SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2019] FAI 40

HAM-BZZ4-18

DETERMINATION

BY

SUMMARY SHERIFF ALLAN MCKAY

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

PRADEEP KUMAR BHOWMICK

Hamilton, 5 July 2019

DETERMINATION

The sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:-

a) In terms of section 26(2)(a) Pradeep Kumar Bhowmick, date of birth 18 January 1985, died at HMP Shotts, Newmiln and Canthill Road, Shotts at 11.30 am on Friday 24 March 2017.

b) In terms of section 26(2)(b) Mr Bhowmick's death was not the result of an accident.

c) In terms of section 26(2)(c) the cause of Mr Bhowmick's death is unascertained.

d) As there was no accident section 26(2)(d) does not apply.

e) In terms of section 26(2)(e) there were no reasonable precautions by which the death might have been avoided.

f) In terms of section 26(2)(f) there were no defects in any system of working which contributed to his death.

g) In terms of section 26(2)(g) *t*here are other facts which are relevant to the circumstances of his death which are dealt with in the note appended hereto.

RECOMMENDATION

In terms of section 26(1*)(*b**)** there are no recommendations which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

This inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") into the death of Pradeep Kumar Bhowmick. Preliminary hearings of the inquiry were held on 16 May 2018, 12 July 2018, 17 September 2018, 29 October 2018, 29 November 2018 and 25 January 2019, before my colleague who was unable to conduct the inquiry. I heard preliminary hearings on 5 March and 16 April 2019. The evidential hearing set down for 2 May was adjourned by consent due to the unavailability of Mr Irvine. The inquiry considered evidence, written

and oral submissions on 21 June 2019. No witnesses were led. Evidence was agreed by joint minute.

Representation at the inquiry:

For the Crown, Mr Faure, Procurator Fiscal Depute

For the family of Pradeep Kumar Bhowmick, Frank Irvine, Solicitor

For Scottish Prison Service, Dominic Scullion, Solicitor Advocate

For NHS Lanarkshire, Paul Reid, Advocate

THE LEGAL FRAMEWORK

1. This was an inquiry held under section 1 of the Act, in accordance with section 2(4)(a), on the grounds that the person who died was, at the time of his death, in legal custody. The inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

2. The purpose of the inquiry held in terms of the Act is for the Sheriff to establish the circumstances of the death, and to consider which steps (if any) might be taken to prevent other deaths in similar circumstances. The Sheriff is required in terms of section 26 of the Act to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction;

    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

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. The Sheriff must also make such recommendations as to the taking of reasonable precautions, the making of improvements to any system of working, the introduction of any system of working and the taking of any other steps which might realistically prevent other deaths in similar circumstances (sections 26(1)(b) and s26(4)).

4. The court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry, and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act sets out that the determination of the Sheriff shall not be admissible as evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death. It also reflects the position that a Fatal Accident Inquiry is not a forum designed to establish legal fault. The procurator fiscal for the Crown represents the public interest. The inquiry is an inquisitorial process.

SUMMARY

Circumstances

[1] Pradeep Kumar Bhowmick was born on 18 January 1985. He was convicted after trial on a charge of supplying a controlled drug in contravention of section 4(3)(b) of the Misuse of Drugs Act 1971. On 3 November 2016 he was sentenced to 12 years imprisonment. He was initially imprisoned in Edinburgh Prison and thereafter transferred to Shotts Prison. He was in legal custody as at the date of his death. On the morning of 24 March 2017 Mr Bhowmick attended a lecture in a classroom on level 4 of Allanton Hall within Shotts Prison. He appeared well and participated in the class. At,

or about, 10.50 am he became unwell. He appeared to have a seizure. Prison staff and prisoners went to his aid. He was placed in the recovery position.

[2] Staff Nurse Alexandra McLellan and Nurse Practitioner Hayley McArthur attended at the classroom. They noted that Mr Bhowmick was unresponsive. There was no vocal response, his pupils were dilated and there was a small amount of blood stained saliva. Mr Bhowmick's pulse became faint and then no pulse was detected. Nurse Practitioner McArthur tried to administer oxygen from a portable cylinder to Mr Bhowmick. She was unable to release the flow of oxygen from the cylinder. Staff Nurse McArthur made arrangements for a replacement oxygen cylinder to be brought to the classroom. No oxygen was administered.

[3] Staff Nurse McLellan and Nurse Practitioner McArthur placed Mr Bhowmick on his back and attached a defibrillator machine. Shocks were given and cardiopulmonary resuscitation (CPR) commenced. Clots of blood came from Mr Bhowmick's mouth and nose so mouth suction was commenced by Nurse Practitioner McArthur using a portable suction machine. The suction machine ceased working whilst Nurse Practitioner McArthur was using it to try and clear blood and other fluids from the mouth and nose of Mr Bhowmick.

[4] Paramedics arrived at approximately 11.10am. They continued with CPR for approximately twenty minutes and administered adrenaline to Mr Bhowmick. They were unable to revive him. Life was pronounced extinct at 11.30am on 24 March 2017.

[5] Following a post mortem Dr Julie McAdam, Forensic Pathologist, of the University of Glasgow found the cause of death to be unascertained.

[6] Toxicology tests revealed a trace of Naproxen, an anti-inflammatory, in Mr Bhowmick's blood. All other tests returned a negative result. Examination of brain tissue revealed no significant abnormality.

[7] At the time of death health care provision at HMP Shotts was managed by NHS Lanarkshire. Staff Nurse McLellan and Nurse Practitioner McArthur were employees of NHS Lanarkshire at the relevant time. Elaine Rogerson is a qualified nurse and was manager of the primary health care team within Shotts Prison at the time of death. She had been in her role since 2009. She attended the classroom on level 4 within Allanton Hall. On her arrival she saw the paramedics with Staff Nurse McLellan and Nurse Practitioner McArthur attempting to resuscitate Mr Bhowmick. She was present when the paramedics stopped CPR. She checked two oxygen cylinders found in the classroom. The cylinders were full and in working order. Staff Nurse McLellan and Nurse Practitioner McArthur were not trained in relation to the use of the oxygen cylinders. The oxygen cylinders and suction equipment were checked in the week prior to the death. The health care providers were not aware of any defects in the equipment at the time of death. Since the death the health care providers have made a change to operating procedures. The "no tamper seal" is now removed from the oxygen cylinders as soon as the cylinders are received from the manufacturer. Ms Rogerson was not aware of any issue relating to the functioning of the suction equipment until raised in these court proceedings.

[8] Following every death in prison custody there is a Death in Prison Learning, Audit and Review ("DIPLAR"). The DIPLAR is the Scottish Prison Service process for

reviewing all deaths in custody. It provides a system for recording any learning and identified actions. It enables a review of every death to take place through a roundtable collaborative multi-agency learning and reflective session. Numerous relevant individuals are invited to the DIPLAR meeting following a death in custody. A NHS representative is invited to participate in this process.

[9] A DIPLAR in relation to Mr Bhowmick's death took place on 10 April 2017. Individuals on behalf of the SPS, NHS, Chaplaincy and social work were invited to attend. Elaine Rogerson, Service Manager at HMP Shotts, attended on behalf of the NHS. Following the DIPLAR, defibrillators are now located on both levels 1 and 3 of Allanton Hall.

[10] Dr Stephen Hearns, MBChB, FRCS, FRCP, FCEM, DipIMC, DRTM, a Consultant in Emergency Medicine and Lead Consultant Emergency Medical Retrieval Service, completed a report dated 30 March 2019. He was instructed and informed by all parties represented at the inquiry. In compiling his report he referred to a published document, the European Resuscitation Council Guidelines for Resuscitation.

a) He was asked whether the delay or non-administration of oxygen had a negative effect on the outcome. He confirmed that not providing oxygen was very unlikely to have influenced the chance of Mr Bhomwick surviving.

b) He was asked whether the functional status of the suction device had a negative effect on outcome. He confirmed the limitations of the suction

device used were very unlikely to have influenced the outcome in this case.

c) He was asked if it would have been possible or appropriate to provide oxygen during resuscitation. He confirmed it would have been possible to administer oxygen to Mr Bhomwick. Before he suffered his cardiac arrest oxygen could have been administered by facemask. After he suffered his cardiac arrest oxygen could have been supplied using a bag valve mask. In addition to the difficulties in opening the oxygen cylinder, administration of oxygen was made more difficult by the presence of blood in Mr Bhomwick's mouth.

d) He was asked whether any steps could have been taken to prevent death in this instance. He confirmed no additional interventions by the nursing staff or prison staff could have prevented Mr Bhomwick's death.

[11] Dr Hearns stated that the initial actions of the nursing and prison staff in response to Mr Bhomwick's collapse were appropriate and in accordance with European Resuscitation Council guidelines. The failure to open the oxygen cylinder was understandable in the circumstances. The chances of an individual surviving following an out of hospital cardiac arrest, as Mr Bhomwick did, are very low. In recent years in Scotland, 92% of such patients have died.

[12] Dr Hearns did not identify any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death being

avoided. He did not identify any defects in any system of working which contributed to the death or any accident resulting in the death.

[13] Dr Hearns suggested recommendations in light of his assessment of the risk of prisoners experiencing medical emergencies or cardiac arrests and the needs of nursing and medical staff providing emergency medical care and resuscitation to such patients. His recommendations were made on the basis that "standard" nursing training did not optimally equip nurses to deal with such emergencies. To improve skills and confidence of prison nursing and medical staff, reduce the emotional effects of such events on staff and improve equipment checking and operation he recommended:

a) The establishment of a clearly defined set of competencies for prison nursing and medical staff for the management of medical and traumatic emergencies, including cardiac arrest based on a needs assessment audit of medical and traumatic emergencies which have occurred within the prison system.

b) The development of robust equipment check and maintenance procedures for medical equipment used in prisons. The benefits of prison nursing and medical staff completing an advanced life support course 3 should be considered.

c) A bespoke training course for medical emergencies likely to occur in the prison environment should be considered, including managing drug overdoses, attempted hangings and assaults to include training on the equipment used within the prison.

d) Prisons should regularly simulate "in-situ" medical emergencies to take place within the prison environment with the staff who would normally be responding and using the equipment which would normally be deployed.

Submissions

[14] All parties represented at the inquiry agreed on when and where Mr Bhowmick died and that the cause of his death was unascertained. They agreed that his death was not the result of an accident, there were no reasonable precautions by which the death might have been avoided and there were no defects in any system of working which contributed to his death. None of the parties submitted I should make recommendations as to the taking of reasonable precautions, the making of improvements to any system of working, the introduction of any system of working or the taking of any other steps which might realistically prevent other deaths in similar circumstances in terms of sections 26(1)(b) and (4).

[15] Those representing the Crown and Mr Bhowmick's family submitted I should make recommendations in terms of section 26(2)(g) based on facts relevant to the circumstances of his death. This was opposed by NHS Lanarkshire. The prison service took a neutral position.

The Crown

[16] Mr Faure for the Crown submitted I should recommend the Advanced Life Support Course 3, referred to by Dr Hearns, as a compulsory component in the prison nursing staff training programme. He submitted this was an example of a training need which is relevant to the circumstances of the death. He referred to Dr Hearns' evidence that there are an increasing number of reasons why the prison population experience medical emergencies including cardiac arrest with prison nursing staff facing medical emergencies on a more regular basis which will include cardiac arrests. Recommending this course as a compulsory component in the prison nursing staff training programme was proportionate, may increase the chance of a prisoner surviving a medical emergency including cardiac arrest and one that is relevant to the circumstances of Mr Bhowmick's death. Mr Faure also made the point Dr Hearns' highlighted the value of "in situ" training for testing systems and improving team performance in high pressure situations, not attainable in a classroom environment involving staff who ordinarily would respond to these emergencies and only using the available equipment. He submitted I should recommend such training.

The Family

[17] Mr Irvine, for the family, adopted the Crown submissions and added to them. He submitted I should recommend the introduction of a 'Critical Incident Review Procedure' for all NHS staff working in the prison service. He pointed out that the only health board representative at the DIPLAR was Elaine Rogerson whose knowledge of the circumstances was limited. There was a clear development need for NHS staff to be fully involved in any debriefing from an incident such as this. Such a debriefing must involve full sharing of information to be meaningful. He was critical of the Health Board position and expressed concern that the role of healthcare services in a prison setting was to provide care equivalent to that of a community setting. He submitted the care provided in prisons should be on a continuing care basis. He questioned the time limit applied to retention of records relating to equipment checks deeming the two year period arbitrary and prejudicial. He did not find the claim on behalf of NHS Lanarkshire that the high security environment in Shotts prison presents 'very real practical difficulties to carrying out in situ training' persuasive.

Scottish Prison Service

[18] Mr Scullion noted that the submissions for the Crown and the family were directed to matters concerning NHS Lanarkshire and made no further comment

thereon. He submitted there was no evidence before the inquiry supporting recommendations directed towards the prison service.

NHS Lanarkshire

[19] Mr Reid noted the Crown did not seek recommendations under section 26(4) and associated NHS Lanarkshire with that position. He acknowledged Dr Hearns made recommendations but emphasised that none of them justified recognition as statutory recommendations under section 26(4) because it could not be said they "might realistically prevent other deaths in similar circumstances." He addressed the issues raised by the Crown and the family by confirming steps taken by NHS Lanarkshire as a result of investigations in relation to Mr Bhowmick's death. He confirmed there was a national review underway as to the competency framework for prison nurses including the particular role nurses can play in providing care in the prison whilst awaiting assistance from emergency care providers. He confirmed medical equipment was checked weekly and records kept for two years. NHS Lanarkshire was reviewing the provision of scenario based training linked with prison staff. The high security environment in prisons, particularly HMP Shotts, presents very real practical difficulties to carrying out in situ training. In relation to Mr Irvine's comments on post incident de-briefing he confirmed NHS Lanarkshire had

engaged in DIPLAR in this case which had been open to any health service employee involved in the incident to attend.

DISCUSSION and CONCLUSION

[20] The inquiry was inquisitorial. It progressed expeditiously and efficiently. All participants were able to participate effectively in furthering the purpose of the inquiry.

[21] The evidence agreed in relation to the circumstances was clear and unequivocal.

[22] I made a determination setting out my findings as to the circumstances referred to in section 26(2)(a) to (f) in agreement with all participants. I made a determination that no recommendations were deemed appropriate in terms of section 26(1)(b) in agreement with all participants.

[23] In determining there were other facts relevant to the circumstances of the death in terms of section 26(2)(g) I have set these out in the summary. I was invited, by the Crown and the family, to add to them by making recommendations. I have declined to do so for the following reasons:

a) The facts did not support me making a finding recommending the Advanced Life Support Course 3 as a compulsory component in the prison nursing staff training programme. Dr Hearns stated that, "the

benefits of prison nursing and medical staff completing an advanced life support course should be considered." There was no suggestion of compulsion. In the course of the inquiry NHS Lanarkshire have acted in accordance with the recommendation as stated by Dr Hearns. They have considered the benefits of their staff completing such a course. Dr Hearns' position is well reasoned and proportionate and has been followed by NHS Lanarkshire.

b) I am satisfied that Dr Hearns' recommendation that the health care provider adopt in situ training has been brought to the attention of NHS Lanarkshire and they have acted upon it. However there are difficulties in carrying out training drills in a prison environment and I am not satisfied that these were fully considered by Dr Hearns. He applied the standard of "optimally" testing systems and improving team performance in making his recommendation and I am not satisfied that is the appropriate legal test. I cannot make a finding recommending in situ training action based on the facts agreed and the test applied.

c) There was insufficient evidence before me to base a recommendation for the introduction of a 'Critical Incident Review Procedure' for all NHS staff working in the prison service. There was no evidence as to the form, content or purpose of such a procedure. The submission was based on criticism of the DIPLAR but that had not been developed in the evidence

agreed. The DIPLAR was explained in evidence and had been carried out following this incident. Adjustments were made in light thereof.

[24] I wish to commend the procurator fiscal depute and those representing the other parties for their helpful and professional contributions. They assisted in agreeing a joint minute which considerably shortened the length of the inquiry hearing and avoided witnesses having to attend to give evidence.

[25] I join with those representatives and genuinely express my condolences to the family and friends of Pradeep Kumar Bhowmick. They attended each hearing and contributed fully to the purpose of the inquiry. They behaved with the utmost dignity in what must have been a difficult and stressful experience.