SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2023] FAI 24

GLW-B934-22

DETERMINATION

BY

SHERIFF BERNARD ABLETT

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

into the death of

JOHN MCDERMOTT WILSON

GLASGOW, 16 May 2023

The Sheriff, having considered the information presented at an inquiry on 6 December 2022 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 finds and determines:

(1) That in respect of paragraph (a) of section 26(2), John McDermott Wilson born 12 October 1965, died on 15 February 2021. He was at that time a prisoner in HMP Low Moss, Glasgow.

(2) That in respect of section 26(2), paragraph (c), the cause of death was pulmonary fibrosis.

(3) I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26(2) of the Act.

(4) I have no recommendations to make under section 26(1) (b).

NOTE

Legal framework

[1] This Inquiry was held under section 1 of the 2016 Act. This was a mandatory inquiry in terms of section 2(1) and (4) of the 2016 Act as Mr Wilson was in legal custody at the time of his death. The purpose of the inquiry was to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[2] The Procurator Fiscal issued a notice of the inquiry on 26 July 2022. A preliminary hearing took place at Glasgow Sheriff Court on 7 September 2022. Miss McLintock, Procurator Fiscal Depute, appeared for the Crown. Mr Devlin appeared for the Scottish Prison Service. The matter was continued until a further preliminary hearing on 15 November 2021 to allow parties to lodge a joint minute of agreement of evidence and written submissions. The further preliminary hearing was subsequently discharged by interlocutor of 11 November 2022 when the hearing became unnecessary.

[3] The inquiry was held on 6 December 2022. Miss Doran, Procurator Fiscal Depute, appeared for the Crown. Miss Fettes appeared for the Scottish Prison Service. A joint minute of agreement was tendered on behalf of the parties and this was received by the court, as were the productions referred to. Miss Doran read out the terms of the Joint Minute of Agreement. Thereafter parties addressed me with reference to their written submissions.

Circumstances

[4] The following narrative is taken directly from the terms of the agreed Joint Minute:

Background

1. On 14 March 1991 JOHN MCDERMOTT WILSON born 12 October 1965 (hereinafter referred to as "the deceased") was convicted at the High Court in Glasgow in respect of the following offences:

   a. Murder – sentenced to life imprisonment with a punishment part of fifteen years, backdated to November 1990

   b. Reset x 2

   c. Breach of the peace

   d. Contravention Firearms Act 1968 x 4

2. The sentence for the offences listed at 1(b) - 1(d) inclusive, as above, ran concurrently with the deceased's sentence for the offence listed in 1(a), above.

3. The deceased punishment part for the offence in 1(a), above, expired on 16 November 2005.

4. The deceased was originally admitted to HM Prison Low Moss (hereinafter referred to as "Low Moss") on 20 March 2012, from HM Prison Glenochil.
The deceased progressed to the National Top End (hereinafter referred to as "NTE") on 17 March 2015 at Chrisswell House at HM Prison Greenock. The deceased was downgraded and returned to Low Moss on 30 February 2016.

5. The deceased failed to return to the NTE from a placement on 15 January 2016. The deceased was unlawfully at large until 18 January 2016. When the deceased was traced on 18 January 2016, the deceased was arrested for a breach of the peace and attempting to defeat the ends of justice. The deceased was under the

influence of alcohol at the time of his arrest. The deceased was thereafter charged with breach of the peace and attempting to defeat the ends of justice, for which a further six-month custodial sentence was imposed. As a result of absconding, the deceased was returned to closed conditions on 18 January 2016.

6. The deceased did not receive regular visits and his last family visit was on 5 December 2019. The deceased deactivated all visitors on his list.

7. The deceased was accordingly in legal custody at Low Moss as at the date of his death on 15 February 2021.

(all as shown at Crown Production Number 4, at pages 1009 - 1020, inclusive)

Medical history

8. The deceased suffered from significant pre-existing health conditions, including Chronic Obstructive Pulmonary Disease (hereinafter referred to as "COPD"), Emphysema, Idiopathic Pulmonary Fibrosis (hereinafter referred to as "IPF") and Asthma prior to his death.

(as at Crown Production 1, page 2)

9. The deceased had a history of regular chest infections

(as at Crown Production 2, page 10).

10. The deceased was a smoker who self-reported smoking between 20 and 39 roll up cigarettes daily. Smoking exacerbated the deceased's pre-existing medical conditions.

(as at Crown Production 3, page 51).

11. The deceased was addicted to heroin. The deceased had been prescribed opiate replacement therapy whilst in custody and at the time of his death, was prescribed 70 ml of methadone daily.

12. The deceased was prescribed several medications at the time of his death including inhalers, doxycycline, zopiclone and baclofen.

(all as at Crown Production 1, page 2)

13. The deceased was referred by Dr Andrew Kirk, General Practitioner at HM Prison Greenock, for a chest x-ray at Inverclyde Royal Hospital following symptoms of coughing and wheezing. The x-ray took place on 20 April 2015. There was no evidence of any active pulmonary disease or fibrotic changes of the lungs and the chest x-ray was "normal". The findings of the x-ray were reported by Dr Kanella-Eleni Karamani.

(as at Crown Production 3, page 976)

14. On 9 January 2017 the deceased had a chest x-ray. The deceased had presented with a daily cough for the preceding six months. The deceased's chest was clear and otherwise presented as systemically well. The finding of the x-ray suggested interstitial lung disease. The heart was not enlarged. The lung volumes were compared with the x-ray from April 2015 and the lung volumes were unchanged from 2015. Following the x-ray in January 2017 the deceased was referred by General Practitioner, Dr Jasek Oczkowskl (hereinafter referred to as "Dr Oczkowskl") to the department of respiratory medicine at Glasgow Royal Infirmary (hereinafter referred to as "GRI") on 3 February 2017. A computerised

tomography scan (hereinafter referred to as a “CT scan”) of the deceased’s chest and abdomen was scheduled for 17 February 2017 at Queen Elizabeth University Hospital (hereinafter referred to as “QEUH”) CT Scanning suite. The deceased attended an appointment with a respiratory physician on 20 February 2017 at the Department of Respiratory Medicine Lung Function Lab of GRI, which found a mild airflow obstruction consistent with stage 1 COPD.

(as at Crown Production 3, pages 863, 865, 867 - 872 (inclusive), 874 and Crown Production 5 at pages 1401, 1404 - 1413 (inclusive)).

15. A chest clinic appointment with Dr Angela Wright, Consultant Respiratory Physician (hereinafter referred to as “Dr Wright”), was arranged for 24 May 2017. The deceased failed to attend this appointment citing confusion over the date.

A further routine referral to the department of respiratory medicine was submitted by Dr Oczkowskl on 26 May 2017 requesting a further appointment for the chest clinic

(as at Crown Production 3, pages 842 - 847, inclusive and page 849).

16. A chest CT was performed at GRI CT scanning suite on 21 June 2017 by Doctor Steven Henderson. The conclusion was that the deceased’s lung appearance was in keeping with severe paraseptal predominant emphysema

(as at Crown Production 3, pages 838).

17. The deceased was seen at the chest clinic at the department of respiratory medicine at GRI, Outpatient Area A, on 10 July 2017 by Consultant Dr Mark Cotton. The deceased reported a daily cough with sputum which was not blood stained for

the previous 18 months. Smoking cessation advice was given, and the deceased was informed about the results of his CT scans. A further appointment was made for the chest clinic in November 2017 to follow up on the deceased's condition with a further review in four months. Dr Wright informed the deceased's GP of the outcome of this consultation

(as at Crown Production 3, pages 839 and Crown Production 5 pages 1428 and 1429)

18. The deceased attended at the respiratory medicine chest clinic at GRI on 7 November 2017. The deceased was examined by Dr Wright. The only symptom complained of by the deceased was a nocturnal cough and daily heartburn.

A proposed treatment plan for the deceased's heartburn and chronic cough was made. The deceased was prescribed a three-month trial of dual acid suppression and given further smoking cessation guidance. The respiratory physician reported that the deceased's pulmonary function tests were good, and only showed mild obstruction. The deceased was discharged from the respiratory clinic.

(as shown at Crown Production 5, pages 1431 and 1432).

19. A chest x-ray was performed on 23 January 2018 as the deceased reported suffering from shortness of breath and a productive cough. There was widespread reticular change throughout both lungs. A repeat x-ray was scheduled with an interval of 6 weeks on 6 March 2018. Comparisons were made Dr John Shand (hereinafter referred to as "Dr Shand") between the deceased's chest radiograph from April 2015 to 23 January 2018. The comparison demonstrated widespread

reticular lung changes and was consistent with infection superimposed upon the deceased's paraseptal emphysema

(as at Crown Production 5, page 1443).

20. The deceased had a chest x-ray on 6 March 2018 to follow up on previous chest radiographs which demonstrated left lung basal changes. The deceased was examined by both Specialist Registrar Dr Ramia Aziz and Dr Helen Griffiths.

A comparison was made of the deceased's chest radiograph from both 23 January 2018 and 20 April 2015. The results of the chest x-ray were reported on 07 March 2018 as demonstrating widespread reticular lung changes, with the lower zone and peripheral predominance. The previously seen increased left basal consolidative changes appeared to have resolved with the appearance now seemingly returned to the baseline for the deceased and the results of March 2018 x-ray were comparable to imaging dating back to 2015

(as at Crown Production 5, page 1447).

21. The deceased had a further chest x-ray on 7 June 2018 following a report of left sided pleuritic chest pain with a cough and yellow sputum. Dr Alasdair McCafferty who examined the images noted that the deceased did have coarse lung markings throughout but that there were no new focal lesions

(as at Crown Production 5, page 1448).

22. The deceased attended at Accident and Emergency at GRI on 3 February 2019 presenting with chest pain and a productive cough. A chest x-ray was performed on same date and comparisons were made to previous x-ray

examinations of the deceased's chest. The results of the chest x-ray were that the deceased's hilar and mediastinal contours were within normal limits with no focal active lung pathology. The deceased was prescribed Clarithromycin (an antibiotic) to treat a chest infection

(as at Crown Production 5, pages 1457 – 1461 (inclusive) and page 1463).

23. A further referral was made by General Practitioner, Dr Joe Daly (hereinafter referred to as "Dr Daly"), to the department of respiratory medicine at the GRI on 31 May 2019 as the deceased was continuing to experience chest pain which was not resolving with analgesia. A CT of the thorax and abdomen was carried out on 18 June 2019 to investigate the deceased's continuing chest pain. The CT scan was compared to the previous examination and imaging of the deceased on 21 June 2017. The result of the June 2019 CT scan showed no concerning abnormality or sinister features to account for the deceased's chest pain, although it continued to show emphysema and fibrosis which had been present in June 2017. Dr Joris Van der Horst and Dr John Maclay, both Consultant Respiratory Physicians concluded that the CT scan in June 2019 was reassuring and as a result the deceased was not referred to the Lung Cancer Clinic

(as at Crown Production 3, pages 756 and 741, Crown Production 5 at pages 1464-1468 (inclusive) and pages 1469-1471 (inclusive)).

24. On 28 November 2019 the deceased developed tenderness in the chest wall and complained of haemoptysis and lethargy. Dr Daly made a referral, marked urgent, to the department of respiratory medicine at the GRI to investigate whether

there was any sinister underlying pathology connected to the deceased's symptoms. A chest x-ray was arranged for the following day on 29 November 2019. In addition, a further CT scan of the thorax and abdomen took place on 16 December 2019. Dr John Maclay, Consultant Respiratory Physician reported the results of both x-ray and scan on 20 December 2019. The outcome of the CT scan was that there were no concerning abnormalities to account for the deceased's symptoms and they were likely caused by the previously diagnosed emphysema and the deceased's continued smoking. Further cessation of smoking advice was given and a recommendation that if the haemoptysis continues a referral to Ear Nose and Throat (hereinafter referred to as "ENT") department would be appropriate to investigate the upper airway. No further arrangements were made for the deceased to attend at future respiratory clinics
(as at Crown Production 3, at pages 424, 759 and Crown Production 5, pages 1472 –- 1480 (inclusive)).

25. In May 2020 the deceased was issued NHS advice to shield during the Covid-19 pandemic because of his underlying health conditions. Despite the advice, the deceased chose not to fully shield or follow the shielding guidance within the prison
(as at Crown Production 2 at page 12 and Crown Production 4 at page 1010).

26. On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the Scottish Prison Service to the NHS. Since then, 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.

Events in 2021

27. Throughout January 2021, the deceased complained of increased respiratory issues, lethargy, decreased appetite and the feeling of irritation to the left side of the neck. A chest x-ray was performed on 20 January 2021. The result of the chest x-ray was reviewed by Dr Shand and a progression of bilateral pulmonary fibrosis, predominately basal, was noted. This x-ray was compared to a previous x-ray in November 2019. There was an increasingly dense reticular pattern in both lungs which was consistent with a progression of the previously diagnosed pulmonary fibrosis with no other significant alteration in the lungs noted
(as at Crown Production 5, page 1490).

28. On 23 January 2021, the deceased was referred to the department of respiratory medicine at GRI by Dr Daly due to shortness of breath and for a review following chest x-ray. A referral was also made to ENT to investigate further the haemoptysis complained of by the deceased alongside the feeling of something being stuck in his throat
(as at Crown Production 5, pages 1491 – 1499 (inclusive)).

29. An appointment to attend the department of Respiratory Medicine at GRI was received on 5 February 2021 and an appointment was assigned for 8 February

2021. An appointment to attend the ENT department at GRI was received on 1 February 2021 and an appointment was assigned for 9 February 2021 (all as at Crown Production 3, page 19).

Events 8 – 14 February 2021

30. On 8 February 2021, the deceased was seen in his cell at approximately 09.00 hours by a Primary Care Nurse at HM Prison Low Moss. There were concerns regarding the deceased's clinical presentation and an ambulance was requested by medical staff. The deceased was breathless, pale in colour and lethargic. Oxygen therapy of the deceased commenced.

31. The deceased was continually monitored by nursing staff at HMP Low Moss until an emergency ambulance arrived at 09.45 hours (all as at Crown Production 2, page 11).

32. The deceased was conveyed to the Glasgow Royal Infirmary (GRI) by ambulance and thereafter admitted as an inpatient within Ward 51.

33. The deceased tested negative for COVID-19 on admission.

34. A chest x-ray took place at 12:05 hours following the deceased's admission to hospital. The x-ray identified the previously diagnosed pulmonary fibrosis. When compared to an earlier radiograph of the deceased's chest from 20 January 2021 there was increased opacity (white spots) which Dr Fraser Hendry considered reflected superadded consolidation (as at Crown Production 5, page 1501).

35. A CT pulmonary angiogram took place on 9 February 2021 at 10.35 hours. The deceased's known pulmonary fibrosis and subpleural honeycombing was present and described as extensive. The deceased was observed to have pronounced mediastinal lymphadenopathy (an enlargement of the lymph nodes located in the mediastinal part of the chest) measuring up to 16mm in diameter. Whilst the deceased tested negative for Covid-19 upon admission to the hospital, the radiological imagining was consistent with a Covid-19 diagnosis. The scan was reviewed by Dr John Shand.
(as at Crown Production 5, page 1502).

Events of 15 February 2021

36. The deceased's condition deteriorated over his time within GRI and did so rapidly on 15 February 2021.

37. The deceased was found unresponsive with no pulse at 18.10 hours by Senior Nurse S Mitchell. Life was pronounced extinct by Dr James Robertson (FY2) at 18.10 hours on 15 February 2021 and the death was verified by Dr Aidan Cahill, Consultant
(all as at Crown Production 5, pages 1506 and 1507).

Post-mortem and toxicology

38. On 5 March 2021 a post-mortem examination was carried out at the Queen Elizabeth University Hospital, Glasgow by Dr Julie McAdam, Forensic Pathologist.

39. The cause of death was established as:

1(a) Pulmonary fibrosis

40. The post-mortem examination revealed severe pulmonary fibrosis which would account for the deceased's shortness of breath and for his death. Pulmonary fibrosis is a disease in which the lungs become scarred (fibrosed) and damaged causing difficulty in breathing. Whilst the radiological imaging of the deceased on 9 February 2021 at hospital was consistent with Covid-19 diagnosis however, he had tested negative for Covid-19 upon admission to hospital and virology studies for respiratory viruses including NCoV 2019 (which causes coronavirus) was negative at post-mortem.

41. There was slight thickening of the right ventricular wall of the deceased's heart, consistent with chronic lung disease.

42. There was a small amount of attached fibrin thrombus in the right ventricle, in keeping with a degree of right ventricular dysfunction in the deceased.

43. There were no other significant natural disease nor injury to the deceased's body revealed as a result of the post-mortem examination.

Submissions for the parties

The Crown

[5] The Crown invited me to rely on the evidence contained within the joint minute of agreement on the basis that all relevant evidence had been incorporated into it, and that there were no other facts which were relevant to the circumstances of Mr Wilson's death.

[6] It was submitted that Mr Wilson's death did not result from an accident, that there were no reasonable precautions which might have prevented the death, and that there were no defects in any system of working which contributed to his death. Accordingly I was invited to make formal findings only i.e. to determine when and where Mr Wilson's death occurred, and the cause or causes of his death, in terms of Sections 26(2)(a) and (c) of the 2016 Act.

The Scottish Prison Service

[7] The Scottish Prison Service invited me to rely on the joint minute of agreement.

[8] It was submitted that nothing could have been done by the SPS to prevent Mr Wilson's death and that the evidence before the Inquiry did not disclose any substantive issues for me to consider. I was invited to make formal findings only.

Conclusions

[9] I found the joint minute of agreement, which had been carefully prepared by both parties, to be comprehensive in its terms. I was able to rely on it and the productions referred to in reaching a determination. I accepted both the submissions made on behalf of the Crown and those made for the Scottish Prison Service.

[10] The deceased suffered from significant health conditions prior to his death, including Chronic Obstructive Pulmonary Disease, Emphysema, Idiopathic Pulmonary Fibrosis and Asthma. The joint minute of agreement confirms that Mr Wilson received a significant degree of medical care from 20 April 2015 until his death on 15 February 2021. Mr Wilson's concerns and symptoms were acted upon and given proper attention, and he received appropriate

treatment. Given the various referrals made, detailed medical examinations carried out, the treatments provided, and the advice imparted by medical staff to Mr Wilson, no criticism can be made of either the Scottish Prison Service or the NHS.

[11] No submissions were made by either party that any accident resulted in Mr Wilson's death or that any precautions could reasonably have been taken which might realistically have resulted in Mr Wilson's death being avoided (section 26(2)(b), (d) and (e)); or that any defect in any system of working had contributed to his death (section 26(2)(f)). Nor were any submissions made that any other facts relevant to the circumstances of Mr Wilson's death fell to be included in my determination (section 26(2)(g)). No submissions were made that I should make any recommendations in terms of section 26(1)(b).

[12] I am satisfied that in all the circumstances formal findings should be made in this case. I have set out those formal findings above.

[13] In conclusion I wish to express my thanks to both parties, for their helpful and professional contributions in agreeing a joint minute which considerably shortened the length of the Inquiry hearing and avoided witnesses having to attend to give evidence, and for their assistance at the preliminary hearings and the Inquiry hearing.

[14] Before closing I wish to offer my sincere condolences to the bereaved family and friends of the late Mr John McDermott Wilson.