

# Professional Discipline and Regulation

January 2008

## Applying the Wisdom of Hindsight

### Background

Sheriff Brown's determination into the death of Marian Cuthbert has recently been reported. Mrs Cuthbert died of congestive cardiac failure and myocardial infarct on 6 March 2003 at Ayr Hospital. She fell at home on 23 November 2002 and fractured her left femur. She was admitted to Ayr Hospital and treated for the fracture. On 17 January 2003 she was transferred to Biggart Hospital, Prestwick for rehabilitation. Her condition ultimately deteriorated and on 3 March 2003 she was transferred back to Ayr Hospital suffering from heart failure, where she died three days later. Her family were of the opinion that the deterioration at Biggart Hospital was largely due to a lack of proper medical care and that her death at that time could have been avoided.

### Determination

Sheriff Brown restricted his findings to those required under sections 6(1)(a) and (b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. Often referred to as "formal findings", these deal with the date, time, place and cause of death. He declined to make findings under section 6(1)(c) in respect of any reasonable precautions whereby the death might have been avoided, despite being urged to do so by the family of the deceased.

Sheriff Brown acknowledged that the court in a fatal accident inquiry has the considerable advantage of the wisdom of hindsight. Armed with that advantage, the court may well be better placed to identify a reasonable precaution capable of interrupting the chain of events leading to the death than someone considering the matter at the

time when that precaution could have been taken. However, the fact that the court is able to identify such a precaution does not imply that its omission was unreasonable. The court must be satisfied that the precaution identified is one which would have been reasonable in the circumstances at the time.

Sheriff Brown also highlighted that the question whether a reasonable precaution "might" have avoided the death is a matter of evidence. Reasonable inferences from the evidence are required, rather than speculation about remote or unlikely possibilities for which there is no evidential foundation.

### Significance

It can often be easy to point to things which could have been done differently in the aftermath of a fatal accident or sudden death. The knowledge of what ultimately transpired can make it difficult to evaluate past decisions and actions fairly. Witnesses may be pressed under cross examination to concede that they ought to have acted differently. Such a concession, if made purely on the basis of hindsight, does not necessarily establish the existence of a reasonable precaution whereby the death might have been avoided.

This is a welcome interpretation of section 6(1)(c) of the 1976 Act. In an inquiry into the death of Kyle Brown in October last year, Sheriff Lothian took the view that "might" meant effectively any chance at all, no matter how slim. Sheriff Brown's interpretation is much more narrow but it remains to be seen if his approach will be adopted in future inquiries.

This Alert! is correct to the best of our knowledge and belief at the time of going to press. It is however written as a general guide, so it is recommended that specific professional advice is sought before any action is taken. We are required by law to protect personal data.

© January 2008, Dundas & Wilson CS LLP and Dundas & Wilson LLP  
All rights reserved

If you have any questions on this decision or any other aspect of our regulatory work, please contact our professional discipline and regulation team:

Laura Donald	<a href="mailto:laura.donald@dundas-wilson.com">laura.donald@dundas-wilson.com</a>	0131 200 7522
Jillian Martin-Brown	<a href="mailto:jillian.martin-brown@dundas-wilson.com">jillian.martin-brown@dundas-wilson.com</a>	0131 200 7501
James Stewart	<a href="mailto:james.stewart@dundas-wilson.com">james.stewart@dundas-wilson.com</a>	0131 200 7644