SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2023] FAI 33

HAM-B727-22

DETERMINATION

BY

SHERIFF JOHN R A HAMILTON KC

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

into the death of

WILLIAM CURRIE

HAMILTON, 4 August 2023

The Sheriff, having considered the information presented at an Inquiry on 6 June 2023 under sections 2(1) and 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, Finds and Determines:

1. That in respect of paragraph (a) of section 26(2), Mr William Currie born 24 July 1964, died on 26 May 2021 at Allanton Hall, Cell A1/51 HMP Shotts, Canthill Road, Shotts ML7 4LE.
2. That in respect of section 26(2) paragraph (b), No accident took place.

3. That in respect of section 26(2) paragraph (c), the cause of death was established as:

   Primary cause: 1(a) Ischaemic heart disease with cardiac enlargement.

   Potential contributing causes: (2) Fatty degeneration of the liver.

4. That in respect of section 26(2) paragraph (d); No accident.

5. I make no finding under paragraph (e) (precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically resulted in the death being avoided):

7. I make the following findings under paragraph (g) (any other facts which are relevant to the circumstances of the death):

   1. That following on from examination of the deceased by Dr Khan on 5 November 2020 a decision was made by Dr Khan that a referral for a myocardial perfusion imaging (MPI) scan should be made. No referral was made. No MPI scan was done. It is unclear why the referral was never made. It may be an example of human and/or administrative error. It is unsatisfactory that no referral was made or scan completed, however it is clear that the lack of referral, scan and results had no impact on either the medical care of the deceased or his death;

   2. That a letter dated 10 November 2020 from Dr Khan recommending an increase in the deceased's Isosorbide medication was received by HMP Dumfries and thereafter transmitted to HMP Shotts, to where the deceased had been moved. The letter of 10 November 2020 was reviewed by

Dr Conroy at HMP Shotts but there is no evidence that the dose of the deceased's Isosorbide medication was increased at the health centre at HMP Shotts, in line with Dr Khan's recommendation. It is unclear why the deceased's Isosorbide medication was not increased. It may be an example of human and/or administrative error. It is unsatisfactory that no change to the dosage as recommended was made, however it is clear that the lack of change in dosage of medication had no impact on either the therapeutic care of the deceased or his death;

Recommendations

8. No recommendations are made under section 26(1)(b) and (4).

NOTE

Introduction

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

The participants and their representatives at the Inquiry

[2] The Procurator Fiscal issued a notice of the Inquiry on 30 September 2022. After sundry procedure the hearing was held on 6 June 2023.

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

- Ms Aimee Doran, Procurator Fiscal Depute appeared for the Crown.
- Mr Stuart Holmes appeared on behalf of Dumfries and Galloway Health Board;
- Mr Daniel Considine, appeared on behalf of the Scottish Prison Service;
- Ms Katherine Trail, appeared on behalf of Lanarkshire Health Board.

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

The evidence

[5] The joint minute of admissions was formally entered into the evidence on 6 June 2023.

The legal framework

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

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

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

[7] Section 26 of the 2016 Act requires the Sheriff to make a determination in relation to the circumstances of the death (section 26(1)(a)) and recommendations on certain matters (section 26(1)(b)). Section 26(2) sets out the factors that the Sheriff must consider

as to what constitutes the circumstances of the death, including the causes of any accident and the precautions that might have been taken, defects in the system of working and any other factors relevant to the death. Section 26(4) sets out the issues for consideration as to whether any recommendations could be made which might realistically prevent other deaths in the future.

Facts and circumstances

[8] William Currie (hereinafter referred to as "the deceased") was born on 22 July 1964.

[9] On 9 May 1989 the deceased was sentenced to a period of imprisonment following a conviction of Assault with Intent to Ravish.

[10] On 15 March 1993, at Kilmarnock High Court, the deceased was sentenced to life imprisonment for murder, which was backdated to 14 October 1992.

[11] On 25 September 2014 the deceased was released on life licence.

[12] On 22 June 2020 the deceased was subject to a custody recall under Section 17 of the Prisoners and Criminal Proceedings (Scotland) Act 1993, as amended, for breaching two license conditions.

[13] On 23 June 2020 the deceased was arrested and returned to custody at HMP Dumfries.

[14] On 10 November 2020 the deceased was transferred from HMP Dumfries to HMP Shotts.

[15] On 16 March 2021, at Dumfries Sheriff Court, following a plea of guilty to a contravention of Section 4(3)(b) of the Misuse of Drugs Act 1971, the deceased was sentenced to 18 months imprisonment at HMP Dumfries.

[16] The deceased's next date for parole review was 18 June 2021.

[17] The deceased had several previous convictions, including fraud, reset, housebreaking, attempting to pervert the course of justice, assault, breach of the peace, and assault and robbery.

[18] On 26 May 2021, the date of his death, the deceased was in legal custody at HMP Shotts.

Responsibility of healthcare within the prison estate

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

[20] In relation to HMP Dumfries, the relevant Health Board is Dumfries & Galloway Health Board.

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

Medical history

[22] The deceased suffered from several significant pre-existing health conditions. He had a history of:

- ischaemic heart disease (a chronic long-term condition),
- chronic obstructive pulmonary disease,
- hypertensive disease,
- leg oedema,
- asthma,
- migraines.

In addition, the deceased was diagnosed with a personality disorder.

[23] The deceased was prescribed several medications whilst in HMP Shotts, including:

- Amitriptyline, 10mg (tricyclic antidepressant primarily used to treat major depressive disorder and a variety of pain syndromes, including migraine)
- Aspirin Dispersible, 75mg (analgesic)
- Atenolol 100mg (high blood pressure, arrhythmias, angina and protection of the heart after heart attack)
- Atorvastatin, 80mg (used in lowering cholesterol and other lipids, and to reduce the risk of heart and blood vessel disease)
- Carbocisteine, 750mg (used to help clear sputum in respiratory disease associated with a productive cough)
- Isosorbide Mononitrate M/R, 50mg (angina prevention and heart failure)

- Fobumix 320 Inhaler (asthma)
- Spiriva Respimat (used to control symptoms of chronic obstructive pulmonary disease)
- Vitamin D
- Gabapentin 600mg (epilepsy and neuropathic pain)
- Quetiapine, 75mg (mood disorder)
- Furosemide, 80mg (oedema and hypertension)
- Ramipril, 10mg (high blood pressure and heart failure)
- GTN spray (angina)
- Salbutamol Easibreathe (asthma)
- Co-codamol 15/500, 2 x tablets (analgesic)
- Ketoconazole Shampoo
- Exocream

[24] In 2006 the deceased had a coronary artery bypass surgery for triple vessel disease.

[25] Following his coronary artery bypass surgery in 2006, the deceased frequently complained of chronic post-operative chest pain and localised pain to the central chest at the area of the scar.

[26] On 13 January 2021 upon transfer to HMP Shotts the deceased requested a GP appointment relating to a swollen leg. The appointment was listed for 25 January 2021.

[27] On 25 January 2021 the deceased did not attend.

[28] On 27 April 2021 the deceased requested another GP appointment. The appointment was listed for 10 May 2021.

[29] On 10 May 2021 the deceased did not attend.

[30] On 14 May 2021 the deceased requested another GP appointment. The appointment which was scheduled for 28 May 2021.

Medical referrals

[31] The deceased had a history of cardiac problems. He was frequently investigated for chest pain following his coronary artery bypass surgery in 2006 for triple vessel disease. This included further investigations and consultations with medical staff at both Accident and Emergency and within specialist units, such as the department of cardiology.

[32] On 5 November 2020 the deceased met with Dr Zaman Khan, Locum Consultant Cardiologist at the cardiology clinic at Dumfries and Galloway Royal Infirmary. The outcome of that clinic was communicated with the deceased's GP at HMP Dumfries, Dr Beaumont, in a letter dated 10 November 2020. This letter was authorised on 11 November 2020 at 15:32:04 by Dr Zaman Khan.

[33] Dr Zaman Khan recommended the deceased have a myocardial perfusion imaging scan (hereinafter referred to as an "MPI") to assess the reversibility of ischaemia. Dr Khan told the deceased the purpose of an MPI scan and gained consent from the deceased to make the referral. Dr Khan advised Dr Beaumont that he would

arrange for such a scan to take place and that further correspondence to the deceased's GP, Dr Beaumont, would follow with the results of the MPI.

[34] MPI tests are unable to take place in NHS Dumfries and Galloway. All patients requiring MPI tests in NHS Dumfries and Galloway must be referred to Glasgow Royal Infirmary.

[35] It is unknown whether a referral was ever made to the Glasgow Royal Infirmary for the deceased to have an MPI.

[36] It is unknown whether an MPI took place in any health board jurisdiction after 5 November 2020.

[37] At the consultation of 5 November 2020 Dr Khan concluded that the deceased's dose of Isosorbide nitrates should be increased to twice daily.

[38] Dr Khan wrote to the deceased's GP on 10 November 2020 making this recommendation.

[39] The letter was received by HMP Shotts health centre and saved to the electronic medical records system and stamped as received.

[40] No further action was noted in relation to this letter. No increase in the dosage of Isosorbide was made.

25 May 2021

[41] On 25 May 2021 the deceased was seen within the common areas of Allanton Hall, the evening before his death. The deceased was captured on CCTV. This CCTV footage was subsequently reviewed by Detective Constables from Police Service of

Scotland who were investigating the death of the deceased. The deceased was observed on the footage collecting dinner from the kitchen and returning his dinner to the bin area and thereafter returning to his cell A1/51 for lock up.

[42] At 1705 hours, Prison Custody Officer (PCO) Stephanie Crawley and PCO Francis Murphy were working as residential officers within Allanton 1. PCOs Murphy and Crawley carried out lock up duty and received a visual and verbal response from all prisoners prior to their cells being locked. This included the cell of the deceased, A1/51. PCOs Murphy and Allanton had no concern for the deceased's welfare at that time.

26 May 2021

[43] On 26 May 2021 PCOs Smith and Lang were carrying out the morning roll count of all prisoners on Allanton 4 (Southside). Allanton 4 (Southside) is where the deceased's cell was situated, at position A1/51.

[44] At approximately 0740 hours, PCOs Smith and Lang attended at the deceased's cell. They observed the deceased to be lying face down within his cell. Both PCOs Smith and Lang entered the deceased's cell. PCO Smith touched the deceased, who was cold.

[45] At 0744 hours PCO Smith initiated a "code blue" call (medical emergency). PCO Smith was unable to detect a pulse from the deceased. PCO Smith and Lang did not perform any further medical intervention on the deceased.

[46] At approximately 0745 hours First Line Manager (FLM) Paul Malone requested an emergency ambulance.

[47] At approximately 0748 hours Prison Nurse, Gordon McPherson arrived at the cell of the deceased. Nurse McPherson observed the deceased's face and exposed arms, and concluded that rigor mortis had set in. Nurse McPherson found the deceased's body to be cold and firm and elected not to perform any cardiopulmonary resuscitation. He placed a pulse monitor on the deceased's right thumb. No pulse or saturation reading was detectable. A thermometer was placed in the deceased's left ear and a reading of 25 degrees was obtained. A cardiac artery pulse could not be felt.

[48] At approximately 0755 hours, emergency ambulance arrived at HMP Shotts.

[49] At approximately 0800 hours Paramedics Martin Fraser and Stefanie Barr attended at the deceased's cell. Nurse McPherson accompanied the paramedics and assisted with rolling the deceased onto his right-hand side. Rigor mortis was confirmed.

[50] At 0802 hours the deceased's life was pronounced extinct by paramedic Stefanie Barr. The condition of the deceased's body was described as, "unequivocally associated with death" owing to rigor mortis and hypostasis being present. Due to the presence of rigor mortis, resuscitation was not attempted.

[51] At 0807 hours the deceased's cell was secured and had an inhibitor applied to the lock by FLM Paul Malone.

Police investigation

[52] On 26 May 2021 at approximately 1012 hours Detective Constable Scott Johnston and Detective Constable Sharon McBride attended at HMP Shotts. DCs Johnston and

McBride were escorted to the deceased's cell, A1/51 by security manager John Brown. The deceased was in situ within his cell.

[53] DC McBride requested scenes of crime to attend at the prison and obtain photographs of the deceased and his cell.

[54] The police investigation concluded that no person entered the deceased's cell until the morning roll count of 26 May 2021.

[55] Police Constables Kenneth Samuel and Colin McBride and Scenes of Crime Officer, Robert Graham attended at HMP Shotts at approximately 1253 hours.

[56] At approximately 1301 hours, Police Constables Samuel, McBride and Scenes of Crime Officer Graham, entered the deceased's cell, A1/51. Photographs of the deceased and the deceased's cell were obtained by Scenes of Crime Officer Graham.

[57] At approximately 1324 hours, Police Constables McBride and Samuel seized several items from within the deceased's cell. This included medications which were subsequently lodged as productions.

Post mortem and toxicology examination

[58] On 17 June 2021, a post mortem examination was carried out at the Queen Elizabeth University Hospital, Glasgow by Dr Julie McAdam, Forensic Pathologist. A report with Dr McAdam's findings was prepared on 11 August 2021.

[59] The cause of death was established as: Primary cause: 1(a) Ischaemic heart disease with cardiac enlargement. Potential contributing causes: (2) Fatty degeneration of the liver.

[60] On 29 July 2021, Dr Peter Maskell, Forensic Toxicologist prepared a toxicology report on two samples of the deceased's blood which was collected post mortem.

[61] The post mortem examination revealed significant heart disease. The deceased had severe atheromatous narrowing (degeneration of the walls of the arteries caused by accumulated fatty deposits and scar tissue) of all three major coronary arteries, though with two patent coronary artery stents.

[62] The deceased's lungs were congested and oedematous, consistent with a cardiac mode of death and the liver was enlarged and showed severe fatty degeneration.

[63] Analysis of post mortem blood revealed levels of gabapentin, amitriptyline, quetiapine, codeine, paracetamol and dihydrocodeine, consistent with therapeutic use.

Medical evidence by affidavit

[64] Dr Zaman Khan in his affidavit evidence dated 19 January 2023 details the clinical examination he undertook of Mr Currie at the consultation on 5 November 2020 at Dumfries and Galloway Royal Infirmary. He also explains his clinical decision making which led him to conclude that Mr Currie ought to have an MPI scan and that Mr Currie's dose of Isosorbide nitrates should be increased. Dr Khan did not consider that there was an underlying cardiac cause for Mr Currie's chest pain, nor had he had experience of a patient with ischaemic heart disease complaining of constant chest pain that was unresponsive to any medication. The referral for an MPI would not have been classified as an urgent referral by Dr Khan. Dr Khan would have anticipated that an MPI scan would take place within two to three months of a referral. To refer a patient

for an MPI scan, Dr Khan had to ask his secretary to refer a patient to the Glasgow Royal Infirmary if that patient required an MPI test. This would be dictated at the end of his clinical letter, as an instruction to his secretary. Whilst working for NHS Dumfries and Galloway, Dr Khan was unable to refer a patient for an MPI scan through either of the two recognised referral routes, namely via the SCI Gateway system or, a paper request form. Dr Khan's opinion is that a referral for an MPI scan was never made to Glasgow Royal Infirmary. Dr Khan had the benefit of reviewing Mr Currie's records, and he noticed no covering letter for an MPI within his records. Dr Khan concluded that the absence of this letter indicates that a referral was never made to Glasgow Royal Infirmary. Dr Khan accepts that he may have failed to complete his dictation with the instruction to his secretary to refer Mr Currie for the MPI scan. Equally, Dr Khan considers that the referral for the MPI scan might not have been sent owing to an oversight by NHS Dumfries and Galloway secretarial staff. Dr Khan's evidence is that he does not remember dictating the clinic letter or what he asked his secretary to do in Mr Currie's case, following the consultation on 5 November 2020. Dr Khan's evidence accepted that on occasions referrals can be forgotten, go missing, or take a long time to be processed. If a referral was forgotten, missing or taking a long time to process, the way in which that is rectified is, according to Dr Khan's evidence, by the patient contacting their own GP, or alternatively contacting the hospital to follow up the appointment. Dr Khan's opinion is that it is unlikely that the MPI scan would have shown true angina as the cause of Mr Currie's chest pain. The chest pain experienced by Mr Currie failed to respond to various anti-angina medications and the chest pain

continuously complained of since the date of Mr Currie's surgery in 2006, would not last that long if it was attributed to angina. Dr Khan's opinion is that in the event that the MPI did disclose true angina, this would not have resulted in any substantive difference to Mr Currie's treatment and the management of his condition would likely have remained unchanged. The MPI scan might have resulted in an increased dose of Isosorbide to improve Mr Currie's heart function temporarily. Even without the MPI scan, Dr Khan decided that Mr Currie's Isosorbide should be increased to twice a day. In his clinical letter to Mr Currie's General Practitioner, dated 10 May 2020, Dr Khan made that recommendation and advised he suggested this to Mr Currie at the consultation on 5 November 2020. Dr Khan's opinion was that ischemic heart disease, of which Mr Currie was diagnosed, was a chronic, long-term condition which Mr Currie would not have recovered from.

[65] Dr David Barr is employed by Lanarkshire Health Board as a General Practitioner within the Health Centre at HMP Shotts and is the Clinical Director for GP services there. He gave evidence by way of affidavit. Dr Barr's evidence was that the letter dated 10 November 2020 by Dr Zaman Khan, Consultant Cardiologist was received at HMP Shotts electronically and saved to the electronic medical records system, known as "vision". The letter dated 10 November 2020 authored by Dr Zaman Khan is also stamped as being received by the health centre on 19 November 2021. Dr Barr's evidence is that the letter was also received in paper form and stamped and initialled by General Practitioner, Dr Stephen Conroy. The letter was ticked to be filed, but no further action was noted. Dr Barr's evidence was that the dose of medication

(Isosorbide) was not increased at the health centre at HMP Shotts, following receipt of Dr Khan's letter, notwithstanding the recommendation to increase Isosorbide. Dr Barr's evidence on Isosorbide aligned with Dr Khan's insofar as stating that Isosorbide has no influence on survival. Dr Barr confirmed that any clinical documentation received by the prison will be printed off, stamped, and seen by one of the General Practitioners.

[66] Dr Conroy is a General Practitioner employed by Lanarkshire Health Board, within the Health Centre at HMP Shotts. His evidence was given by way of affidavit. Dr Conroy's evidence was that correspondence from hospitals relating to treatment of patients received electronically at HMP Shotts are printed, stamped, and placed in a tray to be reviewed. The stamp shows the date the letter was received. The initial on the letter is of the person who received it and the Medical Officer (MO) who reviewed the correspondence. The stamp for the MO has two actions, either for the correspondence to be filed or for the patient to see the MO. However, Dr Conroy confirmed that the MO reviewing the mail can ask for other tasks to be carried out, which are not specified on the stamp. One of those actions can include for the patient's prescription Kardex to be reviewed. If there are changes to a patient's prescription following a patient review or review of correspondence, Dr Conroy confirmed his practice is to write on, or direct the admin team to write on, any updates on the prescription Kardex for pharmacy to review and dispense. Dr Conroy could not recollect reviewing the letter by Dr Khan dated 10 November 2020, despite marking his initials on the letter. He instructed for the letter to be filed in the patient's records. He recorded having seen the letter. No further action

was taken in relation to increasing Mr Currie's medication of Isosorbide. Dr Conroy could not provide an explanation why no further action was taken.

[67] Dr Guy Beaumont is a General Practitioner who covers HMP Dumfries. His evidence was given by way of two affidavits. When a copy of Dr Khan's letter dated 10 November 2020 was received by HMP Dumfries, Mr Currie had already been moved to HMP Shotts.

[68] Joseph Allen is a Service Manager for Prison Healthcare at HMP Dumfries and gave his evidence by way of affidavit. His evidence was that a clinical letter dated 10 November 2020 is stamped as being received by HMP Dumfries on 19 November 2020. Mr Allen gave evidence that following Mr Currie's death an action point from the Death In Prison Learning Review (DIPLAR) was given on the basis that correspondence had not been forwarded to HMP Shotts however he confirmed that this was incorrect and that the correspondence was sent to HMP Shotts. Mr Allen was able to confirm that the correspondence was sent to HMP Shotts by referencing an e-mail trail which demonstrated the correspondence being sent to HMP Shotts.

Conclusions

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

[70] The deceased suffered from significant health conditions prior to his death, including ischaemic heart disease and chronic obstructive pulmonary disease. The joint minute of agreement confirms that the deceased received a significant degree of medical care until his death. Given the various referrals made, detailed medical examinations carried out, the treatments provided, it is unsatisfactory that the referral for the MPI and the recommended increase in dosage of Isosorbide medication were not followed through, albeit these had no material impact on the deceased's health, quality of life or life expectancy.

[71] No submissions were made by either party that any accident resulted in the deceased's death or that any precautions could reasonably have been taken which might realistically have resulted in the deceased's death being avoided (section 26(2)(b), (d) and (e)); or that any defect in any system of working had contributed to his death (section 26(2)(f)).

[72] The Crown made a submission that the failure to perform the MPI and the failure to increase the dose of Isosorbide were other facts relevant to the circumstances of the death and fell to be included in my determination (section 26(2)(g)). Other parties were neutral on the matter.

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

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

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