SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2021] FAI 32

HAM-B4-21

DETERMINATION

BY

SUMMARY SHERIFF LIAM MURPHY

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

into the death of

DAVID McLEISH

Hamilton 5 May 2021

Determination

The Summary Sheriff, having considered all the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland Act 2016 (hereinafter "the Act") that:

(a) David McLeish, died at approximately 0910 hours on 28 December 2019 at St Andrew's Hospice, Airdrie, North Lanarkshire. At the time of his death the deceased was in legal custody.

(b) No accident occurred which resulted in the death.

(c) 1a) Presumed Cholangiocarcinoma with Lymph Node Metastases, II Adenocarcinoma of the Oesophagus, Liver Cirrhosis due to Previous Hepatitis C Infection (resolved) and Alcohol Excess.

(d) There were no cause or causes of any accident resulting in the death, there being no accident that occurred which resulted in the death.

(e) No precautions could reasonably have been taken which might realistically have resulted in the death being avoided.

(f) There were no defects in any system of working which contributed to the death.

(g) There are no other facts relevant to the circumstances of the death.

Recommendations

No recommendations are made under section 26(4) of the Act.

Findings in fact

I found the following relevant facts, by way of admission in the joint minute of agreement between the parties who participated in the inquiry, namely the Crown, the Scottish Prison Service and NHS Lanarkshire to be proved:

1. On 28 June 2011, DAVID MCLEISH, date of birth 23 May 1965 (hereinafter referred to as "the deceased"), was convicted following trial at the High Court of Justiciary, Glasgow, before Lord Bracadale, of murder, which the deceased had committed on 11 December 2010, and for a contravention of

Section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010, which had been committed in November 2010. On the same date the deceased was sentenced to life imprisonment with a punishment part imposed of 17 years imprisonment. The sentence was backdated to 13 December 2010, the date on which the deceased had first been remanded in custody. The deceased's punishment part expiry date was calculated as 12 December 2027, this being the date on which the punishment part of his sentence expired (all as shown at Crown Production Number 3 at pages 19–45).

2. Following conviction and sentence, the deceased was first imprisoned within HM Prison, Greenock, where he had previously been placed on remand. The deceased was thereafter transferred to HM Prison, Shotts, on 12 August 2011 (hereinafter referred to as 'the prison'). The deceased had a considerable schedule of previous convictions, relating to offences committed across Scotland and England, and had spent periods in custody on numerous occasions dating back to 1988. The deceased was released from his most recent custodial sentence two days before committing said murder (as shown at Crown Production Number 3 at pages 47 – 59 and 307).

3. At the date of his death on 28 December 2019 the deceased was a prisoner of HM Prison, Shotts. He was accordingly in legal custody as at the date of his death.

Provision of Healthcare in Scottish Prisons

4. On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the SPS to the NHS. Since then individual regional NHS health boards have been responsible for the delivery of health care services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

Medical History and Time in Prison

5. The deceased was previously an intravenous drug user and had a history of Hepatitis C infection, liver cirrhosis, hypertension, chronic liver disease, asthma, angina, and sciatica. He also described suffering from chronic back pain dating back approximately 20 years and continued to smoke during his time in prison. Following his transfer to HMP Shotts, the deceased requested to be moved again, stating that he wished to be moved to a prison in England to be closer to friends and that he was at risk by staying at HMP Shotts. His request to be transferred was refused. Throughout his time within HMP Shotts, the deceased regularly refused to engage with staff within the prison, in particular refusing to be interviewed for, or attend his annual case conferences, and also refused to participate in any prison programmes designed to target his violent offending. The deceased was also noted to have issues with authority and communication in prison and at times would become verbally abusive to both staff and other prisoners. On several occasions during his sentence he also

became involved in physical altercations with other prisoners (all as shown at Crown Production Number 2 at pages 13 – 15, Crown Production Number 3 at pages 289, 295, and 323, and Crown Production Number 7 at pages 2112 – 2113 and 2121).

6. In October 2017 the deceased was diagnosed with oesophageal cancer having been admitted to hospital for tests following a period where he had been struggling to eat and swallow. Following this diagnosis, the deceased was referred to a dietician and his weight was regularly monitored. He thereafter began his first round of neo-adjuvant chemotherapy for this at the Beatson Cancer Centre, Glasgow, in December 2017, and underwent a second round of chemotherapy in January 2018. On 19 February 2018 the deceased was admitted to University Hospital, Wishaw, in advance of a scheduled esophagectomy the following day. During this procedure the lesion was described as relatively large, and it was recorded that the deceased's risk of re-occurrence was high. The deceased was discharged back to the prison on 28 February. On 2 March 2018 the deceased complained of feeling unwell; he was pale and described sweating, dizziness, and shortness of breath. An ambulance was contacted, however following its arrival at the prison the deceased stated that he was feeling better and did not wish to return to hospital. Prison staff encouraged him to go with the ambulance however he continued to refuse and so the ambulance left. On 13 March the deceased re-attended at University Hospital, Wishaw, where he was advised that test results indicated that the cancer had spread and

that his prognosis was not good (all as shown at Crown Production Number 2 at page 15, Crown Production Number 6 at page 859, and Crown Production Number 7 at pages 1579 1591).

7. Following the surgery the deceased regularly attended at hospital for scans and other treatment, and was seen daily by prison healthcare staff who routinely checked his blood pressure and other observations, and administered his medication. He also continued to see the dietician, with his diet being routinely monitored, and he continued with a 'soft' diet which involved milkshakes and supplements in addition to meals. The deceased was also receiving additional support from a specialist MacMillan nurse. The deceased was regularly visited by the nurse in prison and the nurse also provided advice to the prison healthcare staff on the deceased's care and treatment (as shown at Crown Production Number 7 at pages 1561 – 1581).

8. In late June 2019 the deceased was again admitted to University Hospital, Wishaw, with symptoms of obstructive jaundice. The deceased was then transferred to Edinburgh Royal Infirmary on 9 July 2019 where he was diagnosed with Cholangiocarcinoma, which is a cancer of the bile duct. Hospital medical staff concluded that this was inoperable, due to the location of the cancer, and that there was no other appropriate treatment that could be provided. The deceased was advised that his cancer was terminal and that he had approximately 8 months to live. The deceased was discharged from hospital and returned to the prison on 16 July 2019 before being readmitted to University

Hospital, Wishaw, the following day. A case conference was held at the prison between prison healthcare staff and hospital staff, including a palliative care nurse, on 24 July 2019. During this conference there was discussion of the deceased's prognosis and care needs, as well as his likely future care needs, and whether these could be met in the prison environment. It was also discussed that the deceased had applied for compassionate release from prison following his terminal diagnosis (all as shown at Crown Production Number 6 at page 907, and Crown Production Number 7 at pages 1531 – 1533 and 1559 - 1561).

9. A "Do not Attempt Cardiopulmonary Resuscitation (DNACPR)" form was completed on 20 September 2019. This was revoked on 1 October at the request of the deceased, before being reinstated, again at the deceased's request, on 10 October 2019 (as shown at Crown Production Number 7 at pages 1553, 1643-1645, and 1653 – 1655).

Deceased's Compassionate Release Application

10. The deceased applied for compassionate release in August 2019. His application was considered between August and October 2019. The deceased initially indicated that he wished to live with one of his daughters. A meeting was held on 20 August 2019 where the request was discussed and it was noted that the deceased had previously refused to see a male MacMillan nurse, although would see a female nurse, and had also refused counselling from the chaplaincy worker. There was also concern that the deceased was not being

honest with the social worker as information he provided was contradicted by prison healthcare staff. The deceased later stated that he did not wish to go to his daughter's home if he were to be released, and instead wished to be assessed for admission to a hospice (as shown at Crown Production Number 3 at pages 263 – 269 and 381 – 389).

11. The deceased was interviewed by a social worker on 11 October 2019 in order that his level of risk could be assessed should he be given compassionate release. He was thereafter reviewed by a Consultant and a Community Palliative Clinical Nurse Specialist from St Andrew's Hospice on 4 November 2019. At this time it was determined that, based on their admission criteria, the deceased did not require inpatient admission to the hospice at that time, although that decision could be reviewed at a later stage should the deceased's condition deteriorate or his clinical needs change. It was noted that St Andrew's Hospice did not provide long-term care, and that the deceased also did not require compassionate release to be an inpatient and could continue to be supervised by the Scottish Prison Service should he be transferred to the hospice. On 30 October 2019, the deceased was assessed by Elaine Rogerson, Senior Nurse, during a Palliative Care Meeting. Ms Rogerson assessed that the deceased still posed a degree of physical risk. His overall level of risk had been assessed as "medium" (all as shown at Crown Production Number 3 at pages 255, 257, 315 – 324, and 343).

Events of November and December 2019

12. Throughout November 2019 the deceased's condition appeared to deteriorate significantly and he was presenting as confused, drowsy, and with shortness of breath. He was also complaining of severe abdominal pain and was having increased difficulty in mobilising. On the morning of 25 November the deceased was seen by prison healthcare staff having experienced a further deterioration in his condition. An ambulance was contacted to attend however the deceased refused to attend at hospital and a refusal of treatment form was signed to this effect. Between 26 and 28 November the deceased was noted to be sleepy and shaking, and he was also suffering from hallucinations and appeared jaundiced. On 28 November the deceased agreed to attend at hospital, however stated that he would not go into an ambulance and wished to be taken by car. This was agreed by staff and the deceased left the prison at approximately 1530 hours to attend at University Hospital, Wishaw. The deceased discharged himself from hospital later the same day, arriving back at the prison at around 1900 hours. During a discussion between prison healthcare staff and hospital staff it was noted that the deceased had the capacity to make the decision to discharge himself. Discussions were thereafter held between prison healthcare staff and staff at St Andrew's Hospice, however it was confirmed that the deceased did not yet meet the criteria for admission to the hospice for palliative care as he remained relatively mobile (all as shown at Crown Production Number 7 at pages 1545 – 1551).

13. On 1 December 2019 the deceased was seen in his cell by prison healthcare staff. At this time the deceased was presenting with shortness of breath, was pale, and complaining of a headache. The deceased's observations were taken and it was decided that he was to be transferred from the prison to University Hospital, Wishaw. An ambulance was contacted and he was transferred to hospital. A short time after arriving at hospital the deceased discharged himself, stating that he did not want to wait to see a medical practitioner. He was then returned to the prison. The deceased was reviewed by a MacMillan nurse on 2 December who described a deterioration in his condition. Over the course of the following days the deceased was regularly reviewed and had his observations taken. He was described as appearing in "good form" and good spirits, and he made no further complaints. On 8 December the deceased began complaining again of pain in his arm and on 10 December his Care Plan was updated. On 12 and 13 December the deceased was noted to be still struggling with pain and his medication was reviewed and adapted by healthcare staff. On the evening of 16 December prison healthcare staff were required to attend at the deceased's cell to administer his medication as he was unable to get out of bed; although he was described by staff as alert and orientated when they attended (all as shown at Crown Production Number 7 at pages 1543 – 1545 and 1647 - 1651).

14. On 17 December 2019 prison hall staff requested the attendance of healthcare staff as the deceased was noted to be breathless and wheezy. The

deceased was helped back into bed and the MacMillan nurse was contacted for advice. On 18 December prison hall staff again requested the attendance of healthcare staff as the deceased was unable to get out of bed. The MacMillan nurse was re-contacted and attended at the prison to review the deceased. It was noted that there had been a further decline in the deceased's health and that he was now in the final days of his life. It was agreed by staff at St Andrew's Hospice that the deceased should now be admitted to the hospice for palliative care (all as shown at Crown Production Number 7 at page 1543).

Transfer to St Andrew's Hospice, Airdrie, and Re-Consideration of Compassionate Release

15. The deceased was transferred by ambulance to St Andrew's Hospice on 20 December 2019. At this time compassionate release had not been granted and as a result the deceased was accompanied by security officers who remained with the deceased throughout, although he was not handcuffed. The deceased's condition deteriorated further following his admission to the hospice and he was unable to take any food or medication orally. He appeared fatigued, drowsy, and was agitated. Scottish Prison Service requested that a further report was prepared by social work in relation to the deceased's request for compassionate release; this was completed on 27 December 2019, however the deceased died before his compassionate release could be re-considered (as shown at Crown Production Number 3 at pages 255, and 319 324).

16. The deceased was pronounced life extinct at 0910 hours on 28 December 2019.

Cause of Death

17. A Post Mortem examination was not carried out on the deceased and the cause of death was recorded and registered as:

1a) Presumed Cholangiocarcinoma with Lymph Node Metastases,

II Adenocarcinoma of the Oesophagus, Liver Cirrhosis due to Previous Hepatitis C Infection (resolved) and Alcohol Excess

(as shown at Crown Production Number 1 at page 3).

Findings of the Death in Prison Learning, Audit and Review

18. Following the death of the deceased, a Death in Prison Learning, Audit and Review (DIPLAR) was conducted by Scottish Prison Service (Crown Production Number 2). The DIPLAR identified some elements of good practice and states:

> "Excellent partnership working between the SPS, NHS, and MacMillan Nursing Services who ensured there was a robust care plan in place for Mr McLeish whilst he was located in the establishment.
>
> The establishment's catering department excelled in ensuring Mr McLeish's catering requirements were delivered.
>
> The care and compassion shown by residential staff when dealing with Mr McLeish.

> As a result of pain relief required overnight, a secure, safe care plan was initiated in partnership with out of hours services, evening nursing service, and the SPS was implemented."
>
> (as shown at Crown Production Number 2 at page 9).

NOTE

19. Representation at this inquiry was as follows:
The Crown: Ms Allan, Procurator Fiscal Depute;

Lanarkshire Health Board: Ms Shippin, solicitor;

Scottish Prison Service: Mr McIntosh, solicitor.

[1] The court is grateful to those solicitors and to Ms Middleton, solicitor for the Scottish Prison Service and Ms Shippin for Lanarkshire Health Board for the meticulous preparation of the joint minute and the written submissions which were provided to the court in advance of the inquiry. That made the task of the court easier.

[2] In light of the evidence before the inquiry and the submissions made I am satisfied that the medical care provided to Mr McLeish within the hospice, hospital and prison as is relevant to the remit of this inquiry was appropriate. There was no evidence to suggest that any alternative form of medical treatment, supervision or intervention would have prevented his illness or changed the outcome of it. I agree therefore with the submissions made by all the participants that only formal findings should be made.

[3] At the conclusion of the inquiry solicitors for the parties represented extended their condolences to the family of the deceased. I also extend my condolences.