SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2025] FAI 26

KIL-B934-24

DETERMINATION

BY

SUMMARY SHERIFF MORAG FRASER

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

into the death of

ANDREW WHITEFORD

Kilmarnock, 4 June 2025

Determination

The sheriff, having considered the information presented at the Inquiry, determines in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, (hereinafter referred to as "the 2016 Act"):

In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred)

The late Andrew Whiteford, born 21 September 1983, died at approximately 13.35 hours on 31 May 2022 at Ward 4E, University Hospital, Crosshouse, Kilmarnock.

In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in the death occurred)

The death of Mr Whiteford was not attributable to any accident.

In terms of section 26(2)(c) of the 2016 Act (the cause of causes of death)

The cause of death of Mr Whiteford was:

1a Type 2 Respiratory Failure

1b Airway Obstruction

1c Hypopharyngeal Squamous Cell Carcinoma.

2. Type 1 Diabetes

In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death).

Mr Whiteford's cause of death did not result from an accident.

In terms of section 26(2)(e) (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided.

There are no precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death being avoided.

In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)

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

In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

There are no other facts which are relevant to the circumstances of the death of Mr Whiteford.

Recommendations

In terms of section 26(1((b) of the 2016 Act recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances

Having considered the information presented at the Inquiry, the sheriff makes no recommendations in terms of Section 26(1)(b) of the Act.

NOTE

Introduction

[1] This was a mandatory Fatal Accident Inquiry in terms of section 2(4)(a) of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act").

Mr Whiteford's death occurred while he was in legal custody being a prisoner of HMP Kilmarnock.

Proceedings and Parties.

[2] Notice of the Inquiry was given by the procurator fiscal on 29 November 2024. A preliminary hearing was held at Kilmarnock Sheriff Court on 29 January 2025. The Inquiry proceeded at Kilmarnock Sheriff Court on 23 April 2025. The Crown were represented by Saud Ul-Hassan, Procurator Fiscal Depute. GEOAmey were represented by Ann Bonomy Solicitor; National Health Service ("NHS") Ayrshire and Arran were represented by Robbie Wightman, Solicitor; the Scottish Prison Service were represented by James Halley Solicitor and Serco Limited were represented by Andrew Lothian, Solicitor. No other parties were represented. The next of kin of the late Mr Whiteford, Ms Lisa Whiteford attended the hearing**.**

[3] The evidence at the Inquiry was presented by way of a detailed and comprehensive Joint Minute of Agreement signed by the Crown, GEOAmey Limited, NHS Ayrshire and Arran, Scottish Prison Service and Serco Limited.

[4] In addition to the evidence contained within the Joint Minute of Agreement, the Crown, GEOAmey and NHS Ayrshire and Arran lodged the following productions, referred to therein and forming part of the evidence**:**

1. Crown Production 1 - Adverse Event SBAR Review Level Decision Making Form dated 22/06/2022. This is referred to at Paragraph 3.2 of the Joint Minute of Agreement.

2. Crown Production 2. – Death in Prison Learning, Audit & Review DIPLAR Report and Learning & Action Plan dated 16 September 2022. This is referred to at Paragraph 3.4 of the Joint Minute of agreement.

3. Crown Production 12. - Toxicology report by Dr Hazel Jennifer Torrance, Forensic Toxicologist dated 29 July 2022. This is referred to at Paragraph 2.27 of the Joint Minute of Agreement.

4. Crown Production 13. - View and Grant examination report by Dr Mark Brown, Consultant Pathologist dated 4 August 2022. This is referred to at Paragraph 2.27 of the Joint Minute of Agreement.

[5] GEOAmey lodged one production, a statement of Siobhan O'Brien, Operational Auditor for GEOAmey Limited. This is referred to at Paragraph 4.1 of the Joint Minute of Agreement and is to be treated as equivalent to her oral evidence.

[6] NHS Ayrshire and Arran lodged two productions, (i) statement of Ms Lorna Langstaff, Consultant at the Ear, Nose and Throat Clinic and (ii) statement of Dr Paul Church, General Practitioner. In terms of Paragraphs 4.2 and 4.3 of the Joint Minute of Agreement these statements are to be treated as equivalent to the oral evidence of these witnesses.

[7] There were no witnesses called or productions lodged by the Scottish Prison Service or Serco Limited.

[8] At the hearing on 23 April 2025, the parties submitted that the Inquiry could proceed without oral evidence, relying on the statements of the witnesses in lieu of parole evidence as provided for in the joint minute, the matters agreed in the joint

minute including the contents of productions and the agreed facts. I agreed that this was appropriate and sufficient. I consequently allowed that course of action, closed the Inquiry and reserved my decision (avizandum). The submissions of the parties as to formal findings concurred. I accepted that these were accurate and correct based on the evidence agreed. Accordingly, these are reflected in the formal findings below.

The Legal Framework

[9] The purpose of an Inquiry such as this is set out in section 1(3) of the 2016 Act as being to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. In terms of section 26 of the 2016 Act the Inquiry must determine the following matters:

(a) When and where the death occurred.

(b) When and where any accident resulting in the death occurred.

(c) The cause or causes of the death;

(d) The cause or causes of any accident resulting in the death;

(e) Any precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death or any accident resulting in the death being avoided;

(f) Any defects in any system of working which contributed to the death; and

(g) Any other facts which are relevant to the circumstances of the death.

It is open to the sheriff to make recommendations in relation to matters set out in subsection 4 of section 26 the 2016 Act.

[10] The Inquiry is not intended to establish civil or criminal liability. It is an exercise in fact finding, not fault finding. It is an inquisitorial process. It is not open to me to engage in speculation.

[11] The Procurator Fiscal represents the public interest. The Sheriff's determination must be based on the evidence presented at the Inquiry. The Sheriff's determination is not admissible in evidence and may not be founded upon in any judicial proceedings of any nature.

The Circumstances of the deceased and his death.

[12] Andrew Whiteford was born on 21 September 1983.

[13] At the time of his death on 31 May 2022, Mr Whiteford was a serving prisoner at HMP Kilmarnock.

[14] On 15 September 2021, Mr Whiteford self-referred to medical staff within HMP Kilmarnock in relation to a lump in his throat. An appointment was arranged, however, he refused to attend.

[15] On 22nd October 2021, having reviewed Mr Whiteford, Dr Paul Church, the prison GP, made an urgent referral for Mr Whiteford to University Hospital Crosshouse, Kilmarnock, indicating that he had a concern regarding cancer. A referral was made to an ear, nose and throat ("ENT") specialist.

[16] Mr Whiteford was provided with an appointment to attend at the ENT department on 9 November 2021. GEOAmey officers were assigned to collect Mr Whiteford and take him to his appointment. They were advised en-route that he now declined to attend this appointment.

[17] On 25 November 2021, Mr Whiteford submitted a self-referral to the prison healthcare team requesting a further appointment with the GP.

[18] On 26 November 2021 the GP re-referred Mr Whiteford to the ENT department of the said Hospital as an "urgent cancer suspected referral".

[19] An appointment was scheduled on 7 December 2021. This appointment did not take place as GEOAmey were unable to provide transport.

[20] The said ENT department scheduled a further appointment for Mr Whiteford on 21 December 2021. No letter relating to that appointment was received by the healthcare team and therefore no arrangements were made for him to attend that appointment.

[21] On 3 January 2022, Mr Whiteford presented to the prison healthcare team with lethargy and hemostasis. He was advised to submit a further self-referral form for GP review.

[22] On 4 January 2022, Mr Whiteford attended at the triage area of the said prison healthcare team to collect medication. He presented as having lost weight. He was referred by the nurse to speech and language therapy.

[23] On 7 January 2022, Mr Whiteford was reviewed by a GP and a further hospital ENT appointment was requested.

[24] On 19 January 2022, Mr Whiteford failed to attend an appointment at the said hospital due to pain in his neck.

[25] An appointment was scheduled for Mr Whiteford at the said ENT department on 20 January 2022.

[26] GEOAmey was unable to facilitate attendance at this appointment and it did not take place.

[27] On 8 February 2022 Mr Whiteford attended the said Hospital, following a referral from the said prison heathcare team**.** A preliminary diagnosis of advanced laryngeal cancer was given to Mr Whiteford pending a biopsy. He declined admission and self-discharged against medical advice.

[28] On 7 March 2022, Mr Whiteford attended the said hospital ENT department where Ms Langstaff, Consultant ENT Surgeon performed a Pananendoscopy, biopsy and tumour debulking surgery. The plan was for overnight monitoring post procedure but Mr Whiteford declined admission to hospital.

[29] On 9 March 2022, Mr Whiteford was referred to the palliative care team at the said Hospital due to a rapid deterioration in his condition.

[30] On 10 March 2022 a CT scan was carried out at the said Hospital to determine the stage of Mr Whiteford's cancer.

[31] On 15 March 2022 Mr Whiteford self-discharged from hospital with a Nasogastric tube in situ before discharge medication had been provided

[32] On 22nd March 2022, Mr Whiteford received confirmation of his diagnosis from Ms Longstaff.

[33] Mr Whiteford was granted early release on licence on compassionate grounds on 27 April 2022 effective from 29 April 2022 when he was transferred to Ayrshire Hospice for end of life care.

[34] On 2nd May Mr Whiteford appeared to Hospice staff to be under the influence of an unknown substance. He was also in possession of Diazepam tablets which he refused to give to staff.

[35] On 3 May 2022 Mr Whiteford was found in an unresponsive state and was taken to said Hospital where he was diagnosed as having aspiration pneumonia.

[36] Ayrshire Hospice withdrew Mr Whiteford's placement there due to concerns regarding his misuse of illicit drugs and the risk these may pose to other patients and visitors. No suitable alternative accommodation was identified.

[37] On 6 May 2022 the Parole Board recalled Mr Whiteford's licence.

[38] Mr Whiteford was arrested by Police officers within said Hospital that day and was thereafter continuously supervised by GEOAmey staff within the Hospital.

[39] On 31 May 2022 at approximately 1335 hours Mr Whiteford was observed to have passed away within his bed at the said hospital. Life was pronounced extinct by Doctor Findlay Hutcheson.

[40] On 15 June 2022 Dr Mark Brown, Consultant Pathologist carried out a View and Grant examination. He reviewed the clinical summary provided in the police report and conducted an external examination of Mr Whiteford. He reviewed a toxicology report (Crown Production number 12).

[41] Dr Brown's report comprises Crown Production number 13. He concurred with the said clinical summary regarding the cause of death and determined the cause of death to be:

1a Type 2 Respiratory Failure

1b Airway Obstruction

1c Hypopharyngeal Squamous Cell Carcinoma.

2. Type 1 Diabetes.

[42] On 22nd June 2022, Hannah Campbell-McLean, Clinical Service Manger completed an "Adverse Event SBAR Review Level Decision Making Form". This forms Crown Production number 1.

[43] The aim of this document is to minimise the risk of adverse events occurring by maximising opportunities to learn; ensuring patients are kept safe and staff are supported. The purpose is to support a consistent and timely approach to the identification, reporting, reviewing and learning from adverse events and near misses.

[44] This assessment records that from the initial self-referral being received by the prison healthcare team in September 2021 to the diagnosis of a large hypopharyngeal squamous cell carcinoma, a period of 5 months had passed.

[45] There were several contributing factors to the delay in this diagnosis. These included:

(i) Mr Whiteford declining to attend prison healthcare and secondary care appointments.

(ii) GEOAmey being unable to honour scheduled appointments.

(iii) Notification of a re-scheduled appointment date not being provided to the prison healthcare team.

[46] It is noted within the assessment:

"….following initial GP review, a referral was made timeously to ENT. Staff within the prison setting encouraged the patient to attend planned appointments. At the time, GEOAmey were experiencing significant staffing challenges which impacted on the delivery of the contract across the prison estate. Concerns were escalated locally by the prison healthcare team and through the national prison care network steering group.

There was early identification of the requirement for Palliative Care Specialist Services and subsequent referral was made timeously.

An anticipatory care plan was in place and the patient was supported with decisions to apply for compassionate release.

It is recognised as good practice that the prison and the prison healthcare team were able to attend the planned appointment with the patient to ensure that he had appropriate support.

Despite the challenges faced by the prison healthcare team following the patient's self-discharge from hospital, appropriate plans of care were put in place to monitor and care for the patient whilst in prison.

Support from wider community nursing services was also provided to staff within the prison to ensure that they were appropriately trained to deliver safe care to the patient.

Where concerns were identified by the health care team in HMP Kilmarnock, care was escalated appropriately.

There was good communication with the patient's next of kin and the prison healthcare team.

The patient died in hospital on 31 May 2022 which was not his preferred place of care, however admission was appropriate due to concerns regarding illicit substance use."

[47] The Scottish Prison Service completed their process for reviewing all deaths in custody known as "DIPLAR" on 16 September 2022. DIPLAR refers to "Death in Prison learning, Audit & Review." The DIPLAR Report and Learning & Action Plan review forms Crown Production number 2. This process is designed to provide a system for recording any learning and identified action. The NHS are a key contributor to the review.

[48] From the DIPLAR report the following points were identified as good practice:

a. Mr Whiteford's Personal officer and 1 x member of nursing staff attended hospital with him to receive his diagnosis.

b. the Dossier and Compassionate release application was completed promptly.

c. Effective multi-disciplinary working and communication, particularly in relation to Mr Whiteford's Order of Lifelong Restriction (OLR).

d. NHS Staff were promptly trained in the equipment which Mr Whiteford returned from Hospital with..

e. a high level of care, engagement and support was provided to staff directly involved in Mr Whiteford's care. Mr Whiteford had given consent for NHS and Serco staff to provide information about his personal circumstances to his sister. This allowed his sister to attend the appointment with the palliative care consultant, as well as have regular contact with the healthcare team dealing with Mr Whiteford and senior prison staff.

It was noted that Mr Whiteford's sister did express concern about the unnecessary delay in Mr Whiteford being seen at an external hospital.

[49] The following learning point was identified from the DIPLAR:

> a" Failure by escort contractor to facilitate 2 x Hospital escorts. NHS have had a general meeting with the escort contractor to discuss concerns in relation to the cancellation of hospital appointments. In relation to Serco, there is a database which is required to be completed by Reception COM anytime the escort contractor cannot facilitate an escort, which is then submitted to the SPS."

[50] The action plan stated that Social Work should consider visiting arrangements for any prisoners released on compassionate grounds.

Evidence from Siobhan O'Brien

[51] GEOAmey's evidence was from Siobhan O'Brien, Operational Auditor for GEOAmey Limited by way of her statement lodged as their Production 1. It was agreed in terms of the Joint Minute this should be treated as the equivalent of her oral evidence.

Evidence from Ms Lorna Langstaff

[52] NHS Ayrshire and Arran's evidence was firstly from Ms Lorna Langstaff, Consultant, at the Ear, Nose and Throat Clinic by way of her statement lodged as their Production 1. It was agreed in terms of the Joint Minute this should be treated as the equivalent of her oral evidence.

Evidence from Dr Paul Church

[53] NHS Ayrshire and Arran's evidence was secondly from Dr Paul Church, General Practitioner by way of his statement as their Production 2. It was agreed in terms of the Joint Minute this should be treated as the equivalent of her oral evidence.

Conclusions

[54] On the basis of the evidence presented at the enquiry I am satisfied that I should make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act only. I have set out those formal findings above.

[55] In doing so I have considered carefully sections 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death) and 26(2)(g) (other facts relevant to the circumstances of death) as well as whether there are any recommendations to be made in terms of Section 26(1)(b) of the 2016 Act.

[56] In terms of section 26(2)(f), it is clear from the facts Mr Whiteford did not attend ENT hospital appointments on 9 November 2021, 7 December 2021, 21 December 2021, 19 January 2022 and 20 January 2022.

[57] In relation to the appointment on 9 November 2021, GEOAmey officers were assigned to collect Mr Whiteford and take him to his appointment but were advised en-route that he declined to attend this appointment. No system of working or other circumstances would have impacted the lack of attendance at this appointment.

[58] On 19 January 2022 Mr Whiteford failed to attend a hospital appointment due to pain in his neck. No system of working or other circumstances would have impacted the lack of attendance at this appointment.

[59] In relation to the appointment on 21st December 2021, the evidence was that no letter relating to that appointment was received by the prison healthcare team, and therefore no steps were taken to arrange for him to attend that appointment. In terms of the evidence of Dr Paul Church, the existence of this appointment only became known when a standard "Did Not Attend" letter was received. Dr Church indicates that further checking did not confirm that this appointment had been notified to the administration department who arrange transport. From the evidence, this letter was simply lost in transit as opposed to any failure in any system of work or other circumstance which would have affected the lack of attendance at that appointment.

[60] In relation to the missed appointments on 7 December 2021 and 20 January 2022, these appointments were missed due to GEOAmey being unable to fulfil their transport duties to these appointments. It is a matter of agreement that they were unable to do so due to ongoing staffing issues stemming from the Covid 19 pandemic.

[61] Siobhan O'Brien in her evidence confirms the mechanism for arranging hospital appointments for prisoners. She confirms that between December 2021 and January 2022, the Government restrictions applying to the country placed significant pressure on GEOAmey.

[62] According to Siobhan O'Brien GEOAmey had a significant lack of staff due to illness and also due to self-isolation as a result of being a close contact with someone

who had the virus. They also experienced a fundamental change in the operational environment which resulted in people leaving the organisation. GEOAmey were operating with three times as many absences as they would normally have. In addition virtual courts were being introduced which required GEOAmey to supply staff in Police Stations across the country. Consequently there was a greater demand on staffing as more officers were required in remote locations. GEOAmey were restricted from recruiting at this time due to an inability to hold training sessions as a consequence of social distancing guidelines.

[63] A formal improvement notice was provided to GEOAmey by the Scottish Prison Service at this time requesting that they focus on healthcare.

[64] If GEOAmey were unable to facilitate an appointment at this time prison staff would usually be notified on the day of the appointment. GEOAmey would not usually be aware of staffing levels until the morning of the appointment for the reasons outlined due to the Covid Pandemic.

[65] GEOAmey have undertaken further recruitment following the end of Covid restrictions and have begun to work with the NHS and establishments with whom appointments are made. They now receive a four-weekly update of planned and projected appointments in order that they can forecast the likely demand on resources and plan accordingly.

[66] GEOAmey are also working with the Scottish Prison Service's Population Management so that prisoners are moved to the locality of an appointment in advance.

[67] At the time of the two appointments missed by Mr Whiteford, if GEOAmey were unable to facilitate an appointment the practice was for this to be notified to prison healthcare staff on the day of the appointment. Had this taken place in sufficient time on the days of the appointments, this would have enabled healthcare prison service staff to attempt to make alternative arrangements for transport.

[68] At this point in the pandemic, however, as discussed in paragraphs 62 and 64, GEOAmey would not usually be aware of staffing levels until the morning of the appointment. This was not always communicated to the prison. Even if they had communicated the position to prison healthcare staff, the Scottish Prison Service also had pandemic-related staffing issues and may not have been able to facilitate Mr Whiteford's attendance at the two appointments in question.

[69] It is far from satisfactory that these appointments for Mr Whiteford were missed. There was a system of working in place at the time in terms of how arrangements for transportation of prisoners to hospital appointments were made and diarised, how they were carried out and how it was communicated to the prison if GEOAmey were unable to facilitate transport. These systems simply did not and could not operate as intended given the unprecedented impact and effect of the Covid pandemic in terms of staff illness coupled with the significant effect of government restrictions. I have not identified any systemic defects arising or precautions that might have been taken.

[70] In considering this aspect of the enquiry it is important to bear in mind the precise wording of section 26(2)(f) which refers to "any defects in any system of working which contributed to the death." In her statement of 20 March 2025, Ms Lorna Langstaff,

ENT consultant, considers the impact of the delay due to missed appointments and the impact that would have had on the outcome for Mr Whiteford. Whilst she indicates she is unable to say definitively, she confirms that, given the extent of the tumour at the beginning of March 2022 it must have been present for several months. She points out that the General Practitioner Dr Church recorded in the appointment of 22 October 2021 that Mr Whiteford reported at that time that he had been having symptoms for 9 months prior to seeking medical assistance. While the speed with which cancer progresses varies, she would expect that this type of cancer would progress over " months and months". She expresses the opinion that if Mr Whiteford had attended when he first experienced difficulties with swallowing etc, then it is possible that more effective treatment could have been offered to him. However, she states that even if treatment had been offered to Mr Whiteford at an earlier stage, the success or otherwise of that would have required a high level of commitment from him, and in particular his self-care following upon a laryngectomy not to mention a commitment to refrain from taking any illicit drugs. From the evidence of Ms Langstaff and Dr Church, for there to have been even a possibility of more effective treatment being possible for Mr Whiteford, he would have required to seek medical attention approximately a year before the missed appointments in December 2021 and January 2022. He would also have required to co-operate fully with all appointments and treatment. It is noted that Mr Whiteford failed to attend an initial GP appointment in September 2021, refused to attend an appointment at ENT on 9 November 2021, refused to be admitted to hospital when seen at ENT on 8 February 2022 and in addition self-discharged from hospital on 15 March

2022 without his medications. On 2 May 2022 Mr Whiteford appeared to staff at the Hospice to be under the influence of an unknown substance and was in possession of Diazepam tablets.

[71] During the pandemic, processes had to be adapted or put in place to deal with a fluid, developing situation. Consideration might have been given to adapting procedures with the requirement for a logged call by a reasonable time in the morning between GEOAmey staff and the prison healthcare team to confirm transport could or could not be facilitated and providing for the prison healthcare team to check the position with GEOAmey if they had not received that call, but in the particular circumstances of this case given the clear medical evidence, I cannot find that systems of working in fact contributed to the death of Mr Whiteford. The failure of GEOAmey to transport Mr Whiteford to the two missed appointments on 7 December 2021 and 19 January 2022 cannot be said as a matter of fact in the overall circumstances here to have contributed to his death.

[72] There are no other facts which are relevant to the circumstances of the death of the said Andrew Whiteford beyond those I have considered.

[73] I am satisfied that it would not be appropriate to make any recommendations in terms of section 26(1)(b) of the 2016 Act.

[74] I wish to conclude by expressing my condolences to the loved ones of Andrew Whiteford for their sad loss.