SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2024] FAI 39

HAM-B73-24

DETERMINATION

BY

SHERIFF LOUISE GALLACHER

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

into the death of

ANDREW MCKINLAY

HAMILTON, 12 August 2024

The Sheriff having considered the information presented at the inquiry on the 13 June 2024, under sections 2(1) and 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, Finds and Determines:

1. That in respect of section 26(2) paragraph (a), Andrew McKinlay, born 18 July 1974, died at 0804 hours on 30 July 2021 at HM Prison, Shotts, Newmill and Canthill Road, Shotts, ML7 4LE (hereinafter referred to as HMP Shotts).
2. That in respect of section 26(2) paragraph (b), no accident took place.
3. That in respect of section 26(2) paragraph (c), the cause of death was established as bronchopneumonia.

4. That in respect of section 26, paragraph (d) no accident occurred.
5. That in respect section 26, paragraph (e) there were no precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided.
6. That in respect of section 26, paragraph (f), there were no defects in any system of working which contributed to the death or accident resulting in the death.
7. That in respect of section 26, paragraph (g), there are no other facts which are relevant to the circumstances of Mr McKinlay's death.

RECOMMENDATIONS

I have no recommendations to make under section 26(1)(b) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

NOTE

Introduction

[1] This is a mandatory public Inquiry into the death of Mr Andrew McKinlay in terms of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"), given that the death happened whilst he was in lawful custody.

[2] The procurator fiscal issued a notice of the Inquiry on 18 January 2024. After sundry procedure the hearing was held on 13 June 2024.

[3] There were the following participants to the Inquiry:

- Ms Alice Carey, procurator fiscal depute, appeared for the Crown.
- Ms Kerry Ritchie appeared on behalf of Lanarkshire Health Board.
- Mr Andrew Richmond appeared on behalf of the Scottish Prison Service.

[4] The deceased's family took no part in proceedings.

The evidence

[5] The joint minute of admissions was formally entered into the evidence on 13 June 2024.

The legal framework

[6] The Inquiry was held under section 1 of the 2016 Act. The relevant procedural rules are found in the Act of Sederunt (Fatal Accidents Inquiries Rules 2017) ("the 2017 Rules"). The purpose of the Inquiry is defined by section 13 of the 2016 Act, and is to:

(a) establish the circumstance of the death, and;

(b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[7] Section 26 of the 2016 Act requires the sheriff to make a determination in relation to the circumstances of the death (section 26(1)(a)) and recommendations on certain matters (section 26(1)(b)). Section 26(2) sets out the factors that the sheriff must consider as to what constitutes the circumstances of the death, including the causes of any accident and the precautions that might have been taken, defects in the system of

working and any other factors relevant to the death. Section 26(4) sets out the issues for consideration as to whether any recommendations could be made which might realistically prevent other deaths in the future.

Summary

Facts and circumstances

[8] Andrew McKinlay (hereinafter referred to as "the deceased") was born on 18 July 1974. At the time of his death on 30 July 2021 he was 47 years old.

[9] On 25 July 2014, at the High Court of Justiciary at Glasgow, the deceased was sentenced to life imprisonment with a punishment part of 15 years, having tendered a plea of guilty to a charge of murder of his partner Josephine Steele. This sentence was backdated to 8 November 2013 to reflect the period of time which the deceased had spent on remand prior to his sentencing. During his period of remand, the deceased had been incarcerated at HMP Barlinnie, 81 Lee Avenue Barlinnie Prison, Glasgow and from 19 August 2014 he was imprisoned at HMP Shotts.

[10] The deceased's earliest date of release on parole was the 7 November 2028.

[11] The deceased had 12 previous convictions dating back to 1997 for *inter alia*, misuse of drugs offences, breaching conditions of bail, contraventions of sections 41ZA(3) and 41(9B) Prisons (Scotland) Act 1989 and murder, for which he served multiple custodial sentences.

[12] On 30 July 2021, the date of his death, the deceased was in legal custody at HMP Shotts.

Responsibility of healthcare within the prison estate

[13] Since 1 November 2011, individual regional NHS Health Boards are responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

[14] In relation to HMP Shotts, the relevant Health Board is Lanarkshire Health Board.

Medical history

[15] At around the age of 17, the deceased began experimenting with illicit substances. This led to the deceased becoming addicted to Ecstasy, Acid, Heroin and Benzodiazepines and to him becoming involved in the supply of controlled drugs to fund his lifestyle. At around age 30, the deceased became addicted to alcohol. He consumed alcohol daily until his health deteriorated and he required surgery for pancreatitis.

Medical referrals whilst incarcerated at HMP Shotts

[16] Following his arrival at HMP Shotts on 19 August 2014, the deceased saw Addiction Nurse Alison Barr on 20 August 2014. This was specifically to discuss substance misuse and to perform a related assessment. A Care Plan was discussed with the deceased and signed by him; it was noted the deceased was stable on a current methadone dose of 60mls daily. No immediate plans were made to change that dosage.

Ms Barr observed the deceased showed no signs of sedation or withdrawal and he denied illicit drug use or cravings for same. The deceased had several substance misuse assessments throughout the period he was incarcerated in HMP Shotts. He was prescribed opiate replacement therapy alongside several other prescription medications throughout his period of imprisonment.

[17] The Prison Medical Records disclose that whilst incarcerated the deceased had several relatively recent health issues. The deceased was seen by a Nurse, Rebecca Dyet, on 5 September 2017 regarding a lump on his abdomen, the lump was 2.5cm in diameter. He was referred to Dr Michael Coates for a consultation on 21 September 2017. Dr Coates referred the deceased to hospital as he was suffering from a small incision hernia located just above the umbilicus. This condition emanated from a stab injury 10 years previous. On 19 December 2017, the deceased attended at University Hospital Wishaw, 50 Netherton Street, Wishaw and was seen by Dr Kasem. He was listed for surgery using ventralex mesh. On 11 July 2018, the deceased had surgery, namely an open ventralex mesh repair of the incisional hernia. He was discharged that same date with a prescription for 250mgs of Naproxen.

[18] On two occasions in March 2021, the deceased referred himself to the prison healthcare team for (1) knee pain and (2) spots on his scrotum and inner leg. He was listed to see the GP for both complaints but failed to attend both appointments.

[19] On 4 May 2021, the deceased self-referred to the prison healthcare team as he wished to see a doctor for ongoing wrist pain. He was listed for the GP clinic and seen on 17 May 2021 by Dr Hannah McKinlay. It is recorded that the deceased was "asking

for PPI to be continued, gets acid in back of throat, no wt loss, no vomit no abdo pain, in prison so no alcohol." Additionally, the deceased asked for a "Tubi Grip" for his left wrist. He explained to Dr McKinlay that when he flexed his wrist, he had a shooting pain akin to hitting his funny bone. There was no evidence of injury or trauma to his wrist. He was prescribed ibuprofen gel for his wrist and his prescription for omeprazole was continued.

[20] On 31 May 2021, the deceased reported continuing issues with his wrist and again self-referred to the prison healthcare team. He was subsequently listed for the GP clinic and was examined by Dr Hannah McKinlay on 15 June 2021. It is noted that the deceased's wrist was still sore, on initial examination there was nothing of note, however, when the deceased flexed his wrist it showed classic signs of De Quervians Tenovaginitis. Following said diagnosis, Dr McKinlay spoke with the deceased about a future treatment plan, advised him to continue with the ibuprofen gel and requested that the nurse provide a splint to the deceased. He was given a 2-week sick line to rest his wrist.

[21] On 4 July 2021 the deceased was seen in his cell by Ms Debbie Higgins and observed to be under the influence. On examination, his blood pressure was 130/70, heart rate was 18, temperature was 36.5 and oxygen saturation levels were at 78%. Due to his state of intoxication the MORS (Management of Offender at Risk due to a Substance) policy was instituted at 1700 hours that day. At 1140 hours on 5 July 2021, the deceased was removed from the MORS proceedings by Nurse Gordon McPherson. The deceased admitted to taking the illicit substance "spice", he was talking in full

sentences, there was no discoloration around his lips/fingertips, and he told medical professionals he was feeling fine.

[22] On 7 July 2021 the deceased was seen by the prison healthcare staff as he had complained of shortness of breath. The deceased was medically examined in his cell and as part of the examination he was asked to walk 12m from his bed to the window of his cell and back. After doing so, his oxygen saturation levels were noted to drop to 84%, his respiratory rate was 33bpm, his pulse was 102bpm and his blood pressure was measured at 162/90. The deceased was advised that he required to attend at hospital. He verbally declined to attend hospital.

[23] The deceased was reviewed for a second time on 7 July 2021. He was seen in his cell by prison nursing staff, he was able to sit up without difficulty when the nurse entered the cell. His observations were taken and showed that his respiratory rate was 22 beats per minute, his oxygen saturation levels were 91%, his pulse was 114, his temperature was 36.2 and blood pressure was 148/92. He was advised to attend the Accident and Emergency Department of University Hospital Wishaw, Netherton Street, Wishaw but declined to do so. He signed a refusal of treatment form.

[24] On 8 July 2021, Dr David Barr, General Practitioner and Clinical Director for GP services within the Health Centre at HMP Shotts, was asked to examine the deceased as the prison nurse had noted he had low saturation levels. The deceased explained to Dr Barr that he did not wish to go to hospital. During his consultation with Dr Barr, the deceased's observations were noted, they appeared normal, and he explained to Dr Barr he was not experiencing any pain at that time. On examination Dr Barr found there was

widespread wheezing across the deceased's chest, but he had good bilateral air entry. As such he prescribed the deceased 500mg of amoxicillin, 30mg of prednisolone and salbutamol. He documented that the deceased was to be monitored over the next week and was to be reviewed if necessary. Dr Barr requested a chest x-ray be arranged. Additionally, an Electrocardiogram (ECG) was requested on 9 July 2021. In his affidavit, Dr Barr evidence was that, at the time of his consultation on 8 July 2021, the deceased was in reasonably good health.

[25] On 14 July 2021 the deceased was asked again to attend a consultation with Dr Barr. He refused to do so.

[26] On 21 July 2021 he again refused to attend the treatment room for an ECG. On 22 July 2021 a hospital appointment letter was received confirming that an x-ray had been arranged for the deceased on 2 August 2021.

[27] At the time of his death, the deceased was prescribed the following medication: including:

- Methadone 70mg in the morning
- Mirtazapine 15mg
- Amitriptyline 50mg (morning) 75mg (evening)
- Propranolol 10ml thrice daily
- Fexofenadine 120mg daily
- Omeprazole 40mg
- Lactulose 15ml
- Salbutamol

- Ibuprofen

Much of his medication was kept within his cell and administered himself with the exception of the methadone, which was administered by prison healthcare staff.

Events of 29 and 30 July 2021

[28] On 29 July 2021, the deceased was observed on CCTV leaving his cell at around 1628 hours to collect his dinner before returning to his cell at 1649 hours. Prison Officers KB and AM were locking up the Lamont Hall section of HMP Shotts that evening. They observed the deceased in Cell 4 after he had collected his dinner, he appeared well, he responded verbally to the officers and there were no concerns for his health. The deceased's cell door remained closed until 0732 hours on 30 July 2021.

[29] On 30 July 2021, Prison Officers KA and MB, on duty within Lamont Hall of HMP Shotts, were tasked with opening the doors to each cell for the morning number checks. At approximately 0732 hours, they opened the door to Cell 4, where they found the deceased lying with his face down on the cell floor. Officer MB shouted the deceased's name but received no response. Officer KA entered the cell and shook the deceased's body. He found him cold to the touch and heavy to manoeuvre. Both officers attempted to turn the deceased onto his side but were unable to. They observed there to be a small pool of congealed blood around the deceased's head and that his skin was blue in colour.

[30] Officer Mary Bennett transmitted a radio "Code Blue Lamont 1" alarm (which is terminology for a prisoner having been found unresponsive and without breath) at

0733 hours. The alarm notified NHS staff there was a medical emergency within Lamont Hall, Cell 4. At approximately 0735 hours Nurses Gordon McPherson and Anne O'Neill arrived at the cell. Nurse McPherson entered the cell and saw the deceased was lying face down, parallel with the bed, with his head situated between the desk and bed. Nurse Ann O'Neill went to retrieve the emergency bags, heart start machine and oxygen. Nurse McPherson saw there was blood visible at the deceased's head and his skin was pale in colour. He felt for a carotid pulse, located on the right-hand side of the neck. The deceased was firm to the touch and cold, no pulse was felt upon him. Nurse McPherson checked the deceased's temperature; it was 25.6 degrees. Nurse McPherson advised that rigor mortis had set in and there was no form of medical intervention that could be performed to save his life.

[31] The security manager of HMP Shotts, John Brown, was notified at 0737 hours. The Scottish Ambulance Service were contacted and Nurse McPherson advised of the deceased's temperature and that rigor mortis had set in. He requested that an ambulance crew attend to confirm life was extinct. The ambulance and paramedics arrived at 0755 hours. Paramedic Stewart McCulloch placed electrodes on the deceased's back to confirm there was no asystolic rhythm and he confirmed the deceased's death at 0804 hours.

Police investigation

[32] Following the death, Police Scotland were notified and the deceased's cell was locked and secured with the deceased still in situ. Police Constables Gerard Hattie and

Murray McMillan attended at HMP Shotts at 0938 hours. Upon their arrival the Constables entered the deceased's cell and observed him lying on the floor with his feet positioned towards the cell. They noted there was a small cut above the deceased's left eye. Shortly thereafter, Scenes of Crime Officer Althea Joseph, attended and took general view photographs of the cell and deceased.

[33] Police Constables Hattie and McMillan conducted a systematic search of the deceased's cell and found the following items:

(a) burnt pieces of paper on the desk within his cell;

(b) vape pen found on the floor underneath the deceased's body;

(c) bag containing white powder behind the television on a desk within his cell.

[34] The deceased's body was removed from the prison at 1300 hours on 30 July 2021 by private ambulance with Police Constables Michael Domer and Nicola McLachlan present. The deceased's body was conveyed to the Queen Elizabeth University Hospital. A dark blue polo shirt, black trousers, grey shorts, and a pair of brown socks were seized.

Forensic analysis

[35] Due to concerns that the vape pen and bag containing white powder recovered may have contained illicit substances, both items were sent to Forensic Services at the Scottish Police Authority, Scottish Crime Campus, Craignethan Drive, Gartcosh, G69 8AE. The two items were tested by Forensic Scientists Sarah Ann Murphy and Simon David Dennis on 30 December 2021 and 5 January 2022. The vape pen was

fabricated from a plastic tube containing a mechanical device, similar in appearance to an e-cigarette/vape pen containing a small cartridge. The cartridge was examined and found to contain a colourless liquid. A portion of the liquid was analysed for the presence of controlled drugs within the provisions of the Misuse of Drugs Act 1971, with a negative result.

[36] The bag of white powder was found to consist of a knotted plastic package containing a quantity of white powder. The powder, which weighed 69.19grams, was analysed for the presence of controlled drugs within the provisions of the Misuse of Drugs Act 1971, with a negative result. Reference is made to Crown production 8, Forensic Science Report by Sarah Ann Murphy and Simon David Dennis, Forensic Scientists (reference number 2021-FS-022414).

Post mortem

[37] A post mortem examination was conducted on 18 August 2021 at the Queen Elizabeth University Hospital, Glasgow by Consultant Forensic Pathologist Julie McAdam and the cause of death was recoded as:

1a: Bronchopneumonia

The conclusions contained within the post mortem report are as follows:

> "Post mortem examination revealed established bronchopneumonia involving the right lung and associated with abscess cavity formation and pleurisy (inflammation of the surface of the lung). These changes would be sufficient to account for this man's death, albeit it is perhaps surprising he had not complained of any related symptoms, given that the pathology in the lungs would indicate that infection has been ongoing for some time. The background of chronic obstructive pulmonary disease would have rendered Mr McKinlay

more susceptible to the development of bronchopneumonia and the history of drug abuse may also have been a factor.

The liver showed moderate fatty degeneration with ongoing inflammatory changes in keeping with systemic infection. There was moderate atherosclerosis (narrowing) of two coronary arteries, but no other evidence of natural disease.

There was a laceration through the left eyebrow, consistent with terminal collapse as suggested by the circumstances, but no evidence of injury that would have cause or contributed to death.

Analysis of post mortem blood revealed a level of methadone significantly higher than would be expected in an individual prescribed only 70ml daily, though a wide range of levels can be detected in the blood of those prescribed the drug. Although the possibility that additional methadone has been ingested cannot be excluded, another potential explanation could be that fatty degeneration of the liver with superimposed inflammatory changes (due to systemic infection) has been sufficient to decrease metabolism of methadone, possibly causing a build-up of the drug in blood, albeit this cannot be confirmed. Also present in blood was a therapeutic level of mirtazapine (antidepressant) and a level of amitriptyline higher than would usually be anticipated with normal therapeutic use. However, it is well recognised that this Amitriptyline can undergo post mortem redistribution i.e. the levels in blood can rise after death. The low level of alcohol detected in blood may reflect post mortem production.

In summary, this man had established organising bronchopneumonia which could in itself account for his death. While it is possible that an excess of methadone has been ingested, this cannot be stated with certainty. Of note, if an excess of methadone has been ingested, this would undoubtedly exacerbate the adverse effects of bronchopneumonia on the respiratory system. However, given the lack of clarity, death is best attributed to bronchopneumonia."

Death in Prison Learning, Audit and Review (DIPLAR) report

[38] On 18 October 2021, a Death in Prison Learning, Audit and Review report (DIPLAR) was carried out by the Scottish Prison Service in conjunction with the, NHS Lanarkshire Healthboard. The review team found that there were no significant events or contributory factors which may possibly have related to the deceased's death. They

concluded that everything was done on the day that could have been done. Support was offered to prison staff and prisoners affected by the death. The team also found the prison staff and healthcare team were proactive in dealing with the deceased's physical symptoms prior to his death. In addition to this, there was support around his drugs misuse.

Conclusions

[39] I found the joint minute of agreement, which had been carefully prepared by all parties, to be comprehensive in its terms. I was able to rely on joint minute, and the productions and affidavits referred to, in reaching a determination. I accepted the submissions made on behalf of the Crown, the Scottish Prison Service and Lanarkshire Health Board.

[40] During his incarceration at HMP Shotts, the deceased had several health issues, in respect of which he received appropriate and timeous treatment by both SPS and healthcare staff. On 7 July 2021, the deceased was medically examined by prison healthcare staff on two separate occasions after reporting shortness of breath. Observations were taken on both occasions and, as a result of the findings, the deceased was advised to attend hospital and, on both occasions, he declined.

[41] Following medical examination on 8 July 2021, the prison General Practitioner, Dr Barr, put in motion a series of investigations, which again the deceased declined to attend. In the weeks leading to his death, there were numerous occasions when the deceased was offered but refused to attend for further medical treatment both within

HMP Shotts and at hospital. Additionally, upon examination on 8 July 2021, Dr David Barr did not believe that the deceased presented as acutely ill and warranting of emergency treatment. To the contrary, Dr Barr noted that the deceased appeared to be in reasonably good health.

[42] Prison Officers followed the lock up procedures appropriately and upon the deceased being discovered on 30 July 2021 the medical response was swift.

[43] There were no submissions made by Crown, the Scottish Prison Service or Lanarkshire Health Board that any accident resulted in the deceased's death or that any precautions could reasonably have been taken which might realistically have resulted in the deceased'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)).

[44] No submissions were made paragraph there are no other facts which are relevant to the circumstances of the deceased's death (section 26(2)(g)).

[45] No submissions were made that I should make any recommendations in terms of section 26(1)(b).

[46] I am satisfied that, in all the circumstances, I should make formal findings of the time, date, place and cause of Mr McKinlay's death. I have set out those formal findings above.

[47] I am satisfied that I should make formal findings that there was no accident that resulted in the deceased's death, that no precautions could reasonably have been taken which might realistically have resulted in the deceased's death being avoided and no

defect in any system of working that contributed to his death (section 26(2)(b), (d), (e) and (f), respectively).

[48] I am satisfied that I should make no findings in terms of section 26(2)(g) of the 2016 Act.

[49] I wish to express my thanks to 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.

[50] Finally, I wish to express my sincere condolences to Mr McKinlay's family and friends.