SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2021] FAI 5

HAM-B316-20

DETERMINATION

BY

SHERIFF ALASDAIR LORNE MACFADYEN

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

into the death of

JAMES McINNES, born 31 December 1965

Hamilton 23 December 2020

DETERMINATION

The sheriff, having resumed consideration of the cause, determines in terms of section 26(2) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 2016:

(a) James McInnes, born 31 December 1965, died at approximately 1915 hours on 28 December 2018 at University Hospital, Wishaw, North Lanarkshire. At the time of his death the deceased was in legal custody.

(b) No accident occurred which resulted in the death.

(c) The cause of death was 1a) multiple organ failure due to 1b) systemic sepsis associated with bronchopneumonia and 2) ischaemic heart disease.

(d) There were no cause or causes of any accident resulting in the death, there being no accident that occurred which resulted in the death.

(e) No precautions could reasonably have been taken which might realistically have resulted in the death being avoided.

(f) There were no defects in any system of working which contributed to the death.

(g) There are no other facts relevant to the circumstances of the death.

RECOMMENDATIONS

No recommendations are made under section 26(4) of the Act.

FINDINGS IN FACT

I found the following facts proved, by way of admission in the joint minute of agreement between the parties who participated in the inquiry, namely the Crown, the Scottish Prison Service and NHS Lanarkshire.

1. Following his conviction in June 2012 James McInnes 'the deceased' was recorded as requiring a 'high' level of supervision under the Prisoner Supervision System. This was due to the nature of the index offence and the lengthy sentence imposed. Following a review under this system in January 2014 the deceased's level of supervision was recorded to be 'low'. Throughout his time in HMP, Shotts the deceased was subject to Integrated Case Management (ICM) Assessments on a regular basis; the deceased was routinely described as engaging well, presenting in a polite and appropriate manner, and providing no management issues for staff.

2. The deceased applied for, and was granted, escorted absences from the Prison on several occasions, and as early as November 2012. This was to allow the deceased to see a close family member for whom the deceased had acted as a carer prior to his incarceration, who could not travel to the Prison for visits. There were no recorded problems during any of the absences.

3. The deceased had a lengthy history of substance misuse, particularly intravenous drug misuse, dating back to his teenage years. At the time of his admission to HMP, Shotts on 28 June 2012 the deceased was recorded as being on the methadone programme and was prescribed 120mls per day. This was reduced to 95mls within the first 5 weeks of his sentence. The deceased was also a smoker and had smoked daily since a young age. The deceased continued to smoke throughout his period of imprisonment.

4. The deceased was known to suffer from ischaemic heart disease, ischaemic bowel disease, and malabsorption syndrome. He suffered from chronic leg ulcers, as a result of his intravenous drug misuse, and required to have dressings on these ulcers changed three times per week within the Prison health centre. The deceased also required Total Parenteral Nutrition (TPN), also known as intravenous nutrition feeding, twice daily. However, throughout his time within HMP, Shotts the deceased regularly declined any intervention or ongoing medical treatment and would often refuse to attend hospital appointments with regards to TPN, ongoing nutritional needs, and other healthcare matters. Nursing staff would often find the deceased's TPN infusion incomplete; the deceased having switched off the pump prior to completion of the

treatment. The deceased had also been displaying ongoing chest and respiratory symptoms but, again, he declined any treatment or hospital intervention in relation to this. The deceased was required to sign 'refusal of treatment' forms on each occasion to this effect.

5. On 3 December 2018, at approximately 1900 hours, the deceased was seen by Nurse Practitioner, witness Ann O'Neill. At this time the deceased was feeling unwell and complaining of a chest infection. Witness O'Neill could see that the deceased's face was swollen at his right eye area and he was 'nodding off' during the assessment. However, the deceased declined any treatment or intervention by nursing staff and also refused to attend at hospital. It was noted that he had a prearranged appointment with one of the Prison's General Practitioners the following morning. A 'refusal of treatment' form was signed by the deceased to this effect, he was prescribed antibiotics, and advised to activate the 'call bell' within his cell should he deteriorate further. On the morning of 4 December 2018 General Practitioner, Dr. Michael Coates, saw the deceased within his cell. The deceased was suspected to be suffering from community acquired pneumonia and it was stressed to the deceased that he should be admitted to hospital for treatment. The deceased continued to refuse hospital admission. Dr. Coates recorded that, in his clinical opinion, the deceased continued to have full capacity to make informed decisions. He advised the deceased that, should he reconsider, he should speak to prison hall staff whereupon hospital admission would be immediately arranged.

6. On 5 December 2018 the deceased attended at the Prison's treatment room to have his TPN stopped and removed. He was noted to be presenting with shortness of breath and a gargling sound could be heard when he breathed. The deceased refused to have observations taken but did agree for his pulse and oxygen saturation levels to be recorded following removal of the feeding tube. The deceased thereafter returned to his cell. Staff immediately raised their concerns regarding the deceased's presentation and advice was sought from one of the Prison's GPs. The deceased was again visited in his cell by medical staff, however he refused to be seen by the GP and would not engage in conversation or answer any questions; repeatedly waving staff away. It was reiterated to the deceased that he required hospital admission, and was also at risk of sepsis, but the deceased continued to dismiss staff and also refused to sign a 'refusal of treatment' form. It was again recorded that the deceased appeared to have full capacity.

7. At approximately 1520 hours on 5 December 2018 the deceased was seen by a nurse to have the wounds on his legs cleaned and the dressings changed. At this time the deceased stated that once his dressings were changed he would attend at hospital for treatment. An ambulance was contacted which arrived at the Prison at 1634 hours and transported the deceased to Wishaw General Hospital, arriving at approximately 1718 hours. On arrival, the deceased was treated for community acquired pneumonia and was also noted to have worsening acute kidney injury and sepsis. The deceased was thereafter transferred to the Intensive Care Unit (ICU) on 6 December 2018 where he received renal replacement therapy, treatment for sepsis, and was ventilated from 7 December to 21 December 2018. During this period the deceased repeatedly stated that

he wished to be returned to the Prison as soon as possible, however medical staff recorded that he did not have the physical strength to leave the hospital.

8. On 25 December 2018 the deceased 'irregularly discharged' himself from Wishaw General Hospital. Prior to leaving the hospital the deceased had informed staff that he wished to return to the Prison to be with his friends. The deceased was seen by two Doctors within the hospital who explained that there was a risk the deceased would die should he leave hospital. The prisoner custody officers in attendance with him also attempted to convince the deceased to remain in hospital, however the deceased was insistent that he wished to be discharged. The doctors' view remained that the deceased had full capacity and so an irregular discharge form was completed and the deceased was returned to HMP, Shotts at approximately 0200 hours on the morning of 26 December 2018.

9. At approximately 0820 hours on the morning of 26 December 2018 nursing staff within the Prison became aware that the deceased had discharged himself from hospital when they were alerted by Prison Officers that the deceased was unwell within his cell. The deceased had been found on the floor of the cell, which was covered with a brown fluid, during the morning cell checks. There had been no healthcare staff within the Prison when the deceased had been returned, with medical staff arriving at 0800 hours on 26 December 2018. Nurse Practitioner, witness Ann O'Neill, attended at the deceased's cell and obtained some medical observations, including his blood pressure, temperature, pulse rate, and oxygen saturation. Witness O'Neill observed that the deceased was shivering all over, cold to touch, and yellowish in colour. He was also

speaking very little. Witness O'Neill noted that the brown fluid on the floor appeared to be 'coffee ground vomit'.

10. An ambulance was contacted at 1005 hours to urgently transfer the deceased back to hospital. Paramedics arrived at the Prison at approximately 1020 hours however the deceased refused to attend hospital, stating that "he'd had enough" and, following a long period where both staff and other prisoners attempted to convince the deceased to return to hospital for medical treatment, the ambulance thereafter left the Prison. Following the deceased's refusal to attend at hospital, Mr. Brian Burrell, who was acting in the capacity of First Line Manager on that morning, initiated the deceased on the 'Talk To Me' strategy in order to allow hall staff to carry out observations on the deceased, with a maximum contact interval of 30 minutes.

11. At 1120 hours a 'Code Blue' was activated for the deceased by Prison medical staff following a deterioration in the deceased's condition. Healthcare staff attended at the deceased's cell and obtained further observations. The deceased was noted to have had diarrhoea and was grunting loudly with his eyes open. He was provided with 8 litres of supplementary oxygen and an ambulance was re-contacted to attend. Paramedics arrived at approximately 1230 hours, however the deceased continued to refuse to attend hospital. Finally, the deceased agreed to go with the Paramedics and he was transferred back to University Hospital Wishaw (locally often referred to as 'Wishaw General Hospital', departing the Prison at 1310 hours and arriving at hospital at approximately 1326 hours where he was immediately admitted to the critical care ward with suspected sepsis and multi-organ failure.

12. Following his readmission to hospital it was deemed that the deceased no longer had full capacity and so a Certificate of Incapacity under section 47 of the Adults with Incapacity (Scotland) Act 2000 was completed on the deceased's behalf. The reason for his incapacity was recorded as being 'confusion' and the incapacity was to continue for a period of 1 month (as shown at Crown Production Number 3). A 'do not attempt cardiopulmonary resuscitation (DNACPR)' form was also completed for the deceased on the evening of 26 December 2018 following discussion with the deceased's family members who were in attendance at the hospital. The deceased's condition was noted to be very poor and it was decided on 27 December 2018, following further discussion with the deceased's family, that should there be no improvement in his condition over the following 24 hours then active treatment should cease, with a move to palliative care. The deceased continued to deteriorate significantly throughout 28 December 2018 and was failing to respond to any stimuli by medical staff. Active treatment was withdrawn and the deceased made comfortable.

13. The deceased was pronounced life extinct at 1915 hours on 28 December 2018.

14. Following the death of the deceased, a Death in Prison Learning, Audit and Review (DIPLAR) was conducted by Scottish Prison Service and an Adverse Event Review Report was compiled by NHS Lanarkshire into the circumstances of the deceased's death. The Adverse Event Review Report stated, at page 29, as follows:-

> "There was no evidence from Mr McInnes' healthcare records that there was any omissions of care on 26 December 2018 prior to his admission to University Hospital Wishaw… there were timely and appropriate actions taken… and a structured response was completed."

Both Reviews also highlight that, up until the point of his re-admission to hospital, neither prison healthcare staff nor medical staff within University Hospital Wishaw had any concerns regarding the deceased having full capacity to make informed decisions.

NOTE

Representation at this inquiry was as follows:

The Crown: Ms Allan, Procurator Fiscal Depute;

Scottish Prison Service: Ms Middleton, solicitor; and

NHS Lanarkshire: Mr Rebello, solicitor.

[1] The court is grateful to those solicitors for their meticulous preparation of the joint minute. That made the task of the court easier. More importantly, it sets out in some detail information, repeated in the above findings in fact, which the family of Mr McInnes is entitled to know.

[2] The picture painted in the evidence was that Mr McInnes was in poor health and either received or was offered appropriate medical attention and care from the prison and the hospital. When he lost full capacity, his family agreed that should there be no improvement in his condition over a 24 hour period, then active treatment should cease. Sadly he continued to deteriorate during 28 December 2018, and active treatment was withdrawn. Mr McInnes was made comfortable and died at 1915 hours on that date.

[3] On the basis of the evidence, reflected in the findings in fact, there was no ground for the court to identify any precautions which could reasonably have been taken which might realistically have resulted in the death being avoided. Neither was

there any evidence of any defect in any system of working which contributed to the death.

[4] There were no other facts relevant to the circumstances of the death requiring notice and there was no need to make any recommendations.

[5] At the conclusion of the inquiry, solicitors for the parties represented extended their condolences to the family of the deceased. I also extend my condolences.