SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT KIRKCALDY

[2026] FAI 61

KKD-B89-25

DETERMINATION

BY

SHERIFF ROBERT EDWARDS MORE

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

into the death of

JOSEPH GLASS

Kirkcaldy, 16 November, 2026

DETERMINATION

The Sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 that:

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

Joseph Glass ("Mr Glass"), prisoner at HMP Glenochil was born on 1 March, 1950. He died on 15 May, 2021, aged 71 years. His death occurred at some point between 0505 hours and 0815 hours on 15 May, 2021. His place of death was Cell 14, Abercrombie Hall 3 West, HMP Glenochil.

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

There was no accident which resulted in the death.

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

The cause of death was cardiomegaly (enlargement of the heart) associated with ischaemic and valvular heart disease.

In terms of section 26(2)(d) (the causes of any accident resulting in the death):

There was no accident which resulted in the death.

In terms of section 26((2)(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):

Mr Glass could have been conveyed to hospital when he was attended upon by Scottish Ambulance Service ("SAS") personnel paramedic Douglas Beath and ambulance technician Melissa Porter at 2045 hours on 14 May, 2021. Their clinical assessment of Mr Glass suggested that he should be taken to hospital. Dr Linos Popi was consulted by Mr Beath via telephone and advised that Mr Glass should be taken to hospital. This was conveyed to Paul O'Flaherty who was operating as Security Manager at HMP Glenochil.

Mr O'Flaherty refused to allow Mr Glass to be conveyed to hospital. As a result, Mr Glass remained within HMP Glenochil.

Mr Glass suffered a cardiac arrhythmia which occurred against a background of obstructive coronary artery disease. Had he been conveyed to hospital he would have been in a monitored clinical environment, with continuous cardiac monitoring and immediate access to resuscitation and defibrillation. If defibrillation had been delivered promptly, the arrhythmia would have been survivable.

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

Insufficient training was provided to SAS staff on their functions and decision-making responsibilities as well as those of Scottish Prison Service ("SPS") staff in circumstances in which a clinical assessment was made that an individual detained in prison should be conveyed to hospital.

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

Following the departure of Mr Beith and Miss Porter, Mr O'Flaherty made arrangements for prison staff to conduct observations on Mr Glass in his cell. These observations involved a member of staff attending at his cell door, and rousing Mr Glass to obtain a response from him.

The decision by Mr O'Flaherty to place Mr Glass on observations by SPS personnel following the departure of the ambulance was not appropriate and was not made in accordance with any training or guidance from SPS.

In terms of sections 26((1)(b) (recommendations (if any) as to (a) the taking of reasonable cautions, (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):

Joint guidance has been developed between SAS and SPS to outline the response to medical and trauma healthcare incidents for individuals detained in custody at SPS establishments. The document details key criteria to support the processes related to providing clinical assessment and treatment of people in custody, as well as critical considerations regarding the safety and security of all involved. The document also describes the key standards, roles, and responsibilities of each service, appropriate routes of escalation for SAS crews to support clinical decision-making and safe care, whilst noting and respecting fundamental principles of justice, dignity and human rights. This guidance addresses the system defect which contributed to the death of Mr Glass. In these circumstances, there are no recommendations to be made.

NOTE

INTRODUCTION

[1] This was a mandatory inquiry held under section 2(4)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act") as Joseph Glass was lawfully imprisoned within His Majesty's Prison Glenochil at the time of his death.

[2] Mr Glass' death was reported to the Crown Office and Procurator Fiscal Service on 18 May, 2021.

[3] The first notice in relation to this inquiry, in terms of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 was issued by the Procurator Fiscal on 6 March, 2025.

[4] A preliminary hearing in terms of Rule 3.6 was held at Kirkcaldy Sheriff Court on 24 April, 2025. Further preliminary hearings were held on 30 June, 2025, 1 September, 29 September, 15 December, 2025, 28 January, 2026, and 11 February, 2026.

[5] The inquiry proceeded with the hearing of evidence on 16, 17, and 18 February, 2026 and closing submissions on 2 April, 2026.

[6] The Procurator Fiscal was represented by Ms Webb, Solicitor. The nearest relatives of the deceased received intimation of the inquiry but declined to take part. The other participants were: the Scottish Ambulance Service, represented by Ms Smith, Advocate; the Prison Officers Association Scotland, represented by Ms McIlwham, Solicitor; and the Scottish Ministers for the Scottish Prison Service, represented by Mr Halley, Solicitor.

Evidence

[7] Two joint minutes of agreement were entered into which substantially reduced the need for parole evidence. The first joint minute agreed a number of matters relating to:

- Mr Glass' personal details and medical history;
- the post mortem examination and cause of death;
- how Mr Glass came to be a prisoner at HMP Glenochil;

  and
- responsibility for the provision of healthcare to prisoners.

The minute also contained a general chronology of the events immediately prior to Mr Glass' passing, and that the statements of the following witnesses should be admitted without the need for them to be adopted:

- Alexandra Johnston, nurse, Team Leader at HMP Glenochil
- Alison Robertson, general practitioner
- Alistair Dornan, scene examiner, Scottish Police Authority
- Cliodhna Lane, nurse practitioner
- Daniela Brannan, mental health nurse
- David Armitage, Police Constable
- Gavin McLuskey, Police Constable
- Grant Williams, prison officer, HMP Glenochil
- James Glass, brother of Mr Glass
- Jennifer Blyth, prison officer, HMP Glenochil

- Max Hanes, ambulance technician
- Reece Logan, prison officer, HMP Glenochil
- Ryan Smith, Detective Constable, Criminal Investigation Department
- Sylvia Barclay, patient relations nurse
- William Harley, Detective Sergeant
- Jane Farmer, paramedic

Parties also agreed that all productions and labels were what they bore to be and were prepared on or about the date they bore, that all typewritten witness statements were to be treated as the equivalent of signed manuscript statements, and that documentary evidence should be admitted into evidence without the need for it to be spoken to by its author.

[8] In terms of the second joint minute it was also agreed that the reports of Professor Richard Lyon, Consultant in Emergency Medicine (production 18) and Dr Stuart Hutcheon, Consultant Cardiologist (production 39) be admitted as their parole evidence without the need for those reports to be adopted by the witnesses.

[9] At the evidential hearing I heard parole evidence from:

- David Cross (first line manager at HMP Glenochil),
- Paul O'Flaherty (Security Manager, HMP Glenochil),
- John Grenfell (Prison Officer, HMP Glenochil),
- Douglas Beath (Paramedic, Scottish Ambulance Service),
- Melissa Porter (ambulance technician),
- Dr Linos Popi (general practitioner),

- Peggy Russell (ambulance technician),

  and

- Ronald McCafferty (cellmate of the deceased).

Evidence was also admitted by way of an affidavit from Shereen Cameron, SAS National Patient Safety Manager.

[10] Three inventories of productions were lodged by the Procurator Fiscal and one was lodged by the SAS. There were 41 productions in total.

THE LEGAL FRAMEWORK

[11] The purpose of the inquiry is set out in terms of section 1(3) of the 2016 Act as being to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[12] In terms of section 26 of the Act, the inquiry must determine:

- When and where the death occurred;
- When and where any accident resulting in the death occurred;
- The cause or causes of death;
- The cause or causes of any accident resulting in the death;
- Any precautions which could reasonably have been taken and might realistically have resulted in the death, or any accident resulting in the death, being avoided;
- Any defects in any system of working which contributed to the death; and

- Any other factors relevant to the circumstances of the death.

[13] It is open to the sheriff to make such recommendations as he considers appropriate in relation to the matters which are set out at section 26(4), those being the taking of reasonable precautions, the making of improvements to any system of working, the introduction of a system of working, or the taking of any other steps which might realistically prevent death in similar circumstances.

[14] The Procurator Fiscal represents the public interest. It is not the purpose of the inquiry to establish civil or criminal liability. The inquiry is an exercise in fact finding, not fault finding. It is an inquisitorial process.

THE FACTS

[15] Having regard to the information presented to the inquiry, I found the following facts to be established:

Joseph Glass

[16] Joseph Glass was born on 1 March, 1950. He died on 15 May, 2021, aged 71 years.

[17] At the time of his death, Mr Glass was a convicted prisoner at HMP Glenochil occupying cell 14, Abercrombie Hall West alongside fellow prisoner Ronald McCafferty.

[18] Mr Glass was remanded in custody on 21 December, 2017. At that point he was untried. He was tried and subsequently convicted of various offences, and on 19 September 2018 at the High Court of Justiciary at Edinburgh received an extended

sentence of 11 years' imprisonment, with the custodial element being 8 years. He would have qualified for parole on 20 December 2021, with his earliest release date being 19 December 2025.

[19] Mr Glass was transferred from HMP Barlinnie to HMP Glenochil on 13 August, 2019. He resided in Abercrombie Hall, cell 3/14 for the duration of his stay. Whilst in HMP Glenochil he worked as a tee packer before being moved to work as a passman for the duration of the COVID-19 pandemic. Working as a passman allowed him to be out of his cell. It gave structure and purpose to his day.

Provision of healthcare to prisoners

[20] On 1 November, 2011, responsibility for the provision of healthcare to prisoners transferred from the Scottish Prison Service (SPS) 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.

Attendance by SAS personnel on 14 May, 2021

[21] At 2040 hours on 14 May 2021 the Scottish Ambulance Service ("SAS") received a phone call to attend at the prison in relation to Mr Glass. The SAS were advised that he was in the health centre of the prison. He was described as being generally unwell with difficulty speaking between breaths. Recourse was allocated and mobilised at 20:41.

[22] Paramedic Douglas Beath and ambulance technician Melissa Porter arrived at the prison at 2045 hours and entered Mr Glass' cell at approximately 2100 hours. He was alert and responsive and displayed a good colour. He reported having ongoing back pain for 3 weeks which had been worsening over the previous week. This had been extensively investigated in hospital but Mr Glass was unaware of any test results as yet.

[23] Mr Glass' initial complaint to prison staff had been of chest pain and shortness of breath. When Mr Beath and Miss Porter assessed him he advised of no chest pain or shortness of breath, but of back pain. He had an increased temperature and heartrate and was displaying signs of an infection. The observations of Mr Beith and Miss Porter suggested that Mr Glass would require to be taken to hospital. Two prison officers were identified by SPS first line manager David Cross to escort Mr Glass to hospital.

[24] Whilst he was speaking with Mr Glass in his cell, Mr Beith was asked by the prison security manager Paul O'Flaherty to speak with him outside the cell. Mr Beith left the cell and spoke with Mr O'Flaherty. Mr Beith said Mr Glass possibly had an infection. Mr O'Flaherty told Mr Beith that Mr Glass should not be given any choice as to whether to go to hospital as he would likely want to go to hospital. Mr Beith responded that Mr Glass' observations were such if he was not treated he could not say what would happen. Mr O'Flaherty responded to this by saying that if Mr Glass was not dying then he was not going to hospital.

[25] Mr O'Flaherty said to Mr Beith that the out of hours GP could be consulted and that could result in Mr Glass being booked into a receiving ward at the hospital which would enable prison staff to be released. Mr O'Flaherty then accompanied Mr Beith and

Ms Porter from the prison wing to their ambulance so that the out of hours GP could be contacted. Upon returning to their ambulance, Mr Beith advised Miss Porter that prison staff were not happy that Mr Glass had to be conveyed to hospital due to them being short-staffed.

[26] Douglas Beith submitted an urgent advice request to NHS 24. A telephone consultation then took place between Mr Beath and out of hours trainee general practitioner Linos Popi between 2133 hours and 2152 hours. Miss Porter was present when this call was made but did not hear its content. Mr O'Flaherty was not present when this call was made.

[27] During his consultation with Dr Popi, Mr Beith made reference to there being no staff. Dr Popi believed that this was a reference to prison staff. Dr Popi consulted with his supervisor and advised Mr Beith that Mr Glass should be conveyed to accident and emergency. Mr Beith queried why this was the advice when the presenting complaint was one of back ache. Dr Popi said that it was safest to have Mr Glass assessed at A&E.

[28] Following the consultation with Dr Popi, Mr Beith and Miss Porter returned to speak with Mr O'Flaherty. Mr Beith advised Mr O'Flaherty that the advice which had been received was for Mr Glass to be conveyed to hospital and that this is what they were intending to do. Mr O'Flaherty repeated that if Mr Glass was not dying, he would not be leaving the prison.

[29] Mr Beith completed an electronic patient report which was signed by Mr O'Flaherty. The form was completed saying that consent to treatment had been refused because Mr O'Flaherty had refused to allow Mr Glass to be conveyed to

hospital. Mr Beith believed that Mr O'Flaherty was in the position of guardian to Mr Glass. He did not consider there to be any further options for escalation available to him.

[30] Mr Beith and Miss Porter were not permitted to re-enter the prison in order to discuss treatment options with Mr Glass. Mr O'Flaherty advised them that he would monitor Mr Glass intensively. Mr Beith told Mr O'Flaherty that if there was any sign of deterioration in Mr Glass' condition, then he should again call an ambulance. A copy of the completed electronic patient report was handed to Mr O'Flaherty.

[31] The ambulance in which Mr Beith and Miss Porter had attended left HMP Glenochil at approximately 2200 hours. Mr Glass remained at the prison.

[32] Following the departure of the ambulance, out of his concern for Mr Glass' wellbeing Mr O'Flaherty made arrangements for prison staff to conduct observations on Mr Glass. These consisted of officers attending at the door of Mr Glass' cell, rousing him in order to obtain a response and satisfying themselves that he was ok.

Attendance by SAS personnel on 15 May, 2021

[33] At 0244 hours on 15 May, 2021 the SAS received a second phone call to attend at the prison in relation to Mr Glass. Paramedic Jane Farmer and ambulance technician Peggy Russell arrived at the prison at 0422 hours and spoke upon arrival spoke with Mr O'Flaherty. Mr O'Flaherty told them that they were the second ambulance crew to attend to Mr Glass that night and that if Mr Glass required to go to hospital for any medical reason they were not to give him a choice.

[34] Ms Farmer and Ms Russell entered Mr Glass' cell at approximately 0435 hours. Upon observation Mr Glass stated that he had not taken any overdose. He denied any pain with the exception of normal aches and pains. He appeared quite anxious and stated that he was worried about taking two of his prescribed medications together as he was scared that they might interact. He was put at ease that the medications were fine taken together and he was relaxed after this discussion. His observations were unremarkable. His vital signs were all within normal limits. His breathing and oxygen saturation rates were normal. There was no suggestion of heart arrythmia. There was nothing to suggest that he required to be conveyed to hospital.

[35] The attending SAS personnel reached the view that Mr Glass' ongoing care should be administered by medical staff at the prison and this was conveyed to Mr O'Flaherty. Mr Glass was not conveyed to hospital. The last contact with Mr Glass by ambulance staff occurred at approximately 0452 hours.

[36] Following the departure of the ambulance in which Ms Framer and Ms Russell had attended, the observations of Mr Glass which Mr O'Flaherty had arranged for following the departure of the ambulance staffed by Mr Beith and Miss Porter continued.

[37] At approximately 0720 hours same date a prison officer checked Mr Glass' cell. He appeared to be unresponsive. At approximately 0727 hours, prison officers and prison nurses entered the cell and CPR was commenced. At 0732 hours, the SAS received a third phone call to attend at the prison in relation to Mr Glass. An ambulance arrived at the prison at 0749 hours and paramedics entered Mr Glass' cell at

approximately 0755. A second ambulance arrived at the prison at 0758 hours. Resuscitation efforts were unsuccessful, and he was pronounced dead at 0815 hours.

Medical history

[38] Mr Glass had a past medical history which included alcohol dependency, a previous myocardial infarction in 1988, a squamous dell carcinoma on his lower right leg in 2020, renal stones and peripheral vascular disease. He was an ex-smoker.

[39] Mr Glass was on regular prescribed medication including: amlodipine, aspirin, mirtazapine, co-codamol, GTN spray, lactulose, isosorbide mononitrate, omeprazole, nortriptyline, paroxetine, propranolol, senna and simvastatin.

Post-mortem examination

[40] On the instruction of the Procurator Fiscal at Falkirk, on 24 May, 2021 a post-mortem examination of Mr Glass was undertaken at Edinburgh. This revealed significant disease in the coronary arteries. There was stenosis of the aortic valve. The mitral valve was thickened. There was fibrosis within the myocardium. There was evidence of cardiomegaly. There was atheroma in the lungs.

[41] The medical cause of death was certified as:

a. Cardiomegaly (enlargement of the heart) associated with ischaemic and valvular heart disease.

SAS investigations

[42] Following the death of Mr Glass the SAS conducted a Significant Adverse Event Review. This concluded that the initial decision for Mr Glass to remain within the prison was heavily influenced by the perceived authority gradient of the prison staff and the uncertainty of SAS clinicians on the health care rights of prisoners. The Review noted that there was no specific guidance or training for SAS clinicians on providing health care to patients in a prison environment. It made a recommendation that guidance be developed with SPS outlining appropriate SAS responses to medical support on prison sites, as well as detailing considerations for in and out of hours care, prisoner healthcare rights and additional advice.

Subsequent developments

[43] Joint guidance has been co-produced between the SAS and the SPS to describe the response to medical and trauma healthcare incidents for individuals detained in custody at SPS establishments. The document details key criteria to support the processes related to providing clinical assessment and treatment of people in custody, as well as critical considerations regarding the security and safety of all involved. The document also describes key standards, roles and responsibilities of each service. appropriate routes of escalation for SAS crews to support clinical decision-making and safe care, whilst noting and respecting fundamental principles of justice, dignity and human rights.

SUBMISSIONS

Procurator Fiscal

[44] As all participants did, the Procurator Fiscal acknowledged that there was a factual dispute for the inquiry to resolve as to why it was that Mr Glass was not conveyed to hospital following the attendance by Mr Beith and Miss Porter late on 14 May, 2021. The submission of the Procurator Fiscal was that the evidence of Mr Beith should be preferred to that of Mr O'Flaherty in this regard.

[45] The Procurator Fiscal invited the inquiry to make the following findings in terms of section 26(2)(e) of the 2016 Act:

(i) Mr Glass could have been conveyed to hospital following the attendance of the first ambulance at 2045 hours on 14 May 2021;

(ii) During the first ambulance attendance, Scottish Ambulance Service (SAS) Clinicians could have escalated the incident either to the out of hours GP or sought support from SAS management;

and

(iii) Mr Glass could have been conveyed to hospital following the attendance of the second ambulance at 0422 hours on 15 May 2021.

[46] In terms of section 26(2)(f), the Procurator Fiscal invited the inquiry to make a finding that there was a defect in a system of working which had contributed to the death in that there had been insufficient guidance in relation to SAS responses to medical incidents for individuals detained in custody at SPS establishments, particularly regarding decision-making responsibilities and the healthcare rights of prisoners.

However, she submitted that the draft guidance which has since been developed between SAS and SPS appeared to directly address the system defect which had contributed to Mr Glass' death.

[47] The Procurator Fiscal invited a finding in terms of section 26(2)(g) that the decision by Mr O'Flaherty to place Mr Glass on overnight medical observations was not appropriate.

Scottish Ambulance Service

[48] Ms Smith for the SAS also invited the inquiry to prefer the evidence of Mr Beith to that of Mr O'Flaherty in relation to the factual dispute which arose in relation to the first ambulance attendance. She accepted that it would have been a reasonable precaution for Mr Glass to have been transferred to hospital at that time and submitted that this was indicative of a defect in the SPS and SAS system of working in that prison and ambulance staff had not been appropriately trained on their respective roles when ambulance crews are required to attend to treat a prisoner. This, she argued, was an organisational failing on the part of both organisations: that they had not provided their staff with training on their respective roles, as well as the role the prisoner/patient has to play when providing informed consent to their treatment.

[49] Ms Smith invited the inquiry not to make any finding in respect of the second ambulance attendance on the basis that it could not be said on the basis of the clinical findings of those in attendance at that time that it was reasonable to transfer Mr Glass to hospital.

[50] Ms Smith also invited the inquiry not to make the finding requested by the Procurator Fiscal in relation to a suggested escalation by Mr Beith following the refusal of Mr O'Flaherty to allow him and Miss Porter to return to the prison after having consulted Dr Popi. She submitted that it was not known what any escalation within the SAS would have achieved. The matter had already been escalated to Dr Popi. Mr Beith and Miss Porter thereafter spoke to Mr O'Flaherty, explained the position, and the refusal section of their paperwork was completed. Even if it could be said that further discussion over and above that which was had with Dr Popi could have taken place, there was simply not the evidence available to say that such a conversation might realistically have avoided Mr Glass' death.

[51] Ms Smith made no submissions in relation to section 26(2)(g) and, like the Procurator Fiscal, invited the inquiry not to make any formal recommendations in light of the improvements made since by SAS.

Prison Officers Association

[52] Miss McIlwham's submissions on behalf of the Prison Officers Association in large part focused on the factual dispute underpinning the inquiry's consideration of reasonable precautions and system defects in terms of section 26(2)(e) and (f). She invited the inquiry to prefer the evidence of Mr O'Flaherty to that of Mr Beath.

[53] Miss McIlwham also accepted that a reasonable precaution to have taken would have been for Mr Glass to have been conveyed to hospital following the first attendance. In relation to other facts relevant to the circumstances of death, she cited the

observations which Mr O'Flaherty had arranged following the departure of the first ambulance and referred to Mr O'Flaherty's acceptance that there was no SPS policy to do this and that he had instructed these out of his own concern for Mr Glass.

Scottish Ministers on behalf of the Scottish Prison Service

[54] Mr Halley submitted that Mr Beith and the prison officers who had given evidence to the inquiry had done their best to assist but that there had been significant gaps in the recollections of witnesses. Nothwithstanding any inconsistency in the evidence, all prison officers had confirmed that they rely on the professional judgment of healthcare staff when prisoners require medical intervention as they are not medically trained. Whether or not it was accepted that prison officers impeded the efforts of paramedics to convey Mr Glass to hospital, the officers had confirmed in evidence that is not for them to question the advice of healthcare professionals, and it is simply their role to facilitate the treatment recommended as per their training. Accordingly, he submitted that there were no precautions which could reasonably have been taken by the SPS, and had they been taken might realistically have resulted in the death being avoided.

[55] In relation to any system defect, Mr Halley submitted that there was no defect in any system of working on the part of the SPS which contributed to the death. In evidence, the prison officers had all been in agreement that they are not medically trained, and that it is for healthcare professionals to make decisions relating to the healthcare of prisoners. Moreover, they confirmed that the SPS had no policy in relation

to medical observations of prisoners, as this would be a matter for the NHS staff within the prison. The actions of the prison officers did not fully align with the SPS policies they identified in their evidence. This did not suggest that their training was not sufficient, as prison officers have no scope to question the treatment proposed by healthcare staff, and that they required only to facilitate their recommendations.

[56] Mr Halley also referred to the observations which had been devised by Mr O'Flaherty and merely submitted that should any finding be made in respect of this decision, that it be made clear that it was not consistent with SPS policy.

DISCUSSION AND CONCLUSIONS

Time, place, and cause of death

[57] The facts in support of my findings under sections 26(2)(a) and (c) in relation to the time, place and cause of Mr Glass' death were the subject of agreement. It was also not controversial that there had been no accident which had resulted in the death.

The second ambulance attendance

[58] It was agreed that Mr Glass had been attended on again by SAS staff Jane Farmer, paramedic, and Peggy Russell, ambulance technician in the early hours of 15 May, 2021 and that his clinical observations had been unremarkable. Their conclusion that there was nothing to suggest that Mr Glass required to be taken to hospital at that time was not challenged.

The first ambulance attendance

[59] As acknowledged throughout the inquiry by all parties, where the evidence and other information presented did reveal a sharp factual dispute was in relation to why it was that Mr Glass was not conveyed to hospital following that attendance by paramedic Douglas Beith and ambulance technician Melissa Porter late on 14 May, 2021. There were two principal witnesses to speak directly to those circumstances – Mr Beith himself, and Paul O'Flaherty.

[60] Mr Beith's said in evidence that he had been asked by Mr O'Flaherty to step out of Mr Glass' cell when he had first attended and had been speaking with Mr Glass, at which point he was told by Mr O'Flaherty that if Mr Glass was not dying, then he was not going to be leaving the prison. Mr O'Flaherty suggested that there were staffing issues in the prison and that the out of hours GP could sometimes book a patient into a receiving ward and that would enable the prison staff to leave as responsibility was then taken over by G4S. It was Mr O'Flaherty who suggested that the out of hours GP be called and Mr Beith and Miss Porter were escorted back to their ambulance by him so that this call could be made.

[61] Mr Beith's position was that after he had consulted with Dr Popi and received advice to convey Mr Glass to hospital, he and Miss Porter had been refused by Mr O'Flaherty to be allowed back into the prison to speak to Mr Glass to discuss his treatment options. Mr O'Flaherty had again said that if Mr Glass was not dying, he would not be leaving the prison. Mr Beith regarded Mr O'Flaherty as being in the position of guardian to Mr Glass and did not consider that there were any other ways

available to him to escalate his concerns. Mr O'Flaherty said that he would place Mr Glass on observations in the prison and signed the electronic patient report which had been completed showing that consent to treatment had been refused. Mr Beith advised Mr O'Flaherty to call another ambulance if there was any deterioration in Mr Glass' condition.

[62] Mr Beith's position was supported by that of Miss Porter whose evidence was that after assessing Mr Glass in his cell, she and Mr Beith had returned to their ambulance at which time she was told by Mr Beith that prison staff were not happy that Mr Glass had to leave the prison due to them being short-staffed. In her statement she said that the decision that Mr Glass was to remain within the prison was taken by prison staff.

[63] Mr O'Flaherty explained that he had started his shift after the first ambulance had already arrived and paramedics were attending to Mr Glass. He had been told by his colleague, first line manager David Cross, that Mr Glass would probably have to go to hospital and the necessary paperwork for his escort had been completed. He accepted that he had spoken with the attending paramedics at the point when they had been speaking with Mr Glass in his cell. He had wanted to get an update on what was going to happen and was asking their opinion on whether Mr Glass was going to hospital or not. His position was that it was the SAS staff who had suggested taking further advice and had gone back to the ambulance to do this. The advice which they received was that the out of hours GP did not want to get involved in the decision which he found surprising. The ambulance personnel then asked him if he was happy for

Mr Glass to be left under their care. His response was "If you're telling me he does not need to go to the hospital, then yeah, it's absolutely fine." If they had said that Mr Glass had to go hospital, then he would go. There was no questioning that. He did not question the paramedics on the decision to leave Mr Glass in his care. The only thing the paramedics said to him was that if he was concerned about him later on in the night then feel free to call the SAS back.

[64] Mr O'Flaherty's evidence was supported in part by that of acting first line manager David Cross. He had identified two members of staff who were happy to escort Mr Glass to hospital. He had been struck by Mr O'Flaherty asking the attending SAS staff out of the cell to speak with them and so he had made himself available for that a short distance away. Mr O'Flaherty had taken issue with the paramedics giving Mr Glass the decision as to whether he should go to hospital. He told them to make the decision - not Mr Glass. It was unusual for such a conversation to take place. He did not hear anything else. Mr O'Flaherty was quite assertive: firm, but assertive. The SAS personnel didn't really react; they were very nonchalant. They struck Mr Cross as being quite laid back about it.

Assessment of evidence

[65] I am clear that the evidence of Mr Beith is to be preferred to that of Mr O'Flaherty. I start in this respect from what was not in dispute: the assessments undertaken by Mr Beith and Miss Porter when they first attended at the prison suggested that Mr Glass ought to be conveyed to hospital. The advice which they then

received from Dr Popi was to the same effect. One must query firstly why the ambulance personnel felt the need to take advice from Dr Popi given the conclusions which they themselves had reached – unless there was an intervening factor. In any event, Mr Glass was not in fact conveyed to hospital despite the assessment of the attending ambulance personnel and the advice from the out of hours GP.

[66] I considered Mr Beith to be credible and reliable. He was straightforward in his manner and presentation, as well as in the answers which he gave to questions. He was reflective in acknowledging that in retrospect he ought to have done more to ensure that Mr Glass was conveyed to hospital.

[67] Mr O'Flaherty was also straightforward in his evidence; but I agree with the submission made on behalf of the SAS that his evidence was contradictory in certain respects. As accepted in the submission of the Prison Officers Association, Mr O'Flaherty's consistent position in evidence was that he was not medically qualified, and that the decision as to whether Mr Glass was to be conveyed to hospital rested with SAS staff. That being so, given that it was the assessment of those very personnel that Mr Glass should be conveyed to hospital, there was no reason for Mr O'Flaherty to intervene and tell Mr Beith this.

[68] Crown production 9 is the SAS patient report form compiled in relation to the attendance by Mr Beith and Ms Porter – in essence the paperwork completed by

Mr Beith which was provided to Mr O'Flaherty. It notes the presenting complaint as being back pain. The portion headed "Additional Comments" reads as follows:

> "obs as recorded, signs of infection. 12 lead ecg nil acute. nursing staff dipped pt urine today for suspected infection, no results available at this time. ooh dr phoned at request of prison, ooh gp advised they would not be involved pt would require a&e, information relayed back to prison manager. pt staying here, monitored regularly by staff and reported to nhs nurses in the morning. risks of sepsis and deterioration over night explained to staff and accepted by manager."

This is consistent with the evidence of Mr Beith. For Mr O'Flaherty's account to be accepted, it would mean that having concluded that Mr Glass should be conveyed to hospital, and having then received advice to that effect from another party, Mr Beith then chose to reject both that advice and his own assessment, complete paperwork vouching that rejection, and provide a copy of that to prison staff. That is not credible in my opinion.

[69] I accepted Mr Beith's evidence that he was advised by Mr O'Flaherty that if Mr Glass was not dying then he was not leaving the prison and that in this context there was a mention of staffing issues within the prison. The evidence of Miss Porter that she was told shortly after by Mr Beith that there were such staffing issues supports his credibility. There was evidence which I accepted from Dr Popi that Mr Beith questioned why it was that he was being advised to convey his patient to hospital for back ache. I do not hold that against Mr Beith as it is clear to me that by then he had been placed under considerable pressure – directly or implicitly – to ensure that Mr Glass would not be leaving the prison that evening.

Precautions which could reasonably have been taken – section 26(2)(e)

[70] The evidence to the inquiry of Dr Stuart Hutcheon, consultant Cardiologist, was presented in the form of a report which is Crown production 39. His opinion is that Mr Glass ought to have been conveyed to hospital following the first attendance. Professor Lyon, consultant in Emergency Medicine whose report is Crown production 18, is in agreement. It is accepted by all parties that this is a precaution which could reasonably have been taken. In addition, Dr Hutcheon's opinion is that had Mr Glass been conveyed to hospital at that time, his condition would have been, on the balance of probabilities, survivable. Professor Lyon's opinion is that had Mr Glass been conveyed to hospital at that time, this would have significantly increased his chances of survival. That being so, the precaution is one which, had it been taken, might realistically have resulted in Mr Glass' death being avoided.

Defect in a system of working – section 26(2)(f)

[71] It is clear in my opinion that there were deficiencies in the training which had been provided to SAS personnel in relation to where responsibility for decision-making lay in circumstances where the patient to be conveyed to hospital was a prisoner. This is demonstrated by the fact that Mr Beith considered that Mr O'Flaherty essentially occupied the role of guardian to Mr Glass and – as such – was able to refuse to allow consent for him to be conveyed to hospital. It is also evident from the SAS Framework for Clinical Decision Making which was lodged as Crown production 20. The part of the framework which deals with refusals of treatment only covers the broad scenarios of

where the patient has capacity or does not. It makes no allowance for a situation in which the patient is in custody.

[72] Counsel for the SAS submitted that the deficiency extended to the training and guidance of SPS staff as well. I am unable to agree with this. I am satisfied that Mr O'Flaherty in effect prevented the removal of Mr Glass from the prison by ambulance and his conveyance to hospital. However, his evidence, as well as that of Mr Cross, was that when it came to clinical assessments and decision-making, they as prison officers would defer to SAS staff as they themselves are not medically trained. That is consistent with the fact that responsibility for the provision of healthcare to prisoners does not lie with SPS. What was done here by Mr O'Flaherty did not accord with this.

[73] Where I do agree with counsel for the SAS, as well with the Procurator Fiscal, is that the prison officers lacked proper understanding of the healthcare rights of prisoners in as much as they did not understand that it was the job of SAS staff to discuss treatment options with the patient in order that they might provide informed consent in relation to those. Mr O'Flaherty viewed the decision as to whether Mr Glass would be conveyed to hospital as being one purely for the ambulance personnel to take; his evidence to the inquiry was that they were not to give Mr Glass option of attending hospital, or not. Mr Cross did acknowledge that a prisoner could refuse to go to hospital, but understood that the decision as to whether a prisoner should go to hospital or not was one to be made by SAS. Whilst I accept therefore that there was a defect in a system of working in that SPS staff were provided with inadequate guidance in relation

to the healthcare rights of prisoners, what I am not persuaded of is that this was a defect which contributed to the death.

Could Mr Beith have escalated the incident?

[74] The Procurator Fiscal submitted that a reasonable precaution which could have been taken by the SAS personnel would have been to escalate their concerns or seek further support during their attendance in light of the fact that their clinical judgment was not being respected. She argues that this could have been done either to Dr Popi or through internal SAS channels and that this might realistically have resulted in Mr Glass' death being avoided.

[75] I cannot make this finding. I am firstly unable to say what, if anything, Mr Beith and Ms Porter could have done after they had consulted Dr Popi and when Mr O'Flaherty was refusing to allow them to convey Mr Glass to hospital, even within the terms of the SAS Framework for Clinical Decision Making. Mr Beith reflected in his evidence that he wished he had been more forceful, but I cannot say beyond this what he could have done. In that sense, the reference to "an escalation" is speculative as I simply cannot say what this would be.

[76] Even if there could have been further discussion within SAS, I would not be in a position to conclude that this might realistically have resulted in the death being avoided. It is important to bear in mind that the precaution which the Procurator Fiscal invites me to find is the proposed escalation. The accepted position is that had Mr Glass been conveyed to hospital, his death might realistically have been avoided. However,

conveying Mr Glass to hospital as a precaution is not equivalent to pursuing a form of escalation, whatever form that might take. It is at least one step removed from that. There is no evidential basis upon which I could draw any conclusion as to whether the kind of escalation suggested by the Procurator Fiscal might realistically have resulted in his death being avoided.

The second ambulance attendance

[77] No similar factual dispute arose in relation to the attendance by ambulance personnel Peggy Russell and Jane Farmer. There was nothing in Mr Glass' presentation or which arose from their assessments of him which suggested that he needed at that time to be conveyed to hospital.

[78] The Procurator Fiscal has invited the inquiry to make that a finding in terms of section 26(2)(e) of the 2016 Act that a reasonable precaution which could have been taken would be for Mr Glass to be conveyed to hospital and that this might realistically have resulted in the death being avoided. She founds in this respect on Dr Hutcheon's report where he states:

> "In medical and clinical practice, it is well established that when a patient re-presents with ongoing symptoms, or requires a second assessment in close succession, this is regarded as a marker of potential deterioration. In such circumstances, the situation must be taken more seriously and the threshold for hospital admission and further investigation should be lowered."

[79] In his report, Crown production 18, Professor Lyon states:

> "In my opinion and experience, prisoners represent a high risk group of patients for whom caution needs to be exerted at all times, in particular with regards the need for escalation to hospital assessment. When multiple emergency

> ambulances are requested in a short period of time for the same patient, this in itself should be a cause for concern."

[80] I have been referred to the opinion of the Inner House in *Duncan* v *Lord Advocate* [2025] CSIH 27 at paragraph 27 where it confirms the mandatory nature of a finding under section 26(2)(e) where the evidence satisfies the statutory criteria:

> "It is notable that the provision does not say that a precaution should be set out only if the sheriff considers that it ought to have been taken or that it should have been taken. The threshold for making a finding under section 26(2)(e) has been deliberately placed at a lower level than would be the case if the provision required to be satisfied that a precaution ought to have been taken or that it should have been taken. It is sufficient if the sheriff is satisfied that the precaution could have been taken."

The Procurator Fiscal submits that the need for a second ambulance attendance within a short period of time should have been treated as a red flag, lowering the threshold for hospital admission. "In those circumstances", conveying Mr Glass to hospital is a precaution which could reasonably have been taken.

[81] Given the low threshold for the making of a finding in terms of section 26(2)(e), I was initially attracted to this submission. The evidence of Dr Hutcheon is that had Mr Glass been conveyed to hospital by the second ambulance, "it is most likely that his death would have been avoided". Conveying Mr Glass to hospital is therefore undoubtedly a precaution which could have been taken which might realistically have resulted in death being avoided.

[82] I have reached the conclusion however that the finding invited by the Procurator Fiscal cannot be made on the evidence. The clinical assessment of the attending ambulance personnel revealed nothing which would indicate that Mr Glass

required to be transferred to hospital. Dr Hutcheon has opined that this assessment was reasonable, as was the conclusion drawn by the attending personnel. Indeed, he follows up his opinion regarding the lowering of the threshold in these terms:

> "However, based on the clinical information available, Mr Glass's observations and symptoms suggest that he appeared 'more unwell' during the first assessment at 20.46, and that his observations and overall condition had improved by 04:30"

[83] I am not therefore satisfied that the evidence supports a finding that taking Mr Glass to hospital is a precaution which could reasonably have been taken. In my opinion, to make that finding would amount to a conclusion that the mere fact of Mr Glass requiring a second assessment within hours of the first ought to have resulted in his transfer to hospital - irrespective of his clinical presentation or need. Neither Dr Hutcheon nor Professor Lyon says as much and on the basis of it having been reasonably concluded that there was no clinical need for Mr Glass to be conveyed to hospital, there is not the evidential nexus which would enable the finding to be made.

Other facts relevant to the circumstances of death – section 26(2)(g)

[84] In terms of section 26(2)(g), the inquiry requires to make a determination setting out any other facts which are relevant to the circumstances of death.

[85] Mr O'Flaherty stated in evidence that Mr Glass was made the subject of an observation regime following the departure of the first ambulance and that this persisted beyond the attendance of the second. Mr O'Flaherty said that these observations were not medical in nature - they could not be given that neither he nor

any of those operating under his instruction or supervision were medically trained. However, they were put in place by Mr O'Flaherty on account of a medical event which had occurred. Because of this, they were not appropriate and I have no difficulty in accepting the Crown submission to this effect.

[86] The Procurator Fiscal goes further and argues that the observation regime was not adequate either; however, the issue of adequacy or otherwise does not arise on account of the very fact that the observations were not medical in nature. Even if one could conclude that they were appropriate, or could be understood, they could never reach a threshold of adequacy because they were only put in place in order to monitor Mr Glass' wellbeing, which is not something SPS staff were in a position themselves to assess.

[87] It is not suggested that the regime of observations which was devised following the first attendance on Mr Glass contributed to the death. They are nevertheless relevant to the circumstances of the death and so I am satisfied that a finding in terms of section 26(2)(g) should be made. However, the evidence of the SPS staff at the inquiry was consistent in as much as they are not medically trained and they are to defer to the judgment of medical professionals in that area. Mr O'Flaherty said that he did this out of his own concern for Mr Glass and I accept that. The submission made on behalf of the Scottish Ministers that the decision by Mr O'Flaherty to place Mr Glass on these observations was not consistent with SPS policy is therefore well founded.

Recommendations in terms of sections 26(1)(b) and 26(4)

[88] An affidavit has been provided to the inquiry by Shereen Cameron, National Patient Safety Manager for the Scottish Ambulance Service (SAS) whose role is to lead processes of assurance, quality, governance and management of adverse events, and their associated review, learning and improvement actions.

[89] The findings made in terms of sections 26(2)(e) and 26(2)(f) are restricted to the first ambulance attendance. The Significant Adverse Event Review which was undertaken by SAS following the passing of Mr Glass concluded that the initial decision for Mr Glass to remain at the prison was heavily influenced by the perceived authority gradient of the prison staff and the uncertainty by SAS clinicians on the health care rights of prisoners. It noted that there was no specific guidance or training for SAS clinicians on providing health care to patients in a prison environment. It recommended that guidance be developed with SPS, outlining appropriate SAS response to medical support on prison sites, detailing considerations for in and out of hours care, prisoner healthcare rights and escalation for additional advice.

[90] In her affidavit, Ms Cameron provides the following:

> "Joint guidance has been co-produced between the Scottish Ambulance Service and the Scottish Prison Service to describe the response to medical and trauma healthcare incidents for individuals detained in custody at SPS establishments.
>
> The document details key criteria to support the processes related to providing clinical assessment and treatment of people in custody, as well as critical considerations regarding the security and safety of all involved.
>
> The document also describes key standards, roles and responsibilities of each service. appropriate routes of escalation for SAS crews to support clinical

> decision-making and safe care, whilst noting and respecting fundamental principles of justice, dignity and human rights."

Ms Cameron goes on to outline that a draft of the joint guidance document has been developed and that the final draft document has been approved through the SAS governance approval process.

[91] My findings in terms of section 26(2)(f) relate to a deficiency in the training and guidance provided to SAS staff as regards the roles and responsibilities of both themselves and SPS staff in circumstances where a patient was detained within an SPS institution. It is evident that this deficiency has been identified by SAS and that the guidance which has been approved addresses exactly this. In these circumstances, there is no requirement for a recommendation to be made in terms of section 26(1)(b).

[92] As all participants have done, I extend my condolences to the family and friends of Mr Glass. I would also like to thank all parties for the comprehensive and thorough manner in which they have assisted the inquiry, as well as to express my regret to them that I have not been in a position to issue this determination much sooner, as had been my intention.