

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2015FAI9

DETERMINATION

by

SHERIFF LINDSAY WOOD, Sheriff of the Sheriffdom of Glasgow and Strathkelvin

In an Inquiry held under the Fatal Accidents and Sudden Deaths (Scotland) Act 1986 held at Glasgow on the FIFTEENTH to the NINETEENTH of DECEMBER TWO THOUSAND AND FOURTEEN into the death of **MICHAEL GLANCY**, born 9 February 1961, formerly residing in, Port Glasgow and latterly a prisoner at H M Prison, Low Moss, Bishopbriggs wherein he died on 25 September 2013.

GLASGOW, 10th March 2015.

PART 1

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 Michael Glancy who died at H M Prison, Low Moss, Bishopbriggs on 25 September 2013. Mr Stephen Quither, Procurator Fiscal Depute, appeared in the public interest, Miss Watt, Solicitor, appeared for the Scottish Prison Service, Mr O'Reilly, Solicitor, appeared for the National Health Service, Mr Cahill, Solicitor, appeared for the Prison Officers' Association of Scotland and Miss Malloy, Solicitor, appeared for the family of Michael Glancy.

[2] The Inquiry heard evidence and submissions over the course of five days from 15-19 December 2014. The Crown led evidence from eight witnesses:

1 Thomas Jeffrey

- 2 Peter Senyk
- 3 Colin Dunlop
- 4 Jacqueline Wilson
- 5 Dr Derek Grose
- 6 Dr Carolyn Datta
- 7 Fiona Gilmour
- 8 Lesley McDowall

The Scottish Prison Service led evidence from Stephen Murphy and the family of Mr Glancy led evidence from his sister, Helen Larkin, Professor Alex Spencer and Fiona Cruickshank. No other evidence was led.

Legal Framework

(5) Section 6 of the said 1976 Act requires the presiding sheriff to make determinations on the following matters:

- (a) Where and when the death and any accident resulting in the death took place.
- (b) The cause 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 might have been prevented.
- (d) The defects, if any, in any 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.
- (6) The court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the sheriff's powers do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the procurator fiscal and any other party if so advised.

PART II

Determination as to the circumstances of the death

[7] The sheriff, having considered all the evidence adduced, FINDS AND DETERMINES in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

- (i) In terms of section 6(1)(a) that Michael Glancy, born 9 February 1961 who formerly resided in Port Glasgow, died of natural causes at H M Prison, Low Moss, Bishopbriggs on 25 September 2013. He was found on the floor within his cell just after 7.00 am. Life was pronounced extinct at 7.40 am.
- (ii) In terms of section 6(1)(b), that the cause of his death was:
 - 1a – haemoptysis due to
 - 1b – advanced oesophageal carcinoma with fistula formation
- (iii) In terms of section 6(1)(c), there were no reasonable precautions whereby the death might have been avoided.
- (iv) In terms of section 6(1)(d), there were no defects in the system of working which contributed to the death.
- (v) In terms of section 6(1)(e), there were no facts which were relevant to the circumstances of the death.

PART III

Findings in fact

[8] I found the following facts admitted or proved:

- (1) It was a matter of agreement as contained in a joint minute of agreement signed by all parties that Michael Glancy was sentenced to a custodial sentence of five years with an extended sentence of three years on 18 June 2008. The offences involved assault with intent to rob and contravention of the Firearms Act 1968. Mr Glancy was released on licence but on 5 September 2012, having pled guilty to further charges of assault and robbery, he was given a further custodial sentence of four years and six months with a further extended sentence of three years.
- (2) At the time of his death on 25 September 2013, Mr Glancy was in a single cell 3.D.21 at H M Prison, Low Moss, one of the newest parts of the prison estate and which opened in 2012. He had a new cell which had an en suite shower, a toilet, electrical and TV facilities, modern equipment, a new bed and a new mattress.
- (3) Mr Glancy had previously been referred to the Health Centre Medical Staff for examination following complaints that he had difficulty swallowing. He was diagnosed with oesophageal cancer in December 2012 and attended the Beatson Cancer Centre in Glasgow under the care of Dr Derek Grose, Consultant in Clinical Oncology. Mr Glancy attended the Beatson for radical treatment which consisted of a combination of chemotherapy and radiotherapy. Dr Grose had identified Mr Glancy as having a T4 tumour and the diagnosis was terminal. The typical life expectancy of a patient diagnosed with oesophageal

cancer is one year. The radical treatment was designed to bring the cancer under control and to improve the quality for what remained of Mr Glancy's life.

- (4) As a result of Mr Glancy's cancer, he lost between 7 and 11 kg. He required to be fed by nasogastric tube and the management of that tube proved difficult. Ultimately, Mr Glancy required to stay in hospital at the Beatson between 4 February and 9 May 2013. During this stay, there was regular contact with H M Prison, Low Moss and in particular, with Fiona Gilmour, Mr Glancy's named nurse there. There was discussion about compassionate release. Dr Grose wrote a letter to Fiona Gilmour on 10 April 2013 setting out his views on the illness and giving a probable life expectancy at that point of between 6 and 8 months. Dr Grose wrote that letter to try to fulfil what he understood to be his role in the compassionate release procedure. He was not specifically asked to do that.
- (5) From 9 May to 25 September 2013, Mr Glancy was treated palliatively in H M Prison, Low Moss. He was visited in June, July, August and September by the Palliative Care Consultant, Dr Carolyn Datta. He was also visited by Marie Curie nurses throughout those months. Nurses from the Health Centre visited Mr Glancy four times a day to administer medication and to check on his health. During this period, Mr Glancy was also reviewed by Dr Grose at out-patient clinics. In a further letter to H M Prison, Low Moss from Dr Grose dictated on 14 August 2013, Dr Grose confirmed his view that Mr Glancy was stable and that he would see him again in three months.

- (6) After being diagnosed, Mr Glancy was offered a move to a disabled cell in H M Prison, Low Moss on more than one occasion. He was shown the cell but declined it. He wanted to stay on the third floor with his brother and his friends who were situated there. He was able to self-care, was mobile and continued to socialise with his friends. He was a private man and did not like to discuss his end of life options with others. On occasion, Mr Glancy was of low mood, a bit tearful and emotional. There was discussion about involving the prison chaplain to counsel Mr Glancy. There was a discussion about overnight nursing by the Marie Curie nurses if matters reached the stage where overnight observations were required. There was some discussion of admission to a hospice. Mr Glancy's condition prior to his death was that he was not at the stage of admission to a hospice or in need of an overnight nurse. He was receiving a variety of medications, some of them powerful.
- (7) On the morning of 25 September 2013 at the wake up and prisoner count, Mr Glancy was found in his cell, lying on the floor with blood around him. He had had a massive haemorrhage. He was cold to the touch. Life was pronounced extinct at 7.40 am.
- (8) The cause of Mr Glancy's death was a catastrophic event, haemoptysis, the timing of which could not be predicted. It is a recognised fatal outcome for a sufferer of this type of cancer. Death would have occurred within minutes and if Mr Glancy had been in a hospice, a hospital or at home, his death would have occurred in the same way. If he had been in hospital at the time the

haemorrhage occurred, he would have been administered painkilling medication for the last few moments of his life. Given his condition and the haemorrhage, death could not have been avoided. There was no reasonable precaution which could have been taken to avoid that.

- (9) Mr Glancy's health care both in prison and in the hospital was of a very good standard and no criticism should be attached. The Scottish Prison Service does not have responsibility for delivery of health care and that is done through the National Health Service. Mr Glancy received very good treatment throughout and an appropriate level of pain medication.
- (10) The question of compassionate release does not come under the auspices of 1976 Act. However, the Scottish Prison Service and Scottish Ministers have in place an appropriate policy and procedure for compassionate release. The document is headed "Governors and Managers: Advice" and its subject is "Early Release on Licence on Compassionate Grounds". At paragraph 4.1 of the document, it is stated that such a release may be considered where the prisoner has a terminal illness, death is likely to occur soon and although there is no fixed life expectancy time limit, life expectancy of less than three months may be considered appropriate.
- (11) The two letters from Dr Grose mentioned at paragraphs 4 and 5 were sent to the Health Centre at H M Prison, Low Moss. It appears the letters were simply filed and not passed on to the Scottish Prison Service. That particular system failure on the part of the NHS has since been addressed and there is no need for a

particular recommendation to be made in that regard. Notwithstanding these letters not being available for discussion at daily multi-disciplinary meetings within H M Prison, Low Moss, there was regular discussion about Mr Glancy's condition and the Deputy Governor, Steven Murphy repeatedly sought comment from health care staff as to Mr Glancy's condition and life expectancy. There were no immediate concerns and indeed, if the letter sent in August had been received, it would have given a degree of reassurance. Accordingly, there was no indicator to further trigger the compassionate release process as Mr Glancy was stable and not stated to be within three months of the end of his life.

- (12) A number of factors are taken into account before compassionate release is granted. It is not solely a definitive prognosis of an expected life expectancy but it also requires favourable background information from the Social Work Department and support from the Prison Governor. There would also be various assessments carried out to measure the risk to the public and any benefit which might accrue to the prisoner and his family. There would also need to be support from the prisoner but Mr Glancy was not pressing for this. He seemed relatively comfortable in the prison setting. In all, there was no certainty that a compassionate release application would have been granted
- (13) The concerns of Helen Larkin, Mr Glancy's sister about the delay in Mr Glancy's treatment, he being deprived of medication and receiving poor levels of care and compassion were not borne out by the evidence of Dr Grose and Dr Datta. They gave impressive, compelling and reliable evidence that Mr Glancy was well

looked after following him being diagnosed and Dr Grose testified that even if Mr Glancy had died in the Beatson Cancer Centre, there was nothing which could have been done to save his life.

- (14) An application for compassionate release for Mr Glancy had been partially completed by the SPS after he was diagnosed with terminal cancer. That was on the instructions of the then Deputy Governor, Brenda Stewart. The front page of the application had been completed in case there were, at some stage, sufficient grounds for compassionate release. The form was sent to the Health Centre who would have completed the form when a confirmed life expectancy of three months or less came to their attention. Such an event did not happen as there never was a medical prognosis of a life expectancy of less than three months. There was, however, reasonable monitoring of Mr Glancy's health as there were multi-disciplinary review meetings every morning and Mr Glancy's condition was often discussed. There was nothing of concern to trigger further activity on the compassionate release application and, in effect, the timing of Mr Glancy's death was not predicted.

- (15) Professor Alex Spencer, a former Prison Governor provided a report on behalf of the family, some of which was referred to at the Inquiry. During his evidence, he retracted his report point that Mr Glancy would have lived longer if he had received the appropriate care and supervision. In addition, he made some criticism of the SPS and Mr Murphy but the evidence of Mr Murphy was preferred to his.

Submissions

[9] On behalf of the Crown, the procurator fiscal depute invited me to make certain determinations under sections 6(1)(a) and 6(1)(b) which I have followed. He also asked me not to make any determinations under sections 6(1)(c) and 6(1)(d) which I have also followed. Further, he asked me not to make a determination in respect of Section 6(1)(e) and I have followed that also. The submissions of the Crown are in line with the submissions of the Scottish Prison Service, the National Health Service and the Prison Officers' Association of Scotland. Miss Malloy for the family of Mr Glancy was in agreement with regard to sections 6(1)(a), 6(1)(b), 6(1)(c) and 6(1)(d). There is no doubt where and when Mr Glancy died, the cause or causes of his death and the fact that there were no reasonable precautions which could have been taken whereby the death may have been avoided. Further, there were no defects in any system which contributed to Mr Glancy's death. All parties agreed that he died of cancer and there could be no criticism of his care from diagnosis to his death.

[10] Disagreement comes with regard to section 6(1)(e). The family were critical that the compassionate release procedure was not properly invoked. Miss Malloy submitted that if the application had been processed, this would have allowed for the possibility that Mr Glancy may have been at home or in a hospital setting at the time of his death and made more comfortable in the moments prior to his death. Miss Malloy submitted that Mr Glancy would not have wished to die in jail. There is proper criticism of the two letters from Dr Grose being filed by NHS at Low Moss and not passed to the SPS.

Miss Malloy submitted that the SPS should have been more proactive in advancing the compassionate release process given that Mr Glancy was terminally ill. Miss Malloy acknowledged that there was no guarantee that an application for compassionate release would have been successful but if the process had been properly facilitated, Mr Glancy might at least have had the opportunity of being released and would have died in more dignified circumstances.

Conclusions

[11] There is no doubt where and when Mr Glancy died. He was serving a prison sentence when he contracted cancer and the prognosis was terminal. He spent some time in hospital being treated and then went back to jail where he was well treated palliatively and otherwise. He did not wish to move cell as he was comfortable where he was and in close proximity to his brother and friends. Dr Grose wrote two letters to the NHS Unit at Loss Moss and unfortunately these were not actioned. That has now been addressed to ensure correspondence is properly activated. In effect, the letters were not passed by the NHS to the SPS. The first letter in May 2013 gave Mr Glancy a prognosis of 6-8 months. The second letter of August 2013 confirmed that Mr Glancy was stable and would be seen again in three months' time. Unfortunately, Mr Glancy died in September when he had a massive haemorrhage associated with his cancer. The doctors agreed this was a catastrophic event which could not have been predicted. He was found dead in his cell on the morning of 25 September 2013. If the event had happened at home, in a hospice or in hospital, he would still have died. Death would

not have been avoided. Mr Glancy's sister was critical of the care and treatment of her brother throughout. She looked at it from a lay person point of view. However, I much preferred the evidence of Dr Grose and Dr Datta who confirmed that Mr Glancy was well cared for and looked after. There is also criticism of the compassionate release procedure not being followed. I have a certain sympathy with that claim but I do believe that there was never a point whereby the procedure should have been fully triggered. There are various factors which need to be satisfied before a prisoner is released in such circumstances and understandably, these are particularly stringent. It is not enough of itself that the prisoner has little time to live. There is also the interest of the public, the prisoner, his family, social work considerations and assessment of other risks. There also has to be a medical prognosis that the prisoner is probably within three months of death. In Mr Glancy's case, we never got to that and the last definitive guidance was from Dr Grose in August 2013 when he seemed satisfied that Mr Glancy's condition was stable and that he would see him again in three months' time. In actual fact, the compassionate release procedure had been started for Mr Glancy given he had terminal cancer. The front page of the application form was filled in but the application did not benefit from the two letters from Dr Grose as these were misfiled. However, on a regular basis, the SPS were being kept informed of Mr Glancy's condition and there was nothing to trigger the completion of the application and at the time of his death, there was no prognosis that he had less than three months to live. Further, the court could not conclude that if fully invoked, the application would have been granted. Accordingly, taking full account of the acceptable evidence led and the various

submissions made, I was persuaded that there were no reasonable precautions whereby Mr Glancy's death could have been avoided and that there were no defects in any system of working which contributed to his death. Mr Glancy had unfortunately contracted a serious form of cancer, was properly treated and cared for, and the circumstances leading to his death could not have been avoided. As far as the compassionate release procedure is concerned, there were certain flaws relating to the non-actioning of two letters (and which has since been addressed to my satisfaction) but this did not amount to a matter which was relevant to the circumstances of the death. Indeed, there was never a "three month" trigger point as I have mentioned previously, there was no certainty the compassionate release application would have been granted and in the lead up to Mr Glancy's death, he was stable, relatively comfortable and there were no signs that death was imminent. Accordingly, I make no findings in respect of sections 6(1)(c), 6(1)(d) and 6(1)(e) of the Act.

[12] Finally, I wish to thank all of the witnesses for their assistance with this Inquiry and the solicitors for their valuable and professional contributions. I conclude by recording my condolences to the family of Mr Glancy and in particular to his mother who sat in court throughout the Inquiry and conducted herself with the utmost dignity and respect.

SHERIFF L WOOD
Sheriff of Glasgow and Strathkelvin

GLASGOW, 10th March 2015