

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT ALLOA

DETERMINATION

by

SHERIFF DEREK O'CARROLL, Advocate, Sheriff of Tayside Central and Fife

**following an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry
(Scotland) Act 1976**

held at Alloa Sheriff Court into the circumstances of the death of

GIOVANNI COCOZZA

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ALLOA, 7 July 2014

The Sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Giovanni Coccozza, determines in terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, as follows:

(1) In terms of section 6(1)(a) of the Act, Mr Coccozza died at Stirling Royal Infirmary on 7 March 2011 at 07.25.

(2) In terms of section 6(1)(b) of the Act, the cause of death was an intracerebellar haemorrhage secondary to longstanding hypertension. At the date of death, Mr Coccozza had a metastatic non-small cell lung cancer, first diagnosed less than 24 hours before his death, which had spread to his liver. That cancer did not however materially contribute to the cause of death.

(3) In terms of section 6(1)(c) of the Act, there were no reasonable precautions whereby the death might have been avoided.

(4) In terms of section 6(1)(d) of the Act, there were no defects in any system of working which contributed to the death.

(5) In terms of section 6(1)(e) of the Act:

- a) Mr Coccozza suffered from a metastatic cancer of the lung and liver from at least September 2010, quite possibly earlier, from which Mr Coccozza showed non-specific symptoms, which remained undiagnosed (and therefore untreated) until the point of his death from an intracerebellar haemorrhage.
- b) The failure to diagnose that cancer was attributable to the combined effect of a series of shortcomings, both personal and institutional, occurring within Aberdeen Royal Infirmary, HMP Peterhead and HMP Glenochil. At paragraphs 131 to 137, the nature of those shortcomings is summarised.
- c) Had it not been for those shortcomings, it is likely that the existence of the cancer would have been diagnosed earlier, quite possibly before the end of 2010.
- d) The absence of timely diagnosis resulted in Mr Coccozza losing two opportunities. The first was access to treatment for his cancer, though any such treatment could only have been palliative and would not have

extended his life (given that the cause of death was an intracerebellar haemorrhage), though it might have improved his quality of life. The second was the chance of being considered for compassionate release from HMP Glenochil in terms of section 3 of the Prisoners and Criminal Proceedings (Scotland) Act 1993

- e) The failure to timeously diagnose and therefore treat the cancer did not however have an effect on the timing of the ICH from which Mr Coccozza died.

Makes the following findings in fact:

- (1) Mr Giovanni Coccozza was born on 25 June 1932.
- (2) Mr Coccozza was a long-term prisoner having been sentenced in July 2009.
- (3) Mr Coccozza was transferred to HMP Peterhead in November 2009.
- (4) While at HMP Peterhead, Mr Coccozza saw the medical officer there complaining of unexplained symptoms including increasing confusion, sleepiness, increasing frailty and chest pains. Blood tests indicated reduced kidney function.
- (5) On 21 July 2010 Mr Coccozza was referred to Aberdeen Royal Infirmary by Dr Bruce, medical officer at HMP Peterhead. He sought a medical assessment and advice. On 28 August, Dr Lois Jacob saw Mr Coccozza at Prof Webster's clinic at Aberdeen Royal Infirmary, arranged for blood tests and an ultrasound scan of Mr Coccozza's abdomen. That scan took place on 22 September 2010.
- (6) The results of those tests and the ultrasound scan were reviewed by Professor John Webster when he first saw Mr Coccozza at his clinic on 20 October 2010. The report relating to the ultrasound scan noted: "There is an 8cm heterogeneous lesion in the right lobe of the liver which demonstrates vascularity. This may represent an atypical haemangioma or focal nodular hyperplasia, however malignancy cannot be excluded".
- (7) Given Mr Coccozza's medical condition, his age and the ultrasound scan report, most clinicians, including Prof Webster would consider that the liver

lesion revealed in the ultrasound scan was malignant, that is to say cancerous, unless proven otherwise.

- (8) Where cancer is suspected, early diagnosis and treatment is of great importance; the earlier the diagnosis and treatment, the better the chances of a beneficial outcome. That principle is widely accepted in the medical profession.
- (9) On 20 October 2010, Prof Webster completed a standard form seeking a CT scan to be done on Mr Coccozza's abdomen, intending to obtain more information about the liver lesion. In view of Mr Coccozza's reduced kidney function, he requested that the CT scan be done without a contrast medium being administered. He knew that while the use of a contrast medium would provide better images, it would be harmful to Mr Coccozza. Nonetheless, in his opinion, even a CT scan without contrast would be useful to him in diagnosis of the liver lesion.
- (10) He sent that CT request form by internal post to the Radiography Department on 20 October 2010. That form took 8 days to arrive at the Radiology Department. That delay was not unusual. That form was "vetted" on 1 November 2010 by Dr Gomersall, consultant radiologist.
- (11) Dr Gomersall rejected the request. In her view, a CT scan without contrast would not provide Prof Webster with any useful information about the lesion. In her view, a further ultrasound scan of the liver, with a contrast medium which would not interfere with kidney function, was preferable. She did not phone Prof Webster or his secretary to discuss the matter or alert him to the rejection.
- (12) Instead, Dr Gomersall believes that in line with her normal practice she completed a rejection form noting her views and sent it to Prof Webster that day. If sent, that rejection form was not received by Prof Webster, nor was any note made of it being sent, nor was any copy kept.
- (13) There was in 2010, and as at February 2014, no standard practice within the Radiology Department within Aberdeen Royal Infirmary for

dealing with rejected imaging requests: each practitioner chooses their own method.

- (14) There was in 2010, and as at February 2014, no established method at the Radiology Department of ARI, of providing an 'audit trail' for rejected imaging requests. Although since 2010, electronic means of delivery of imaging requests and responses to those requests has been implemented, it is not universal.
- (15) There was in 2010, and as at February 2014, at the Radiology Department of ARI, no common or standard protocol regarding making requests for imaging and processes associated with such requests.
- (16) Prof Webster did not notice that the CT scan request he had made had not been implemented. He did not have an effective system for ensuring that all imaging requests were monitored to see that they were carried out.
- (17) Mr Coccozza was transferred by the Scottish Prison Service from HMP Peterhead to HMP Glenochil on 3 December 2010. A "Medical Transfer Form" was completed at HMP Peterhead just before the transfer. It noted Mr Coccozza needed medication to be supervised as otherwise he would forget it or take too much. The form made no mention of the following facts: that Mr Coccozza had been referred to ARI for investigations; the results of the ultrasound scan; that cancer was suspected; that further investigations had not been completed. Neither did the SPS Healthcare Records Summary Sheet make any mention of those facts. Both the transfer form and the summary sheet ought to have noted those facts.
- (18) Mr Coccozza was at the date of transfer receiving 15 separate medications to treat hypertension, heart failure, raised cholesterol and some minor ailments. He had a pacemaker and had had replacement hips.
- (19) On 3 December 2010, he was noted to be confused at reception at HMP Glenochil. On that date, Mr Coccozza was assessed by nurses at HMP Glenochil. Mr Coccozza said he suffered from memory loss. It was noted that he might ask the same questions many times over without recalling he had done so, that he might need prompting regarding personal care and layout

of surroundings. That information was placed in writing in his medical records.

(20) Mr Coccozza was seen by Dr Alastair Duncan Howie, a medical officer at HMP Glenochil, on 6 December 2010. Dr Howie did not read any part of Mr Coccozza's medical records. Nor did he read the Medical Transfer Form, nor the comments made by nurses at HMP Glenochil a few days previously regarding his mental state. Dr Howie relied on Mr Coccozza to give an account of his medical position.

(21) Mr Coccozza said he had no medical issues. Dr Howie recorded his Mr Coccozza's medical notes that Mr Coccozza was "quite well". That was inaccurate: Mr Coccozza was at that time not a well man. He ought not to have relied on Mr Coccozza's account of his medical position. Dr Howie did not notice that previous investigations while Mr Coccozza was at HMP Peterhead had revealed a possible malignancy in Mr Coccozza's liver.

(22) Around 29 December 2010, another medical officer at HMP Glenochil, Dr Parish, reviewed Mr Coccozza's medical notes in full, prompted by a medical mishap resulting from Mr Coccozza having forgotten that he had already received a flu vaccine, telling the nurse that he had not had the flu vaccine, and receiving another vaccination before the mistake was discovered. That review alerted her to the fact that cancer of the liver was suspected but the follow up CT scan ordered by Prof Webster had not been done.

(23) Alarmed, Dr Parish immediately contacted Dr Webster on 29 December 2010, which prompted a letter from him to the prison medical team, setting out the circumstances and suggesting that follow up be done locally. There was no urgency indicated in that letter and there ought to have been. Until alerted by Dr Parish, Prof Webster had not realised that the CT scan had not been done.

(24) Dr Parish had concerns about the state of Mr Coccozza's mental health arising from her review of his medical records and sought specialist

assistance. That was not done and concerns expressed by her as regards his mental health were not followed up.

(25) Dr Parish arranged an early appointment with Dr Peter Bramley, consultant gastroenterologist at his regular surgery in the prison on 19 January 2011.

(26) Dr Bramley's "clinic letter" written on 19 January 2011 following consultation noted Mr Cocozza's frailty and that Mr Cocozza was "obviously in poor health". That clinic letter, addressed to the medical team at the prison took three months to be typed and sent, by which time Mr Cocozza was dead. That type of delay was not unusual though an urgent letter might have been typed in 2 to 4 weeks.

(27) On 19 January 2011, Dr Bramley completed and sent an imaging request form to the Radiology Department at The Forth Valley Hospital. He requested a CT scan, without contrast. That was exactly the same request as had been unsuccessfully made three months previously by Prof Webster and was made for the same reason.

(28) That request was received by the Radiology Department at the Forth Valley Hospital on 24 January 2011 and was rejected the following day, for exactly the same reason as Professor Webster's similar request had been refused. There was no attempt by radiology staff to first discuss the matter with Dr Bramley before rejecting the request. More time was thus lost.

(29) On 14 February 2011, following discussion with a member of the Radiology team at Forth Valley Hospital, Dr Bramley completed a further request for imaging, this time an MRI scan. An MRI scan cannot normally be carried out on a person who has a pacemaker.

(30) Dr Bramley completed the standard checklist form with Mr Cocozza who incorrectly told Dr Bramley that he did not have a pacemaker. There was no clear note in Mr Cocozza's medical records concerning Mr Cocozza's pacemaker. If there had been, it is unlikely that an MRI scan would have been arranged and likely that some other form of imaging would have been used.

- (31) On 4 March 2011, Mr Coccozza attended the Forth Valley Hospital for the planned MRI scan. The procedure was abandoned when the radiologist discovered that Mr Coccozza had a pacemaker. Mr Coccozza was referred back to his medical officer at the prison. More time was thus lost.
- (32) On 6 March 2011, Mr Coccozza became very ill while at HMP Glenochil. He was admitted as an emergency to Stirling Royal Infirmary at around 2pm. There, he had a CT scan for the first time, though of his head rather than his liver. That revealed a large 4cm haemorrhage in the left cerebellar hemisphere causing pressure on surrounding structures. He had suffered an intracerebellar haemorrhage (a type of stroke in layperson's terms) ("an ICH").
- (33) By 11.30 pm on 6 March 2011, Mr Coccozza was deeply unconscious and virtually moribund. There was no treatment possible except for minor palliative treatment. Death from the ICH, once the event had commenced, was inevitable.
- (34) Mr Coccozza died at 07.25 on 7 March 2011. The proximate cause of death was the ICH.
- (35) The ICH was secondary to long standing hypertension (high blood pressure in layperson's terms) from which Mr Coccozza had suffered from over 30 years. That hypertension had made him susceptible to an ICH. That ICH could have occurred at any time.
- (36) An x-ray taken of Mr Coccozza's chest on the day of admission to SRI revealed that he had a 6.8cm hilar mass lesion in the right lung. That lesion was cancerous. It was a primary metastatic cancer.
- (37) On 10 March 2011, Dr Clifford Perera and Dr David William Sadler carried out an autopsy on Mr Coccozza. Dr Perera was the lead pathologist. They prepared a report of that examination dated 19 April 2011. The cause of death was given as "I. (a) Complications of a Metastatic Carcinoma". The report concluded *inter alia* that in addition to the tumour mass in the lung, there was a tumour mass in the liver and that it was likely that the cancer was metastatic, originating in the lung. No tumour was found in the brain.

That report, and a subsequent revised report dated 19 December 2013 were significantly inaccurate in many respects. In particular, the cause of death was incorrect.

- (38) As at the date of death, Mr Coccozza was suffering from a metastatic cancer originating in his lung which had spread to his liver. That cancer was certainly present in both organs as at September 2010 and quite possibly for some time before that time. It is likely that that cancer was responsible for at least some of his reported symptoms. That cancer was a significant co-morbidity and ought to have been entered as such on the death certificate under Part II.
- (39) That cancer did not cause Mr Coccozza's death. Neither, on the balance of probabilities, is it likely to have caused or significantly contributed to the death of Mr Coccozza from the ICH. Had he not died from the ICH, he would have died from the cancer later. It was incurable.
- (40) The failure to diagnose that cancer was attributable to the combined effect of a series of shortcomings, both personal and institutional, occurring within Aberdeen Royal Infirmary, HMP Peterhead and HMP Glenochil.
- (41) Had it not been for those shortcomings, it is likely that the existence of the cancer would have been diagnosed earlier, quite possibly before the end of 2010.
- (42) The absence of a more timely diagnosis resulted in Mr Coccozza losing two opportunities. The first was access to treatment, though any such treatment could only have been palliative and would not have extended life, though it might well have improved his quality of life. The second was the chance of being considered for compassionate release from HMP Glenochil in terms of section 3 of the Prisoners and Criminal Proceedings (Scotland) Act 1993.
- (43) The failure to diagnose earlier and therefore treat the cancer did not however have an effect on the timing of the ICH from which Mr Coccozza died.

Makes the following recommendations

- (1) Aberdeen Royal Infirmary Radiology Department should review its procedures so as to ensure that there are in place clear and uniform protocols concerning the way in which requests for imaging which are not unconditionally accepted are dealt with. In particular, it would be desirable if possible that where an alternative form of imaging is proposed, there be discussion with the requesting physician and any professional differences resolved at the time of consideration of the request, thus avoiding unnecessary delay. Furthermore, procedures of dealing with imaging requests should be reviewed so that a clear audit trail for each and every request made, including those requests which are rejected, is kept. Time consuming paper methods of making and rejecting imaging requests should be phased out where at all possible.
- (2) Those making imaging requests should ensure that they have in place systems to monitor the outcome of every request made and which are capable of identifying timeously any imaging request which has not been carried out.
- (3) Prisoner records should contain an accurate, comprehensive and regularly updated easily accessible summary of the prisoner's significant medical history and current issues to ensure that those treating the prisoner can quickly obtain an understanding of the prisoner's medical position and treat appropriately. The full use of technology should be employed to this end wherever possible.
- (4) Procedures for transferring prisoners should be reviewed and standardised to ensure that when a prisoner is transferred, a careful review is made of the prisoner's medical position by the transferring prison so that all notable features, especially in relation to current treatment and investigation, are clearly brought out in the prisoner's medical records.
- (5) Procedures in the receiving prison for dealing with transferred prisoners should be reviewed and standardised to ensure that within a short period of a prisoner being transferred, a medical officer at the receiving prison

consults with the prisoner and reviews his/her medical position with reference to his/her medical records and any observations made by other medical staff following reception.

NOTE:

Introduction

- [1] This was a Fatal Accident Inquiry into the death of Giovanni Cocozza who was, at the time of his death, a prisoner at HMP Glenochil. A Fatal Accident Inquiry must be held whenever a prisoner dies, in terms of Section 1(1)(a)(ii) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act"). This is therefore a mandatory Inquiry.
- [2] This document contains my written determination as required by section 6 of the 1977 Act. In terms of Rule 11(3) of Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977, I consider that it is not reasonable to fix an adjourned sitting of the enquiry for the sole purpose of reading out this determination. A copy has been sent to the parties and the Lord Advocate and a copy will be placed on the SCS website
- [3] A procurator fiscal depute, Mr Brian Robertson, appeared for the Crown. Ms Kiera Dargy solicitor, of Anderson Strathern WS, appeared for the Scottish Prison Service ("SPS") and Mr Stuart Holmes, solicitor advocate with Central Legal Office, appeared for Grampian NHS.
- [4] It is the duty of the Procurator Fiscal to adduce evidence with regard to the circumstances of death: section 4(1) of the Act. The Inquiry was advised that the Procurator Fiscal had been in dialogue with members of the family of the deceased. The family did not wish to be present or represented at the Inquiry.
- [5] The petition by the Crown seeking the fixing of the Inquiry was presented at Alloa Sheriff Court in April 2013, over two years after the date of death, a period of time that appears on the face of it to be very long considering that the Inquiry was mandatory and that there were no connected criminal or

civil proceedings causing delay. The preliminary hearing, at which procedural matters were considered, was held on 31 July 2013. However, the Inquiry did not hear any evidence till until 30 January 2014. In all, the Inquiry heard 9 days of evidence. I make further comments below on all these procedural aspects. Evidence was concluded on 10 April 2014 and I heard submissions from the parties on 21 May 2014.

[6] The purpose of the Inquiry, in terms of section 6(1) of the Act is for the sheriff to make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction :

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided;
- (d) the defect, if any, in the system of working which contributed to the death or any accident resulting in the death;
- (e) any other facts which are relevant to the circumstances of the death.

[7] I also make recommendations which are set out above. These recommendations are just that: they are not legally binding. Nonetheless, I hope that they will be considered by those whom they concern and that they may help produce improvements in the processes to which they relate. I also deal with three other matters which arose in this Inquiry which I consider to be of some public interest. The first concerns the fact that although this was a mandatory Inquiry and there were no associated civil or criminal legal proceedings, it nonetheless took the Crown about 2 years to lodge its petition seeking this Inquiry in court. That is dealt with at paragraphs [139] to [142] below. The second concerns the views initially taken by the Crown to how this Inquiry should progress, its views on the matters in issue and the way in which evidence was to be placed before the Court. That is dealt with at paragraphs [143] to [151] below. The third concerns the flawed way in

which the post mortem examination was carried out and reported. That is dealt with at paragraph [138].

[8] The Inquiry heard evidence from the following witnesses (all of whom were called by the Crown):

- a. Professor John Webster, Physician at Aberdeen Royal Infirmary (who treated Mr Coccozza at Aberdeen Royal Infirmary while Mr Coccozza was imprisoned at HMP Peterhead);
- b. Dr Lesley Gomersall, radiologist at Aberdeen Royal Infirmary, (who dealt with the first request for a CT scan of Mr Coccozza at Aberdeen Royal Infirmary);
- c. Dr Alastair Howie, medical officer and retired consultant physician (medical officer at HMP Glenochil who treated Mr Coccozza there);
- d. Dr Cecilia Parrish, general practitioner and former medical officer, (medical officer at HMP Glenochil who treated Mr Coccozza there)
- e. Dr David Sadler, pathologist, senior lecturer at Dundee University (one of the two pathologists who carried out the autopsy);
- f. Dr Peter Bramley, consultant gastroenterologist at Stirling Royal Infirmary (who treated Mr Coccozza while at HMP Glenochil) ;
- g. Dr James Grant, MBE, general practitioner (independent medical witness).

[9] By the conclusion of evidence, the Crown had lodged 22 productions, comprising around 400 pages, nearly all of which comprised medical records and medical reports.

The principal issues for the Inquiry

[10] A large number of issues arose for consideration in the course of the Inquiry, many of them overlapping and some of them quite contentious. They included the following:

- What was the cause of death, cancer or an intracerebellar haemorrhage (“an ICH”) or both?
- If the primary cause was cancer what relationship did that have to the ICH?

- If the primary cause was the ICH, what effect if any did the cancer have on the ICH?
- Did anything else cause or contribute to the ICH?
- Was the medical care received by Mr Coccozza deficient in any way? If so, what effect, if any, did that have on the death of Mr Coccozza?
- Could anything have been done to prevent or delay Mr Coccozza's demise?

Each of these questions of course raised other subsidiary issues, as the evidence showed. It is to that evidence that I now turn. Below, in respect of each of the seven witnesses, I summarise the evidence that each witness gave to the Inquiry. In my Discussion of the evidence I explain my conclusions on the evidence, especially where there was a conflict. My findings in fact, arising from the evidence, are given above.

The evidence in summary

[11] *Professor John Webster.*

His qualifications and experience are as follows. He is a consultant physician with NHS Grampian dealing with inpatients and outpatients. He runs a hypertension clinic. Hypertension is raised blood pressure in lay-person's terms. He has been a consultant in Aberdeen Royal Infirmary since 1984. He qualified in medicine in 1973, has the usual medical qualifications and is a Fellow of the Royal College of Physicians in Edinburgh. He has done considerable research into problems associated with hypertension. He works in the acute stroke unit in Aberdeen. He has specialised in strokes and has studied cause and effect. He has an honorary chair of medicine at Aberdeen University and is a NHS consultant.

[12] Mr Coccozza was first seen in his clinic by Dr Lois Jacob on 25 August 2010 following an earlier referral by Dr Bruce, medical officer at the Peterhead prison. The referral was made by letter dated 21 July 2010 because of concerns that Mr Coccozza was "generally more confused and sleepier than usual. He had been having chest pains on and off but really, he himself does not complain of any specific symptoms". Dr Bruce noted that blood tests had shown marked

changes in his urea and CREA. Dr Bruce said he “was unsure as to why he has become generally frailer along with the change in his electrolytes” and asked for an assessment and advice. Dr Jacob arranged for blood tests and an ultrasound scan, which took place on 22 September 2010. Prof Webster saw Mr Coccozza in his clinic on 20 October 2010 and reviewed the results of the blood tests and ultrasound scan. Prof Webster’s principal concern was with the deteriorating kidney function. The scan showed no obvious cause for his impaired kidney function. However the report from the radiologist stated “there is an 8 cm heterogeneous lesion in the right lobe of the liver which demonstrates vascularity. This may represent an atypical haemangioma or focal nodular hyperplasia, however, malignancy cannot be excluded.” Lesion means abnormality. Vascularity means a high degree of blood flow. Heterogeneous means of mixed density. The first two possibilities are not of any great significance. Malignancy however is synonymous with cancer. He felt that a malignancy was most likely on the basis of Mr Coccozza’s age. Lesion implies malignancy unless proven otherwise, so further tests were needed. In cases of suspected cancer, early diagnosis is very important.

- [13] On 20 October 2010, Prof Webster requested a CT scan, without contrast. That is to say, he requested that the CT scan be done without Mr Coccozza being injected with a contrast medium. That would normally be done in order to provide enhanced images from this CT scan. Due to the poor kidney function of Mr Coccozza, he was not a suitable candidate for the contrast medium. However, Prof Webster believed that a CT scan image of Mr Coccozza’s liver, even without contrast, would still yield useful diagnostic information. That request was put in writing and sent to the Radiology Department using the internal mail. At that point, a request for a scan would take about six weeks on average to be completed. Although he believed it was possible that Mr Coccozza had cancer, he did not seek any high priority to be given to the scan request, stating that the degree of urgency was a decision by the radiologist. He agreed however that it was highly preferable for such a scan in such circumstances to be done as soon as possible. The first

priority was to seek to exclude malignancy as a diagnosis, if possible. Although he had made a reference to the previous ultrasound scan, which had prompted this request, he did not quote the terms of the report from that scan on the written request. The time taken for a scan to be done is now three weeks from the date of request.

[14] That request was received by the radiology department on 28 October 2010, 8 days later. That is not an unusual period for requests made by internal mail to be received and dealt with by the radiology department.

[15] That request was dealt with by Dr Gomersall on 1 November 2010. Unknown to Prof Webster at the time, the request was rejected because in Dr Gomersall's opinion, a CT scan without contrast would not yield useful results. Instead, what she proposed was that a further ultrasound be carried out, this time with the use of a type of contrast medium which would not affect kidney function. Neither the rejection nor that proposal was ever received by Prof Webster or his secretary. Prof Webster did have some systems for following up imaging requests and dealing with reports that were received and other matters. However, he had no system in place for ensuring that all requests made were followed up in one way or another. The hospital did not at that time have a robust system for dealing with situations where a request for a scan was declined or rejected. Although Prof Webster learnt much later that there was meant to be a radiology form which was to be used to deal with rejected requests, he had never seen such a form ever in his time at Aberdeen Royal Infirmary.

[16] Only a tiny proportion of requests were ever rejected in such a way and where there was a rejection, he would expect a telephone call: his telephone number was on the request form. If he had received written notice of a rejection of the scan, he would certainly have remembered it. The hospital is presently in the state of transition; moving to electronic systems. It is easier to identify whether a scan has been rejected. There is still however a potential for something similar to happen again. There is even now no complete audit trail which is a weakness in the system. There is still no

system in the hospital in place for dealing with requests for scans which are not carried out.

[17] No-one from the HMP Peterhead medical team enquired about what investigations were being done for Mr Coccozza. Mr Coccozza was then transferred to HMP Glenochil on 3 December 2010.

[18] Prof Webster heard nothing further about Mr Coccozza until around Christmas 2010 when he or his secretary received a telephone call from Dr Parish, medical officer at HMP Glenochil, who realised for the first time that the CT scan had not been done. By this time of course, Mr Coccozza having been moved to a different prison in a different area, Prof Webster no longer had clinical responsibility for him. Prof Webster, in response, wrote to Dr Parish on 30 December 2010, briefly relating Mr Coccozza's recent medical history, referring to the 8 cm lesion in the liver, the CT scan not having been carried out and stating that that fact "may be a reason" to refer Mr Coccozza for further investigation in Stirling. He also said that a test result showed that Mr Coccozza's alpha fetoprotein level in his blood was normal. Alpha fetoprotein is a marker for primary liver cancer. Therefore, it was unlikely that Mr Coccozza had *primary* liver cancer. However, that did not rule out secondary liver cancer in the liver. He accepted that his letter did not impart any need for urgency. That ended his involvement with Mr Coccozza during Mr Coccozza's lifetime.

[19] Over two years later, Prof Webster was contacted by the Crown and asked to give his views on various aspects relating to the medical care provided to Mr Coccozza and his subsequent death. In response to those enquiries, Prof Webster provided a very detailed clear and comprehensive account of his involvement by way of letter dated 3 October 2013 which is Crown production 6A. In that letter, which he spoke to in evidence, he offered the further following views. The fact that Mr Coccozza had been a prisoner had no influence on the speed or nature of initial assessment or investigation. However, the transfer to Glenochil may have delayed the diagnostic process. At that time, Mr Coccozza was "seriously ill". His opinion

was that Mr Cocozza had a primary lung cancer with secondary spread to the liver. By the time a likely diagnosis of malignancy had been recognised on 20 October 2010, Mr Cocozza already had metastatic disease in his liver, was becoming increasingly frail and had significant co-morbidities (impaired kidney function, coronary heart disease and congestive heart failure). Even at that point, he would not have been a good candidate for aggressive chemotherapy. It was possible but unlikely that Mr Cocozza would have been able to live longer by earlier treatment. More important would have been his quality of life. Earlier diagnosis might have added something to this but it was highly unlikely.

[20] Expanding on that view in evidence, Prof Webster said that survival from cancer depended on three things being: the type of cancer; degree of spread and most importantly the clinical state of the patient. Here the cancer appeared to have been a non-small cell cancer which carries the worst prognosis. The disease appeared to be at stage 4, which is the most advanced stage. Further, the “performance status” of Mr Cocozza was low as his general health was very poor. He did not agree that when Mr Cocozza was assessed on admission to Glenochil prison that he was “fairly well” as stated by Dr Howie. Any treatment for the cancer would not have affected Mr Cocozza’s survival. His “performance status” could have been improved by treating other causes of his ill-health.

[21] Prof Webster had the opportunity before and during his evidence to comment on the views of the pathologist, Dr Sadler, as regards the medical condition of Mr Cocozza and the cause of death and in particular, the relationship between the ICH and the cancer. He also had the opportunity of reading the post mortem reports prepared by Dr Sadler being Crown productions 2 and 11. He was very critical. He disagreed that the cancer was a contributor to the ICH. In his view, the cause of death was the ICH which was due only to the hypertension that Mr Cocozza had suffered from for 35 years. Mr Cocozza had also been taking aspirin, because of his heart disease,

which produces a 50% increase in relative risk of an ICH due to the reduction in clotting tendency.

[22] There were in his view only three possible mechanisms whereby Mr Coccozza's primary and secondary cancer could be linked to the ICH diagnosed on 6 March 2011 from which he died the following day. The first is a metastatic tumour in the brain, secondary to the primary cancer, from which the bleeding into the brain occurs. However, that possibility is excluded by Dr Sadler's post mortem which states in terms that no such secondary growth was found. The second possibility is that the cancer produced a paraneoplastic effect which led to the bleeding into the cerebellum. However, that effect, which occurs in about 30% of small cell cancers, is associated only with small cell cancers, and according to Dr Sadler's report, Mr Coccozza had a *non-small cell* cancer which is never associated with that type of effect. That possibility is thus excluded. The third possibility is that the extensive metastatic cancer in the liver led to blood clotting abnormalities thus producing the bleeding into the cerebellum. However, that possibility was highly unlikely as the liver cancer was in part only of the liver, Mr Coccozza was never at any time jaundiced and his liver function tests on 1 November 2010 were normal.

[23] In his view, the cause of death that he would have put on the death certificate would have been "1(a) intracerebellar haemorrhage; 1(b) hypertension; 2. Non-small cell cancer. 3. Severe coronary artery disease". The hypertension was in all likelihood a direct contributor being in his opinion the single biggest risk factor for a stroke. In his view, the cancer did not contribute to the ICH. The stroke was unpredictable.

[24] Dr Webster also wrote a letter dated 4 February 2014 for the purposes of the Inquiry to the Crown which was lodged and is Crown production 17. He did so after having reviewed the other Crown productions including the complete medical records of Mr Coccozza including the records relating to his admission to Stirling Royal infirmary on 6 March 2011. He spoke to that letter when giving evidence a little later in the Inquiry. He reaffirmed his

conclusion that Mr Coccozza died of an intra-cerebellar haemorrhage unrelated to his metastatic lung cancer. The medical records on admission of Mr Coccozza to the Stirling Royal infirmary on 6 March 2011 and the CT scan of his brain on that day and X-ray showed that he had suffered an unsurvivable bleed to the brain which was not capable of being operated on. There was no evidence in those records of cerebellar metastatic disease. The mechanism of the cerebellar haemorrhage was most likely to have been due to hypertension as a predisposing cause. The aspirin that he was taking due to his heart problems may also have been a factor. Aspirin increases the risk of stroke by 50% as compared to the background risk. The bleeding could not have been caused by the lung cancer. In particular, his prothrombin time (the most readily available routine test of coagulation) was normal. Furthermore, after having considered further the possibility of a paraneoplastic syndrome caused by hormonal release from a small cell lung cancer, while that type of tumour can undoubtedly cause such an effect, the autopsy shows that he had a non-small cell lung cancer and such a syndrome is only extremely rarely associated with such types of cancer. Even if Dr Sadler had made a mistake and the cancer was a small cell lung cancer, the dramatic paroxysmal rise in blood pressure shown in the hospital records is never associated with that syndrome. On reflection, on the death certificate, he would simply provide that the cause of death was intra cerebellar haemorrhage. The presence of metastatic cancer would however be expected to be contributing in a non-specific, indirect way to Mr Coccozza's general decline and was undoubtedly a factor in the decision to offer Mr Coccozza palliative rather than definitive treatment in his final hours and he would record that in Part II of the death certificate. He would be surprised if some of Mr Coccozza's general decline in health as noted in his records in 2010 was not related to his liver cancer and that would have made him vulnerable to other illnesses

[25] Prof Webster also expressed his concerns about the number of "aberrations" in the autopsy report. The principal ones were as follows.

[26] The autopsy report providing the account of Mr Cocozza's admission to the hospital on for March 2011 and "readmission" on 6 March 2011 is largely inaccurate. The examination of Mr Cocozza's body failed to note he had had bilateral hip replacements. It failed to note that Mr Cocozza had a cardiac pacemaker. It recorded that Mr Cocozza's heart was of normal size and shape when his heart was considerably heavier than normal (549 g as opposed to the normal 350 to 400 g), which is likely to have been due to severe hypertensive heart disease. The report wrongly located the position of the liver tumour and also of the cerebellar haemorrhage. All that made him wonder how reliable the autopsy report might be.

Dr Lesley Gomersall, radiologist

[27] Her qualifications and experience are as follows. Dr Gomersall has been a radiologist at the Aberdeen Royal Infirmary since 1988 and a consultant since 1995. She has the usual medical qualifications to be expected of someone in her position.

[28] She deals with imaging requests of all kinds. Her department gets about 100 new requests for imaging each day which are dealt with by the complement of 22 consultant radiologists and around 200 radiographers and other staff. She prepared a report from records: Crown Production 8. Mr Cocozza had an ultrasound examination on 22 September 2010 which showed a focal lesion in the liver, incidental to a finding with regard to renal function. The lesion was thought to be a haemangioma, a focal nodular hyperplasia (both being types of benign non-malignant lesion) or a malignancy (that is to say cancer). It was impossible without further investigation to determine which of the three possibilities applied to this lesion. This result was sent to Prof Webster and received by him.

[29] A further request for imaging was made by Prof Webster on a request form (Crown Production 18), dated 20 October 2010. That request was received by the Department on 28 October 2010 and was "vetted" on 1 November 2010 by her. That delay between sending and receipt is not unusual.

[30] The request referred to the recent ultrasound scan showing an 8 cm mass in the right lobe of the liver with a question mark against the word “haemangioma” and requested a scan of the abdomen, but without contrast due to the low eGFR count. The request form gave Prof Webster’s name, his ward number, contact number but not his secretary’s number. She accepted that given the previous result, a malignancy in the liver was a possibility which require to be considered. If the referring doctor considered that the problem was a malignancy, scans would be done (at that time) in 2 to 3 weeks instead of the 3 to 4 weeks which was then the usual waiting period for a scan. The request that no contrast be used showed that Prof Webster understood that due to the impaired kidney function, contrast could not be used as that might cause serious harm to the patient. However, Dr Gomersall’s view was that a CT scan without contrast would be useless as it would not tell Prof Webster anything about the lesion. She therefore rejected the request.

[31] She would have completed a paper form and returned it to Prof Webster using a form like the blank copy at Crown production 19. However, no copy of the form that she believed she would have sent was kept. That is normal practice. A note was made on her Department’s computer system of the reason for rejection and the alternative suggested, being ultrasound with contrast. There is no system for checking that the rejection form is received by the referrer. She did not attempt to telephone Prof Webster. She would not want to interrupt Prof Webster’s work just to advise him of the rejection of his request. She would expect the rejection form to have taken 10 days to get to Prof Webster using internal mail. She did not regard the request as urgent in comparison with some types of requests that are made. There is a fast track system for cases where cancer is suspected. But Mr Coccozza’s case was not dealt with in this way.

[32] The form making the request did not specify suspected malignancy although malignancy was a possibility identified in the original ultrasound scan report. A fast track scan would be done in 2 to 3 weeks rather than the

normal 3 to 4 weeks. She thought the request for imaging should have been given medium priority.

[33] The Radiology Department is moving to an electronic system of requests and responses to those requests but that is not implemented as yet and will take another year to do so. That would be a better system. The failure that happened in Mr Cocozza's case could still happen today. The hospital trust discourages the use of email for patient correspondence as the contents would not find their way into patient medical notes unless they were printed off. Nonetheless telephone discussions with other doctors are permitted and are sometimes done.

[34] There is another form sometimes used for rejection of imaging requests although there was no copy available for the Inquiry. Some practitioners would dictate a separate note when a request was rejected. There were no guidelines or protocol in the Radiology Department about the procedure to be followed when a request for imaging was to be rejected. How rejections of requests for imaging were to be done was left to the judgement of the individual practitioner. There was therefore no consistent practice across the Department.

[35] In her view, follow-up of requests for imaging is the responsibility of the doctor making the request. The failsafe system in the hospital is follow-up appointments to be made by the requesting doctor with the patient when a check can be made to see if things have been done. She assumed prisoners get follow-up outpatient appointments like anyone else. Rejections are made in about 4% of cases.

Dr Alastair Duncan Howie

[36] His qualifications and experience are as follows. Dr Howie was a consultant physician at Stirling Royal Infirmary and the Forth Valley Hospital specialising in respiratory medicine and general medicine. He retired as a full-time consultant in 2007 becoming part-time until 2011. He presently works part-time as a forensic medical examiner two days per

week. Between 2009 and 2011, he was a part-time medical officer at HMP Glenochil on a locum basis. Dr Howie had never practised as a GP.

[37] He received specific training from the prison service as regards ACT procedures (which are concerned with assessment of risk of suicide). In his view, the medical work which he had done during his career was transferable to this role. There were also meetings for all medical officers organised by the employing agency once every two months to which he went three or four times per year over 10 years. The SPS did not provide any training documentation with regard to treatment of prisoners as patients. There was no documentation or instructions issued by the Prison Medical Service concerning the duties of a medical officer with regard to receiving new patients at the prison apart from the ACT procedures. It was left to the individual clinical judgement of the medical officer as to what to do with new prisoner patients. It is expected that the patient will update the medical officer on outstanding and current issues. In his view, all or most patients would be able to give the information which the medical officer would need. At that time, the Prison Medical Service was under the control of Scottish Prison Service. Now, the service is operated by the NHS.

[38] In December 2013, at the request of the Crown, he prepared a short report (at Crown Production 7) on his dealings with Mr Coccozza after review of Mr Coccozza's medical notes. Dr Howie remembered seeing Mr Coccozza after his transfer from HMP Peterhead. Prisoners are always seen by a doctor after transfer. The purpose is to check any current medical issues. Crown Production 4 shows the medical records of Mr Coccozza. The entry on 6 December 2010 was completed by Dr Howie. Mr Coccozza had been seen by a nurse on 5 December 2010. Dr Harry recalled that Mr Coccozza walked with a stick and had problems with his right hip. He conversed with Mr Coccozza. Mr Coccozza was calm and articulate. Mr Coccozza said he was well. He said he had no allergies. Dr Howie asked questions with regard to risk of self-harm and Mr Coccozza said he was not at risk. That was the extent of the consultation. In the medical notes, Dr Howie

recorded Mr Coccozza's condition as being "fairly well". Explaining that, he said that for a man of 78 he looked fairly well and was not acutely ill. In Dr Howie's view, he looked in reasonable health. He noted that Mr Coccozza had spent a large amount of time bedbound because of his conditions. Mr Coccozza did not volunteer that he had recently had an ultrasound scan or that further investigations were to be made. Neither did he make any reference to impaired kidney function or the lesion on his liver.

[39] Dr Howie did not review Mr Coccozza's medical records. He did not notice anything about the ultrasound scan and the results. He did not look at any of the records prepared on Mr Coccozza whilst he was in HMP Peterhead. He explained that medical officers see so many prisoners that it was not "our practice" to review everything in the patient's records unless "our attention" is brought to a problem. That would apply even to recent records and letters so that unless matters were brought to "our attention" nothing would be done. He worked on the assumption that the medical officer who had dealt with a transferred prisoner in the transferring prison has done all that was medically necessary. No one medical officer had specific responsibility for Mr Coccozza's care; that was the responsibility of the team. He accepted however that in principle, review of a transferred prisoner's medical notes could be done. If he had known about the investigations that had been started while Mr Coccozza was in HMP Peterhead, he would have contacted Prof Webster directly.

[40] Dr Howie explained that when a prisoner is transferred, there is usually a transfer letter relating to outstanding medical issues. He would have expected such a letter to have been in Mr Coccozza's records but was not there. [Such a form can in fact be seen in Mr Coccozza's medical records at CP4, pages 8 and 9. That form states that "all medication supervised as forgets to take them or takes too many". It states that the active medical problems are hypertension and raised cholesterol and CCF. No mention is made of the result of the August 2010 ultrasound scan or of the outstanding request by Prof Webster for a CT scan. The form was completed on 1 December 2010,

prior to transfer, being 3 December 2010]. Dr Howie accepted that at page 109 of Mr Coccozza's medical notes, an assessment of Mr Coccozza on his admission to HMP Glenochil had been carried out by Heather Meacham, practitioner nurse in the mental health team. That assessment records that Mr Coccozza had "problems with his short term memory", that he might "need reminding of the layout of his surroundings", that he "may need prompting to collect his meals and attend for medication, that he may need prompting to attend to his personal hygiene and get dressed". It also recorded that he "may ask the same questions on several occasions as he will not recall that he has already gleaned the information that he needs which may make him frustrated and agitated". The assessment notes that he had been referred for further assessment from the mental health team. Dr Howie accepted that this assessment was carried out three days before he saw Dr Coccozza, that it would have been in the notes but that he did not recall having seen it.

[41] In his view, the medical officer at HMP Peterhead would not be expected to have expedited the CT scan. He said that it would depend on the patient prisoner raising the issue and that if the patient did not raise the issue, he would not expect the medical officer to do anything about the CT scan until the result of the CT scan appeared. In general, prisoners are very interested in their medical condition and are keen to see a medical officer and would be able to raise any medical issues with the medical officer on transfer. So far as the medical officer at HMP Peterhead was concerned, he would only expect the medical officer to chase up the further investigations being carried out at Aberdeen Royal Infirmary if there was a change in Mr Coccozza's condition.

[42] Dr Howie accepted that Mr Coccozza, at the time that Dr Howie saw him, suffered from a number of different ailments for which he received about 15 different medications. They were as follows: a cardiac drug, painkiller, antidepressants, antihistamine, indigestion treatment, a laxative, aspirin (for heart disease), treatment for elevated cholesterol, treatment for gout, vitamins, diuretic and anti-hypertensive treatment. Mr Coccozza was aged 78. Dr Howie stated that even if he had seen all Mr Coccozza's notes at

the time that he examined him on 6 December 2010, he would still have described him as “fairly well”. He did not accept that the reference in the notes to Mr Coccozza being frail, having memory problems and dizziness was potentially referable to a diagnosis of cancer.

[43] Dr Howie had no further dealings with Mr Coccozza in 2010. On 14 January 2011, he first became aware of Prof Webster’s involvement with Mr Coccozza’s case and the investigations that Prof Webster had caused to be carried out and investigations which had not yet been completed. That was when he first saw the letter, typed on 5 January 2011, from Prof Webster, at page 108 of Mr Coccozza’s medical records. Dr Howie wrote a letter (pg 107 of Mr Coccozza’s medical records) dated 18 January 2011 to Dr Bramley, consultant gastroenterologist at Stirling Royal Infirmary after receipt of that letter briefly noting that Mr Coccozza had had an ultrasound of his abdomen showing an 8 cm lesion on his liver, that Prof Webster had planned to do a CT scan “but in view of his transfer it would seem more appropriate that this be investigated locally” and enclosed a copy of Prof Webster’s recent letter. There was no explicit reference to the delay that had occurred in carrying out this further investigation or any suggestion that there was any degree of urgency or that a malignancy was suspected. Dr Bramley had seen Mr Coccozza in his regular clinic at the prison on 14 January 2011 as a result of Dr Parish’s intervention so his letter was written after that consultation. Dr Howie agreed that malignancy of the liver was a real possibility and that if a malignancy is suspected, in general, one should investigate as soon as possible. If a lesion is found in a lung, he would expect investigations including a bronchoscopy to be completed within a total of about 2 ½ weeks.

[44] Dr Howie had no further dealings with Mr Coccozza during his lifetime. He did not think that there were any concerns that should have been raised and brought to his attention with regard to Mr Coccozza’s state of health.

[45] Dr Howie reviewed Mr Coccozza’s medical records for the purposes of the Inquiry including those around the time of death. In his view, the

cause of death was likely to have been an ICH given the symptoms exhibited by Mr Coccozza on 6 March 2011. Mr Coccozza's unequal pupils suggested a catastrophic occurrence in the brain and nothing else could explain that having come on so acutely. He did not accept that the lesion was the cause of death. He had seen hundreds of patients with carcinoma but he had never come across a case where a complication of the cancer was an ICH. He was aware of the possibility of cancer producing paraneoplastic results, leading to ICH, but never with an acutely raised blood pressure. The records were marked "do not resuscitate" which in his view was because his general condition was such that the heart should not be restarted: he was unlikely to recover from the stroke. The X-ray taken the day before death showed a lesion on the lung which was cancerous. It was clear that Mr Coccozza had suffered a bleed to the brain and was in a bad condition on 6 March 2011. The ICH was unrelated to the cancer in Mr Coccozza's lung and liver in his view. He was surprised by the content of the post mortem report as in his view he would expect the primary cause of death to be given as a stroke in Part I of the death certificate, with hypertension as a contributory cause. Cancer should be at Part II of the death certificate, being another significant condition from which he suffered at the date of death, which was a significant co-morbidity not having a direct linkage with the primary cause of death. Fatty deposits in the coronary arteries would have contributed to the stroke.

[46] Dr Howie had had a lot of experience of dealing with patients with lung cancer when he was a consultant. He had probably dealt with around 200 cases per annum, being about 6000 in his career. He agreed that the most common cause of ICH is rupture of vessels due to long-standing hypertension. He did not agree that either small cell cancers or non-small cell cancers could increase the likelihood of a stroke. Lung cancer commonly metastasises to the brain and liver. However, the post-mortem report found no metastasis in the brain. Small-cell cancer is the most malignant. All lung cancers are highly malignant with poor prognosis. The survival rate for non-

small cell cancers is 6 to 12 months. If a cancer has already metastasised it is almost inevitably fatal. Treatment for such cancers is palliative. The purpose of such treatment is not to prolong life but to alleviate symptoms and suffering. However, palliative treatment might incidentally prolong life. The chances of survival if there has been metastasis and if the patient is in poor health are nil. The symptoms of metastatic lung cancer would likely to be loss of weight, patient being off their food and a general deterioration in the patient's condition including general weakness. Sometimes there are no symptoms. Coughing blood is a common symptom but that is not recorded for Mr Coccozza. A long history of hypertension makes a person more susceptible to ICH.

[47] Because, in all likelihood Mr Coccozza had a cancerous lesion in his liver in September 2010, it is likely that at the same time, he would have had the lung cancer which was discovered the day before his death. If Mr Coccozza had received a CT scan in October 2010 and the cancerous nature of the liver had been discovered, in his view there would have been no symptoms of the cancer to palliate. In general, treatment for cancer depends on co-morbidities, the patient's views, the family's views and the advice of the doctors. Even if a cancer patient has no symptoms, there would still be a discussion with the patient with regard to treatment. In Mr Coccozza's case, if the cancer had been discovered earlier, he would have expected discussions with him with regard to treatment to have taken place.

[48] He was aware that prisoners diagnosed with terminal conditions might be released early on compassionate grounds. That would depend on prognosis (the general test was whether the patient had three months or less to live) and whether the prisoner was capable of being looked after in the community. That applied to any prisoner in HMP Glenochil in principle and would have applied to Mr Coccozza. If the diagnosis of cancer had been made earlier than it was, it was likely that there would have been discussions with regard to compassionate release soon after diagnosis of lung cancer.

Dr Cecilia Parish.

[49] Her qualifications and experience are as follows. Dr Parish was a medical officer with the Scottish Prison Service from 2009 to 2 January 2011. She was employed as a locum. She was a medical officer at HMP Glenochil and at HMP Cornton Vale. She presently works as a general practitioner. She qualified in medicine in Mexico in 1996. She has been a GP practitioner since 2008. Since 2011 she has been employed as a GP in a practice in Fife working full-time. At the time that she worked in HMP Glenochil, the role of medical officer, which is equivalent to that of GP, was not covered under the general NHS contract.

[50] Every prisoner has to be assessed within 24 hours of arrival at a prison, or 72 hours if transferred. The purpose is mainly to check for suicide risk as well as checking on medication and medical needs. There was no training provided by the SPS as to the way in which that initial assessment was to be done. The only training provided was as regards risk of suicide.

[51] In Crown Production 4, page 2, is found the "SPS Healthcare Records Summary Sheet" which should provide a "summary of important illnesses, investigations and allergies". That is to be completed by a medical officer. When she first saw that sheet on 20 December 2010, all that had been entered there, on two dates in 2009, was the following: "Hypertension", "hypercholesterolemia", "CHF" [congestive heart failure] and a reference to a right hip replacement and revision. On 20 December 2010, which was the first time she had seen Mr Coccozza's records, she became involved at that stage because a nurse had alerted her to an error made as regards flu vaccination: Mr Coccozza had been asked whether he had had the flu vaccine; he said he had not, and so the vaccine was given to him. The nurse noted afterwards from his medical records that he had previously received the flu vaccine.

[52] As a result of that error, Dr Parish carried out a full review of Mr Coccozza's medical records around 29 December 2010. (The reference in CP 4, at page 30 to that review having been done on 23 December she said was

erroneous and the date at page 31, being 29 December 2010, was correct). She spent about 45 to 60 minutes going through the records. She noted that Mr Cocozza had medical issues which had not been addressed properly in her view being CHF, kidney failure, memory problems, history of alcohol abuse, chronic back pain, gout and problems of comprehension. She added to the medical notes and the summary sheet that day in those terms. While carrying out that review, she saw the earlier correspondence from Prof Webster and discovered that the CT scan requested by Prof Webster had not been carried out: Mr Cocozza had been “lost in follow up”. She phoned Prof Webster and spoke to his secretary that day. She understood that there had been a provisional diagnosis of hepatoma, being primary liver cancer. She could not now recollect exactly where she obtained that understanding. She also made an appointment for Mr Cocozza to see Dr Bramley at his regular surgery in HMP Glenochil. She regarded the situation (suspected cancer and investigations not followed through) as urgent.

[53] It is part of the GP general services contract that a full review and summary of all patient records is done for every patient within eight weeks of taking on a new patient. The first-time interview is a staple of GP practice. GP practice should be the same in prison as it is in the community but all GP practices do things differently. It is a matter for the individual GP how the first interview is to be dealt with. Her practice is to take 10 to 20 minutes for the first interview but it might take longer. Following the interview, she prepares a care plan for the patient noting what actions required to be taken to help the patient. If there are ongoing medical issues, she would note that in the summary form which is a standard part of the prisoner medical records. However, that contract did not apply as regards patients in the Scottish Prison Service at that time. There was no such rule in the prison. She thought it would be a good idea to do that. The electronic system used by the prison service at the time had a facility for the noting of a summary of the patient’s conditions but that facility was disabled. Therefore it had to be done in writing. She understands that records in prisons are now largely

paperless so that there is no access to older paper records unless they are requested. All patient records are kept within the prison. The NHS took over the prison medical service from November 2011.

[54] Following her review of Mr Coccozza's medical notes, she made a referral to the mental health team because she was concerned about Mr Coccozza's core memory, his lack of understanding, his reduced coordination and cognitive impairment. This was what the nurses dealing with Mr Coccozza within the prison had told her. She sought a cognitive impairment assessment to be done by a psychologist. Mr Coccozza was only the third prisoner in two years for whom she had requested a cognitive assessment. That did not appear to have been done. Mr Coccozza saw a mental health nurse not a psychologist. But a mental health nurse cannot assess capacity so he was never psychologically assessed. The ACT assessment that was done on Mr Coccozza, as it is done for all new prisoners, is purely focused on suicide risk. It is not concerned with any other type of examination of the patient's mental condition. Mr Coccozza's memory loss had been noted shortly after Mr Coccozza had been admitted to the prison which can be seen from the records. Due to his memory loss, she would have had difficulties in relying on Mr Coccozza's account of his medical history. She expressed that concern to the health care managers on 29 December 2010. She expressed concern that he was being given medication without supervision. She noted that whilst he was in HMP Peterhead, his medication had been supervised. After Mr Coccozza had been seen by Dr Howie, Dr Howie changed the administration of medication from supervised to unsupervised. She did not know why he did this and never discussed it with him. She changed Mr Coccozza's medication so that it was "strictly supervised" because of her concerns about Mr Coccozza's understanding.

[55] She said that Mr Coccozza was not capable of looking after himself. Mr Coccozza did not seem to show much awareness of his medical condition. Some doctors simply ask the patient whether they have medical conditions and if the patient's answer no, that is taken at face value. However, prisoners

have very “fruitful imaginations” when giving their health history which means their accounts cannot be relied on and record should be checked. However, if a prisoner has been less than six months in prison, records may simply not be available.

[56] She would not have described Mr Coccozza as “fairly well” when she reviewed his records. He was systemically well in the sense that he was not acutely unwell. That was an end of her involvement with Mr Coccozza as she left the Scottish Prison Service very shortly afterwards.

Dr David Sadler.

[57] His qualifications and experience are as follows. Dr Sadler is a forensic pathologist. He is a senior lecturer in the Department of Forensic Medicine at the University of Dundee and has been senior lecturer there since 1996. He qualified in 1986 in medicine and as a pathologist in 1987. He is a member of the Royal College of Pathologists. Pathology has been his specialism for most of his career. He does around 200 to 250 post-mortems per annum and does them under contract with the Crown through Dundee University for the Tayside area. He is used to giving evidence in court and providing reports for court purposes. Most deaths he deals with are natural deaths or suicides.

[58] He was instructed by the Crown, together with Dr Clifford Perera, to carry out an autopsy of Mr Coccozza. The autopsy was carried out on 10 March 2011. Dr Perera was the lead pathologist and Dr Sadler was the second pathologist. The lead pathologist consults with the second pathologist as to when the autopsy is to be done. The lead pathologist takes the lead on recovering notes and arranging for the attendance of police at the autopsy. Both pathologists are there for identification of the body. The lead pathologist does the external examination of the body and dictates findings. When that is finished, the second pathologist reviews the findings of the first pathologist before the internal examination is carried out. The lead pathologist takes photographs of the body including lesions and scars. After the external examination, both pathologists review and discuss the plan for

the internal examination. The evisceration of organs and dissection is done by the lead pathologist; the second pathologist is there to discuss anything arising and is there at the end of the examination to discuss findings with the lead pathologist. Together, the two pathologists then formulate their views on the cause of death and whether further investigations are needed. The lead pathologist may take photographs of the internal body. The lead pathologist compiles the post-mortem report from dictation which is then revised and passed to the second pathologist for review and discussion. The post mortem report is prepared, signed sent to the procurator fiscal and represents the concluded view of the two pathologists. What is provided at this stage is a summary report comprising no more than three pages. A full report may be prepared later on request, as was done in this case.

[59] Dr Perera returned to Sri Lanka in late 2011 or early 2012 after having been in Scotland for about two years. While in Scotland, Dr Perera was not undertaking autopsies full-time. He had a clinical practice on which he spent most of his time. At the time of Mr Cocozza's autopsy, Dr Sadler was satisfied that Dr Perera was competent to deal with autopsies but he is not sure now as a result of this case. There had been no previous problems concerning Dr Perera.

[60] Crown Production 2 is a copy of the initial post mortem examination report prepared by Dr Perera and Dr Sadler dated 15 March 2011. The full post mortem report (Crown production 11) was compiled shortly before the commencement of this Inquiry on 19 December 2013. It was compiled by Dr Sadler based on Dr Perera's dictation and review of the photographs taken by Dr Perera. He had difficulties in preparing the full report as the histological samples (samples taken for examination under the microscope) had been disposed of. There would have been histological samples of the lung, liver and brain. Further, the internal photographs of Dr Cocozza's body were incomplete. There were only photographs of the liver, not the lung or brain. There were no other photographs available. He would have

taken more if he had been the lead pathologist. He suspected they were never taken.

[61] At that time, the policy with regard to retention of histological samples was that they would not be retained for longer than they needed to be. They used to be disposed of about two years after the autopsy. In Mr Coccozza's case, the destruction of the samples took place shortly before he went to look for them in 2013. The samples were destroyed even though it would have been known that an FAI was mandatory. The second full report therefore was prepared relying on incomplete records. The full report includes the whole of the contents of the initial report. Now samples are kept indefinitely where autopsies involve two pathologists unless they are marked for disposal.

[62] At page 1 of the full report, the cause of death as appearing on the death certificate prepared following the post-mortem examination is given as follows: "I. (a) complications of a metastatic carcinoma." No other cause is given. There was no mention of a stroke or ICH as a cause of death in the initial post mortem report. Dr Sadler accepted that the report had underplayed the clinical significance of the ICH which deserved a lot more description and inclusion as a cause of death.

[63] Prior to Dr Sadler giving evidence at the Inquiry, he and the procurator fiscal depute had entered into certain amount of correspondence regarding the contents of the post-mortem examination report in the light of contrary views as to the cause of death expressed by others including Prof Webster. Dr Sadler had an opportunity of careful and detailed consideration of the contrary views expressed by others as regards the findings in the post-mortem examination report, the accuracy of the report and the conclusions as to cause of death. In the light of that further information and opinion, he altered his views on the cause of death and did so more than once during his evidence. His final views are given below.

[64] The findings of the post-mortem were that there was no doubt that Mr Coccozza had a lung tumour and there was little doubt that he also had a

liver tumour. As regards criticisms made by Prof Webster of the post-mortem report, he accepted that the account given at page 2 as regards the history of admission by Mr Coccozza to Stirling Royal Infirmary was not correct. He did not himself review the medical records in relation to his admission to Stirling Royal Infirmary, but those records would have been available at the time of the autopsy. The report fails to mention that Mr Coccozza had a pacemaker but Dr Sadler accepted that Mr Coccozza may have had one and that it was taken out and his colleague forgot to mention it. He accepted that the post-mortem report incorrectly said that the tumour was on the right lobe of the liver but said that it would not matter as there were no pathological consequences. He accepted that the site of the ICH was on the left side of the brain according to the hospital CT scan record and not on the right-hand side as stated in the post mortem report. In his view, it was likely that the cancer originated in the lung which then metastasised into the liver, though without the histological report and samples, which should have been undertaken, one could not be certain. There was no metastasis into the brain. Therefore the stroke could not have been a result of bleeding by a metastatic tumour into the brain. He accepted that the description of the heart being of normal size or shape was incorrect as a weight of 549g is much higher than the normal maximum of about 400 g. The likely cause of the enlargement was hypertension.

[65] As regards the use of the term “non-small cell cancer” in the post-mortem report, that is a misleading term in his opinion and is not a term that he uses. Although the report uses that term, he signed the report without finding out what it meant. He did not think that that term was meaningful as it comprises three different types of cancer. Different cancers behave differently. He thinks that the term “non-small cell cancer” may have been a typing error but given the passage of time and the lack of records, he cannot be sure now. The difference is significant because small cell cancers behave differently to other types of cancer and are capable of producing variable

clinical phenomena (paraneoplastic syndrome) which might have contributed to the ICH.

[66] Dr Sadler accepted that there was no mention of the size of the ICH, which there should have been. From the hospital scan of the brain, he estimated its size at 3 cm which is quite large. The brain was much heavier (1453g) than normal which was probably due to additional blood in the brain caused by the ICH

[67] In his view there was a causal connection between the cancer and the ICH. The physiological effect of the lung and liver cancer was extensive. The lung cancer would have blocked airways and reduced aeration of the blood. Blocking of airways and blood vessels produces mechanical effects reducing function. The x-ray taken on 6 March 2011 shows a lung tumour rather larger than the 4 cm tumour noted in the post-mortem examination report and in his view was large enough to contribute to death. The liver tumour is recorded in the post mortem report being 13 x 7 cm but it appears from a photograph of the liver taken by Dr Perera, that the tumour was larger, occupying around half of the liver mass. That too would have contributed to the ICH and death. The liver tumour might have had an effect on blood clotting and could have increased the risk of haemorrhage and the ICH. The liver tumour is likely to have been a major factor in the development of the ICH.

[68] Under cross-examination, Dr Sadler accepted that Mr Coccozza was first admitted on 6 March 2011 to SRI and his symptoms indicated that Mr Coccozza had suffered a stroke that day. He was not able to dispute Prof Webster's conclusion that the prothrombin time, (which is a measure of the blood clotting factor), was normal at the time of Mr Coccozza's admission to hospital on 6 March 2011. He was unable to explain how, given Mr Coccozza was suffering a stroke at that time and his prothrombin time was normal, the liver cancer might have contributed. He suggested that the clotting problem had arisen before the stroke started but then righted itself once the stroke had commenced but was not very confident about that suggestion. He

agreed that if Mr Coccozza had had blood clotting problems, visible bruising elsewhere on the body would have been likely, but that his examination showed no such bruising. Dr Sadler's final opinion as regards cause of death was as follows "I. (a) complications of metastatic cancer of the lung and hypertensive ICH".

[69] With the benefit of hindsight, he says that he ought to have taken the lead at the autopsy, he ought to have prepared a full report providing his full findings at the time of examination and not 2½ years later and many more photographs ought to have been taken. More histology samples should have been taken and none should have been disposed of. A more careful check should have been made as to the site of lesions in the organs. The report should have noted the removal of the pacemaker and the cause of death ought to have been clarified with regard to the contribution of the ICH. If this enquiry had commenced much earlier than it did, there would have been a better chance of the samples not having been disposed of.

Dr Peter Bramley.

[70] His qualifications and experience are as follows. Dr Bramley is a consultant physician in gastroenterology, including hepatology, at the Forth Valley Hospital for the Forth Valley Health Board. He provides a service to prisoners at HMP Glenochil and HMP Cornton Vale. He has been a consultant with Forth Valley Health Board for 19 years, first qualifying in medicine in 1985. He has the usual medical qualifications appropriate for a physician in his position.

[71] He dealt with Mr Coccozza in 2011. He produced a report, Crown Production 10, as regards his involvement with Mr Coccozza which report is based on records and his personal recollection. On 14 January 2011, his secretary received a phone call from Dr Parish seeking an appointment with him for Mr Coccozza on an urgent basis. He also received a letter dated 18 January 2011 from Dr Howie concerning investigations which had been started but not completed by Prof Webster in Aberdeen. On 19 January 2011, he saw Mr Coccozza in his prison clinic and saw letters written by Prof

Webster together with the results from Aberdeen Royal Infirmary. At the end of the clinic, he discussed the case with Dr Howie and said that he had seen Mr Coccozza and would be ordering a CT scan.

[72] On the same day, he wrote a "clinic letter", for the purpose of creating a record for Mr Coccozza's medical records, noting the liver lesion, that Mr Coccozza appeared frail using a stick, was difficult to mobilise on the couch and that Mr Coccozza had multiple medical issues but appeared to be clinically stable. He noted that the tumour markers (alpha fetoprotein and CEA), were largely normal. The letter stated that if the lesion was malignant, Mr Coccozza might not be suitable for any intervention due to his state of health, though palliation measures might be suitable. The letter stated that Mr Coccozza was "obviously in poor health". (He accepted that that description was difficult to square with his own entry in Mr Coccozza's medical notes made at almost exactly the same time being: "health OK"). He said he would see Mr Coccozza back in his clinic once the results of the CT scan were known in the next 6 to 8 weeks. He told Mr Coccozza that a lesion had been seen in his liver which was possibly benign and that further investigations would be performed.

[73] That letter was addressed to the medical officer at Glenochil. Although dictated on 19 January 2011, it was not typed until 20 April 2011, some three months later, by which time Mr Coccozza was dead. A postscript to the letter that he dictated was added by his secretary regretting the death of Mr Coccozza. That three-month delay was normal for letters which were not marked urgent. If he had marked the letter urgent, it might been typed in 2 to 4 weeks.

[74] On 19 January 2011, he completed and submitted a form to the Radiology Department at the Forth Valley Hospital. He agreed that investigation of the liver lesion was a priority as a matter of proper medical practice. Since the purpose of the scan was to attempt to exclude the possibility of cancer, the request for the scan was urgent. His request was for a CT scan without contrast due to the renal impairment (which was exactly

the same request made by Prof Webster some months before, which was rejected by the Aberdeen Royal Infirmary Radiology Department). His view was that although a CT scan with contrast would produce a better image than one without contrast, nonetheless, it would still produce information of use, such as an indication as to whether the growth had increased in size since the ultrasound scan. His desire was to obtain a scan, with or without contrast, leaving it to the Radiology Department to decide whether to use a contrast medium. He considered whether to request an MRI scan but decided not to because it was an arduous process.

[75] That request was received by the Radiology Department on 24 January 2011. On 25 January 2011, that request was rejected by the Radiology Department on the grounds that the CT scan would not show anything of use. (That of course was the same conclusion as had been made by the Aberdeen Royal Infirmary Radiology Department some months previously). It was recommended by the Radiology Department that an MRI scan be considered if the patient was suitable. On 14 February 2011, Dr Bramley completed the standard form for assessment of suitability for a patient to undergo an MRI scan. Question 2 asked the patient whether he had a cardiac pacemaker. Mr Coccozza said he had not. It appeared from the other questions that Mr Coccozza was suitable for an MRI and the form was returned to the Radiology Department on 14 February 2011. An appointment was then made for Mr Coccozza to have an MRI scan on 4 March 2011.

[76] On that day, the MRI scan was not carried out because the radiographer discovered that Mr Coccozza had a pacemaker. Dr Bramley did not know Mr Coccozza had a pacemaker because Mr Coccozza had said that he had not and even when he reviewed Mr Coccozza's medical notes for the purpose of this enquiry, he could find no reference to his having a pacemaker. Thus, nearly a further month elapsed from the time that he saw Mr Coccozza to the time that an appointment was made for Mr Coccozza to have a scan, that scan to take place about six weeks after having seen Dr Bramley.

[77] Mr Coccozza died before a further scan could be organised. Having now seen a photograph of the diseased liver, Dr Bramley's opinion was that even with the tumour of that size, there may have been no effect on liver function and that is evidenced by the liver function tests carried out when Mr Coccozza was admitted to Stirling Royal Infirmary on 6 March 2011 which showed that the albumin levels were normal and that the clotting protein was normal so that the tumour had no effect on those functions. A liver might operate normally even with 80 to 90% of liver disease.

[78] In general terms, once a patient has been diagnosed with cancer, there is a multidisciplinary team meeting set up to treat the patient and decide on next steps. In the case of Mr Coccozza, palliative care might have been the only realistic possibility. Palliative care has the potential to improve life expectancy even though that is not its purpose. In the case of a stage 4 cancer, (that is with a spread to the liver from the primary site) in the case of non-small cell cancer, the median survival rate is 6 months from diagnosis. In small cell cancers, the median survival rate is 8 to 13 months from diagnosis. The term "non-small cell cancer" is in common use: it is the main term which is in use to describe certain types of cancers. There is a recognised clinical distinction between "non-small cell cancers" and "small cell cancers".

Dr James Alexander Grant

[79] His qualifications and experience are as follows. Dr Grant retired from full-time practice as a GP in 2013. He is a fellow of the Royal College of General Practitioners and was made MBE for services to community health care in Scotland. He has a very varied experience in medical practice so his career has not been typical of the general practitioner. His practice involves spending a significant amount of time with patients with cancer. He was formerly employed by Tayside Health Board to review standards of health care of prisoners. Until June 2013 he was senior partner in general practice in Auchterarder and had special responsibility for St Margaret's Hospital which is a 14 bed community hospital providing high-quality rehabilitative

care, palliative and hospice care. Since Tayside Health Board assumed responsibility for provision of medical care within the prisons in its area, he has been spending one or two days per week at HMP Perth and HMP Castle Huntly. He has been examining the problems concerning medical care of prisoners and examining improvements so as to attempt to bring their quality of care closer to that found generally in the community. That task is a major challenge.

[80] He was not involved in any aspect of the care of Mr Coccozza. His evidence concerned standards of care within the prison service generally and in the community. His evidence also concerned his opinion as an independent practitioner concerning the standard of medical care received by Mr Coccozza as well as his opinion on Mr Coccozza's cause of death.

[81] In general terms, the aim of provision of care for those approaching the end of their life is to provide a high standard of palliative care using drugs in complex combinations to maximise quality of care and reduce side effects as much as possible so as to provide optimal quality of care till the end of life. Good quality palliative care may relieve pain and provide a quality of environment and access to friends which may incidentally extend life by giving the patient more to live for. Early diagnosis of terminal conditions is absolutely fundamental. If the disease is cancer, it is important that one does not miss symptoms. A patient suspected of having cancer should be referred for the earliest possible diagnosis. Once diagnosis is made, the physician enters into detailed discussion with the patient concerning treatment, whether curative or palliative.

[82] Dr Grant examined all Crown productions for the purposes of giving evidence at this enquiry. He estimated the lung tumour was about 10 to 12 cm in size. The effect of that would depend entirely on what vessels and structures within the lung had been impacted by the tumour. It is possible, even for a tumour of that size, that no major effects might result. Symptoms of cancer generally might include tiredness, loss of weight and a look of exhaustion. Mr Coccozza had no evidence of coughing blood or

breathlessness. His symptoms were vague and general, which can occur in cases of cancer. In his opinion, it is for that reason, when a man in Mr Coccozza's position complains of such vague and general symptoms, an x-ray of his chest should have been carried out at a much earlier stage. If an x-ray had been done of Mr Coccozza's chest in 2010, it is very likely it would have shown the lung tumour.

[83] By 29 December 2010, Mr Coccozza was anaemic, his red blood cell count was down, he was confused and obviously not particularly well. Many general practitioners would probably have repeated bloods and have arranged for an x-ray at that point, which would have been a very reasonable thing to do. Dr Grant would have been very surprised if on examination there had been no sign of a lung tumour by the end of 2010. If cancer had been diagnosed around that point, he would have been sent to an oncologist and a biopsy would have been taken of the tumour which would have identified whether the cancer was small cell or another type. That is essential to be able to properly discuss options with the patient. Chemotherapy can be offered for lung tumours, depending on the cell type. Given the site of the lung tumour, there was no possibility of surgery. Radiotherapy is not usual for lung cancer. The earlier cancer is diagnosed the better and the greater the chance of living longer.

[84] With regard to the investigations carried out while Mr Coccozza was in HMP Peterhead, in his opinion, it was appropriate to have requested the CT scan. It was reasonable to conclude that there was a risk of cancer even at that point since in Mr Coccozza circumstances one should conclude that the lesion on the liver was malignant until proved otherwise. Mr Coccozza ought to have had an urgent CT scan within two weeks of the result of the ultrasound scan. In his view, the physician who orders investigations has responsibility to see that the investigations are carried out, to be cognisant of the results and to carry out any further treatment needed. In his own practice, he has "safety netting" procedures to ensure that follow-up is not

lost. If there had been a CT scan even without contrast, the doctor would still have obtained some useful information.

[85] That Mr Cocozza was examined by Dr Howie on 6 December 2010 and described by him as “fairly well” suggests that Dr Howie felt that Mr Cocozza was not complaining and had no concerns about him when transferred. It is surprising that Mr Cocozza did not mention the unfinished investigations but it may be that he did not know that there were to be further tests. In his experience, prisoners’ account of medical history is likely to be unreliable as prisoners have active imaginations when describing their medical history. Therefore one needs information from the records to be sure.

[86] The need for further investigation remained urgent. The CT scan had not been done in Aberdeen and Mr Cocozza had been transferred to HMP Glenochil. However, judging by the entry of 14 January 2011 in Mr Cocozza’s records, there is no suggestion of urgency and he had to question why that was so. The possibility of probability of malignancy had been first raised three months before that date yet it appears from the records that the request was just for a routine non-contrast scan. By February 2011, Mr Cocozza was suffering from further non-specific symptoms which could have been related to anaemia. He obviously was not well and obviously had not been right for some months. His history suggested that he needed urgent scanning to see what the problem was

[87] It was difficult to comment on Mr Cocozza’s memory because no objective assessment had been done of that. A standard GP tool is a ‘mini-mental health test’ which involves asking a series of questions of the patient producing a score out of 30. A score of 22 or less is significant, meaning there has been some loss of memory. It is a very useful screening tool. A trigger for such an assessment would be if the patient forgets to come to the window for medication or forgets when to get it.

[88] Within prisons, all new prisoners are seen within 24 hours by a nurse at least. The ACT check is done. In an ideal world, the GP would do an

assessment of the patient's medical history, assess whether he needs detoxification, write up notes and make any necessary referrals. There ought to be transfer documentation accompanying any prisoner transferred from one prison to another. In Mr Cocozza's case there should have been a transfer document completed to flag up the scan issue. It would not have been difficult to do. Dr Parish's summary of the relevant medical background of Mr Cocozza was very useful. He believed that that should be done in a standard format known to all so that any practitioner could see what needs to be done. The existing transfer form is inadequate. Similarly, the list of drugs taken by the prisoner are "not attached to the problem". This is a systemic issue in prisons, so there is no linkage between the drugs being taken by the prisoner and the reason for the drugs being taken on the computerised file. In prison, records are only partially held electronically so one still has a huge pile of paper as regards any patients. One cannot trust the computer system therefore since not everything is in it. An endemic problem in prisons is lack of continuity which increases greatly the problems of providing adequate care. In principle however a prisoner is entitled to the same form of care to the same standards as any person in the community. That is a fundamental value.

[89] In his opinion, the primary cause of death was an ICH secondary to poorly controlled and long-standing hypertension. A contributory cause of death was primary pulmonary carcinoma with secondary metastasis to the liver. He reached that view having regard to the notes. In particular, the detailed notes regarding Mr Cocozza's presentation on 6 March 2011 concerning Mr Cocozza's pupils changing in size as the day went on is indicative of the ICH having already occurred and developing. That was the cause of death and was the primary cause. The fact that Mr Cocozza had the tumour was contributory but was not the cause of death unless it can be shown that the bleeding that had occurred in the cerebellum was as a result of metastatic spread. But there is no evidence for that. Hypertension is a recognised major contributor to ICH. Prolonged hypertension leads to

enlargement of the heart. A post-mortem examination revealed a very much larger heart than normal.

[90] As regards symptoms, Mr Coccozza is noted to have been debilitated. If one has secondary cancer the classic symptom is loss of weight and anaemia leading to tiredness. That is implied in most cases of cancer. The dizziness, memory loss and weakness that Mr Coccozza had been complaining of before his death is associated with cancer. Those symptoms were contributory to the ultimate cause of death. In the general case, even if symptoms had not been documented, one would expect a patient with lung cancer as large as Mr Coccozza's, to have such symptoms. In his view, given the symptoms that Mr Coccozza had been complaining of for some time, the "diagnostic antenna should have been twitching" from September 2010 onwards.

[91] However, Dr Grant was of the opinion that even though there had been undue delay in carrying out diagnostic tests to reveal the cancer from which Mr Coccozza suffered, there probably would have been no difference to the outcome. Given Mr Coccozza's age, medical background, co-morbidities and the spread of cancer, a person in that condition would not respond well to treatment. He would probably still have died within a relatively short time. However, if offered palliative treatment, there is always the possibility that his life might have been extended by a few more months.

[92] It was completely impossible to say that if he had not had cancer, he would have had the stroke (ICH), in any event. All one can say is that a person with raised blood pressure has a higher risk of a stroke but one cannot say when it will occur. A person in Mr Coccozza's circumstances had higher risk factors but one cannot say when a stroke would have been likely to occur. The tumour probably increased the likelihood of a stroke. That is because of anaemia, resulting from the tumours, resulting in hyper-dynamic circulation meaning that the heart has to work harder putting pressure on circulation, thus increasing the chance of the stroke. It was clear to him from the medical records that Mr Coccozza had anaemia.

[93] Concerning improvements that should be instituted within the prison medical service, there should be a computerised system of record documentation such as DOCMAN to ensure follow-up and review of patient care, which should be checked on a daily basis. Patients in prisons need patient advocates. Sir Harry Burns¹ said that prisoners are the most deprived medically in Scotland. Prisoners are not the easiest to provide advocacy for and he can understand why it is difficult to attract doctors to work within the prison environment. Patient advocacy is an important role for GPs in the community. He believed that the lack of patient advocacy in prisons may have led to a lack of alacrity in dealing with Mr Cocozza's symptoms. When he went to work in HMP Perth, he was shocked by how poor things were and how high the turnover was among doctors and nurses. The role of medical officer in the prison needs to be made more attractive so as to help improve the quality of medical services offered to prisoners.

Submissions

[94] Following the conclusion of evidence, I asked for written submissions and fixed a hearing to consider them. I also asked the parties make submissions, if they saw fit, on the reasons for the delay in the petition seeking this mandatory Fatal Accident Inquiry being lodged at Alloa Sheriff Court (more than two years after death) and the impact on the proceedings that that delay may have caused. I also asked the parties to make any submissions they saw fit as regards the significance, if any, of the compassionate release provisions contained in section 3 of the Prisoners and Criminal Proceedings (Scotland) Act 1993. I would like to express my gratitude to each one of the three representatives for having prepared and circulated their submissions within the specified timetable and for the very detailed and considered nature of the submissions, all of which have been of considerable assistance to me. I do not consider that it is necessary for me to repeat those submissions in detail given that they have been made in writing, are lodged in court and have been discussed in the public hearing

¹ Chief Medical Officer for Scotland 2005 to 2014

set aside for that purpose. I think it suffices for present purposes to summarise very briefly the essence of the submissions for each party. All parties were agreed that Mr Coccozza died on 7 March 2011 at 07.30 at Stirling Royal Infirmary (though in fact, the hospital records state that death was at 07.25, that statement being noted at 07.30). It was the findings that should be made under section 6(1)(b) [cause of death], s6(1)(c) [reasonable precautions], s6(1)(d) [defects in system of working] and s6(1)(e) [other factors relevant to circumstances of death] that were contentious.

Crown submissions.

[95] Section 6(1)(b). The cause of death should be given as: "I. (a) Intracerebellar haemorrhage; (b) metastatic effects of carcinoma; 2. Hypertension". Alternatively: "I. (a) ICH. 2. Metastatic effects of carcinoma." The mechanism of death was ICH. But a mechanism has underlying causes and the undiagnosed cancer was on the evidence a significant contributor to the ICH and was therefore part of the cause of death. There is a compelling common sense view that to exclude the cancer from the cause of death is to underplay the role of the cancer. The failure to diagnose cancer raises a large number of issues of public concern. The failure was due to lack of urgency, lack of follow-up, unnecessary delays, systems failures, and unreasonable reliance on Mr Coccozza for an accurate medical history.

[96] Section 6(1)(c). On the footing that the cancer was a factor contributing to Mr Coccozza's death, the correct question to ask is whether the death might, not would, have been avoided. That means lively possibilities, not probabilities. One applies the wisdom of hindsight and looks to the future. If Mr Coccozza had had a chest x-ray or CT scan in October 2010 or later, the cancer would likely have been diagnosed by October or November 2010. If there had been proper communication systems at Aberdeen Royal infirmary between Prof Webster and the Radiology Department, timely further imaging would have taken place. Time is of the essence where cancer is suspected. If Prof Webster had indicated a greater urgency for a scan when he wrote in December 2010, an

earlier scan might have taken place. If the cancer had been diagnosed earlier and the cancer treated, it might not have contributed in the same way to the ICH. The delay in diagnosis led to a loss of options of treatment which might have avoided or delayed death.

[97] Section 6(1)(d). The principal defect in system of work was failure of communications among medical practitioners and the system of work did not clearly allocate who had responsibility for deciding on the level of urgency.

[98] Section 6(1)(e). In addition to matters relevant to the previous headings, the following are matters of public interest and are relevant to the death. Medical records should contain summaries of the prisoner patients' medical conditions. Transfer arrangements as regards medical records need improved. The delay in the scans taking place both while Mr Coccozza was at HMP Peterhead and at HMP Glenochil and the lack of urgency in investigation in taking place are of public interest. The lack of clarity as to who has responsibility for prioritisation is of public concern as is the reliance by hospital medical staff on prisoners for their medical history.

[99] The Crown made a number of suggestions for recommendations to be made by the Inquiry in order to deal with the various shortcomings identified in the evidence.

[100] As regards the delay in presenting the petition to fix this FAI, it was submitted in writing as follows. "Letters were sent to the family explaining procedures regarding mandatory FAIs. They did not respond to these and it became apparent they did not wish involvement. The case required lengthy investigations including consideration for conjoining with another cancer death in custody [also at HMP Glenochil]. It was necessary to make enquiries with suitable medical witnesses to identify the appropriate expert to give an expert report in both cases. After reports were obtained, conjoining was considered then ruled out and separate FAIs were fixed. The Crown regrets that investigations took a longer period of time than would be preferred, but would point out that the court should take account of the tension which exists between time, accuracy and appropriate proceedings and the need for investigations in the interests of all parties and the court. In addition investigation of the present case occurred at a time of changes taking place within [Crown Office and Procurator Fiscal Service]. These changes are expected to speed up

investigations in future cases.” The procurator fiscal depute was asked if he could elaborate on this written submission but he declined to do so.

[101] As regards the question of compassionate release, it was submitted in writing that the issue was not raised by any party to the hearing nor was it intimated to other parties who might have had a relevant interest. In any event, that issue would involve elements of speculation and therefore would be inappropriate for comment. Responsibility for terminally ill prisoners is a relevant issue only once a terminal condition is diagnosed. This was not relevant to the circumstances of the present case [because, I assume, no diagnosis was in fact made timeously]. The procurator fiscal depute was asked if he could elaborate on this written submission but declined to do so.

[102] Finally, the procurator fiscal depute helpfully supplied a three page note summarising the relevant law applicable to FAIs generally. Useful though that note is, there is nothing contentious in it. The other parties and indeed myself accept the various legal propositions set out therein. I have referred to some of those matters at the outset of this determination and I do not think it necessary to further elaborate on those legal principles in the circumstances.

Submissions on behalf of the Scottish Prison Service.

[103] The principal thrust of the submissions was that Mr Coccozza died from an unpredictable ICH that was unrelated to the metastatic cancer and therefore the Inquiry should make formal findings only. As regards section 6(1)(b), the cause of death was certainly the ICH. What cannot be said with any certainty is that the cancer was connected to the death. The weight of evidence was firmly against that.

[104] Even if the cancer did in some way contribute to the death, there was no way of predicting the fatal ICH. Even if the cancer had been diagnosed earlier, he would have received no treatment as there were no symptoms to palliate and he would have died when he did even if the cancer had been diagnosed when it was. As regards section 6(1)(c) and (d), no reasonable precautions could have avoided the death happening and no defects in the

system of working contributed to his death. It was accepted that it might have been possible for Mr Coccozza's cancer to have been diagnosed before the end of 2010. By then however he had aggressive metastatic cancer with multiple comorbidities but was nonetheless asymptomatic. No curative treatment was possible. Palliative care would have made no difference. The stroke was unpredictable and fatal. An earlier diagnosis of cancer would not have prevented the fatal ICH. Therefore there were no reasonable precautions which could have avoided death and neither did any possible defects in the system of working contribute to death.

[105] While a number of issues were raised at the Inquiry which might be seen to be in the public interest to consider under section 6(1)(e), none of those issues are relevant to the circumstances of death and therefore no findings should be made under that heading. Even if the Inquiry does consider that those issues are relevant to the circumstances of death, the determination should note that changes have been put in place since the death of Mr Coccozza and furthermore that the Scottish Prison Service no longer provides medical services within prisons.

[106] The SPS had no submissions to make with regard to the delay in presenting the petition to establish this FAI.

[107] As regards the issue of compassionate release under section 3 of the 1993 Act, it was submitted orally as follows. The Scottish Prison Service is not the only body concerned with compassionate release: both the Scottish Ministers and the Parole Board are involved. The SPS has a policy concerning how compassionate release under section 3 is to be dealt with which is as follows. The starting point for consideration of compassionate release under section 3 is actual knowledge of a terminal illness by the prisoner or a family member or a medical officer. In Mr Coccozza's case, no-one had any knowledge of his terminal illness until he was at the point of death, so compassionate release could not have taken place on the facts in this case.

[108] Had an earlier diagnosis of Mr Coccozza's terminal cancer been made, an application seeking compassionate release under section 3 could have been initiated. That process, taken as a whole, takes a minimum of four weeks to come to a conclusion. The process is triggered by knowledge of a prisoner's terminal illness. The Scottish Prison Service Headquarters Health Branch is then informed. That leads to a multi-disciplinary case conference. There, consideration is given to the nature of the illness, the prognosis, the available treatment, the degree of "incapacitation" from which the prisoner suffers (which the SPS solicitor interpreted as incapacitation resulting from the illness, rather than any other cause) and whether there are suitable community facilities. Then an application for compassionate release is submitted to the PLSRD² and the advice of the Parole Board is sought. The Scottish Ministers would then make the final decision as to whether to order compassionate release. The policy is that a life expectancy of 3 months or less may be considered as appropriate to trigger compassionate release.

[109] Mr Coccozza, had no incapacitation as a result of the cancer so that would tend to point away from the possibility of his being eligible for compassionate release, had the policy been applied to him. Even if it had been known earlier that Mr Coccozza was suffering from terminal cancer, and even if the section 3 policy been applied, it is impossible to say whether the decision would have been to release him on compassionate grounds. That decision is a discretionary one taken by the Scottish Ministers (in practice, by the Justice Minister) and depends on consideration of a large number of variables, impossible to ascertain hypothetically and on which no evidence has been led in this Inquiry. The most that can be said is that had Mr Coccozza's metastatic cancer been diagnosed much earlier than it was, he *might* have been eligible for compassionate release. On the facts, the earliest that a decision in his favour could have been made was February 2011. The decision may well not have been in his favour; it is doubtful on the evidence

² The SPS solicitor said she did not know what this acronym stood for but I understand it may be the Parole and Life Sentence Review Division (of the Scottish Executive Justice Department), which advises the Scottish Ministers.

that it would have been. All he lost was the chance of being considered for compassionate release.

Submissions on behalf of NHS Grampian.

[110] As regards section 6(1)(b), the cause of death was an ICH resulting from a history of elevated blood pressure. That was the conclusion that should be reached on the weight of evidence. As regards section 6(1)(c) and (d), no reasonable precautions could have been taken which might have prevented the death. On the evidence, there were no real and lively possibilities that the death could have been prevented by a precaution that was available at the time of death and which could reasonably have been put in place. The cause of death was a stroke, unrelated to cancer and nothing could have been done to prevent the stroke, on the evidence. Even if, contrariwise, the cancer was a contributory factor to the stroke, it was incurable and earlier diagnosis would have made no difference to the progression of the cancer and therefore any contribution that it made to the ICH. On similar reasoning, it cannot be said that there was any defect in a system of working which contributed to the death. As regards section 6(1)(e), findings under this head, unlike findings under paragraphs (c) and (d) of section 6(1), concern matters which are in the public interest, relevant to the circumstances of death but which do not have a causal link to the death. It is appropriate to consider under this heading whether Mr Coccozza could have survived in the event that he had not been killed by the stroke. There is no evidence that he would have been and therefore no finding under this heading is appropriate. The cancer was terminal, at stage 4, was incurable and palliative treatment would have had no effect on the eventual and inevitable outcome. There are no other findings which are appropriate under this heading.

[111] NHS Grampian had no submissions to make as regards the delay in presentation of the petition to fix this Inquiry. It had no submissions to make on the relevance or otherwise of section 3 of the 1993 Act to this Inquiry.

Discussion and conclusions on principal issues

Credibility and reliability of witnesses' evidence.

[112] The Inquiry heard from seven witnesses, all being qualified in medicine and the majority having a considerable degree of seniority. As one would expect, each one of those witnesses did their best to answer the questions put to them openly and honestly. I did not detect any attempt by any of them to shade their evidence or otherwise to tailor their evidence in the interests of themselves or their employers. In particular, I do not accept the contention of the Crown that the decision of Prof Webster to provide a detailed highly critical written analysis of the post mortem examination report during the course of his evidence (which was heard over the course of two days separated by two weeks) was one that was motivated by an attempt by Prof Webster to exculpate himself from any criticism that might be made by this Inquiry of his actions whilst Mr Coccozza was under his care. That analysis was provided to the Crown which, quite properly led Prof Webster on its contents and put it to Dr Sadler. The Inquiry benefited substantially from that report which in my view was a thoroughly professional piece of work designed solely to provide the Inquiry with the benefit of Prof Webster's considerable knowledge and experience and which succeeded in illuminating the complex medical issues that this Inquiry has had to grapple with. As regards Dr Sadler's evidence, to his credit I should note that though he was not the lead pathologist and therefore did not have primary responsibility for carrying out a number of steps in the autopsy and the preparation of the initial post mortem report, he nevertheless did not attempt to avoid his share of responsibility for the various errors in that post-mortem report or to blame Dr Perera. His admission of the errors in both reports was full and frank and while his ultimate conclusion as to the cause of death was not shared by other witnesses, it was his honest professional opinion based on the facts and medical science, as he understood them. I should say however that as regards the degree of

reliance that I have placed on the evidence of these seven witnesses, I have found some more reliable than others for reasons I explain below.

Cause of death.

[113] This is the single most important question in this enquiry. That is not just because determination of the cause of death is one of the questions which the Inquiry is bound to determine. It is important also because some other questions which the Inquiry is bound to determine turn on this question. If, as the Crown contends, the cause of death was some combination of the ICH and metastatic cancer, the delays in diagnosis and the reasons for those delays may require findings concerning reasonable precautions, the medical care provided or not provided, and defects in systems of working. If however, as the Scottish Prison Service and NHS Grampian contend, the cause of death was simply the ICH, which event was independent of the cancer from which Mr Coccozza was then suffering, and if that ICH was quite unpredictable, no such additional findings might be possible.

[114] The starting point is the medical records concerning Mr Coccozza's admission to Stirling Royal Infirmary on the early afternoon of 6 March 2011 up to and including his death the following morning at 07.25 (the timing in the notes being 07.30, though the death occurred 5 minutes earlier). Those records were spoken to by Prof Webster, Dr Sadler, Dr Grant and Dr Howie. They all agreed that on the early afternoon of 6 March 2011, Mr Coccozza was admitted as an emergency to Stirling Royal Infirmary and that his symptoms on admission were classic symptoms of a stroke. Ironically, it was only on this day, in the early evening, for the first time that Mr Coccozza had a CT scan and x-ray; though of course the CT scan was of his head rather than his liver and the x-ray was of his chest. The CT scan showed that there had been a large haemorrhage in the left cerebellar hemisphere. It had a life-threatening appearance according to Prof Webster who was of the opinion it was not survivable. Certainly, the records show that nothing other than palliative treatment was carried out. By 23.30 that evening, Mr Coccozza was

deeply unconscious and virtually moribund. He died at 07.25 the following day. In my view, it is quite clear on the balance of probabilities that the immediate cause of the death of Mr Coccozza was this ICH.

[115] *Possible contribution to the ICH by cancer.* The next stage is to consider the more controversial question as to what, if anything, caused or contributed materially to that ICH.

[116] One possibility is that cancer caused or contributed to the ICH. Before considering that possibility, it is as well to first be clear about the characteristics of the cancer from which Mr Coccozza undoubtedly suffered. An unidentified lesion measuring 8cm was found on Mr Coccozza's liver during the ultrasound scan on 22 September 2010 which at that time was thought might be malignant. The post-mortem examination carried out on 10 March 2011 revealed a large tumour mass measuring 13cm x 7 cm. It is reasonable to deduce that the lesion present in September 2010 was the same as discovered in March 2011, and that it was tumorous then too. The alpha fetoprotein result obtained following the test of Mr Coccozza's blood on 20 October 2010 was negative thus ruling out hepatoma (that is, primary liver cancer)³. Therefore the liver cancer must have been secondary. The x-ray done on 6 March 2011 showed a large tumour on the lung, subsequently shown in the post-mortem to be a non-small cell cancer. The universal view of the witnesses was that the lung cancer was the primary cancer which had metastasised. So the liver cancer was secondary to the lung cancer. Therefore, the lung cancer must have been present in September 2010 at the latest. That was Dr Howie's and Dr Grant's view, which fits these facts. Given that the symptoms suffered by Mr Coccozza which prompted the original self-referral to the Peterhead medical officer which led in turn to the referral to Prof Webster were first noted by the Peterhead medical officer in July 2010, and given that his symptoms included marked and increasing frailty which is

³ Although Dr Parish said that she understood that hepatoma had previously been diagnosed, I consider that she must have been mistaken in that understanding; there is no other support for that view. There was evidence to the effect that hepatoma, while having the specific meaning of primary liver cancer (which she well understood), was a term sometimes used loosely to describe any type of liver cancer. It may be that someone to whom she spoke while carrying out her review used that term in that loose sense.

commonly found in cancer patients, it seems quite possible that the cancer was present in Mr Coccozza's body at that stage. However, although lung cancer commonly metastasises to the brain, it did not in Mr Coccozza's case, according to the results of the autopsy. Neither was the cancer found elsewhere.

[117] Can it be said that the metastised cancer, present in Mr Coccozza's body for over six months by the date of the ICH, caused or contributed to his death from the ICH? Prof Webster's opinion, expressed clearly with detailed clinical reasons, is that it did not. The two matters were quite unrelated. Dr Howie also opined that the cancer and the ICH were unrelated. He had seen hundreds of patients die from metastatic cancer of the lung but none from an ICH as a complication. This type of cancer would not affect clotting. The stroke was in his view an unrelated event. Dr Sadler took a different view. In his opinion, the physiological effects of the lung cancer and the likely adverse effects on blood coagulation due to widespread hepatic metastasis undoubtedly contributed to the ICH and it was not possible to dissociate the cancer from the ICH. Dr Grant too took a different view. While he agreed that the primary cause of death was the ICH, a contributory cause of death was the cancer. The tumour probably increased the likelihood of death as Mr Coccozza had anaemia, probably resulting from the cancer, which would lead to hyper-dynamic circulation, increasing the chances of a stroke.

[118] In my view, Dr Webster's opinion is to be preferred on the balance of probabilities. His evidence, based on research findings and his considerable experience, including specialist work in his stroke clinic, was detailed, cogent and convincing as regards how a cancer and an ICH might be causally related, and as to the unlikelihood that they were in this particular case. Dr Howie's limited evidence on this point was supportive of that conclusion. By contrast, I regret to say that I did not find Dr Sadler's opinion at all convincing. He was unable convincingly to challenge Prof Webster's analysis and, quite properly, felt obliged, as a pathologist, to defer to Prof Webster's clinical experience. He appeared, in some of his written evidence,

to be under the impression that the lung cancer was small cell cancer (which is sometimes associated with paraneoplasia) when his own post mortem report found that the cancer was non-small cell cancer, which is not associated with such an effect. He was unfamiliar with the term “non-small cell cancer” even though it is in common use clinically according to the evidence of some other of the witnesses, whose evidence I accept. While of course, normally one would place substantial weight on the views of a pathologist as to the cause of death, in this case (and I hope that it is understood that my findings do not amount to a more general criticism of his professional abilities), I regret to say that the considerable shortcomings in the post mortem reports co-authored by him did not inspire confidence in the soundness of his professional views in this case. While, in my view, it was likely that the cancer had had noticeable effects on Mr Coccozza’s well-being (as I shall explain below), I do not find, on the balance of probabilities, that those effects included either causing the death of Mr Coccozza or materially contributing to the ultimate cause of death.

[119] In so finding, I do not neglect the opinion expressed by Dr Grant. His opinion concerning undiagnosed anaemia, likely to have been a result of the metastatic cancer, which would likely have caused an increase in blood pressure and thus likely to have contributed to the ICH, came out on the last day of evidence during cross-examination. That evidence appeared, I think, to take all parties by surprise. It was not part of his written evidence. It was not explored in any depth so that, for example, the relative importance of the contribution of hypertension and the undiagnosed anaemia to increased blood pressure (and thus the stroke) could be explored. Importantly, no other witness gave any opinion as to whether Mr Coccozza had anaemia and if so, its likely cause. Thus, the Inquiry had no other evidence regarding the possible contribution to the ICH made by anaemia, then undiagnosed, resulting from the undiagnosed cancer. While not dismissing Dr Grant’s opinion on this matter, and with great respect to him, I am unable on the weight of evidence to agree with his views on this point. On balance, I

consider that the weight of evidence supports Prof Webster's opinion for the reasons given above.

[120] *Contribution to the ICH by hypertension.* I deal next with the related question which concerns the possibility of hypertension (chronic raised blood pressure) being the cause or at least a material contributor to the ICH. Prof Webster's view was that hypertension was the most likely predisposing cause. The mechanism whereby hypertension leads to ICH was explained by him in detail in his evidence. Dr Howie thought that hypertension was a contributory cause and was in general terms in his experience the most common cause of ICH. Dr Sadler's final view appeared to be that the cause of death was one that involved three or four elements, all equally implicated, one of which was hypertension. Dr Grant's view was that the hypertension was secondary to the principal cause of death, being an ICH.

[121] I considered that the evidence of Prof Webster on this point was the most authoritative. I considered that he had the most experience in that area, he ran a stroke clinic and was still in practice as a consultant. His explanation as to how hypertension leads to ICH was the clearest. His view was supported by Dr Howie, who had long experience in practice and Dr Grant, equally experienced albeit in a different area of practice. In so far as Dr Sadler's opinion on this point differs from those doctors, I prefer their view to his on this point. In my view, the chronic and long lasting hypertension suffered by Mr Coccozza over 35 years is likely, on the balance of probabilities to have materially and significantly contributed to the ICH. The effect of the hypertension on Mr Coccozza for 35 years was such that he was at a higher risk than normal of suffering a stroke of some description, including the type of stroke from which he died, an ICH. The timing of that stroke was unpredictable. Once the bleeding into the cerebellum had started, it is quite possible, on Prof Webster's evidence, that the extent of bleeding was exacerbated by the effects of one of the medications that Mr Coccozza was taking for his heart and vascular ailments: aspirin. However, the contribution of that medication to the death is insufficiently clear for me to

determine that either the medication or the underlying ailment made a material contribution to the cause of death.

[122] I conclude also, that even if the cancer had been diagnosed earlier, as I believe it ought to have been, the ICH would not, on the balance of probabilities, have been avoided. I accept the evidence of Prof Webster, Dr Howie and Dr Grant that the event was unpredictable. I also accept their evidence that even if the cancer had been diagnosed earlier, the treatment options were limited, that it was incurable and I draw from their evidence the implication that even if the cancer had been diagnosed earlier, no treatment would have affected either the occurrence of the ICH, or its timing. However, if there had been earlier diagnosis, there would likely have been other consequences for the benefit of Mr Coccozza, which I deal with below.

[123] *Conclusion on section 6(1)(c) question.* It follows from the foregoing, that I cannot determine for the purposes of section 6(1)(c) of the 1976 Act there were any reasonable precautions whereby the death might have been avoided.

[124] *Conclusion on section 6(1)(d) question.* It also follows that I cannot determine for the purposes of section 6(1)(d) that there were any defects in any system of working which contributed to the death. While in my view, there were certain defects in certain systems of working (and that phrase is to be broadly interpreted), and that those defects contributed to the failure to timeously diagnose the cancer, those defects cannot be said to have contributed to the death. In my view however, those defects are relevant to the circumstances of death and I say more about this below.

[125] *Relevance of cancer to section 6(1)(e) question.* Notwithstanding the fact that I do not determine that the cancer contributed to the cause of death, (in the sense that there is insufficient evidence on the balance of probabilities to demonstrate a causal link between the cancer and the ICH), that does not mean that the cancer was irrelevant to the circumstances of death. At the date of death, Mr Coccozza was suffering from advanced metastatic cancer of

the lung and liver and had been since at least September 2010, and probably some time before that date. In my view, on the evidence, that cancer was symptomatic (albeit the symptoms were non-specific) and had been since at least the date that he was referred to Aberdeen Royal Infirmary by Dr Bruce in July 2010 with symptoms of unexplained increasing frailty and other symptoms. He continued to suffer increasingly from frailty and tiredness until death as well as other unexplained symptoms. I accept the evidence of Dr Grant, a very experienced GP with considerable experience of dealing with terminally ill patients on a day-to-day basis, that the dizziness, memory loss and weakness that Mr Cocozza had been suffering before death were likely to be associated with the cancer and that is what one would expect in a patient with cancer as advanced as Mr Cocozza's.

[126] In that regard I prefer his evidence to the contrary evidence of Dr Howie. Dr Grant's evidence was generally impressive, thorough and knowledgeable. He impressed me as a doctor with a deep genuine and abiding concern for his patients and one who spent a great deal of time looking after their interests as individuals and in maintaining the highest standards of medical practice generally. He struck me as a doctor who has habitually and carefully studied the effects of illness on his patients over decades and who was acutely aware of the effects, large and small, of disease in them on a daily basis. His opinion as to the expected effects of cancer on a patient I found quite persuasive. I regret to say that I did not form the same impression of Dr Howie. He is not a GP by training. His view as to whether the cancer was symptomatic at the stage he examined Mr Cocozza is, without intending any slight, not a wholly independent one. Moreover, his consultation with Mr Cocozza on 6 December 2010 did not strike me as indicative of a medical officer who paid careful attention to the condition of Mr Cocozza. He made no attempt to read Mr Cocozza's medical notes prior to or at that consultation; not even the transfer form prepared by medical staff at HMP Peterhead. He relied instead on the accuracy of Mr Cocozza's account of his medical condition: even though Mr Cocozza's memory loss

had been recorded by nurses 3 days before (a fact recorded in the notes which Dr Howie had, but did not read); Mr Coccozza had his medication supervised when in HMP Peterhead (otherwise he might forget, a fact recorded on the unread transfer form) and even though Dr Howie accepted that prisoners are apt to be rather poor historians (in that they tended to invent, exaggerate or imagine things). I found it surprising that he found Mr Coccozza to be “quite well” considering the ailments from which he suffered, his medical history and the medication he received: that was a finding rather different from other witnesses, Prof Webster, Dr Parish and Dr Grant. I found it odd that Dr Howie changed Mr Coccozza’s medication to unsupervised even though it had been supervised while in HMP Peterhead and even though recent examination of Mr Coccozza had revealed defects in memory.

[127] While of course I appreciate that doctors in the prison medical service are under a great deal of pressure, that their job is very difficult, and while equally it would be quite unfair to regard that the one brief consultation Dr Howie had with Mr Coccozza as representative of his practice generally (and I do not say that) nonetheless, I regret to say that I was unable to feel a great deal of confidence in Dr Howie’s opinion on this particular point.

[128] I note also that while suffering from the effects of the ICH in SRI, Mr Coccozza’s medical records were marked Do Not Resuscitate. That, according to Dr Howie, indicated that because of the generally poor state of health of Mr Coccozza, his heart should not be restarted should it stop. Thus, his general state of health, which I find had been deleteriously affected by the cancer, had an effect on the decision taken by those treating him in the hospital to mark his records thus.

[129] Thus, at the date of death, Mr Coccozza was suffering from advanced metastatic cancer and the effects of that disease. That co-morbidity was in the opinion of most of the witnesses who gave evidence on this point (including Prof Webster) sufficiently significant to be entered on the death certificate under Part II. Moreover, the decision not to resuscitate was

influenced by his general state of health which I find was affected by the cancer. Thus, while I cannot find on the evidence that the cancer was the cause or a cause of death, the existence of the undiagnosed cancer was in my view clearly relevant to the circumstances of the death.

[130] Moreover, the evidence to this Inquiry has raised a number of important matters which are of public interest generally. I note that Ian H Carmichael in his text on Fatal Accident Inquiries⁴ has referred with approval to the following statement by Sheriff Brian Kearney: “The provisions are section 6(1)(e) are still wider and, in my view entitle, and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the course of the inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such a comments or recommendation.” I respectfully adopt that view. The matters on which I am about to comment occupied a considerable part of the Inquiry’s time and were fully examined by all parties. I require to make a determination under section 6(1)(e) of the 1976 Act concerning the following matters.

Multiple shortcomings in medical practice and procedures and failure to timeously diagnose cancer

[131] *Aberdeen Royal Infirmary.* There was a failure to see that the CT scan ordered by Prof Webster on 20 October 2010 was done or a suitable alternative imaging process substituted. The monitoring procedures by Prof Webster concerning the outcome of his scan request were inadequate. There were unsystematised and ineffective systems in place used by radiologists when rejecting imaging requests. There was no efficient system for resolving the difference in professional opinion (between Prof Webster and Dr Gomersall) about the utility of a CT scan without contrast. The internal mail system would commonly take 10 days to deliver paper requests from one part of the hospital to the radiology department, and the same length of time for return, which appears excessive and is unexplained. Even in 2014, paper requests are still in use and electronic means of making requests (which offer

speed and auditability) are not yet fully in place. There was then, and now, no complete and effective means of ensuring a complete audit trail as regards requests for imaging and the results of those requests. There was no common or standard protocol in the hospital regarding the means of making requests for imaging and processes associated with such requests.

[132] Following Dr Parish's actions, Prof Webster acted swiftly in writing to the medical team at HMP Glenochil. That alacrity was justified. However, given a malignancy had been suspected by him some months before, and given that such cases ought to be investigated without delay, and given that substantial delay had already occurred, it is unfortunate that his letter did not impress any degree of urgency at all. It ought to have done in my view. I should note however that Prof Webster accepted candidly that with hindsight he ought to have impressed on the medical team at HMP Glenochil a greater sense of urgency. Nonetheless, of course, at that point, Mr Coccozza was no longer his patient and others were then responsible for his care and his diffidence may be explained by his consideration of professional courtesy.

[133] *HMP Peterhead.* No one in HMP Peterhead appeared to notice that investigations commenced by Dr Bruce had not been completed and that there was, at the date of transfer of Mr Coccozza on 3 December 2010 an outstanding need for a CT scan. There was no mention of that incomplete investigation on the transfer form that accompanied Mr Coccozza from HMP Peterhead to HMP Glenochil.

[134] *HMP Glenochil.* There was a failure by the medical team at HMP Glenochil on the transfer of Mr Coccozza to that prison on 3 December 2010, to notice that investigations commenced in July 2010 into Mr Coccozza's deteriorating medical condition had not been completed. In particular, there was no established practice that a check on the transferred prisoner's medical notes be made to ascertain current medical issues. No such check

⁴ *Sudden Deaths and Fatal Accident Inquiries*, paragraph 11-46, referring with approval to statement by Sheriff Kearney in the *Mildred Allan* FAI, 1985 (referred to, apparently with approval, by Lord Cullen in his Review of FAI legislation in 2009 at paragraph 8.9)

was made by Dr Howie when he first saw Mr Coccozza on 6 December 2010. As a result, he did not notice that Mr Coccozza had a number of outstanding medical issues including memory failures and the uncompleted investigations commenced by Prof Webster. Neither did he notice that there was a transfer letter from HMP Peterhead which did refer to memory problems. Neither did he notice a finding by a nurse at HMP Glenochil, made three days previously, referring to Mr Coccozza's short term memory problems. The reliance by Dr Howie on Mr Coccozza to accurately recount his current medical condition was difficult to understand given the general lack of reliability of accounts given by prisoners of their medical situation and given Mr Coccozza's memory problems. The description of Mr Coccozza as being "fairly well" is difficult to square with Mr Coccozza's age and various medical conditions and is contrary to the views of Prof Webster and Dr Grant that Mr Coccozza was obviously in poor health. At HMP Glenochil, there was no system for summarising current medical issues for incoming prisoners, whether transferred from another prison or otherwise, which is to be contrasted with the General Services Contract for General Practitioners which require such a summary to be done within eight weeks. It is concerning that such a facility does now exist electronically but is apparently disabled. It may be however that improvements have since been made as a result of transfer for responsibility of the care of prisoners from the Scottish Prison Service to the NHS. There was no training or protocols in place for dealing with new patients apart from the ACT procedures.

[135] It was only due to the admirable efforts of Dr Parish, who took the time and care to accurately and carefully examine Mr Coccozza's medical notes, and prepare a summary, following a medical mishap concerning Mr Coccozza, that the uncompleted investigation into Mr Coccozza's health was discovered and again only thanks to her immediate efforts that Prof Webster was alerted that the CT scan he had ordered had not been done. In such a matter that fact ought not to have been left to chance. Further, it is concerning that although Dr Parish sought a psychiatric assessment, that

was not done and neither was any mini-mental health test carried out. Neither were the concerns raised by the nurses who examined Mr Coccozza on 3 December 2010 about his mental health followed through.

[136] It is of concern that although Dr Bramley acted with expedition to see Mr Coccozza in his surgery, his request for imaging to be done at Stirling Royal Infirmary, knowing as he did then about the substantial delay, failed to carry any sense of urgency. It is puzzling that the request he made, being a CT scan without contrast, was exactly the same request as had been made by Prof Webster, which request had been refused by the radiologist at Aberdeen some months before. It is perhaps therefore unsurprising that that request too was refused by a radiologist at SRI for the same reason as Dr Gomersall rejected the request. That was rejected in paper form which took some time to reach Dr Bramley. There was no telephone call to discuss matters with Dr Bramley. Thus, yet more time was lost. It was not until nearly a month later that an amended request by Dr Bramley, this time for an MRI, was received by the Radiology Department at SRI.

[137] It is somewhat unfortunate that although that MRI was arranged reasonably quickly for 4 March 2011, it required to be abandoned because Mr Coccozza had a pacemaker and an MRI cannot normally be carried out where there is one. Dr Bramley cannot reasonably be criticised for that failing: he completed the form together with Mr Coccozza who had apparently forgotten he had a pacemaker. Further, there was no clear indication on his medical notes that he had a pacemaker. If there had been an accurate summary of significant medical issues in his medical records, and if that summary had been consulted before the MRI request was made, it is likely in my view that the existence of the pacemaker would have been noted and that an MRI would not have been arranged and instead some other procedure would have been adopted.

Flawed post mortem examination and reports

[138] A further matter of some public concern is the flawed autopsy and post-mortem examination reports. The autopsy and reports were flawed in

numerous respects. The recent medical history of Mr Coccozza detailed there was almost entirely inaccurate. There was a failure to do histology on anything except for the lungs and brain: in particular there was no histology of the liver lesion. There was a failure to keep records of such histopathological examination that was done. There was a failure to retain histopathological samples of the lung and brain which were disposed of after two years so that it was not possible for example to check that the lung cancer was non-small cell cancer. There was a failure to take photographs of the external body, lungs and brain. There was a failure to ensure that all such samples and photographs as were taken were kept. The full report of the post-mortem was not done until well after the petition to fix the inquiry had been granted by the Court, which had consequences as regards the accuracy of the report and (understandably) the ability of Dr Sadler to recount exactly his findings. Last, and not least, Dr Sadler's conclusion as to the cause of death was mistaken.

Approach to Inquiry Procedure by Crown

[139] A further matter of public concern in my view is the approach of the Crown as regards certain aspects of this enquiry. I should make it clear that the concerns I am about to express cannot be said to relate to the circumstances of the death of Mr Coccozza since they relate not to the circumstances of his death but the investigation of his death by means of this Inquiry. Thus, I make no determination in respect of section 6(1)(e) as regards these matters. Nonetheless, in my view they are of some public interest and I believe it is right that I should note my concerns about the following.

[140] *Delay in commencement.* Around two years passed before the petition to fix the Inquiry was lodged at this Court. It is difficult to understand clearly the reason for that delay. As I note above, this Inquiry was mandatory, given that Mr Coccozza had died while in custody. Thus, it was evident from the time that the Crown instructed the post-mortem shortly after Mr Coccozza's death in March 2011, that a Fatal Accident Inquiry would

have to be fixed. The Crown has given an explanation for that delay which is recorded above at paragraph [100]. However, that explanation leaves unanswered questions as regards what being done between March 2011 and April 2013 and why it was that such matters as are referred to in the Crown's explanation took so long to resolve. The procurator fiscal depute said that he could give no further explanation other than the written one I have noted above. I do not criticise him personally for that, he was acting on instructions. Nonetheless, it is still unclear to me why it took two years for the petition to be presented to this Court. It was unclear to me from that explanation what steps the Crown have taken in order to see that in future Fatal Accident Inquiries are held sooner⁵.

[141] I note that in the Cullen Review, which reported five years ago, at chapter 6.7, Lord Cullen found as follows: "The delay in cases reaching a hearing is disheartening and frustrating for the relatives of the deceased. It may also cause distress to persons who may be the subject of criticism, whether or not well founded, such as members of the staff of the Scottish Prison Service. It may also lead to loss of, or deterioration in, evidence." While in this case, the relatives of the deceased were not a party to the inquiry, these remarks are nonetheless pertinent to the circumstances of this Inquiry. There was a loss of evidence in this Inquiry: in particular, certain samples which had been retained by Dr Sadler were disposed of before Dr Sadler could reacquire them for the purposes of his further report. Dr Sadler's entirely understandable lack of memory as regards exactly what happened during the post-mortem examination is an example of deterioration in evidence caused by the delay in establishing this FAI.

[142] I note also that at paragraph 6.14 of his review, Lord Cullen recommended "that COPFS should review its application of resources and expertise in order to ensure FAIs are held as promptly as possible after the death." While I note that the recommendation made by Lord Cullen at paragraph 3.44 to establish a central FAI team appears to have been implemented, it is a matter of some regret that the substantial delay seen in this case in commencing the FAI has

⁵ As this Determination was being finalised, the Scottish Executive published on 1 July 2014 a consultation paper on proposed new legislation and other measures to reform FAI procedure which take account of recommendations

occurred. I note also that at paragraph 6.22, Lord Cullen recommended that “in cases in which an FAI is mandatory, the Procurator Fiscal should be required to apply for an FAI at an early stage after the death so that the Sheriff, the relatives and other interested parties can be informed as to the state of investigation, the expected timescale for the FAI and any factors likely to affect progress.” It is unfortunate that this recommendation, which would have had particular relevance to this FAI, was not followed although of course I understand that this recommendation, like all other recommendations made by Lord Cullen, was not binding on the Crown. If this recommendation had been followed, and this Court had been seized of the matter at an early stage, it may have been that the delay seen in this case would not have happened. At the very least, there would have been public explanation given as to the state of preparation by the Crown and the reason for any continuing delay in the commencement of the evidential part of the inquiry. That, I consider, would have been in the public interest⁶.

[143] *Initial approach taken by Crown (and Scottish Prison Service) to substantive and procedural matters.* The second matter concerning the approach of the Crown to this Inquiry concerns the approach taken by the Crown to procedure in the Inquiry when the matter first called before me by way of a preliminary hearing on 31 July 2013. The inquiry had been previously fixed to commence on 29 August 2013 and the purpose of the preliminary hearing was to discuss procedural matters for that inquiry. On 30 July 2013, I viewed for the first time a large number of documents which were contained on an encrypted pen drive lodged by the Crown in process. Those documents included a large number of unsigned statements, copy medical records, a joint minute, a review by the witness, Dr Grant, of the medical records and the first post-mortem report. Fortunately, I had time to read some of those documents before the preliminary hearing the following day.

[144] At the preliminary hearing, there was an appearance by the procurator fiscal depute and by a solicitor for the Scottish Prison Service (not

in the Cullen Review and which deals *inter alia* with the question of reduction of delay.

⁶ I note that the consultation paper published on 1 July 2014 proposes that this recommendation be implemented.

the solicitor who appeared in the evidential part of the Inquiry). I was told by the procurator fiscal depute that he did not intend leading any witnesses and that he would be relying on the contents of a joint minute as the whole evidence in the Inquiry. That joint minute, between the Crown and the Scottish Prison Service, contained an agreement between them on a large number of facts including that the cause of death was “complications of metastatic carcinoma” (that is, adopting the conclusion of the post-mortem report) and a very abbreviated account of the medical attention that had been afforded to Mr Coccozza between July 2010 and March 2011. The joint minute agreed a report by Dr Grant and in addition purported to agree the contents of unsigned written statements provided by a number of individuals (not including the majority of witnesses who subsequently gave evidence). Thus, I was told, that the circumstances of death were uncontroversial, that no oral evidence needed be led and that unsigned statements, incorporated into the joint minute, would suffice as evidence.

[145] I expressed my surprise that the Crown proposed to proceed in this way for the following reasons. First, the Rules do not permit evidence to be given by way of an unsigned statement, whether incorporated in a joint minute or not. In terms of Rule 10 of the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977, a Sheriff may admit in place of oral evidence a written statement by that person “signed by that person and sworn or affirmed to be true before [a named official]”. In other words, the presumption is that evidence is to be given orally but in certain circumstances, an affidavit may be admissible in lieu. The procurator fiscal depute nonetheless insisted that unsigned statements were perfectly competent in lieu of oral evidence. In my view, while of course uncontroversial evidence, as Lord Cullen notes in his Review, may be agreed by joint minute, that is quite a different matter to unsigned statements being adopted in lieu of oral evidence, at least as regards substantial matters and especially as regards controversial matters.

[146] Secondly, I told the parties that it appeared from my brief perusal of the productions that Mr Coccozza had complained of certain symptoms in

July 2010, that he had decreased renal function and that further examination in October 2010 showed an 8 cm lesion on his liver resulting in an instruction to carry out a CT scan, the scan was not done and the missed CT scan was not noticed at that time. The productions appeared to show that amongst other things, the term “hepatoma” was noted on the ultrasound scan on 22 October 2010 (not something that eventually turned out to be true) and while that date (appearing in Dr Grant’s first report, itself commissioned by the Crown) appeared puzzling, it nonetheless appeared that there had been a diagnosis of liver cancer, or something like it, in October 2010. I noted that if that was the case, it appeared that nothing had been done about it either in HMP Peterhead or in HMP Glenochil. From the papers, (flagged up by Dr Grant’s report), it was apparent that no CT scan of the liver was ever carried out. It appeared that Mr Coccozza complained of increasing ill-health during November to March 2011. Thus, at first sight, the matter of an untreated cancer appeared to be an issue. Furthermore, it seemed from those papers that there was a contradiction between the cause of death as stated in Dr Grant’s review and the cause of death given in the post mortem report.

[147] It seemed to me at that time that the material lodged by the Crown raised important questions including whether the stroke was the result of the cancer, what was the true cause of death, when the cancer was first diagnosed, whether the CT scan was ever carried out, the adequacy of the medical care offered to Mr Coccozza, the SPS procedures concerning prisoners on transfer and the cause of death as given in the post mortem report. It appeared to me that on the face of the Crown’s productions, contrary to what both agents asserted to me at the hearing, the circumstances were far from routine, that real substantive issues arose for the Inquiry and that the proffered joint minute did not deal with any of these issues.

[148] I regret to say that both parties had overlooked these matters. That was especially disappointing given that the Crown had had some two years to investigate and consider the circumstances. I gave the parties time to

reconsider their position and fixed a continued preliminary hearing which took place on the date originally fixed for the first day of the inquiry proper.

[149] At that continued hearing that the parties, having reconsidered the Crown's productions and after having taken further advice agreed that there were important substantive matters which had not previously been noted. I was told that further time was required to investigate those matters and identify the appropriate witnesses to give oral evidence. It was not until 7 November 2013 that those enquiries and investigations were completed and the Crown and the Scottish Prison Service were in a position to agree a date for the hearing of evidence. That of course caused yet further delay in the hearing of this Inquiry.

[150] Unfortunately, the Inquiry was unable to commence on the fresh date set down, 23 January 2014. That was because on that day, Grampian NHS appeared for the first time in the Inquiry process, sought leave to take part and sought an adjournment for the purposes of preparation. Grampian NHS had not had any formal intimation of the Inquiry made to it and had only recently become aware that the Inquiry was to take place. Time was needed to prepare. With some reluctance, I granted both requests and the Inquiry was continued to 30 January 2014. The Court appreciates the speed with which the solicitor advocate for that party got himself prepared for the Inquiry. Thereafter, evidence was heard on another 9 days followed by a day of submissions, ending on 21 May 2014. It is unfortunate that the Inquiry was split up in the way it was. That was due to a variety of unavoidable difficulties, principally inescapable timetabling problems, lack of court capacity, other professional commitments on the part of witnesses, agents and myself and a short illness. Despite the best efforts of all involved, not least myself, I regret that the Inquiry could not have reasonably been heard over a shorter timescale.

[151] I should add, as a matter of fairness, that I have no criticism whatsoever to make of the procurator fiscal depute as regards the manner in which the Inquiry was conducted following the continued preliminary

hearing. On the contrary, as regards all aspects of the Inquiry, in which the Crown bears the primary responsibility of bringing forth all relevant evidence and arranging for the attendance of witnesses and provision of documents, he acquitted himself very well. His detailed and searching examination of witnesses and notably the quality of his final written submissions were very beneficial to the Inquiry. Although I did not find myself in agreement with all the conclusions that he urged me to make, that was not through any lack of effort and skill on his part to persuade me otherwise

Final remarks

[152] To conclude this Note, I find that there have been a number of institutional and personal failures meaning Mr Coccozza was not well served in the last nine months of his life. Neither were his interests well-served even after death. Despite his case first being referred for further investigation in July 2010, and despite the possibility of cancer first being realised in September 2010, that diagnosis was not confirmed until the point of death. Despite further investigations first having been ordered in September 2010 because of a real suspicion of cancer, those investigations were never completed. If further investigations of the liver lesion had been more timeously carried out, that would probably have led to the discovery of the cancer there and probably also the cancer in the lung. Then, the usual procedures regarding treatment could have been carried out. Those investigations could reasonably have been completed sometime before the end of 2010. As it happens, the failure to complete the investigative process did not cause the death of Mr Coccozza. Neither did that delay prevent treatment that would have delayed death. However, if that cancer had been timeously diagnosed, the following would have been the likely consequences for Mr Coccozza to his benefit.

[153] First, there would have been discussions between him and medical staff about treatment and palliative treatment may have been offered which may have improved his quality of life and could even have enhanced it.

However, given that there was no direct connection between his metastatic cancer and the ICH, it is unlikely that any such treatment for his cancer would have extended his life.

[154] Second, if the cancer had been timeously diagnosed, as the submissions from the Scottish Prison Service have made clear, the possibility of compassionate release in terms of section 3 of the 1993 Act would have been triggered. On the evidence, if the CT scan requested by Prof Webster had been carried out, or the alternative suggested by Dr Gomersall, it is likely that a definitive diagnosis of cancer would have been made some time before the end of 2010. That diagnosis would have triggered the compassionate release procedure. Thus, it is likely that a decision would have been made on whether to release Mr Coccozza on compassionate release sometime around January 2011. I accept the submission made by the Scottish Prison Service that all one can say at this juncture, given the nature of the process as explained, is that Mr Coccozza would have been entitled to be considered for compassionate release and that there is no certainty that he would have been successful in any such application. While the submission from the SPS was that he would have been unlikely to have been successful, I do not accept that. Rather, the true position at this juncture is that there would have been a possibility of compassionate release under section 3 but whether he would have been successful is at this stage impossible to determine: it is an open question. I accept therefore the SPS submission that the delay in diagnosis led to a loss of the chance, rather than the loss of a probability, that he would have been compassionately released. If he had been compassionately released, he would probably have spent his last weeks of life in more congenial surroundings than HMP Glenochil. He was denied that chance by the shortcomings in diagnosis and medical care that I have described above.

[155] While in this case, I have concluded that the cause of death was not the undiagnosed cancer but an intervening ICH, my concern is that if the ICH, which was unpredictable, had not occurred, Mr Coccozza might have

continued to remain undiagnosed for some time before the truth was established. This is against a background where it is universally accepted that early and swift diagnosis of suspected cancer is extremely important. It appears to me that many of the failures leading to the lack of timely and accurate diagnosis were institutional failures and the concern must be that if this happened in Mr Coccozza it could happen to others. The consequences for others of a similar series of institutional failures could be more catastrophic for them than it was for Mr Coccozza, killed as he was by an intervening event. Dr Grant agreed with what he said was Sir Harry Burn's view: that prisoners are the most deprived medically in Scotland. I hope that the contents of this Determination will assist those who wish to improve the shortcomings in the systems that I have attempted to describe above so that the treatment of prisoners may approach the quality of care that is generally expected among those cared for in the community. As Dr Grant said, a prisoner is entitled in principle to the same quality of care as anyone who is at liberty. That principle he said was fundamental. I agree.

**Sheriff Derek O'Carroll, Advocate,
Sheriff of Tayside Central and Fife
7 July 2014**