SHERIFFDOM OF LOTHIAN & BORDERS AT EDINBURGH

[2021] FAI 52

EDI-B847-20

DETERMINATION

BY

SHERIFF DOUGLAS R G KEIR

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

into the death of

JOHN SMITH

Edinburgh, 6 September 2021

The sheriff, having considered the information presented at the inquiry determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") that:

(1) In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):

The late John Smith died at a point during the night of 20 April 2019 into the early hours of 21 April 2019, prior to his discovery at around 0800 hours on 21 April 2019 within his cell in the Selkirk Unit at HMP Addiewell, Station Road, Addiewell, West Lothian. He was pronounced life extinct at 1110 hours on 21 April 2019.

(2) In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

No finding is made as the death did not result from an accident.

(3) In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

Mr Smith's death was natural and caused by:

1a) Bronchopneumonia (probable Klebsiella pneumoniae);

1b) Chronic obstructive pulmonary disease and recent acute rhinovirus and parainfluenza type 3 infection;

2) Ischaemic heart disease.

(4) In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

No finding is made as the death did not result from an accident.

(5) In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

Hourly visual observations of Mr Smith by prison staff during the night of 20/21 April 2019.

(6) In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

The system of work for communicating/recording instructions from healthcare staff to prison staff in relation to the overnight observations of patients was defective insofar as such instructions were not routinely communicated/recorded in written form.

(7) In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

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

Recommendations

(1) In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (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):

No recommendations are made.

NOTE

Introduction

[1] This inquiry was held into the death of John Smith. Mr Smith was a serving prisoner at HM Prison Addiewell who died on 21 April 2019. Preliminary hearings in the inquiry were held on 11 March 2020, 3 November 2020, 9 February 2021, 16 April 2021, 22 June 2021, 21 July 2021 and 9 August 2021. The inquiry took place over four days between 23 and 26 August 2021.

[2] The parties were represented as follows:

(1) Mr Morrison, PF Depute ("PFD"), represented the Crown;

(2) Mr Christie, solicitor, represented the family of Mr Smith;

(3) Ms Middleton, solicitor, represented the Scottish Prison Service ("SPS");

(4) Ms Wallace, solicitor, represented the Prison Officers' Association Scotland ("POAS");

(5) Ms Toner, Advocate, represented Sodexo;

(6) Mr Holmes, solicitor, represented Lothian Health Board ("LHB").

[3] The representatives had responsibly agreed a significant amount of evidence in two separate joint minutes of agreement. That resulted in the need for oral evidence to be significantly reduced. The inquiry heard oral evidence from the following witnesses:

(1) Dr AW, Consultant Physician

(2) Ms AF, Deputy Charge Nurse

(3) Ms SJ, Registered General Nurse

(4) Ms JR, Registered General Nurse

(5) Professor AH, Consultant Respiratory Physician

Ms SJ and Professor AH had prepared reports on behalf of the family while Ms JR had prepared a report on behalf of LHB which they referred to during their evidence. I found all five witnesses to be credible and reliable and considered that they were all doing their best to assist the inquiry.

[4] The statements of a number of witnesses were agreed as the equivalent to parole evidence as follows:

(1) JK, Prison Custody Officer ("PCO"), HMP Addiewell

(2) PP, PCO, HMP Addiewell

(3) MO, Senior PCO, HMP Addiewell

[5] The Crown had also lodged the following productions:

(1) Final Post-mortem report by Dr IW dated 26 August 2019

(2) Death in Prison Learning and Audit Review (DIPLAR) report dated 17 May 2019

(3) Death in custody documentation

(4) Medical records

(5) Medical report by Dr DN dated 16 April 2018

The legal framework

[6] This inquiry was held in terms of section 1 of the 2016 Act. Mr Smith died in legal custody and therefore the inquiry was a mandatory inquiry held in terms of sections 2(1) and 2(4) of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") and was an inquisitorial process. The Crown represented the public interest.

[7] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Smith and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules).

[8] Section 26 of the 2016 Act sets out what must be determined by the inquiry. Section 26 of the 2016 Act is in the following terms:

"Section 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. "

[9] In this Note I will, firstly, set out the summary of the facts that I have found proved. Secondly, I will set out a brief outline of the submissions made by the Crown and the other parties. Thirdly, I will consider the circumstances identified in sections 26(2)(a) to (g) of the 2016 Act and explain, with reference to the information before the inquiry, the conclusions I have reached.

Findings in fact

I found the following facts admitted or proved:

[10] John Smith was born on 11 June 1950.

[11] Mr Smith's death occurred within the single occupancy cell where he was resident, namely Cell S02, Selkirk Unit, HMP Addiewell. Mr Smith's death occurred at a

point during the night of 20 April 2019 into the early hours of the morning of 21 April 2019, prior to his discovery at around 0800 hours on 21 April 2019.

[12] At the time of his death, Mr Smith was in lawful custody at HMP Addiewell.

[13] On 25 January 2019, following a jury trial at Livingston Sheriff Court, Mr Smith was found guilty of four charges of historical lewd, indecent and libidinous practices and behaviour.

[14] On 8 March 2019, Mr Smith was sentenced at Livingston Sheriff Court to 3 years and 6 months imprisonment.

[15] Prior to the trial, Mr Smith was assessed by Dr DN, Consultant Respiratory Physician, with a view to assessing his fitness to attend court. Dr DN prepared a report after examination of Mr Smith on 16 April 2018. The following diagnoses were noted: severe chronic obstructive pulmonary disease ("COPD"), a low body mass index, prostate cancer, and a subdural haemorrhage which he had been diagnosed with in 2016. A chest x-ray revealed hyper-inflated lungs with a relative paucity of lung markings, consistent with severe COPD. In relation to the low body mass index, Dr DN noted that "He [Mr Smith] is underweight with a BMI of 15.8 (normal 19-26). This is often a manifestation of severe COPD and is associated with increased mortality related to COPD". Under the heading "Prognosis", Doctor DN noted: "In view of the severity of this man's lung disease, his prognosis is very poor. Based on a prognostic tool called the BODE index, the predicted 4 year survival for a patient with the pattern and severity of disease that Mr Smith has is approximately 18%".

[16] On 19 December 2018, Mr Smith had been in hospital and at that time was found to have an infective exacerbation of COPD, a previous subdural haematoma with mild residual left-sided weakness, malnutrition, previous supraventricular tachycardia and cor pulmonale; and it was noted that he had been a long term smoker who had given up smoking in 2017.

[17] On admission to HMP Addiewell on 8 March 2019 it was recorded within Mr Smith's prison health centre medical records that he suffered from: suspected asthma, COPD, dependence on a wheelchair, low vision with cataracts, impaired hearing, prostate cancer, poor mobility and frailty.

[18] The NHS is responsible for the provision of healthcare to prisoners, such as Mr Smith. Since 1 November 2011, individual regional NHS health boards have been responsible for the delivery of health care services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

[19] Sodexo operates HMP Addiewell in Scotland under contract to the Scottish Ministers as representing the SPS. HMP Addiewell is operated independently of the rest of the prison estate in Scotland by Sodexo. It has its own management chain, directly employed staff group, and its own policies and procedures. Sodexo has responsibility for the operation of the prison and for recruiting and managing staffing resource. On employment with Sodexo, staff undergo initial training lasting nine weeks and, thereafter, ongoing additional training. Other than where it is obliged to adopt and implement SPS policies in terms of their contract, Sodexo adopts and implements its own policies in the operation of the prison.

[20] On admission to HMP Addiewell on 8 March 2019, Mr Smith was placed on the "Talk to Me" suicide prevention policy. He was placed on observations under the said policy because of an identified risk of suicide. He showed no active intentions to commit suicide. He made no attempts to self-harm; he did not refuse medications; nor did he not stop eating, as he had initially threatened. He was removed from "Talk to Me" observations on 22 March 2019.

[21] On 9 March 2019, Mr Smith's prison health centre medical records were updated in respect of his medication and medical history up to the date of his admission to HMP Addiewell. On the same date, a Personal Care Plan at HMP Addiewell was offered to, and accepted by, Mr Smith.

[22] On 16 April 2019, Mr Smith was transferred from HMP Addiewell to St John's Hospital, Livingston by ambulance as a result of increasing breathlessness associated with a cough on a background of known COPD and a recent course of antibiotics and corticosteroids. Dr AW, Consultant Physician, was the consultant in charge of Mr Smith's care on admission to St John's Hospital. Mr Smith was found to be frail with features of advanced COPD, hyper-inflated chest and bronchospasm. Following a CT pulmonary angiogram, it was confirmed that Mr Smith had severe emphysema and associated bronchopneumonia.

[23] On 16 April 2019, swabs were taken from Mr Smith's throat and tested for virology. The results of those tests were received on 18 April 2019 and confirmed that rhinovirus (common cold) and parainfluenza (influenza type 3) were present.

Mr Smith's condition stabilised during the course of his admission, he was reinitiated on corticosteroid therapy with a commencement of doxycycline and regular nebulisers.

[24] It was acknowledged in a Summary Discharge Letter dated 1 May 2019 by Dr AW that during his last admission to hospital, Mr Smith had advanced airways disease and this would likely prove life limiting.

[25] On 17 April 2019, medical staff at St John's Hospital discussed a "Do Not Attempt Cardiopulmonary Resuscitation" ("DNA CPR") protocol with Mr Smith. With his full agreement, a DNA CPR protocol was put in place for Mr Smith. The DNA CPR protocol applied only to CPR treatment.

[26] By 19 April 2019, Mr Smith's condition had improved and his observations were considered stable. He had no further medical requirement to remain within hospital and was discharged back to HMP Addiewell. He had been prescribed doxycycline and prednisolone, oral morphine, verapamil in relation to his heart rate, and lorazepam to alleviate breathlessness.

[27] Deputy Charge Nurse AF received Mr Smith when he was discharged back to HMP Addiewell on 19 April 2019. She confirmed with St John's Hospital that Mr Smith had a diagnosis of parainfluenza. As a result, she arranged for Mr Smith to be segregated in the Selkirk Unit of HMP Addiewell on the morning of 20 April 2019 in line with infection and quarantine control measures. Mr Smith was housed in Cell S02, a single occupancy cell, within the Selkirk Unit. Barrier nursing conditions were put in place for any staff members coming into contact with Mr Smith, including the wearing of full personal protective equipment.

[28] Following Mr Smith's return to HMP Addiewell on 19 April 2019, DCN AF placed him on precautionary 30-minute observations due to her concerns about his health. She contacted the prison staff on the wing where Mr Smith was located and advised them that the 30-minute observations should consist of both a visual and verbal check. As part of these observations, the relevant prison officer had to ensure that they established verbal communication with Mr Smith.

[29] On 20 April 2019, a Care Plan was commenced. It was noted within said Care Plan: "Potential for Compassionate Release: to be discussed with Senior Management and Prison Management". Patient skin care was offered to Mr Smith but was refused by him as he stated he was tired.

[30] At Mr Smith's specific request, he was removed from 30-minute observations as he did not want to be continually disturbed and wished to rest. This followed a discussion between Mr Smith and DCN AF at around 1000 hours on 20 April 2019 during which she explained to him that the observations were for his own benefit. It was DCN AF's intention that prison staff would continue to carry out visual observations only on a regular basis whereby they would check on him by lifting the hatch on his cell door. Healthcare staff would also carry out their own observations on Mr Smith throughout the day and check his vital signs when administering his medication.

[31] Located within Mr Smith's cell was a cell buzzer. Said buzzer was located on the internal wall of the cell adjacent to the cell door. The bed within the cell was positioned

along the wall adjacent to the door. The head of the bed was located at the wall directly opposite the cell door.

[32] During the course of her discussions with Mr Smith on the morning of 20 April 2019, DCN AF formed the view that he was able to mobilise sufficiently using his wheelchair to access/activate his cell buzzer.

[33] DCN AF carried out observations on Mr Smith and took his vital signs throughout the day on 20 April 2019, the last of which was around 1700 hours. Mr Smith presented well and his vital signs indicated no deterioration in his condition – they were within the normal range for a person with Mr Smith's underlying health conditions.

[34] Notwithstanding DCN AF's intention that Mr Smith should continue to be observed on an hourly basis during the course of the night from 20 April into 21 April 2019, no such observations were carried out.

[35] At around 0720 hours on 21 April 2019, PCO EC commenced his shift in the Selkirk Unit. At that time, he began a numbers check on prisoners within the Unit by checking through the hatch of each cell to ensure everyone was within their cell and showing no obvious cause for concern. Mr Smith's cell was checked in this manner at this time. PCO EC noted that Mr Smith was lying on his side and appeared to be sleeping. There were no specific observation instructions so PCO EC did not attempt to obtain any response from Mr Smith during this check.

[36] At around 0800 hours on 21 April 2019, PCO EC and PCO GM put on protective personal equipment and entered Mr Smith's cell in order to serve breakfast. PCO EC

noticed that Mr Smith had not moved since his earlier check. Both PCOs tried to obtain a verbal response from Mr Smith but were unable to do so, before PCO EC shook him to try to rouse him. Mr Smith was stiff to the touch and cold, and PCO EC noted that "he looked dead". A "Code Blue" was initiated and an ambulance was summoned. Mr Smith's life was pronounced extinct at 1110 hours on 21 April 2019.

[37] On 25 April 2019 a post mortem was carried out at Edinburgh City Mortuary by Dr IW, Consultant Forensic Pathologist. During the post mortem examination, additional disease was identified in the form of three vessel coronary artery atheroma and chronic disease involving the kidneys. Toxicology results indicated the presence of morphine, lorazepam and verapamil, all of which were drugs prescribed to Mr Smith. Dr IW noted that Mr Smith's reduced body mass, presumed at least in part to relate to underlying chronic COPD, may have resulted in particular risk of infection and subsequent decline.

[38] Mr Smith's cause of death was determined to be natural and was certified as:

1a) Bronchopneumonia (probable Klebsiella pneumoniae);

1b) Chronic obstructive pulmonary disease and recent acute rhinovirus and parainfluenza type 3 infection;

2) Ischaemic heart disease.

[39] A Standard Operating Procedure for the welfare of patients with deteriorating long term conditions, illness or injury was implemented by Sodexo within HMP Addiewell with effect from 26 August 2020. Its purpose is: (i) to ensure that there is a consistent approach to a patient's long term condition generally deteriorating or a recent

illness or injury that has been clinically assessed as not requiring an immediate emergency response; and (ii) to clarify roles and responsibilities for NHS Lothian and staff within HMP Addiewell.

Submissions

[40] All parties made oral submissions on 26 August 2021. All parties sought formal findings in respect of sections 26(2)(a) and (c) of the 2016 Act. The formal findings sought were based on the agreed evidence before the inquiry and my findings in relation to sections 26(2)(a) and (c) of the 2016 Act mirror those sought by each of the parties. All parties agreed that no findings were appropriate in respect of sections 26(2)(b) and (d) of the 2016 Act on the basis that the death did not result from an accident.

[41] Both the Crown and the family submitted that a finding should be made in terms of section 26(2)(e) of the 2016 Act on the basis that it would have been a reasonable precaution to locate an assistance buzzer within easy reach of Mr Smith while he was within the bed in his cell in the Selkirk Unit. The family also submitted that it would have been a reasonable precaution to have carried out overnight hourly visual observations.

[42] In terms of section 26(2)(f) of the 2016 Act, both the Crown and the family submitted that there was a lack of effective recording of DCN AF's instruction that prison staff should maintain overnight hourly visual observations, with the result that

no such observations were carried out, and that this represented a defect in the system of working at HMP Addiewell which contributed to Mr Smith's death.

[43] Both the Crown and the family invited the inquiry to make a recommendation in relation to the provision of an appropriate assistance buzzer for prisoners who suffered from significant ill health.

Discussion and conclusions

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[44] In this inquiry there was no dispute as regards when and where the death occurred. Mr Smith died at a point during the night of 20 April 2019 into the early hours of 21 April 2019, prior to his discovery at around 0800 hours on 21 April 2019 within his cell in the Selkirk Unit at HMP Addiewell, Station Road, Addiewell. He was pronounced life extinct at 1110 hours on 21 April 2019.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred)

[45] There was no dispute that Mr Smith's death did not result from an accident and it is therefore not necessary to make a formal finding under this section of the 2016 Act.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[46] There was no dispute as regards the cause or causes of death. The conclusion of Dr IW, Consultant Forensic Pathologist, has been set out at findings in fact [37] and [38]. Dr IW carried out a post mortem examination of Mr Smith on 25 April 2019. During the post mortem examination, additional disease was identified in the form of three vessel coronary artery atheroma and chronic disease involving the kidneys. Mr Smith's death was determined to be natural and was certified as:

> 1a) Bronchopneumonia (probable Klebsiella pneumoniae);
>
> 1b) Chronic obstructive pulmonary disease and recent acute rhinovirus and parainfluenza type 3 infection;
>
> 2) Ischemic heart disease.

[47] In the circumstances, I determine that the cause of death was as recorded in the medical certificate.

Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death)

[48] There was no dispute that Mr Smith's death arose as a result of natural causes. In the circumstances, Mr Smith's death did not result from an accident and it is therefore not necessary to make a formal finding under this section of the 2016 Act.

Section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)

[49] Section 6(1)(c) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter referred to as "the 1976 Act)" was the predecessor to section 26(2)(e) of the 2016 Act and required the court to consider "the reasonable precautions, if any, whereby the death and any accident resulting in death might have been avoided". In Carmichael's textbook Sudden Deaths and Fatal Accident Inquiries (3rd edition), at paragraph 5-75, the author sets out what is considered to be the correct approach to section 6(1)(c) of the 1976 Act:

> "If the cause of an accident is known, then it may well be possible, even with what is now said to be the 'wisdom of hindsight' to point to something which, if done, might have avoided or even prevented the death or accident resulting in death… The precise wording of section 6(1)(c) must be kept in mind. What is required is not a finding as to reasonable precautions whereby the death or accident resulting in death 'would' have been avoided, but whereby the death or accident resulting in death 'might' have been avoided… Certainty that the accident or death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution."

[50] The explanatory notes to the 2016 Act clearly envisage a similar approach being taken to section 26(2)(e) of the 2016 Act. The explanatory notes state at paragraph 72:

> "72. Subsection (2)(e) requires the determination to set out any precautions which were not taken before the death which is the subject of the FAI, but that could reasonably have been taken and might realistically have prevented the death. The precautions that the sheriff identifies at this point relate to the death which is the subject of the FAI and might not be the same as those recommended to prevent other deaths in the future under subsection (4)(a). In subsection (2)(e)(i), 'reasonably' relates to the reasonableness of taking the

> precautions rather than the foreseeability of the death or accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have so done."

As such, the task of this inquiry is to consider, with the wisdom of hindsight, whether there were any precautions which could reasonably have been taken which might realistically have resulted in death, or any accident resulting in death, being avoided. I consider that a precaution might realistically have resulted in the death, or any accident resulting in death, being avoided, if there was a real or lively possibility that it might have done so.

[51] In the present case, the majority of the evidence was either agreed or undisputed and a significant proportion of the findings in fact are based on that agreed evidence. The main issues which emerged from the oral evidence heard by the inquiry were: (i) whether it was reasonable for healthcare staff at HMP Addiewell to have relied upon a combination of hourly visual observations and the standard assistance buzzer in Mr Smith's cell as a means of monitoring his health during the night of 20/21 April 2019, and (ii) whether the system of work for communicating/recording instructions provided by healthcare staff to prison staff in relation to the overnight observations of patients was defective.

[52] It was not disputed that the state of Mr Smith's health had been poor for several years prior to his death. Both Dr AW, a Consultant Physician and Mr Smith's treating consultant at St John's Hospital, and Professor AH, an experienced Consultant in Respiratory Medicine, confirmed in their evidence to the inquiry that Mr Smith's respiratory disease was severe and at an advanced stage. Dr AW considered that

Mr Smith had a 50% chance of not surviving for another two years while Professor AH assessed Mr Smith's life expectancy at no more than one year once all of his co-morbidities were taken into account.

[53] DCN AF explained during the course of her evidence that she was well aware of the fragile nature of Mr Smith's health. Moreover, when she had observed him on his return from St John's Hospital on the evening of 19 April 2019, she was sufficiently concerned about his condition that she placed him on 30 minute visual and verbal observations at that time. As part of those observations, the prison officer conducting the observations had to obtain a verbal response from Mr Smith to confirm that all was well. DCN AF contacted the prison staff on the prison wing where Mr Smith was located to advise them of her instructions. Her instructions were given verbally and there was no separate written instruction.

[54] DCN AF ascertained from St John's Hospital that Mr Smith had been diagnosed with parainfluenza. As a result, she arranged for Mr Smith to be segregated in the Selkirk Unit at HMP Addiewell in line with infection and quarantine control measures. Mr Smith was moved to Cell S02, a single occupancy cell, within the Selkirk Unit on the morning of 20 April 2019 where DCN AF assessed him again at around 1000 hours. At that time, she noted that Mr Smith's condition had stabilised and that his vital signs were back in the normal range for an individual with his underlying health conditions. DCN AF considered that Mr Smith looked much better and was not as breathless as he had been the previous evening. Having completed her assessment, DCN AF stated that Mr Smith made it clear that he wanted to be removed from the 30-minute visual and

verbal observations. He told her that he did not want to be continually disturbed and that he wished to rest. DCN AFs confirmed that she explained to Mr Smith that the observations were for his own benefit. Standing Mr Smith's insistence that he be removed from such observations, and having provided his informed consent to DCN AF for those observations to cease, DCN AF advised that she recognised there remained a need for continued monitoring. As such, she included in Mr Smith's Care Plan that he should be placed on "signs and symptoms" checks. These checks would involve healthcare staff carrying out observations on Mr Smith throughout the day and checking his vital signs when administering his medication. Prison staff would also be instructed to carry out regular checks on Mr Smith by lifting the hatch on his cell door to observe him in his cell, while Mr Smith was told that he should alert healthcare/prison staff to any change in his condition by either using the buzzer located in his cell or shouting for assistance. DCN AF confirmed that the instructions given to prison staff in this regard would have been given verbally only and that there was no separate written instruction.

[55] DCN AF advised that she had carried out subsequent observations on Mr Smith at around 1200 hours, 1400 hours and 1700 hours on 20 April before her shift finished at around 1800 hours. She explained that when she last observed Mr Smith at around 1700 hours, his vital signs remained within his normal range and that she had no concerns about his condition at that time. DCN AF stated that she intended that hourly visual observations should be maintained by prison staff overnight whereby they would check on Mr Smith by lifting the hatch on his cell door.

[56] DCN AF's evidence at the inquiry was that she had notified the relevant prison staff about the need to maintain such observations on Mr Smith overnight and to watch out for any signs of deterioration in his condition, with particular focus on signs of respiratory distress. She explained that these instructions would have been given verbally but she would also have included this requirement in the "Night Report" for 20/21 April 2019. DCN AF advised that the "Night Report" at HMP Addiewell covered the entire prison population and contained a list of prisoners who might have specific medical needs and about whom healthcare staff had an ongoing concern. DCN AF advised that at the time of Mr Smith's death, a copy of the Night Report was not routinely retained – as such, a copy was not available to review at the inquiry. However, she also advised that the practice at HMP Addiewell had changed in around October 2020 and copies of every Night Report were now retained and recorded.

[57] In contrast to this evidence, statements were provided to the inquiry on behalf of PCO PP, PCO JK and SPCO MO. They were the prison staff on duty in Selkirk Unit on consecutive shifts throughout the day on 20 April 2019 and overnight on 20/21 April 2019. All three advised in their statements that they were unaware of the need to carry out hourly observations on Mr Smith. As a result, no such observations were carried out.

[58] On the basis that the inquiry only heard parole evidence from DCN AF compared to the agreed statements from the three prison officers, it is difficult to make a full assessment of their respective credibility and reliability. I am satisfied that DCN AF was doing her best to assist the inquiry. However, at the same time, I am satisfied that

there was a breakdown in communications between the healthcare staff and the prison staff and that this was exacerbated by the absence of written/recorded instructions specific to Mr Smith, the end result of which was that the intended overnight hourly observations were not carried out.

[59] In relation to the suitability of such observations, both Ms JR (a nursing expert who provided evidence to the inquiry on behalf of LHB) and Professor AH both gave evidence that they supported hourly visual observations as an appropriate means of monitoring Mr Smith's condition overnight. While Ms SJ (a nursing expert who provided evidence to the inquiry on behalf of the family) asserted that Mr Smith's express instructions to be removed from the 30-minute visual and verbal observations should have been overridden by healthcare staff, this was at odds with the evidence of Ms JR and Professor AH and I prefer their evidence on this point. Moreover, there was no suggestion that Mr Smith lacked capacity to provide such instructions and, as per finding in fact [30], Mr Smith provided his informed consent to DCN AF in relation to the removal of the 30-minute observations. Taking all of this into account, I am satisfied that DCN AF's intended hourly visual observations of Mr Smith would have been a reasonable precaution that could have been taken on the night of 20/21 April 2019.

[60] Turning to the issue of the buzzer in Mr Smith's cell, DCN AF advised that when she had assessed Mr Smith at 1000 hours on 20 April 2019, she was satisfied that he was sufficiently mobile to be able to access/use the buzzer if required. While Mr Smith used a wheelchair to mobilise, she had seen him transfer himself from his wheelchair to his bed. Mr Smith had also told her that he did not need any assistance either for transfers

or to use the toilet in his cell. In response to questioning by Mr Christie, DCN AF accepted that there was the possibility that Mr Smith might have been too weak to mobilise to use the buzzer if his condition had suddenly deteriorated. However, she was satisfied that Mr Smith could shout out from his cell if he required assistance and, in any event, prison staff would have been carrying out regular observations to monitor for signs of deterioration in his condition. Both Ms SJ and Ms JR criticised the location of the buzzer in Mr Smith's cell on the basis that it was not immediately adjacent to the bed and was also fixed to the cell wall so therefore could not be moved. As such, they considered that the buzzer might be difficult to access if Mr Smith was in respiratory distress. However, notwithstanding this criticism, there was an absence of evidence before the inquiry about what sort of alternative buzzer arrangement might have been appropriate. Ms JR was not asked to provide any comment on this issue while Ms SJ conceded during the course of her evidence that she only had experience of alternative types of buzzers within a healthcare unit setting. As such, she was not able to offer any useful comment on what would have been reasonable or practicable within the Selkirk Unit where Mr Smith was located. Moreover, both Ms JR and Professor AH stated to the inquiry that they considered hourly visual observations would have been appropriate for Mr Smith irrespective of any perceived shortcomings with the buzzer located within his cell. On that basis, I do not consider that any specific finding about the cell buzzer can be made.

[61] Returning to the overnight hourly visual observations, having determined that this was a precaution that could reasonably have been taken, the next issue for

consideration is whether or not there was a real or lively possibility that such a precaution might have resulted in Mr Smith's death being avoided. During the course of her evidence, Ms JR stated that, in her view, Mr Smith had either died in his sleep or died suddenly. However, in contrast, Professor AH stated that he believed that it was more likely than not that Mr Smith's condition had deteriorated over a period of several hours. In support of this position, Professor AH noted that Mr Smith's condition had been stable when he was assessed by DCN AF at around 1700 hours on 20 April 2019. More significantly, Professor AH highlighted that there were no findings in the Post Mortem report carried out on Mr Smith to provide any support for the suggestion that his death had resulted from a sudden event such as a heart attack. The content of the Post Mortem report was agreed by parties by way of joint minute. I also did not understand any party to challenge this part of Professor AH's evidence. I therefore have no difficulty in accepting Professor AH's evidence in this regard and I am satisfied that it is more likely than not that Mr Smith's health deteriorated over a period of several hours during the night of 20/21 April 2019.

[62] Proceeding on this basis, I also accept the evidence of Dr AW, Professor AH, Ms SJ and DCN AF that the signs of respiratory distress, even for someone such as Mr Smith with advanced respiratory disease, would have been sufficiently noticeable to non-medically trained persons such as the prison staff on duty. There was consistent evidence from all four witnesses that where someone was suffering from respiratory distress, there would be noticeable visual cues including rapidity of breathing, the person sitting up and leaning forward due to their inability to breath, and also that the

person would be panicking as they struggled for breath. Accordingly, I am satisfied that had there been effective communication between healthcare and prison staff, resulting in hourly visual observations being carried out, the signs of respiratory distress as Mr Smith's condition deteriorated over a period of several hours would have been picked up during the course of those hourly observations.

[63] Having noted Mr Smith's deteriorating condition, and relying on the evidence in particular of Ms SJ and Ms JR, I consider that it is likely that prison staff would have called an emergency ambulance. I am also satisfied that it is likely that Mr Smith would have survived long enough for the ambulance to arrive at HMP Addiewell and transfer him to hospital where he would have received life-prolonging treatment. In this regard, I accept the unchallenged evidence of Professor AH who stated that the attending paramedics would have had equipment such as oxygen and nebulisers in the ambulance to enable them to provide emergency treatment to Mr Smith and that it was likely that he would have been successfully conveyed to hospital. In terms of the subsequent treatment at hospital, the court heard evidence from both Dr AW and Professor AH. As previously noted, there was no dispute about the severity of Mr Smith's medical problems. Dr AW confirmed the details of the treatment provided to Mr Smith at St John's Hospital between 16 and 19 April 2019. When asked what further treatment might be provided to a patient like Mr Smith were he to experience respiratory distress, Dr AW indicated that treatment options might have more of a palliative focus. However, he also stated that such options would be appropriate if Mr Smith was noted to be deteriorating notwithstanding other measures having been taken. On that issue,

Professor AH highlighted that Mr Smith had yet to receive long-term oxygen therapy and his view was that this would be a treatment option if Mr Smith had entered respiratory failure. Professor AH also noted that while Mr Smith had been recorded in the medical records as an ex-smoker, it appeared that he was still smoking a small number of cigarettes on a daily basis prior to his death. In such a scenario, while he would have been precluded from receiving oxygen therapy at home, he would still have been a candidate for oxygen therapy within a hospital setting. Moreover, Professor AH advised that there were several other treatment options that Mr Smith could have received had he been re-admitted to hospital, including enhanced nebulisers, antibiotics and steroids, all of which could have been administered irrespective of the DNA CPR protocol that was in place.

[64] Taking all of this together, I am therefore satisfied that there was a real or lively possibility that the precaution of carrying out overnight hourly visual observations would have resulted in Mr Smith's death being avoided. The question of how long Mr Smith would have further survived having received such treatment is not a matter for this inquiry.

Section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)

[65] Section 6(1)(d) of the 1976 Act was the predecessor to section 26(2)(f) of the 2016 Act and required the court to consider "the defects, if any, in any system of working which contributed to the death or any accident resulting in death". Sheriff Kearney in

his determination into the death of Mildred Allan (an extract of which is set out in Carmichael at paragraph 8-99) set out what is considered to be the correct approach to section 6(1)(d) of 1976 Act and also now section 26(2)(f) of the 2016 Act:

> "In deciding whether to make any determination (under s.6(1)(d)) as to defects, if any, in any system of working which contributed to the death or any accident resulting in the death the court must, as a precondition to making such a recommendation, be satisfied that the defect in question did in fact cause or contribute to the death."

[66] In the present case, I have found that there was a breakdown in communication between healthcare staff and prison staff at HMP Addiewell during the course of 20 April 2019 which led to no observations being carried out on Mr Smith during the night of 20/21 April 2019.

[67] As detailed above, there was unchallenged evidence before this inquiry that instructions from healthcare staff to prison staff at HMP Addiewell for matters such as the overnight observation of prisoners were not routinely communicated/recorded in written form. This system of work was criticised by Ms SJ in particular and I am satisfied that the failure to properly communicate/record such instructions amounted to a defect in the system of work. It stands to reason that had instructions regarding the proposed observation of Mr Smith been properly communicate/recorded, they would have been received by prison staff in the Selkirk Unit where Mr Smith was located, the prison staff on duty that night would have followed those instructions and carried out the specified hourly visual observations. It therefore follows, for the reasons given above, that I am satisfied that this defect contributed to Mr Smith's death.

[68] That said, it must be recognised that a new Standard Operating Procedure ("SOP") for the welfare of patients with deteriorating long term conditions, illness or injury, such as Mr Smith, was implemented by Sodexo within HMP Addiewell with effect from 26 August 2020. The introduction of the SOP was unconnected to Mr Smith's death. As per finding of fact [39], the purpose of the SOP is: (i) to ensure that there is a consistent approach to a patient's long term condition generally deteriorating or a recent illness or injury that has been clinically assessed as not requiring an immediate emergency response; and (ii) to clarify roles and responsibilities for NHS Lothian and staff within HMP Addiewell.

[69] The procedure set out by the SOP to be adhered to by healthcare and prison staff includes the following requirements: (i) the relevant NHS healthcare professional will notify the HMP Addiewell Residential Manager of the identity of any patient with a long-term condition that may generally deteriorate or who has suffered a recent illness or injury, and which requires regular visual and verbal checks; (ii) the relevant NHS healthcare professional will produce and provide to the HMP Addiewell Residential Manager a care plan for the patient detailing the maximum time period between checks and the date for reviewing the care plan; (iii) the NHS healthcare professional initiating the care plan will record the time and date of initiation and will sign the care plan; (iv) the HMP Addiewell First Line Manager of the residential area where the individual is located will sign and date the care plan to evidence that it has been received; (v) the HMP Addiewell First Line Manager will delegate the task of welfare observations to a named PCO; (vi) the HMP Addiewell First Line Manager will ensure that the named

PCO fully understands and recognises their responsibilities and understands what to do if there is a deterioration in the patient; (vii) the named PCO will sign for receipt of the care plan and will undertake the welfare observations as specified, noting and responding as necessary to any identifiable concerns during their period undertaking the welfare observations; (viii) the named PCO will ensure that the name of the PCO taking over their responsibility is recorded on the welfare care plan and that the care plan requirements and individual responsibilities are fully understood by the PCO taking over; (ix) the NHS healthcare professional will record all information within the patient's electronic records; (x) the NHS healthcare professional will meet with prison staff on a daily basis to discuss and communicate any changes to the patient's care plan; and (xi) the NHS healthcare professional will update the care plan when any changes are required.

[70] On this basis, I am satisfied that the SOP addresses the concerns raised regarding the system of work in place at the time of Mr Smith's death and therefore no recommendation falls to be made.

Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

[71] I do not consider that there are any other facts which are relevant to the circumstances of Mr Smith's death.

Recommendations

Section 26(1)(b) of the 2016 Act (recommendations (if any) as to (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)

[72] As I have set out in paragraphs [60] and [68] to [70] above, and in particular standing the introduction of the SOP by Sodexo, I do not consider that any recommendations fall to be made.

Postscript

[73] At the outset of the inquiry I extended my condolences to Mr Smith's family. I wish to formally repeat my condolences to Mr Smith's family in this determination.