

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2017] FAI 6

DETERMINATION

BY

SHERIFF LINDSAY WOOD

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)
ACT 1976**

into the death of

WILLIAM ANDREW COLCLOUGH

Glasgow, 20 February 2017

PART I

Introduction and legal framework

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of William Andrew Colclough who died at Glasgow Royal Infirmary on 20 December 2015. Mr S Quither, Procurator Fiscal Depute, represented the public interest and Ms A Chalmers, Solicitor, represented the Scottish Prison Service. The family of Mr Colclough were not represented.

[2] A joint minute of agreement was entered into by parties and received by the Inquiry. No other evidence was led.

Legal framework

[3] Section 6 of the said 1976 Act requires the presiding sheriff to make determinations in the following matters (a) where and when the death took place; (b) the cause of such death; (c) the reasonable precautions, if any, whereby the death might have been avoided; (d) the defects, if any, in any system of working which contributed to the death; and (e) any other facts which are relevant to the circumstances of the death.

PART II

Determination as to the circumstances of the death

[4] The Sheriff, having considered all the evidence FINDS and DETERMINES that in terms of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

(i) that in terms of section 6(1)(a) that William Andrew Colclough, born 24 July 1967, died of dysfunction and failure of a number of organs including cardiovascular and respiratory systems as well as liver, kidney and clotting dysfunction and biochemical abnormalities consistent of multiple organ failure at Glasgow Royal Infirmary on 20 December 2015. Life was pronounced extinct at 0003 am.

(ii) that in terms of section 6(1)(b) that the cause of his death was

1a Septic shock due to bronchopneumonia (clinical diagnosis) and upper gastrointestinal haemorrhage from ruptured oesophageal varices

2 Complications of alcohol and injecting drug abuse

- (iii) that in terms of section 6(1)(c) there were no reasonable precautions whereby the death might have been avoided
- (iv) that in terms of section 6(1)(d) there were no defects in any system of working which contributed to the death
- (v) that in terms of section 6(1)(e) there were no other facts which were relevant to the circumstances of the death.

PART III

[5] After considering the joint minute of agreement and hearing submissions I made the following findings:

- (1) On the 2nd and thereafter on the 11th of December 2015, at Glasgow Sheriff Court, WILLIAM ANDREW COLCLOUGH, date of birth 24 July 1967, formerly residing in Glasgow (hereinafter referred to as “the deceased”), in respect of cases bearing Procurator Fiscal’s reference numbers GG15012292 and GG15016430 was detained in custody.
- (2) Following upon said detention, the deceased was incarcerated in terms of same and as at the date of his death in Glasgow Royal Infirmary (hereinafter referred to as “GRI”) on 20 December 2015 he was incarcerated in HMP Barlinnie, Glasgow (hereinafter referred to as “Barlinnie”). He was accordingly in legal custody as at the date of his death. As at said date his cell was Cell C1/39 in C Hall of Barlinnie.
- (3) Following upon becoming unwell after returning from court on 11 December, the deceased was kept under review overnight and then medically examined at

Barlinnie by Dr Joseph Daly the following day. Dr Daly formed the view the deceased should be admitted to hospital and an ambulance was called. At 1115 am on 12 December 2015, the Paramedic Team Leader June Marie Maxwell and Paramedic Julie Granger were instructed to attend at Barlinnie in relation to the deceased having taken unwell with some sort of breathing difficulty. They arrived at Barlinnie at 1123 am and were then directed to where the deceased was. Upon examination, he was found to have low oxygen, a temperature and low blood pressure. He was given 28% oxygen and 1 gram of paracetamol for his temperature which was 38.9 degrees, as opposed to an optimum 36.9 degrees. His oxygen saturation level was 82% and rose to 93% after being given oxygen. He was then taken by chair to the ambulance and taken by ambulance to the GRI Acute Assessment Unit, where he arrived at 1154 am and was admitted at 1211 pm.

(4) Within GRI, the deceased was diagnosed as suffering from pneumonia with associated septic shock and respiratory failure. He was transferred to the Medical High Dependency Unit and due to concerns about his condition, to the Intensive Care Unit at about 1204 am on 13 December to receive advanced respiratory support from a ventilator and support for blood pressure. There was some improvement over the following five days but late on 18 December, he significantly deteriorated due to a bleed from his gullet, most likely due to alcohol related liver disease. His kidneys subsequently failed and due to his overall poor condition, both acutely and chronically, he was not suitable for renal dialysis, a decision taken in consultation

with input from gastroenterology and intensive care consultants and with agreement of his family. Thereafter, he died at 0003 am on 20 December 2015.

(5) After being incarcerated in Barlinnie, and then taken to GRI, as narrated *supra*, the physical and mental health of the deceased was monitored on a regular basis. Thereafter, the security and, in general terms, the health of the deceased while he was in GRI and until he died, was monitored by SPS staff, who maintained a record of events which forms part of SPS prison records in relation to the deceased.

(6) At or about 0130 am, on Sunday 20 December, Police Constables Adam Lawman and Lucy Anderson were instructed to attend at GRI in relation to the report of the death of the deceased. Upon arrival, they gathered information and took witness statements about his death. The deceased was subsequently removed from GRI and taken to Queen Elizabeth University Hospital, Glasgow (hereinafter referred to as ("QEUH")) for post mortem examination.

(7) On 30 December 2015 at QEUH, a post mortem examination was carried out on the deceased by Dr Michael Parsons, Forensic Pathologist. In his post mortem, Dr Parsons states as part of his conclusions *inter alia*:

"The available history indicates that Mr Colclough had a history of alcohol and intravenous drug abuse, the latter complicated by hepatitis C infection...

On the basis of the pathological findings in conjunction with the medical notes, it would appear that this man died due to septic shock secondary to bronchopneumonia in combination with heavy bleeding from his oesophagus (upper gastrointestinal haemorrhage) as a complication of liver cirrhosis...the most likely cause of which (cirrhosis) was a combination of chronic alcohol abuse and hepatitis C infection due to intravenous drug abuse...

As to the cause of death in this case, the medical notes describe dysfunction and failure of a number of organs including cardiovascular and respiratory systems as well as liver, kidney and clotting dysfunction and biochemical abnormalities...consistent of multiple organ failure; however this is a clinical diagnosis and one that does not appear to have been made formally by the doctors treating Mr Colclough. The likely cause of this man's death would appear to be a combination of sepsis due to bronchopneumonia and upper gastrointestinal haemorrhage secondary to liver cirrhosis, which in turn was most probably a complication of alcohol and injecting drug abuse."

(8) Intimation of the death of the deceased was provided to the procurator fiscal at Glasgow by the Registrar for South Lanarkshire on 15 February 2016.

Submissions

[6] Both the procurator fiscal depute and Ms Chalmers asked that I make formal findings on the basis that Mr Colclough had died of natural causes and that nothing could have been done to save his life. He had been treated appropriately from falling ill on 11 December 2015 until his death nine days later.

Conclusions

[7] The reason for this Inquiry is simply because Mr Colclough died in legal custody albeit in hospital due to his deteriorating health condition. The joint minute lodged by parties is largely incorporated into my findings and there is nothing untoward whatsoever with regard to the circumstances of Mr Colclough's death.

[8] I wish to commend Mr Quither, the Procurator Fiscal Depute and Ms Chalmers, Solicitor for the Scottish Prison Service for their helpful and professional contributions to this Inquiry.

[9] I also wish to record my condolences to the mother and sisters of Mr Colclough who attended on him in hospital.