OUTER HOUSE, COURT OF SESSION

[2024] CSOH 114

P245/24

OPINION OF LADY HALDANE

in the Petition of

KAREN DUNCAN

Petitioner

for

Judicial Review

Petitioner: Reid KC; MDDUS
Respondent: MacPherson, advocate; SGLD

3 January 2025

Introduction

[1] The petitioner is a General Practitioner in practice in Inverness. The first respondent is a sheriff who presided over a Fatal Accident Inquiry into the death of a young child, hereinafter referred to as "J". She issued her determination following that inquiry on 21 December 2023. She has not entered this process. That is not unusual in this type of proceeding. The second respondent is the Lord Advocate, convened to represent the public interest. The Lord Advocate has entered these proceedings, as is usual.

[2] The determination issued on 21 December 2023 made a number of findings, as is required in terms of the relevant legislation, including, in respect of the petitioner, a single finding that it would have been a reasonable precaution, which might have resulted in the

death of JM being avoided, had the petitioner referred JM to the Paediatric Assessment Unit following a consultation on 1 November 2019. The petitioner seeks reduction of that part of the determination (in other words a declaration that one aspect of the determination is of no legal effect) on the basis, firstly, that the sheriff misdirected herself in law in making that finding, and secondly and in any event that she failed to engage with the submissions made on behalf of the petitioner that such a finding was not open to her, and failed to provide a reasoned analysis of those submissions.

Background

[3] JM was born on 26 March 2018. She died on 25 November 2019 at the Royal Hospital for Children, Glasgow. The cause of her death was complications of left nephroblastoma, otherwise known as Wilms' tumour, and associated therapy. Wilms' tumour is a very rare childhood cancer. On 20 October 2019 JM was referred to the Paediatric Assessment Unit ("PAU") at Raigmore Hospital following a call to NHS 24 and a subsequent review by the NHS Highland Out of Hours service. She was examined by specialist paediatric clinicians, diagnosed with constipation, and provided with Movicol treatment for that condition. On 1 November 2019 JM was reviewed by the petitioner within the GP practice. This was an emergency appointment booked by JM's mother. Mrs M described on-going anxiety for JM because of continuing symptoms of the same nature as previously complained about. Mrs M advised the petitioner that she could feel a mass on the left side of JM's tummy. The petitioner was unable to carry out a full examination of JM's abdomen because she was unwilling to cooperate with examination. She did not believe that JM's tummy was distended. She was unable to find any lumps or masses. Her examination was not as extensive as she would have liked. She did not think her findings were reliable as a result.

Nevertheless, she assumed that the mass reported by JM's mother was perhaps related to the paediatric diagnosis of constipation and offered this explanation to Mrs M. On 6 November 2019, JM was referred to Raigmore Hospital as an emergency following a further review at the GP practice by the petitioner's colleague. Following review, JM was discharged with an increased dose of her Movicol constipation treatment. On 7 November 2019 JM's mother telephoned the PAU at Raigmore Hospital for further advice. On 15 November 2019, JM was admitted to Raigmore Hospital as an emergency, having been taken there by ambulance from her home after becoming unresponsive. She was diagnosed as suffering from a Wilms' tumour and transferred to Glasgow for specialist treatment. Chemotherapy was commenced. JM died on 25 November 2019 at the Royal Hospital for Children, Glasgow. It was not a matter of dispute that the tumour from which JM suffered, although rare, has a high survival rate up to a relatively late stage, and that had JM been diagnosed on or before 6 November 2019, she probably would have survived.

[4] A Fatal Accident Inquiry into JM's death was ordered. This took place over 4 days of hearings in the summer and autumn of 2023. The first day of hearings was in person, with the rest being conducted by way of Webex video platform. When the sheriff issued her determination, she made a number of findings in terms of section 26 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, including, in addition to formal findings as to time, date and cause of death, findings in terms of section 26(2)(e) as to precautions that could reasonably have been taken and which, had they been taken, might realistically have avoided JM's death. None of those findings are challenged bar the following finding in respect of the petitioner:

> "On 1 November 2019, at Culloden Surgery Inverness, Dr Karen Duncan the consulting GP could have referred Jessi to the PAU for further assessment."

[5] The issue for determination is whether that was a permissible finding open to the sheriff having regard to the evidence before her, and what might be taken from that evidence. The parties take opposing views of the correct legal approach to findings made in terms of section 26 of the 2016 Act. The petitioner contends that established practice and precedent over a considerable number of years means that such a finding was impermissible on the basis of the evidence, the respondent contends that the sheriff was not only entitled to make that finding, she was, having regard to the language of the statute, mandated so to do.

The applicable legislation

[6] The inquiry into the death of JM was conducted in terms of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. It received Royal Assent on 14 January 2016 and repealed the Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976. The 2016 Act emerged from a review of Fatal Accident Inquiry Legislation, which was carried out by the Rt Hon Lord Cullen of Whitekirk KT and published in November 2009. He observed that there were a number of differing views on the interpretation of section 6(1)(c) of the Act then in force (the "reasonable precautions by which the death might have been avoided" provision, read short) and offered the view that having regard to the public interest in the learning of lessons from the circumstances of a fatality, there was force in the contention that hindsight should be taken into account. That report formed the basis of a consultation on proposals to Reform Fatal Accident Inquiries Legislation in July 2014. It noted Lord Cullen's recommendation that legislation should clarify and/or say more about what "reasonable precautions whereby the death and any accident resulting from the death might have been avoided" sheriffs may recommend. The resultant legislation was the 2016 Act referred to

above. For present purposes, the material sections are sections 1 and 26, which are in the following terms:

> "1 **Inquiries under this Act**
>
> (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—
> (a) investigate the circumstances of the death, and
> (b) arrange for the inquiry to be held.
> (2) An inquiry is to be conducted by a sheriff.
> (3) The purpose of an inquiry is to—
> (a) establish the circumstances of the death, and
> (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.
> (4) But it is not the purpose of an inquiry to establish civil or criminal liability.
>
> …
>
> **26 The sheriff's determination**
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
> (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.
> (3) 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—
> (a) if the precautions were not taken, or
> (b) as the case may be, as a result of the defects.
> (4) The matters referred to in subsection (1)(b) are—
> (a) the taking of reasonable precautions,
> (b) the making of improvements to any system of working,

(c) the introduction of a system of working,
(d) the taking of any other steps,
which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—
(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature"

[7] By way of comparison, the equivalent provision to section 26 in the previous legislation was section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 which provided:

"6. Sheriff's determination etc.

(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction—
(a) where and when the death and any accident resulting in the death took place;
(b) the cause or causes of such death and any accident resulting in the death;
(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
(e) any other facts which are relevant to the circumstances of the death.

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

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

[8] A comparison of the two provisions shows, amongst other matters, that the question of foreseeability has now formally been excluded in terms of section 26(3) of the 2016 Act, consistent with the recommendations of Lord Cullen having regard to the nature and purpose of such inquiries, as well as to address the variable approach to this question in determinations made in terms of the 1976 Act. It can also be seen that there has emerged a

slightly different use of language as between section 6(1)(c) and section 26(2)(e) – "the reasonable precautions, if any, by which…." has become "any precautions which could reasonably have been taken". Parties differed on the significance, if any, of this different linguistic emphasis between the two provisions. The material placed before me did not elucidate explicitly the underlying rationale, if any, for this change in language.

Submissions for the petitioner

[9] Mr Reid, for the petitioner, invited me to sustain his first and second pleas-in-law and to reduce the determination insofar as it finds that a precaution which could reasonably have been taken and which might realistically have resulted in the death of JM being avoided would have been for the petitioner to have referred JM to the Paediatric Assessment Unit at Raigmore Hospital on 1 November 2019. He broke his submissions down into four parts; the broad context; the legal framework underpinning Fatal Accident Inquiries (FAI's) and the law in respect of reasons; what was before the sheriff in terms of evidence and submissions; and the determination itself and why it is flawed, being predicated upon an error of law and an absence of reasons.

The broad context

[10] In terms of context, Mr Reid set out the background to these undoubtedly tragic events, as narrated above. He stressed that this was not a challenge taken lightly, recognising that the mere fact of challenging the determination would inevitably be distressing to the family of JM. However he emphasised that the finding under challenge was not one lawfully open to the sheriff and not one that should have been made, which is why reduction of that specific finding only was sought.

The legal framework

[11] Mr Reid indicated that this submission had three elements to it; the statutory framework; previous determinations; and finally the supervisory jurisdiction of the court and how that interacts with FAI's. Mr Reid observed that this was the first time that a Judicial Review had been brought under the 2016 Act and that there was little binding guidance available to sheriffs on the proper approach to findings in terms of section 26. It was clear that foreseeability was not relevant, as that was explicitly stated in subsection (3). The test in regard to reasonable precautions now explicitly involved a two stage assessment - firstly whether there was a precaution that might reasonably have been taken and whether that precaution might realistically have resulted in the death being avoided, in other words a cumulative test. The focus in the present case was on what was reasonable, and what constituted a precaution. Whilst recognising that the language of the 2016 Act did not exactly mirror that of its predecessor legislation in this respect, Mr Reid contended that it could not be assumed that there had been any intention to change what was expected of a sheriff in this regard. In any event, it was important to recognise that both Acts did not talk of any "step" that might have been taken, but referred specifically to a precaution.

[12] As to what might be meant by "precaution", Mr Reid placed reliance upon two previous determinations which he stated were routinely cited in FAI's where the actions of medical professionals were being considered. These were the determination in the inquiry into the death of *Lynsy Myles*, dated 27 February 2004, and the inquiry into the death of *Marion Bellfield* dated 28 April 2011. Looking firstly at the determination in *Myles*, Mr Reid contended that the issue facing the then Sheriff Stephen in that inquiry was very similar to that facing the sheriff in the present case, namely whether a CT scan ought to have been

arranged prior to a particular date, and whether such a scan would have been a reasonable precaution which might have avoided Ms Myles's death. In that context Sheriff Stephen had made the following observation at page 23:

> "What is the correct approach to section 6(1)(c) issues in medical FAIs?
>
> The key word must be 'reasonable' - in judging what is reasonable and particularly whether the actings of medical professionals or indeed any other professional achieves a certain standard care must be taken by lawyers before we embark on a critique of the treatment carried out by doctors. As lawyers we are no more than tutored laymen who can apply normal analytical skills and common sense. Whereas we may question and indeed criticise medical professionals, lawyers cannot be the arbiters of what is reasonable based upon our examination alone. There is always a risk in Inquiries such as this that emotive issues arise, perfectly understandably."

[13] Mr Reid submitted that this passage contained "sound advice" and explained why expert evidence was admissible in FAI's, otherwise, he queried rhetorically, why have it? Put another way, with the benefit of hindsight in the *Lynsy Myles* case no one would not have scanned Ms Myles or, in the present case, referred JM, but it was important that emotive issues did not cloud the task that the court was being asked to do. The question was, what could reasonably have been done, so that in the future a clinician did not miss a chance to avoid a tragedy. Further on, at page 25, Sheriff Stephen continued:

> "Again lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is clear appropriate testimony which challenges the treatment a patient receives. The view I take of this matter is that for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff. Before I can find a precaution to be reasonable in the context of a medical issue, there must either be 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 the course of 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. This clearly requires there to be a standard by which the actings of doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification and reflecting the jurisprudence surrounding medical negligence issues it must avoid the situation whereby medical professionals become hamstrung in

> their treatment of patients because of concern that their view and their clinical judgement may be called into question by a colleague who takes a differing view"

[14] That passage, submitted Mr Reid, was a correct statement of the approach to be taken. Recognising that the language employed by Sheriff Stephen mirrored to some extent that found in actions of clinical negligence based upon the test in *Hunter* v *Hanley* 1955 SLT 213, Mr Reid contended that the rationale underlying *Hunter* v *Hanley* was to prevent the practice of defensive medicine, and that that same rationale lay behind the determination in an FAI - that the "reasonable judgment" of the medical professional should be respected. Mr Reid acknowledged that the *Hunter* v *Hanley* test was not directly applicable in the context of an FAI but submitted nevertheless that the test was what was reasonable, and that caution in that regard was required when considering the actions of medical professionals. Put another way, the cautionary note drawn from *Hunter* v *Hanley* was not to be quick to criticise and rather to accept that a range of views were possible. When considering precautions, the key question was what thing should reasonably have been done to avoid the death. If "x" or "y" were both reasonable, it was not open to find that a reasonable precaution would be to do "y" instead of "x". If, hypothetically, the death in question reveals a problem with a particular practice, for example the prescription of a particular drug, then the reasonable precaution would be not to prescribe that drug. However where the question was one of clinical judgment in choosing between one course of action and another, then in that situation the sheriff could not find that one course ought to have been taken as a reasonable precaution.

[15] Mr Reid sought to draw support for his submission by returning to the determination in *Myles* at page 29, where Sheriff Stephen made the following observations:

> "It would be unreasonable to desiderate precautions by analysing backwards from what is now known to be a rare and unusual condition in its presentation and use

> that knowledge to analyse the clinical judgement of those treating Lynsy at the critical times. As has been indicated the decision when and whether to scan has to be an exercise in clinical judgement, a judgement that will inevitably vary greatly depending on the level and area of expertise. What may be routine or reflex in Neuro Sciences requires clinical judgement in other areas. It would cause critical difficulties for the NHS to suggest that patients presenting with persistent headaches should routinely be scanned, far less suggesting that all patients presenting with headaches should be scanned, that would lead to catastrophic consequences for NHS users and would be completely impractical and would have the effect of ensuring that those most in need of scanning were denied the opportunity."

From this passage Mr Reid drew the proposition that the lesson cannot be that a medical professional should always do "x" if there is a risk of "y" - which in the present case translated to, always re-refer to secondary care if there might be a change in diagnosis. Any recommendation has to be a "real world" recommendation taking into account a "real world" health service. Against that background, it was of note that Dr Wallace, who had given expert evidence at the FAI had said he was not critical of Dr Duncan. Mr Reid contended that nothing in the determination in *Myles* turns on the language of the 1976 Act, and that there was no reason why the "learning" to be gained from *Myles* did not read across to the analysis of a determination under the 2016 legislation.

[16] Mr Reid then turned to the determination of Sheriff Braid (as he then was) in the Fatal Accident Inquiry into the death of *Marion Bellfield*, issued in April 2011. The key question focussed in that inquiry was whether or not the carrying out of a CT scan was a reasonable precaution which might have avoided the death of Mrs Bellfield. Sheriff Braid found that it was. In the body of the determination, Sheriff Braid examined the question of reasonable precautions in more detail. Mr Reid founded on paragraphs 40 and 41 of the (un-paginated) determination which are in the following terms:

> "[40] In considering whether to find, in terms of section 6(1)(c) of the Act, that there were reasonable precautions whereby Mrs Bellfield's death might have been avoided, it is necessary to decide what is meant by reasonable precautions, and whether a precaution may be considered to be reasonable only if the need for it could

> have been anticipated at the time of the events leading to the death. The latter task is not made any easier by the divergence of judicial opinion on the issue. Since a fatal accident inquiry is not concerned with questions of negligence or fault, and there is no need to consider whether an accident or death was foreseeable, then it seems to me that there is no reason in principle why, in certain circumstances, a section 6(1)(c) finding should not be made in relation to a precaution which should not have been foreseen as necessary, particularly when the finding does not carry any connotation that the failure to take the precaution was negligent. Accordingly, I consider that Mr Fitzpatrick's submission, that a precaution is a measure designed to address a known or foreseeable risk, was overstating the position. I can conceive that there will be some situations where a risk which was not foreseeable could have been prevented by the taking of a reasonable precaution, which should be taken in future. In such situations, it can easily be seen that there is some purpose to the making of a finding under section 6(1)(c), in order that lessons might be learnt so that future deaths might be avoided in similar circumstances.
>
> [41] However, that is not to say that every single thing which might have been done and which might have avoided the death should, if it was a reasonable step to have taken, make its way into a finding under section 6(1)(c). Not only would that not be helpful in avoiding future deaths, but it would involve placing an unjustifiably wide construction on the word 'precaution'. Whatever that word means, it must place some limit on the sort of acts or events which should be included in a 6(1)(c) finding. 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 judgment thereafter."

[17] Mr Reid contended that the approach set out by the then Sheriff Braid in the passage referred to from *Bellfield* above was the correct approach, that it had not been followed by the sheriff in this case and that therefore she had erred in law. The sheriff had before her a

submission on behalf of the petitioner adopting this approach which she had rejected without reasons being offered. Mr Reid accepted that the submission had been noted but that there was no hint that the sheriff had applied her mind to the correctness or otherwise of that submission.

[18] Mr Reid then moved on to examine the interrelationship between the supervisory jurisdiction and Fatal Accident Inquiries. He began by looking at the case of *Lothian Regional Council* v *The Lord Advocate* 1993 SLT 1132. This case was authority for the proposition firstly that judicial review of a Fatal Accident Inquiry was competent, and secondly that all that can be reduced is something that fell within section 6(1) of the 1976 Act. The *Lothian Regional Council* case however also made clear that reduction of a particular finding could only occur where that finding was severable from the rest of the determination. Mr Reid submitted that that was the position here so far as the order that he sought in respect of the finding made so far as Dr Duncan was concerned. The same approach had also been taken in the case of *Smith* v *The Lord Advocate* 1995 SLT 379. Mr Reid also accepted, under reference to *Sutherland* v *The Lord Advocate* 2017 SLT 333 that firstly the conduct of an FAI is not a fault finding exercise; rather it is a process which is entirely separate and distinct from the determination of any question of civil liability; and therefore that reasonable foreseeability is not a relevant consideration. He also accepted that the process involved, of necessity, the use of the benefit of hindsight without reference to the state of knowledge at the time of the death. However Mr Reid drew parallels between what was said in paragraph 34 of *Sutherland* and the present case. Paragraph 34 is in the following terms:

> "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 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

> 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."

[19] In particular, he contended that Dr Duncan had two options available to her. Firstly to allow the course of treatment in secondary care which had been started to continue, or to refer JM back to secondary care. That, Mr Reid contended, is an exercise of clinical judgment and therefore the failure to refer back in the present case could not be described as a "reasonable precaution". There were two options, both of which were reasonable. In making that submission Mr Reid relied upon the evidence given by Dr Norman Wallace during the course of the FAI. He contended that it was accepted by Dr Wallace that the petitioner was entitled to place weight and reliance upon what had happened in secondary care. Drawing those strands together, Mr Reid asked the court to approve paragraph 41 in *Bellfield* and suggested that the court in so doing could take comfort that to do so was to march in step with paragraph 34 of *Sutherland.*

[20] Mr Reid then turned to the legal framework underpinning the duty to give reasons. He submitted that it was uncontroversial that the findings in an FAI required reasons and that the touchstone for the quality of those reasons could be found under reference to *Wordie Property Co Ltd* v *The Secretary of State for Scotland* 1984 SLT 346 at page 348, in short that the decision must leave the informed reader and the court in no real and substantial doubt as to what the reasons for it were and what were the material considerations which were taken into account in reaching it. Or, as slightly differently expressed by the editors of *De Smith's Judicial Review* (8th Edition at paragraph 7.15):

> "In short, the reasons must show that the decision makers successfully came to grips with the main contentions advanced by the parties and must tell the parties in broad terms why they lost or as the case may be, won. Provided the reasons satisfy these core criteria, they need not be lengthy."

What was before the sheriff in terms of evidence and submissions

[21] Mr Reid then moved to the third part of his submissions and began this chapter by looking firstly at the evidence of the petitioner and the evidence of Dr Wallace. He submitted that the starting point for the petitioner's evidence was found in her witness statement which had been lodged with the inquiry and which was to be found at page 147 of the joint bundle. In particular Mr Reid focused on the last paragraph of that statement and placed particular emphasis on the petitioner's evidence firstly, that she stated that she generally had a "low threshold for assessment", secondly that she stated she was "reassured that she (meaning JM) had already been seen in the PAU with the same clinical picture and there had been no deterioration or change that would merit a further referral", and that, thirdly, she ended her witness statement by stating "however, should a similar case present itself in future I would have a much lower threshold for seeking further specialist input to reconsider the diagnosis and investigate further." That last sentence submitted Mr Reid was unsurprising having regard to the experience that the petitioner had gone through, however it should not be construed as an acceptance that what she did was unreasonable, and more significantly did not support the recommendation ultimately made by the sheriff.

[22] Mr Reid then turned to examine the transcript of the evidence of the Fatal Accident Inquiry beginning with the evidence of Dr Norman Wallace between pages 38 and 41. From this passage, Mr Reid contended, Dr Wallace could be taken as accepting that the petitioner was entitled to place some reliance upon the fact that JM had already presented to the Paediatric Assessment Unit and why, therefore, she might be entitled to feel "falsely reassured" by the previous paediatric opinion which suggested that the mass JM's mother reported might possibly be loaded bowel. This opinion mirrored the evidence given orally

by the petitioner at the Fatal Accident Inquiry and set out at pages 53 and 54 in particular. This passage of evidence, according to Mr Reid, was an example of the petitioner exercising clinical judgment on whether to refer back to specialist care. It was of note, said Mr Reid, that there had been no re-examination by the procurator fiscal on that point and that therefore it could be taken that the Crown had no issue with that factual position.

[23] Mr Reid then turned to a critique of the evidence of Dr Norman Wallace. He began by looking at his expert report. The key passage of Dr Wallace's report could be found at paragraph 3.0 and was in the following terms:

> "a further opportunity however to correctly diagnose the patient was missed on 1 November 2019 when Dr Karen Duncan noted '*Mum thinks she can feel a mass on the left side of her tummy*'. This history alone from a concerned patient should have mandated an urgent referral but I can understand why Dr Duncan was again falsely reassured by the previous paediatric opinion which suggested that the mass might be '*possibly still loaded bowel*'".

Mr Reid observed that it was not entirely clear from this passage whether this was to be construed as a criticism or not. Mr Reid then turned to passages from Dr Wallace's evidence at the FAI. During the course of cross-examination, beginning at page 76 of the transcript it was put to Dr Wallace as follows:

> "Whilst it might have been reasonable for her (referring to the petitioner) to refer J back, it was also reasonable for her not to do so in light of her recent assessment by the paediatrician. Would you agree with that or not."

Dr Wallace's ultimate response, to be found at page 77, beginning from line 17 was as follows:

> "It certainly would have been reasonable, we can't disagree with that, it would have been entirely reasonable for her to refer back. But the more critical question was, was it reasonable for her not to have sought a further paediatric opinion and in my experience, of course in most of my experiences in terms of litigation, and that's a slightly different issue, you're looking to what the ordinarily competent GP would do in similar circumstances, and while I said that I have a lot of sympathy with Dr Duncan because she was falsely, and considerably falsely reassured by the paediatric opinion that had been provided just a matter of days previously. So there

> is considerable shelter in the actions of Dr Duncan and many GPs in similar circumstances acting with ordinary skill and care might have managed the child in the same way because she had been falsely reassured by the paediatric opinion."

Dr Wallace's evidence then continued at the top of page 79 in the following terms:

> "… I think that many, as I have said before, GPs might have managed her in a similar way having been falsely reassured by the paediatric opinion, which is the overriding issue from my perspective in this case. I mean, as you appreciate, general practice is a very lonely and, I agree, increasingly pressurised profession and we are disproportionately and hugely influences by specialist opinion, and rightly so. And that can't really be overestimated and overstated and I think that's the prime issue in this. So I wouldn't be specifically critical of Dr Duncan in that situation."

Mr Reid submitted that this last passage was the critical one – Dr Wallace had stated at the FAI that he would not be critical of the petitioner in that situation. However, Mr Reid continued, that chapter of evidence was not referred to or found in the determination. It was noteworthy that at the end of the cross-examination of Dr Wallace there had been no re-examination, and no challenge to his evidence that he would not be specifically critical of the petitioner. Therefore there had been no challenge to the proposition that it was reasonable for the petitioner to have relied upon secondary examination. That was the evidence that the sheriff had before her – the petitioner's explanation, and Dr Wallace's unchallenged evidence that he was not critical of her relying on secondary care diagnosis.

[24] Mr Reid then moved to examine the submissions that had been made to the sheriff at the conclusion of the FAI and which were lodged in process. Mr Reid had a number of specific criticisms to make of the written submissions presented by the Crown in the FAI. Mr Reid drew particular attention to the crown submission at paragraph 6 which was in the following terms:

> "On 1 November 2019 arrangements could have been made for JM to be referred by the consulting GP (the petitioner) to the paediatric assessment unit.
>
> In Dr Norman Wallace's opinion, an urgent referral would have been reasonable based on the information available to the consulting GP."

Mr Reid's submission was that this was simply not correct and he went further, contending that there was no reasonable or proper basis for that submission. Mr Reid submitted that the Crown's summary of the evidence upon which that submission had been made, did not follow from the evidence. He contended that, given the Crown responsibility to fairly present the evidence and not to advocate a side, it was wrong of the Crown to make no mention of Dr Wallace's evidence that he would not be critical of the petitioner. It was legitimate to expect that a balanced summary of the evidence would include that reference.

[25] Turning then to the submissions made on behalf of the petitioner Mr Reid focused particularly on paragraph 4 of the submissions which were in the following terms:

> "If the court believes that there is a reasonable precaution that could have been adopted, but that there is no evidence that it might realistically have avoided the death, then the test is not met and it is respectfully submitted that a finding in terms of section 26(2)(e) cannot be made. Similarly if the court considers that there is a means by which the death might realistically have been avoided but that it would have required a doctor to do something which would not, in the circumstances, have amounted to a reasonable precaution, then the test is not met."

It was significant according to Mr Reid that there had been no engagement with that submission on the part of the sheriff. Further on, at paragraphs 12 to 17 there had been detailed submissions on the question of reasonable precautions and in particular, at paragraph 17, the correct legal approach as proposed by senior counsel for the petitioner was summarised in the following terms:

> "The approaches of Sheriff Braid (as he then was) and Lord Armstrong are commended to the court. It is respectfully submitted that, on the evidence before it, the court is not entitled to conclude that it would have been a reasonable precaution for Dr Duncan (the petitioner) to have made a further referral, because the unchallenged evidence of Dr Wallace was that it was reasonable for her not to do so, and Dr Duncan did not herself accept that she acted unreasonably in not re-referring."

[26] The written submissions for the parties were supplemented by further oral submissions, and a partial transcript from the submissions hearing was also lodged. Mr Reid looked firstly at a passage from the oral submissions for the Crown. There the procurator fiscal, on behalf of the Crown, made the following submission:

> "The court is being asked to consider the precautions, my Lady, and those are actions which could reasonably have been taken and might have realistically resulted in death being avoided. The Crowns submissions in respect of those actions are based on what the experts said. Of course it is that case that if one course of action is taken and was reasonable, it doesn't preclude other reasonable courses of action from being available. So, even if a doctor did do something, there might have been something else which would have been reasonable and might have led to earlier diagnosis and life being saved."

Mr Reid was critical of that submission. He said that this was not the "Bellfield Sutherland" approach. More fundamentally, Mr Reid submitted it was clear that there was a stark legal issue between the approach of the Crown and the approach taken on behalf of the petitioner as to the proper legal test. The Crown's submission did not engage with the evidence of Dr Wallace, which was unchallenged, and appeared to proceed on the basis that reasonable could mean one of a number of reasonable options. That submission depended on the evidence of Dr Wallace drawn from his report and ignoring his oral evidence. Mr Reid contrasted that approach with the approach taken on behalf of the petitioner. He pointed to an oral submission in which, by way of preamble to more detailed submissions counsel for the petitioner had stated:

> "My Lady should be aware that a finding that a doctor has failed to take reasonable precaution which might realistically have avoided the death of a child is self-evidently of the utmost seriousness and can have significant professional and regulatory consequences for the doctor concerned, and the inquiry cannot and should not make such a finding without a clear legal basis for doing so, and without being satisfied that the evidence before it actually justifies that finding."

Mr Reid adopted that proposition and reiterated that a finding in an FAI is not a finding without consequence. It was clear from the transcript of submissions, he contended, that

there was a real dispute between the representatives of the petitioner and the Crown about the nature of the evidence and the applicable law. Counsel for the petitioner at the FAI was heavily critical of what was said to be the failure on the part of the Crown to provide meaningful legal analysis of the test that ought to be applied in determining whether a precaution was a reasonable one that could have been taken. The submission went further and contended that the available authorities (*Myles*, *Bellfield*, and *Sutherland*) supported the legal proposition that in a scenario where a doctor has acted reasonably, but an alternative reasonable course of action was also open to them, no finding in terms of reasonable precautions that might have been made in terms of the legislation, could be made. Despite this being a clear area of dispute between the parties, Mr Reid observed that it could be seen from the conclusion of the transcript that there had been no questions from the sheriff to either party emerging out of the submissions.

The sheriff's determination

[27] Mr Reid then turned to look at the determination itself. The relevant passages from the determination so far as the petitioner was concerned, began at paragraph 38. Mr Reid was critical of the use of the reference to caution in paragraph 38:

> "I was generally directed to be cautious about making any finding that these two doctors (referring to the petitioner and one other GP) could have taken reasonable precautions as it was submitted that the evidence was insufficient."

Mr Reid submitted that if the sheriff had taken it that she was being urged to be "cautious" then she had misunderstood the submission made on behalf of the petitioner. Rather, he suggested, the submission had been clear – it was not open to the sheriff to make a finding in relation to the petitioner on the basis of the evidence before her. Reference at paragraph 52 of the determination to Dr Wallace being "critical" of the consultation with the

petitioner was wrong. Dr Wallace had not been critical of the petitioner, in fact he had said the opposite, in terms, during the course of his evidence. Specifically his unchallenged evidence was that he was not critical and that it was reasonable for her to do what she did. He had not been re-examined on that point and nor was he questioned by the sheriff. Whilst it might be reasonable to say that the passage in the determination might be a gloss or summary of one paragraph from his report it did not represent his evidence as a whole. On the same theme, where the sheriff had found at paragraph 65 that Dr Wallace gave an opinion that the petitioner should have made an urgent referral to PAU on 1 November 2019 again this was wrong. He had not said that the petitioner should have made a referral, rather his only view was that it had been reasonable not to refer and no criticism had been advanced. The summary provided by the sheriff at the end of paragraph 65 in the following terms:

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

went straight to the heart of the legal issue that had been identified by counsel for the petitioner in submissions. A further error could be found in paragraph 67 where the Sheriff had conflated two limbs of the legal test – it did not follow that because the death would be avoided that the referral was a reasonable precaution to take. More fundamentally Mr Reid contended that the last sentence of paragraph 65 (quoted above) represented the totality of reasoning so far as the finding in respect of the petitioner was concerned. These were not reasons in any accepted sense. It followed, according to Mr Reid that his second plea-in-law must be sustained and reduction must follow. The sheriff had failed to provide a reasoned determination so far as the petitioner was concerned. Amplifying that proposition, Mr Reid

submitted that these "reasons" could not support the determination made in paragraph 5(e). The sheriff had not even implicitly referred to the authorities; she had not dealt with the submission that was a principal focus at the hearing. It was to be inferred that she must have rejected the submission made by senior counsel on behalf of the petitioner, and if that were so in so doing the sheriff had rejected a quarter of a century of authority. She had a responsibility to explain why she was rejecting that submission and she had failed to do so. There was nothing in the determination that showed that the sheriff had successfully come to grips with the main contentions of the parties. Therefore the only conclusion could be that she had not engaged with the main contentions by the parties.

[28] Mr Reid emphasised that his reasons challenge stood independently of his first ground of challenge. Put another way he said it would be possible to find against him on the meaning of section 26(2)(e) of the 2016 Act, that is to say against the proposition that where two courses of action were possible no finding in terms of section 26(2)(e) should be made however the reasons challenged stood alone, this was not an adequate determination at common law, and that alone justified reduction.

Submissions for the respondent

[29] Mr MacPherson adopted his note of argument. He broke down his submissions into two broad chapters, firstly whether the finding of the sheriff can be supported having regard to the legal framework and secondly whether the reasons were adequate. Looking firstly at the wording of section 26(2)(e), Mr MacPherson submitted that although there was no material distinction between that provision and its predecessor they were nevertheless different. A sheriff is mandated to make findings relating to the matters set out in subsection (2). He suggested that the focus should be on the word "any" and the word

"could" where they arise in subsection (2). The reasonableness qualification would come into play where there might be a dispute. On that analysis, the first question should be whether there was a precaution, and the second being whether it could have been taken, before getting to the question of whether such a precaution was reasonable. If the sheriff answered the first question in the affirmative - that there was a precaution that could have been taken, then provided such a precaution was reasonable, section 26(1) directed the sheriff to set out her findings as to the circumstances. Put another way, if there was a precaution which was reasonable, then the sheriff must make a finding to that effect.

[30] Such an approach required a definition of the word "precaution" and Mr MacPherson too commended the analysis of the then Sheriff Braid in *Bellfield* in this regard. Mr MacPherson submitted that "precaution" did not connote every "thing" that could have been done, even if reasonable, rather a precaution meant something done in advance to avoid something happening. It involved an element of looking forward with a future outcome in mind. However there was nothing in the word or its definition that imported the concept of reasonableness at this point. Mr MacPherson observed that in this regard the submission in *Sutherland* to the effect that a precaution must involve an element of foresight had been superseded by the explicit language of section 26(3) of the 2016 Act. That said, Mr MacPherson submitted that there was not much to be taken from the word precaution other than it had to be something done in advance. The true focus lay on what was reasonable, and whether it was reasonable to take the precaution.

[31] Mr MacPherson emphasised that there was nothing in the terms of section 26 which carried the implication of fault or blame - that was plain because of the use of the word "could" rather than "should". Therefore given that criticism in that context was not necessary, the evidence of Dr Wallace should not be taken as asserting or implying

"criticism" in a professional negligence sense. The plain language of the provision meant that if a precaution could have been taken, which was reasonable, then the section directs the Sheriff to make a finding. A finding made by the Sheriff in that context did not imply criticism. This determination was therefore different from that in *Lothian Regional Council* v *The Lord Advocate* where the sheriff had made very critical findings of certain individuals for which there was no basis in the evidence. That was a very different situation from making a finding assuming the statutory test is satisfied.

[32] Mr MacPherson's position so far as the determination in *Myles* was concerned is that this should no longer be followed. It proceeded on the basis that *Hunter* v *Hanley* and the test set out therein was a relevant factor, and it was clear, on the basis of *Sutherland*, that that was no longer correct. That was not the case here, rather the sheriff had simply made a finding in relation to a reasonable precaution that could (emphasis added) have been taken. The answer to the complaint made by the petitioner to the effect that it could not be reasonable to scan every patient, or refer every child back was found in that language - if there was evidence that it was reasonable to send this child back, then that was sufficient to meet the statutory test. In any event, Mr MacPherson continued, it was important to bear in mind that in the present petition, the petitioner did not challenge the proposition that it would have been reasonable to refer JM back to the paediatricians, rather the focus was on the assertion that it was reasonable to take another course of action.

[33] Mr MacPherson acknowledged that in a "medical" FAI, where a sheriff was considering the exercise of judgment on the part of the practitioner in question, it was legitimate to consider how far that could go, but once again the key distinction in this context is that no criticism in the sense of attributing fault is being made. It was equally legitimate to consider whether it would be helpful to make the finding in question, in the

sense of providing learning for the future. Here, the criticism was that there was no additional learning from the tragic outcome in this case that would make a difference, but the language of the statute bound the sheriff to make a finding on the basis of the evidence before her. The danger in adopting the approach contended for by the petitioner was that comparing different approaches to determine what was reasonable inevitably drew one back to the *Hunter* v *Hanley* test. That was concerned with the standard of care, and in that scenario the court required evidence that the conduct complained of fell outwith the realms of reasonable practice. That approach had no part to play in the interpretation of section 26. If there was evidence that it was reasonable to do one thing, and also reasonable to do another, that did not take away from the obligation on the sheriff to make a finding. Put another way, if both avenues of treatment are in play, and one is a precaution, and both are reasonable, then a finding in terms of section 26(2) was required.

[34] That was important in the present case because there was more material before the sheriff than simply JM's presentation at the relevant consultation. If there had only been one consultation and no relevant history then it might be reasonable to say there were no grounds for referral, but that was not the case here. The situation in this case resonated with the language employed in *Bellfield* at paragraph 41 where the then Sheriff Braid had expressed the point thus:

> "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 judgment thereafter."

In short, if referral is obviously a precaution that could be taken, the minute that precaution becomes reasonable it is within the ambit of a finding in terms of section 26(2).

[35] Mr MacPherson then turned to look at the evidence which was available to the sheriff. She had the expert report of Dr Wallace, in terms of which he categorised the failure

to refer JM on 19 November as a "missed opportunity" to correctly diagnose the patient. The history alone mandated an urgent referral but he could understand why the petitioner was "falsely reassured" by a previous paediatric referral. It was clear that Dr Wallace was not suggesting the petitioner should have made the diagnosis herself following that consultation. This missed opportunity followed on from an earlier GP consultation (with another GP) which also represented a missed opportunity to refer JM. This was evidence the sheriff was entitled to accept, and in accepting that the failure to refer represented a missed opportunity to diagnose and prevent the death of JM, the sheriff was by the language of the statute mandated to make the finding that she did. Referral was a precaution that could have been taken, and it was a reasonable precaution. In addition to the expert report of Dr Wallace, the sheriff had available to her his oral evidence which was to the same effect, whilst he equally acknowledged that it was understandable that the petitioner was falsely reassured by the earlier paediatric assessment.

[36] Moving on from the evidence, Mr MacPherson examined the authorities relied upon by the petitioner. In reality, he submitted, these amounted to two FAI determinations and one decision in a Judicial Review. The two determinations were not, strictly speaking, "authorities" and in terms of precedent nothing had been presented that was binding , the decision in *Sutherland* being an Outer House decision. In any event, the decision in *Myles* had plainly been superceded by *Sutherland* so far as it related to the question of foreseeability and both had now been superceded by the terms of the 2016 Act which made explicit the fact that foreseeability is an irrelevant consideration. In similar vein, any reliance upon or comparisons drawn with *Hunter* v *Hanley* in *Myles* had no substance and had in any event been overruled by *Sutherland.* The consequence was, according to Mr MacPherson that the proposition advanced by the petitioner that a finding can only be

made if the medical practitioner in question accepted that they had acted unreasonably, or an expert opines that they acted unreasonably was misconceived. The true question was what was reasonable by way of a precaution in any given case. Any analysis underpinned by consideration of negligence fell into the trap of the negative - that is to say a contention that the medical practitioner did not act with reasonable care. There was nothing in the language of the 2016 Act that required that to be done. In that regard *Sutherland* quoted *Bellfield* with approval and did not have the effect contended for by the petitioner.

[37] *Sutherland* ought to be regarded as highly persuasive, submitted Mr MacPherson, being a decision based on similar facts and circumstances to the present case. In that case, a cardiac surgeon elected not to perform surgery on a patient who later died from an aortic dissection. The Sheriff found that a reasonable precaution by which the death might have been avoided would have been to refer the patient's scans to an expert radiologist for their view, which might have led to the dissection being discovered. The Lord Ordinary (Armstrong) held that that was a finding open to the sheriff on the evidence. *Sutherland* was authority for the proposition that in the context of an FAI it is a question of what could have been done, a test very different to that necessary for a finding of negligence.

[38] Mr MacPherson then addressed the second broad ground of challenge relating to the reasons underpinning the findings made by the sheriff. Mr MacPherson accepted that the sheriff did not proffer a response to the submissions advanced by the petitioner, but Mr MacPherson submitted that it was not at all clear from the transcripts provided that a coherent and in any event certainly not a correct position in law had been advanced on behalf of the petitioner and any failure to address those submissions directly did not fatally undermine her conclusions. In any event it is clear that the sheriff had these submissions. They are summarised at paragraphs 38 and 40 of the determination. Paragraph 38 seems to

refer directly to the petitioner's submission about whether there was sufficient evidence. Paragraph 40, even if a brief summary, clearly bears to be a reference to the arguments made by the petitioner. The petitioner's submissions focussed, erroneously on the language of fault that had no part to play in this statutory regime.

[39] The context was significant, because what was being produced was a determination, a creature of statute. Thus properly understood, notions of being able to understand who had "won and lost" (*De Smith*) did not feature. This was not a dispute, the process was not adversarial, and it was not a "decision". The determination had no bearing on future legal proceedings, rather it is a fact finding exercise which requires the sheriff to set out findings, not to reach a decision on one point as against another. Once the sheriff had made her finding in paragraph 65, that was sufficient when read together with paragraph 66. Any use of the word "critical" has to be looked at broadly in the statutory context.

[40] In the result, Mr MacPherson submitted that the petitioner's first ground of challenge failed because there was an ample basis for the finding complained of, and the second ground failed because although there were absences in aspects of the reasoning, those were not fatal to the finding made in respect of the petitioner.

Reply for the petitioner

[41] In a brief reply, Mr Reid rejected the criticisms made of the positon advanced on behalf of the petitioner at the FAI. The logic of the respondent's position, he suggested, was that referral services would be inundated with patients being referred to them by GP's. That was wrong because it was an exercise of clinical judgment on the part of the GP as to which resources to engage. A "precaution" must have content and meaning, otherwise there was

no possibility of learning for the future if, faced with a range of options, all would constitute reasonable precautions.

[42] Further, the approach contended for by the respondent invited disapproval of and departure from an established line of precedent and practice that had subsisted for over two decades. That was not what the sheriff had been asked to do and it was not appropriate for the respondent to invite this court to depart from that established practice having not troubled the sheriff with that suggestion. The submission made on behalf of the petitioner to the sheriff was correct in law, and if it were not, the sheriff had an obligation to engage with that submission and say why it was not correct. Mr Reid renewed his motion to reduce the determination to the extent sought.

Analysis and decision

[43] There were matters upon which the parties were in agreement. Firstly, that the test in *Hunter* v *Hanley* was of no application in the context of a fact finding exercise such as an FAI, where no attribution of fault is made. Secondly, there was agreement that hindsight was relevant in considering findings that might be made, having regard in particular to the future learning and education aspect of such inquiries, and thirdly, as now confirmed in the 2016 Act, the question of foreseeability was not relevant. Parties were also agreed that, as a matter of fact, had the petitioner referred JM to hospital after the consultation on 1 November 2019, it is likely she would have survived.

[44] Parties did however fundamentally disagree as to the correct approach to the task mandated by section 26 of the 2016 Act. The petitioner's position, in a nutshell, is that in making a finding that a reasonable precaution which might have avoided the death of JM was if she had been referred by the petitioner to specialist paediatricians, the sheriff has

erred in law. That error arises because there was evidence available to the sheriff to the effect that the petitioner equally could not be criticised for being falsely reassured that JM had already been seen by paediatricians who had diagnosed her to be suffering from constipation. The submission on behalf of the petitioner was that in such a situation, based on practice and precedent, sheriffs should not, and do not make findings in respect of reasonable precautions that might have been taken.

[45] No examples of what was said to be this almost invariable approach were placed before me. Whilst of course there is no reason to doubt what Mr Reid said in this regard, it would have been useful, and provided some additional insight, had such material been available. Instead, the proposition advanced was that the two determinations in *Myles* and *Bellfield*, whilst not binding authorities, are routinely referred to as supporting the contention that where there are two reasonable courses of action, then a finding in relation to reasonable precautions will not be made. Despite both these determinations, and indeed the decision in *Sutherland*, also relied upon, pre-dating the coming into force of the 2016 Act, the petitioner's positon is that there is not and should not be, any change in approach.

[46] As indicated above, it was accepted by parties that the language of the 2016 Act does not exactly mirror that of its' predecessor. In particular, the language has changed from being "the reasonable precautions" to "any precautions which could reasonably have been taken…" The petitioner suggests that that is not a material change and does not affect the legal approach contended for by her. The respondent initially agreed that the difference between the two provisions was not material, but did submit that the wording was nevertheless different, and that meant that where there was evidence from which a sheriff could find that there was a precaution that was reasonable, then that mandated a finding under section 26(2) (e).

[47] Although it was not possible to discern explicitly from the face of the report and consultation document referred to when and why the decision to amend the language of the 2016 Act in the manner described above came about, it is apparent from that material that there was a desire to clarify what sort of recommendations sheriffs might make in relation to reasonable precautions. In the foreword to the Scottish Government Consultation Paper on the proposed new legislation the then Cabinet Secretary for Justice wrote:

> "…….in general the purpose of an FAI is to establish the time, place and cause of death and, crucially, any precautions which might be taken in future to avoid deaths in similar circumstances. FAIs are therefore held in the public interest – they are not intended to provide a venue for bereaved families to establish grounds for future civil action."

The phrase "any precautions" is one which ultimately found its way into the 2016 Act. It carries a wider connotation than the language used in the predecessor legislation, albeit the differences are perhaps marginal. However the distinction drawn between the purpose of an inquiry in contrast to that of civil litigation remains explicit.

[48] That is of significance having regard to the proper approach to determinations under the 2016 Act. The petitioner urges an approach which pays proper respect to questions of clinical judgment in the context of a "medical" FAI. That is an uncontroversial proposition. However that is not the same thing as an approach which suggests that a sheriff is disabled from making a finding in terms of section 26(2)(e) if more than one course of action was available (assuming that course of action is a precaution) which was reasonable. The language of section 26(2)(e) refers to <u>any</u> precautions - the qualification of those being precautions which could reasonably have been taken then follows. There is nothing in the statutory language which suggests that a finding may not be made where another option was available. To approach matters in that way in effect mirrors the *Hunter* v *Hanley* test which it is agreed has no part to play in an FAI. In the present case of course, the question

was whether to refer, or not to refer. Mr Reid characterised that as a clinical decision. It might be said that a clinical decision carries a connotation of choosing between different types of treatment, rather than whether to refer or not to refer to a specialist, or whether to operate, or not (as was the case in *Sutherland*, where the Lord Ordinary drew a distinction between decisions involving clinical judgment, and the decision, in that case, not to operate).

[49] In that regard, although neither party made explicit reference to it, the comments of the then Sheriff Braid at para [46] of his determination in *Bellfield* are instructive. He said the following:

> "46. 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"

[50] Although that analysis is not binding on me, it encapsulates entirely correctly the proper approach and I respectfully adopt and endorse it. That analysis was of course contained in a determination that pre-dated the coming into force of the 2016 Act but having regard to the more expansive language of section 26(2)(e) it is entirely consistent with the language of the statute as now framed. Applying that approach to the present case, the evidence of Dr Wallace that he could understand why the petitioner felt reassured by the earlier referral and that he would not be critical of her in so feeling, has to be seen in its' proper context. That context is a passage of evidence in which he is moving between the

statutory test and the test employed in litigation, with which he is clearly familiar (see the passages of evidence quoted in para [23] above). He is not, viewed fairly, departing from his view that referral would have been a reasonable precaution. He is simply saying that he would not be critical of the petitioner, employing the test of a doctor exercising ordinary skill and care, for having been falsely reassured in all the circumstances. It was not in dispute that, that test is not one that is relevant for the purposes of a determination in an FAI.

[51] It follows that I accept the submission for the respondent that where there was evidence before the sheriff, which she accepted, to the effect that a referral to the Paediatric Assessment Unit was a precaution which could reasonably have been taken which might have avoided the death of JM, she was entitled, indeed mandated, to include a finding to that effect in her determination. Therefore I can discern no error of law in the approach of the sheriff to this question, and the first ground of challenge accordingly fails.

[52] Mr Reid submitted that even if his first ground of challenge did not find favour, then the determination nevertheless fell to be reduced on the basis of a lack of adequate reasons. In summary, the criticism under this heading is that the sheriff failed properly to engage with the competing submissions of the parties, nor did she set out her reasons for accepting or rejecting those submissions. As a result the informed reader and the court were left in real and substantial doubt as to what the reasons for the determination were and what were the material considerations which were taken into account in reaching it (*Wordie*). Or, as Mr Reid also expressed it, parties could not know who had "won" or "lost" from the face of the determination and what the sheriff had made of the competing submissions on the law.

[53] It may be a moot point as to how useful any analogy employing the language of "winning" and "losing" might be in the context of an FAI. That said, there can be no real

dispute that any judicial decision, whether it be in the context of a litigation or an inquiry such as this, should be comprehensible, and set out what evidence has been accepted and which rejected, and the conclusions reached in light of the findings on the evidence. Some decisions of course go further and provide detailed analysis of the parties competing contentions and the view taken by the fact finder of those. In the present case, Mr MacPherson accepted that the sheriff had not engaged in any detail with the submissions of the parties, but submitted that was not fatal to her determination so far as the petitioner is concerned. It was important to remember that this was not an adjudication between parties, rather it was a fact finding exercise, with the potential to make recommendations based on the facts found established. If there are reasons for the findings, which he argued could be found in paragraphs 65, 66 and 67 in the determination, that was sufficient to discharge the statutory duty.

[54] Mr Reid is correct to say that the sheriff has not met the parties head on when comes to analysing in detail their submissions. No doubt she could have put the matter beyond peradventure by stating that she rejected the legal analysis put forward by the petitioner. However there is no standalone obligation in terms of the statute, or as a matter of generality, for a fact finder to accept or rebut in an overly analytical fashion, the competing contentions of the parties. The key touchstones for adequacy of reasons as discussed in various authorities are as follows: the reasons given should be intelligible and they must be adequate, allowing the reader to understand why the matter was decided as it was and what conclusions were reached on the principal important issues; reasons can be briefly stated; the degree of detail required depends on the nature of the issues falling for decision; the reasoning must not give rise to a lot of doubt as to whether the decision-maker erred in law;

the reasons need to deal with only the main issues in dispute, not to every small consideration (*South Bucks District Council* v *Porter* (No.2); *De Smith* on Judicial Review).

[55] By that measure, the sheriff has set out her findings in relation to the evidence, in particular the evidence of Dr Norman Wallace upon which she relied in making the finding complained of; she has recorded in summary form the competing submissions of the parties; and she has determined that it was open to her to make a finding in terms of section 26(2)(e) on the basis of the evidence which she accepted. This is not a situation as was discussed in *Smith* v *the Lord Advocate* 1995 SLT 379, where the sheriff made findings unsupported by the evidence. The reasons are adequate, as that term is understood in the relevant authorities. The second challenge based on inadequate reasoning also fails.

Disposal

[56] I shall repel the first and second pleas in law for the petitioner, sustain the third and fourth pleas in law for the respondent, and refuse the petition. I will reserve all questions of expenses meantime.