there was no history of constipation or vomiting and that J had passed a loose stool about midday that day. The nurse noted that J was clearly distressed, that her abdomen appeared distended, that J became more distressed when touched, that bowel sounds could not be heard and that her temperature was 37.7 degrees. A full examination was not possible due to the child's distress and the nurse therefore felt that it was unsafe to send her home without further examination, observation and, if required, treatment. J was then admitted to the paediatric ward for further examination, treatment and observation. The treating paediatrician, Dr Bhutto a locum doctor, conducted an assessment of the child with a junior colleague. He took a history from Mrs M, who advised him that J had not eaten for three days; that she had abdominal pain; that she was crying constantly; that she had passed a large blood clot in her stool two weeks previously; and that her bowels were opening every day. During the consultation J was very distressed. Dr Bhutto carried out a basic ENT examination, listened to J's heart sounds and chest and examined her visually. He conducted an abdominal examination and felt a mass or lump on the left side. He concluded, incorrectly, that this was a faecal mass and diagnosed constipation. Dr Bhutto ruled out the need for an abdominal x-ray. He prescribed a glycerine suppository as a laxative. This was administered by nurses. Ibuprofen and another laxative were also prescribed and the child was discharged home.

[13] On 28 October 2019 J attended an appointment with a different general practitioner at the practice. The doctor was aware from the notes that J had previously attended with his colleague and he noted that she previously had blood in her nappy. He was aware that she had subsequently been diagnosed with constipation by the PAU and had been prescribed treatment for that. Mrs M described ongoing symptoms and concerns of the same nature as previously. The doctor prescribed further constipation treatment as requested by Mrs M.

[14] On 1 November 2019 J attended an appointment with the reclaimer at the practice. This was an emergency appointment booked by Mrs M. She described ongoing anxiety for J because of continuing symptoms of the same nature as she had previously reported. She advised the reclaimer that she could feel a mass on the left side of J's tummy. The reclaimer was unable to carry out a full examination of J's abdomen because of her presentation. She did not believe that J's tummy was distended. She was unable to find any lumps or masses. Her examination was not as extensive as she would have liked. As a result, she did not consider her findings to be reliable. Nonetheless, she assumed that the mass reported by Mrs M was perhaps related to the paediatric diagnosis of constipation and she offered this explanation to Mrs M. The sheriff found that the reclaimer was asked by Mrs M about the possibility of the family arranging a private scan of J's tummy and that the reclaimer dismissed this suggestion. She did not enquire what current treatment J was receiving for the diagnosis of constipation. Mrs M advised the reclaimer that J was moving her bowels regularly. The reclaimer did not issue any further prescription, nor did she refer J for any further investigation or treatment. She did not consider that there was any information gained at the appointment to merit further referral or investigation.

[15] On 6 November 2019 following a further appointment at the practice, J was admitted as an emergency to the PAU at Raigmore Hospital. She was once again assessed by

Dr Bhutto. J was unsettled, crying and irritable. Her blood pressure was elevated. Dr Bhutto carried out an abdominal examination and found J to be tender on her left side. He felt a mass on her left side and recorded it as faecal loading. He did not request any imaging of the mass. He concluded that J was still suffering from constipation. She was discharged that evening with increased levels of constipation treatments. Mrs M was asked to contact the children's ward as a follow-up. She did so and reported that J was managing eight sachets of the laxative, was drinking well, but had poor appetite. She was passing stools four times per day.

[16] On 15 November 2019 J collapsed at home after vomiting. She was again admitted to Raigmore Hospital as an emergency. A different doctor felt what appeared to be an abnormal mass on the left side of the abdomen. An ultrasound examination revealed a tumour on J's left kidney. She was then taken by air ambulance to the Royal Hospital for Children in Glasgow for treatment.

[17] J was then diagnosed as suffering from a Wilms' tumour on her left kidney. This is otherwise known as nephroblastoma. Emergency chemotherapy treatment was commenced the following day. Despite J receiving maximum organ support, her liver was failing. On 25 November 2019 the child suffered cardiac arrest and died at approximately 01.50, aged 20 months. The post-mortem examination recorded the cause of death as complications of left nephroblastoma and associated therapy.

[18] Wilms' tumour or nephroblastoma is a very rare childhood cancer. There are fewer than 50 cases per year in the United Kingdom. It is a kidney tumour and usually affects children between 1 and 3 years of age. Current research shows that even advanced stage Wilms' tumour has a cure rate of 85%.

[19] At the inquiry, expert medical evidence was given by Dr Norman Wallace, an expert in general medical practice, and Professor Hamish Wallace, an expert in paediatric oncology.

[20] Dr Wallace referred to the Oxford Handbook of General Practice; this represented the knowledge he would expect an ordinary general practitioner to possess. He noted that with reference to diagnosis of childhood malignancy, the handbook explained as follows:

> "Always have a high index of suspicion and if in doubt refer for a specialist opinion. … If a mass is found refer immediately. If the child is uncooperative and abdominal examination is not possible or if examination is difficult consider referral for urgent abdominal ultrasound … Referral to be seen on the same day or within two weeks – any child with … abdominal mass".

[21] In his report, which formed the basis of his evidence-in-chief, Dr Wallace was critical of the consultation with the reclaimer on 1 November 2019. He noted that this had been an emergency appointment booked by Mrs M because J was continuing to display the same symptoms despite treatment. His opinion was that this amounted to a missed opportunity to diagnose the patient correctly. The history of the child's mother thinking that she could feel a mass on the left side of J's tummy should have mandated an urgent referral to the PAU. Dr Wallace expressed some sympathy with the reclaimer and could understand why she had been reassured by the previous paediatric opinion. He described her assessment on the day as "substandard" but mitigated by the false reassurance offered by the earlier paediatric opinion. In cross-examination, Dr Wallace agreed with the proposition put to him that, given the recent paediatric opinion, it was also reasonable on one view for the reclaimer not to re-refer J to the PAU.

[22] Professor Wallace gave evidence to the effect that even advanced stage Wilms' tumour has a cure rate of around 85% and that if further investigations had been arranged the abdominal mass would have been discovered and an onward referral to a children's cancer unit would have been made. Any diagnosis in the period up to and including

6 November would have resulted in the likelihood of cure. Professor Wallace was clear that the delays in J's diagnosis significantly contributed to her death.

The sheriff's conclusions on precautions

[23] The sheriff noted that during the period between 3 October and 6 November 2019 Mrs M consulted heath professionals on five occasions with consistent complaints. J's symptoms were consistent and persistent.

[24] The opinions given by Dr Wallace and Professor Wallace were consistent with each other: there were missed opportunities on at least three occasions during that period to diagnose J correctly.

[25] For present purposes it is important to note that the sheriff observed that Dr Wallace gave an opinion that the reclaimer should have made an urgent referral to the PAU on 1 November 2019. In his opinion, the fact that Mrs M had reported finding a mass on the left side of J's tummy was enough to mandate such a referral; this was, therefore, a reasonable approach. Instead, the reclaimer assumed that the reported mass was due to a loaded bowel, notwithstanding Mrs M's report of the child moving her bowels regularly. Dr Wallace described the reclaimer's assessment of J on that date as substandard. He acknowledged in cross-examination that, on one view, it was reasonable for the reclaimer not to re-refer given the false reassurance of the paediatric opinion obtained some days before the reclaimer's consultation with J. The reclaimer in her evidence did not accept that she could have taken any other reasonable measure at the consultation. She did, however, concede that now, in similar circumstances, she would act differently and would apply a lower threshold for onward referral. Dr Wallace described the consultation on 1 November as a further missed opportunity to diagnose J correctly.

[26] A summary of Dr Wallace's opinion was that it would have been reasonable to refer J back to the PAU on 1 November given the reported abdominal mass, but it was also reasonable not to refer back given the recent paediatric diagnosis.

[27] The sheriff held that on the basis of Dr Wallace's opinion, a referral to the PAU was one reasonable course of action which the reclaimer could have taken.

[28] Having reached these conclusions, the sheriff then asked herself whether a referral to the PAU on 1 November was a reasonable precaution which, had it been taken, might realistically have resulted in J's death being avoided. In accordance with Professor Wallace's evidence, the sheriff found that any full and proper investigation of J's symptoms was likely to have led to a diagnosis which in turn would have led to immediate treatment. If treatment had commenced during the period up to and including 6 November 2019, Professor Wallace's opinion was that survival and cure were not just possible, but probable. A referral to the PAU on 1 November would have resulted in further investigations in the unit. Such investigations, if carried out properly, would have resulted in a correct diagnosis. If a correct diagnosis had been made, treatment would have commenced and survival was likely. Therefore, if the reclaimer had made a referral on 1 November it might realistically have resulted in the death being avoided.

[29] On the basis of that evidence the sheriff reached the conclusion that further referral by the reclaimer to the PAU on 1 November 2019 was a reasonable precaution to take in all the circumstances. It is this finding (and only this finding) that the reclaimer says was one that the sheriff was not entitled, as a matter of law, to make.

The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016

[30] The 2016 Act was passed following a comprehensive review of the operation of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 conducted by Lord Cullen of Whitekirk KT. He issued a consultation paper, to which a substantial number of responses was received. The work of the review included an examination of the determinations of sheriffs in FAIs in the preceding decade, to gain an understanding of the practical and legal issues with which they had been concerned in the operation of the system for FAIs. The review also looked into the systems for inquiring into fatal accidents in other jurisdictions, in particular England and Wales, Northern Ireland, the Republic of Ireland, New Zealand, Victoria and Alberta, in order to see whether there were approaches which could be usefully considered.

[31] In paragraph 8.11 of his review Lord Cullen noted that section 6(1)(c) of the 1976 Act was concerned with "the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided". He considered that two points arose. First, some had said that what was contemplated was a "real and lively possibility". Another view was that the test was higher than that. Yet another was that it was enough if the avoidance of the accident could not be ruled out. His Lordship referred to determinations in FAIs conducted by different sheriffs and to a leading textbook in which these varying views had been expressed.

[32] Secondly, Lord Cullen observed that there was a division of view as to whether "might have been avoided" did or did not include a consideration of hindsight. His Lordship commented that, having regard to the public interest in the learning of lessons from the circumstances of a fatality, there was considerable force in the view that sheriffs should take hindsight into account.

[33] For these reasons Lord Cullen recommended that consideration should be given to the clarifying of the meaning of section 6(1)(c), if necessary by amendment to the legislation. In its response to the review published in 2011 the Scottish Government accepted this recommendation.

[34] The explanatory notes accompanying the 2016 Act explain that the purpose of the measure was to modernise the legislative framework for FAIs in Scotland. The Act implemented the recommendations of the review insofar as they had been accepted by the Scottish Government.

[35] The purpose of an FAI is to establish the circumstances of a death and consider what steps, if any, might be taken to prevent other deaths in similar circumstances (section 1(3)), but it is not to establish civil or criminal liability (section 1(4)). An FAI must be held into the death of a person which occurred in Scotland while the person was (a) acting in the course of his or her employment or occupation (section 2(3)); (b) while the person was in legal custody (section 2(4)(a)); or (c) while a child was being kept or detained in secure accommodation (section 2(4)(b)). In relation to any other death of a person which occurred in Scotland, an FAI may be held if the Lord Advocate considers that the death was sudden, suspicious or unexplained or occurred in circumstances giving rise to serious public concern and that it would be in the public interest for an FAI to be held (section 4(1)). The FAI with which these proceedings are concerned was a discretionary inquiry held under section 4(1).

[36] An FAI is conducted by a sheriff (section 1(2)), is held in public (section 21) and is largely conducted in accordance with the civil rules of evidence applicable in the sheriff court (section 20(3)). As soon as possible after the conclusion of the evidence and submissions in an FAI, the sheriff must make a determination, setting out certain findings

and, if appropriate, recommendations (section 26(1)(a) and (b)). The findings which must be made are prescribed by section 26(2):

> "The circumstances referred to in subsection (1)(a) are –
> (a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) any precautions which –
> (i) could reasonably have been taken, and
> (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death,
> (g) any other facts which are relevant to the circumstances of the death."

[37] For the purposes of subsection (2)(e) and (f) it does not matter whether it was foreseeable before the death or accident that the death or accident might occur if the precautions were not taken or, as the case may be, as a result of the defects (section 26(3)). The matters on which recommendations may be made include the taking of reasonable precautions which might realistically prevent other deaths in similar circumstances (section 26(4)(a)). Importantly, a determination is not to be admissible in evidence, and may not be founded on, in any judicial proceedings of any nature (section 26(6)).

The petition for judicial review

[38] The reclaimer sought reduction of the sheriff's determination insofar as it found that a precaution which could reasonably have been taken and which might realistically have avoided J's death would have been for the reclaimer to have referred her to the PAU for further assessment on 1 November 2019.

[39] The reclaimer averred that it was not open to the sheriff to make such a finding under and in terms of section 26(2)(e) of the 2016 Act. In reliance on the approaches taken in

determinations issued by sheriffs in certain other FAIs, the reclaimer contended that where a doctor took one of two or more reasonable options it was inappropriate and amounted to an error in law to find that one of the other available options would have been a reasonable precaution. It was also argued that the sheriff had failed to provide adequate reasoning for making the challenged finding.

The Lord Ordinary

[40] The Lord Ordinary observed that the language of section 26(2)(e) referred to "any" precautions. There was nothing in the statutory language which suggested that a finding might not be made where another option was available. To approach matters in that way would be to mirror the test for establishing medical negligence; this had no part to play in an FAI (c.f. *Hunter* v *Hanley* 1955 SC 200). There was evidence before the sheriff to the effect that a referral to the PAU was a precaution that could reasonably have been taken which might have avoided the death. The sheriff was entitled, indeed mandated, to make such a finding in her determination. The reasoning in her determination was sufficient to explain why she made the challenged finding.

Reclaimer's submissions

[41] Sheriff Braid (as he then was) in the *FAI into the death of Marion Bellfield* [2011] FAI 21 at paragraph 41 was correct to hold that where there were two equally sound clinical options available to a doctor, each of which would have avoided death, it would be wrong to say that the option not selected was a reasonable precaution, which ought to have been taken. While that case was decided under the 1976 Act, the reasoning applied also to section 26 of the 2016 Act. A similar approach had been taken by the Lord Ordinary in

Sutherland v *Lord Advocate* 2017 SLT 333; [2017] CSOH 32 at paragraph [34] and by sheriffs in other FAIs.

[42] The Lord Ordinary's approach emptied the word "precautions" of any meaning. Dr Wallace accepted in cross-examination that it was reasonable for the reclaimer not to have referred J to the PAU. Such evidence precluded a finding that it could have been a reasonable precaution to have made the referral.

[43] The sheriff's reasoning was inadequate. Her determination did not allow the reader to understand why the matter was decided as it was and what conclusions were reached on the principal issue. She did not explain why she rejected the reclaimer's submissions.

Respondent's submissions

[44] The Lord Ordinary correctly interpreted section 26(2)(e) of the 2016 Act. The sheriff required to make a determination which set out findings as to the circumstances; these included any precautions which could reasonably have been taken and which, had they been taken, might realistically have resulted in the death being avoided. Section 26(1)(a) and (b) required the sheriff to perform two different exercises. Section 26(1)(a) involved the sheriff considering the matters set out in section 26(2) objectively and with the benefit of hindsight. Foreseeability played no part in that process. Section 26(1)(b) involved the sheriff considering whether it was appropriate to make recommendations as to the matters set out in subsection (4), being steps which might prevent other deaths in similar circumstances. This exercise involved the sheriff applying foresight as to future risk. In the present case the sheriff made no recommendations. In any case where a finding was made that there was a precaution which could reasonably have been taken, it did not follow that a

recommendation should be made that it be taken in the future (i.e. without the benefit of hindsight).

[45] Sheriff Braid was correct to say in *Marion Bellfield* that a precaution was an action or measure taken beforehand against a possible danger or risk (paragraph 41). The words "any precautions" in section 26(2)(e) of the 2016 Act were wide enough to cover referral of a child to a hospital for specialist input, even if it was reasonable not to refer the child.

[46] It was irrelevant whether the decision to refer was a clinical one. The reclaimer's approach imported the *Hunter* v *Hanley* test by the back door. Such an interpretation was inconsistent with the plain terms of the statutory provision. Section 26(2)(e) was not concerned with precautions which ought reasonably to have been taken, but rather with precautions which could reasonably have been taken. A finding under that provision did not imply that a clinician ought reasonably to have acted differently, but merely that he or she could reasonably have done so.

[47] Read as a whole, the determination did not leave the informed reader in any doubt as to the sheriff's reasoning on the point now in issue. It satisfied the need for information as to the circumstances of J's death and allowed the informed reader to understand why the findings had been made and explained the evidence on which they were based.

Analysis and decision

[48] An FAI is a fact-finding exercise held in the public interest. Its purpose is not to establish guilt in a criminal sense or to make a finding as to fault or to apportion blame as can be done in a civil case (*Black* v *Scott Lithgow Ltd* 1990 SC 322, Lord President Hope at 327). Whether there has been negligence on the part of a doctor (or anyone else) causing or contributing to death is a matter for civil proceedings not for an FAI.

[49] The question before the court is whether the Lord Ordinary was right to hold that the sheriff correctly interpreted and applied the terms of section 26(2)(e) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 in finding that on 1 November 2019 at the Culloden Medical Practice, Inverness the reclaimer could have referred J to the PAU for further assessment and that this amounted to a reasonable precaution which could have been taken and that had it been taken it might realistically have avoided J's death.

[50] As is the case with any statutory provision, the court's task in interpreting section 26 is to identify the meaning of the words used by Parliament in the context of the legislation in which the words appear (*R(O)* v *Home Secretary* [2023] AC 255, Lord Hodge at paragraph 29). The primary source by which meaning is ascertained is the words which Parliament chose to enact as an expression of the purpose of the legislation. This exercise gives rise to no difficulty in the present case because the meaning of the words found in section 26(2)(e) is plain and unambiguous.

[51] Section 26(1)(a) makes clear that as soon as possible after the conclusion of the evidence and submissions in an FAI the sheriff must make a determination setting out the sheriff's findings as to the circumstances mentioned in subsection (2). The circumstances referred to in subsection (1)(a) are listed in subsection (2), as quoted above at paragraph [36]. They include: when and where the death occurred; when and where any accident resulting in the death occurred; the cause or causes of the death; the cause or causes of any accident resulting in the death; any defects in any system of working which contributed to the death or any accident resulting in the death; and any other facts which are relevant to the circumstances of the death. Subsection (2)(e) identifies, in clear and unambiguous terms, another circumstance which the sheriff must set out in his or her determination, namely:

"(e) any precautions which—

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,"

For present purposes the key word in this provision is "could". If the evidence presented at the FAI shows that a precaution could reasonably have been taken and that had it been taken it might realistically have resulted in the death or any accident resulting in the death being avoided then the sheriff must set out such a precaution in his or her determination. The duty to do so is a mandatory one created by the statutory provision. The sheriff has no discretion not to make such a finding where the evidence satisfies the statutory criteria. It is notable that the provision does not say that a precaution should be set out only if the sheriff considers that it *ought* to have been taken or that it *should* have been taken. The threshold for making a finding under section 26(2)(e) has been deliberately placed at a lower level than would be the case if the provision required the sheriff to be satisfied that a precaution ought to have been taken or that it should have been taken. It is sufficient if the sheriff is satisfied that the precaution *could* have been taken.

[52] The word "precautions" should be given its ordinary and natural meaning: a measure, action or step taken beforehand against a possible danger, risk or inconvenience. Section 26(2)(e) is evidently couched in wide terms. Not only is this clear from the fact that it is precautions which <u>could</u> have been taken and <u>might</u> realistically have avoided death which require to be identified, it is also notable that the provision refers to <u>any</u> precautions. It is important to acknowledge also that the legislation does not distinguish between FAIs in which questions of decision-making by doctors arise and FAIs concerned with the investigation of deaths occurring in other circumstances. The duty to identify any

precautions falling within the scope of section 26(2)(e) arises in every FAI, whatever its subject-matter may be. The wide meaning of the provision is entirely consistent with the policy and purpose of the 2016 Act: to create a system for the investigation of sudden, accidental and unexplained deaths by an independent prosecutor and by a public inquiry conducted by a sheriff, the fundamental objective of these processes being to try to avoid the occurrence of deaths in similar circumstances in the future. The proceedings are inquisitorial and are not concerned with establishing blame. They are, in short, intended to enable lessons for the future to be learned. That this is the context and underlying policy of the 2016 Act is made clear, in particular, by section 1(3) which provides that the purpose of an FAI is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[53] These considerations explain why it is important that a wide power has been conferred on the sheriff to identify any precautions which could have been taken which might have avoided the death. The identification of such precautions, even though it may have been reasonable not to take them in the particular circumstances of the case, may serve to encourage reflection and re-evaluation of established practices and understandings by interested parties, such as government, local authorities, statutory bodies, regulators, professional bodies, training authorities and the like.

[54] A number of determinations in other FAIs were cited to the court in the course of the hearing on the summar roll. Most were issued at a time when the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 was still in force and are, therefore, of no real assistance in the context of interpreting the different statutory language in the current legislation. In deference to the submissions advanced to us, we would, however, make the following brief observations.

[55] In *Lynsy Myles* (27 February 2004) the sheriff stated that before a precaution could be a reasonable one in the context of a medical issue, there must be either an admission by the treating doctor that he failed to take a precaution or course of action which he clearly ought to have taken or took an action which in the exercise of ordinary care ought not to have been taken; failing that, there would require to be established by independent evidence the manner in which the doctor in a particular area of expertise and with the particular experience ought to have acted (page 25). Insofar as this statement may be taken to imply that a finding that a precaution could reasonably have been taken can only properly be made in circumstances where the test for medical negligence laid down in *Hunter* v *Hanley* 1955 SC 200 has been established, we consider it to be unsound. The test for medical negligence had no part to play under the 1976 Act. It is equally irrelevant in the context of the 2016 Act. The test for medical negligence is not concerned with competing options which may all be individually reasonable.

[56] Reference was also made to the observations of Sheriff Braid in *Marion Bellfield* [2011] FAI 21 where his Lordship said this at paragraph 41:

> "The natural meaning of 'precaution' is an action or measure taken beforehand against a possible danger or risk. Further, since one purpose of a fatal accident inquiry is to inform those with an interest of what precautions should be taken in future, a finding under section 6(1)(c) must carry with it the implication that the precaution ought, with the benefit of hindsight, to have been taken in the case which resulted in the death, albeit without any necessary implication that the failure to take it was negligent. That being so, I agree that when one has a situation which solely involves the exercise of clinical judgment, where a range of reasonable actions might be taken, and the choice as to which to take rests on the skill and experience of a doctor based upon such information as is available to him at the time, and the doctor happens to choose a course which results in death, it would be wrong to hold that the selection of another option within the range, which might have prevented the death, was a reasonable precaution which ought to have been taken. Not only does that involve straining the meaning of *precaution*, but such a finding would be of no real practical benefit to others in the future. A Fatal Accident Inquiry cannot prescribe how doctors or nurses should exercise their judgment. Put another way, the true precaution which ought to be taken in any given case may simply be a

> requirement that a patient is seen by a suitably skilled doctor, rather than how the doctor exercises his skill and judgement thereafter."

[57] We have no difficulty with Sheriff Braid's definition of precaution. We would, however, observe that whatever the position may have been under the 1976 Act, it would be erroneous to say that a reasonable precaution finding made under section 26(2)(e) of the 2016 Act necessarily carries with it the implication that the precaution ought to have been taken. As we have explained, the provision concerns what could have been done, not what ought to have been done or what should have been done. The statutory wording permits no other interpretation. It follows that the fact that the choice of precaution involves the exercise of medical skill and judgement does not mean that it would be wrong to hold that the selection of another option within the reasonable range amounted to a reasonable precaution which could have been taken. We would reiterate that there is no special approach which falls to be applied where an FAI is concerned with clinical decisions taken by doctors or indeed any other person possessing special skill or expertise, such as a lawyer, engineer or architect. While a certain level of deference to judgemental decision-making may have a part to play in the context of establishing negligence in civil proceedings, such an approach is not appropriate in an FAI.

[58] In paragraph [46] of *Bellfield* Sheriff Braid went on to say the following in a passage relied on by the Lord Ordinary:

> "The next question which arises is whether it was in this case a *reasonable* precaution. In deciding that question, I must deal with the submissions presented to me to the effect that it would be open to me to find that a CT scan was reasonable only if I reached the view that what was done was unreasonable. With respect, I do not consider that to be correct. I have already pointed out that negligence is not in issue and that it is not the function of this inquiry to attribute blame. It is therefore nothing to the point to inquire as to whether what was done was reasonable, and it seems to me to involve a *non sequitur* to hold that a precaution which was not taken can be held to have been reasonable only if what was done was not reasonable. To take that approach respectfully seems to me to apply the principles and language of

> negligence, which are irrelevant for the purposes of this inquiry. I do not see why it is not open to me to hold that, even though what was done was reasonable, other reasonable precautions might also have been taken which might have prevented the death."

[59] We agree with the Lord Ordinary that this analysis encapsulates the correct approach under the 2016 Act. In short, the fact that one particular reasonable precaution was taken by a doctor (or anyone else) does not mean that a different precaution may not also have been one that could reasonably have been taken. This approach is entirely consistent with the policy of the 2016 Act: to identify how matters could reasonably have been handled differently in ways which might realistically have avoided the death.

[60] In *Sutherland* v *Lord Advocate* 2017 SLT 333; [2017] CSOH 32 it was correctly held that the 1976 Act was intended to permit retrospective consideration of matters with the benefit of hindsight and that the aim of the process was to identify the circumstances of the death and inform subsequent actings with a view to avoiding such a death in future (paragraphs [29] and [30]). The same applies to the 2016 Act. The Lord Ordinary in *Sutherland* was also right to say (paragraph [33]) that the rationale behind *Hunter* v *Hanley* was of no application in a determination made following an FAI. He added that an analysis of what would have been a reasonable course of action for the doctor in the light of information known at the time was not a relevant consideration in determining whether a reasonable precaution might have resulted in the death being avoided. Again, we agree.

[61] In paragraph [34] of *Sutherland* the Lord Ordinary said the following:

> "It was submitted that it would be possible to envisage a situation, involving the exercise of clinical judgment, whereby a doctor was presented with two or more options and could not know which was in the patient's best interests. I accept that in such a situation where the optimal course was not taken, it would not be appropriate to determine that the selection of another of the available options would have been a reasonable precaution. I accept that to do so would distort the ordinary meaning of 'reasonable precaution' and would in any event be of no assistance for the future. I

> am satisfied, however, that the circumstances of the petitioner's decision, not to operate, were not of that type."

[62] While the reclaimer sought to rely on this passage, we are not persuaded that it assists in the circumstances of the present case for a number of reasons. First, the *dictum* was not concerned with the 2016 Act. Secondly, the reclaimer accepted in her evidence that she would now adopt a lower threshold if she had to decide whether to seek specialist input to reconsider the diagnosis and investigate further. So, the finding now challenged can be said to be of assistance for the future. It serves to draw to the attention of (amongst others) the medical profession the decisions made in the present case and provides learning for the profession in the event that similar circumstances were to arise in the future. The finding thus informs the medical profession, with the benefit of hindsight, that within the range of reasonable options, there was the option to refer for further assessment. Seized with such knowledge, clinicians may be disposed in future to consider applying the lower threshold for referral which the reclaimer would now herself adopt. This learning may well prove to be of benefit to the general public and to the medical profession. Thirdly, the exact meaning and intended import of the *dictum* are not, with respect, entirely clear. It is unclear what is meant by the reference to the optimal course in the context of circumstances where the hypothetical doctor could not know which of the options was in the patient's best interests. For these reasons we do not consider that the *dictum* assists in the circumstances of the present case.

[63] Finally, we were referred to a determination issued by the Sheriff Principal in *Leo Lamont and others* [2025] FAI 15. At paragraphs 127 and 128 the Sheriff Principal agreed with what had been said in *Sutherland* at paragraph [34]. She added that where a range of reasonable options is available, the decision as to which to choose falls to be determined by

the knowledge, skill and experience of the clinician and the information available to him or her at the time; it was a matter of clinical judgement. The Sheriff Principal then stated that if the selection of a particular option had resulted in death, it would not be appropriate to find that the selection of an alternative option was a precaution which could reasonably have been taken in terms of section 26(2)(e); the statutory test would not be met. For the reasons we have already explained, we do not (with respect) consider that this analysis of section 26(2)(e) is correct. It fails to give proper effect to the language used in the provision, particularly the word "could". If the evidence shows that other reasonable precautions could have been taken and that they might realistically have avoided death had they been taken, it is the duty of the sheriff to set out such precautions in his or her determination.

[64] It is clear that this is exactly what the sheriff did in her comprehensive and careful determination in the present case. The evidence fully justified her finding that on 1 November 2019 at the Culloden Medical Practice, Inverness the reclaimer could have referred J to the PAU for further assessment and that this amounted to a reasonable precaution which could have been taken and that had it been taken it might realistically have avoided J's death. The sheriff correctly interpreted and applied section 26(2)(e) of the 2016 Act. She did not err in law.

[65] That leaves just the challenge based on the proposition that the sheriff's reasons for making the finding under section 26(2)(e) were inadequate. Ultimately, this was only faintly pressed at the hearing on the summar roll. We have no hesitation in rejecting the point, essentially for the reasons given by the Lord Ordinary. Reading the determination fairly and as a whole, the informed reader would not have been left in any doubt as to the basis for making the challenged finding. The sheriff's reasons for making the finding were unquestionably adequate and intelligible. There was no need for her to rehearse parties'

submissions on questions of statutory interpretation or to engage in an elaborate exercise of legal analysis. There was ample factual and opinion evidence to support the challenged finding. The sheriff set out the relevant evidence fully in her determination. The determination satisfied the public interest in the need for information concerning the circumstances of J's death.

[66] We refuse the reclaiming motion and adhere to the Lord Ordinary's interlocutor of 3 January 2025.