2011 FAI 24

SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

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

FATAL ACCIDENT INQUIRY

INTO THE DEATH OF

WILLIAM CHARTERS BROWN

SHERIFF'S DETERMINATION

GREENOCK **7th May 2010**

The Sheriff, having on 10,11, and 12 March 2010 held and inquiry under Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, ("the Act") into the circumstances of the death of William Charters Brown and having considered all of the evidence adduced and submissions made thereon at the enquiry DETERMINES as follows:

(a) William Charters Brown, (DOB 14.5.43) who was a patient at Inverclyde Royal Hospital, Greenock in the legal custody of HM Prison, Gateside, Old Inverkip Road, Greenock, died at The Coronary Care Unit, Ward J, Inverclyde Royal Hospital, Greenock on 23rd November 2007 at 07:00 hrs.

(b) The cause of death was

(a) Pulmonary thrombo-embolism

Due to

(b) Deep venous thrombosis of the right calf

I decline to make any other findings.

NOTE

Evidence was led by the Procurator Fiscal Depute Mr Justin Farrell, from Robert Ainsworth, Consultant Forensic Pathologist at the Department of Forensic Medicine and Science at Glasgow University, Gordon Hannah, Clinical Nurse Manager at HM Prison, Greenock, Kenneth Campbell, Police Constable, Strathclyde Police, Greenock, Claire Delussey, Prison Custody Officer, Reliance Custodial Services, George Kidd, Operational Support Manager, Reliance Custodial Services, Doctor Helen Papaconstantinou, Consultant Cardiologist, Inverclyde Royal Hospital, Greenock and Doctor Peter Bloomfield, Consultant Cardiologist, Edinburgh Heart Centre, Royal Infirmary of Edinburgh, Edinburgh

Also present were Mr Stewart, the solicitor for Greater Glasgow Health Board, Mr Batchelor, solicitor for Reliance Custodial Services and Miss Gordon, solicitor for the Scottish Prison Service. Several productions were lodged including the Forensic Report and Medical records. A Joint Minute was also lodged in respect of Doctor Alice Clauser's evidence as to the steps taken shortly prior to Mr Brown's death. She was the doctor who pronounced the death on 23rd November 2007. There were also productions lodged on behalf of Reliance Custodial Services numbering 1 to 4.

I heard evidence over three days and submissions from the Procurator Fiscal Depute and the three solicitors present. I would also mention that at the outset of the hearing Mr Hendry had originally appeared on behalf of the family but in the light of the non contentious nature of Doctor Bloomfield's medical report, he asked to be excused from acting on behalf of the family and he withdrew.

The submissions from the Procurator Fiscal Depute were that he asked me to make Findings in respect of 6 (1) (a) and (b) with regard to the place, time and cause of death and also to make a Finding in terms of 6(1) (c) of the Act. He reminded me that it was a reasonable precaution that might have prevented the deceased's death that I had to consider and having heard the evidence asked me to Find that the re-administering of

Clexane of a higher or lower dose should have been administered after the 20 November 2007 to control blood clots. He also asked me to find that the other precaution that could have been taken was that therapeutic stockings should have been provided to prevent blood clots developing. In support of submissions he asked me to consider that Doctor Papaconstantinou was aware that the deceased was susceptible to blood clots because of his immobility and that she stopped the administering of both Clexane and Clopidogrel. It was not by way of criticism that he referred to her decision but her evidence that she accepted that there was a need to review the deceased's medication after she had stopped those two drugs. From the evidence the drug was not re-administered between the 20 and 23 November. In support of submission he also referred to the evidence of Mr Bloomfield who accepted that someone who was immobilised to the extent that Mr Brown was created a risk that required to be managed. It was his submission that had the Clexane been re-administered it might have resulted in the death being avoided. While there was evidence from Mr Bloomfield that he might not have done anything differently I had to carefully consider his evidence because he was not personally present to judge the clinical presentation of the deceased. The Doctor's obligation is to strike a balance between giving the drug Clexane and the consequences of not doing so. Her duty of care was to manage the anti coagulant risks of her patient in respect of the drugs she chose to administer. Doctor Papaconstantinou was aware of the immobility of the deceased and the potential protection that either Clexane or the surgical stockings could give. He had no submissions to make in respect of the 6(1)(d) or (e).

I then heard very brief submissions from Miss Gordon and Mr Batchelor in respect of the role of the Scottish Prison Service and Reliance Custodial Services in relation to the steps they had taken. They both urged me to make Findings in respect of 6(1)(a) and (b) and to make no other Findings. Following their submissions I indicated to them, that from the evidence I had heard, I was satisfied that there was nothing that could have been differently done in respect of either the Scottish Prison Service or Reliance Custodial Services that would have made a difference to the outcome for the deceased and that I would be making no comment in relation to that in the terms of this determination.

Mr Stewart adopted the Procurator Fiscal's submissions in relation to 6(1) (a) and (b) of the Act but asked me not to make any Findings in respect of 6(1)(c) of the Act. There were two elements to whether or not I made a Finding in terms of 6(1)(c) and that related

to any precautions suggested being reasonable and further more that it might have prevented the death. In respect of the evidence that had been heard at the enquiry the diagnosis had not been made that there was a Pulmonary Embolism but that he had had an Acute Coronary syndrome. Doctor Papaconstantinou explained the basis of her treatment was in the diagnosis of an Acute Coronary syndrome which was consistent with his presentation. The issue with regard to stopping Clexane and not to administer a prophylactic dose was taken on her consideration of his presentation and symptoms. She gave reasons for stopping the drug and Doctor Bloomfield took no issue with that and his evidence in this regard was not challenged by the Procurator Fiscal. It was reasonable to stop it because the ECG was normal and the troponin levels were normal therefore there was no indication that a full dosage of Clexane or Clopidogrel should continue to be administered. Doctor Papaconstantinou had noted that the administering of the drugs should be reviewed and said so in her evidence. With regard to the notes there was no indication that a review had not taken place by the doctors who subsequently treated the deceased. The fact that it is not documented does not mean that it was not considered and a decision taken not to re-instate it. As Doctor Papaconstantinou indicated doctors and consultants have a trust between themselves with regard to reviewing a patient's care. There was no evidence about the decisions taken after 20 November by the other medical practitioners involved. That particular point was not put to Doctor Bloomfield. The questions asked of Doctor Bloomfield seem to relate to the mobility of the deceased. It would not necessarily be expected that a prophylactic would be given. In her evidence Doctor Papaconstantinou accepted that she considered risks and acted upon those risks. As Doctor Bloomfield said a doctor is aware of risks existing all the time when dealing with a patient in their care but a balancing exercise has to be done in relation to the risks and the care. Both doctors were clear that in the assessment of the patient and their risks and the medication was a matter of clinical judgment. Furthermore it had been Doctor Bloomfield's position that he would not have done anything different having taken into account the risks that were presented. Clinicians are always mindful of the risks and the issues that they have to deal with. In her evidence Doctor Papaconstantinou also stated that she was aware of DVT and aware of his immobility but that she had assessed these risks and even having regard to what had now transpired she did not consider that she would have done anything differently given the clinical presentation of the deceased. While much was made of the issue of mobility he suggested that the evidence from Doctor Papaconstantinou was not so clear as to say that she was so concerned about his

mobility that she was aware that action in respect of the DVT would be required. The risk has to be seen in the context of the clinical presentation. While Doctor Bloomfield had accepted that with the background of immobility, Clexane could have been given, for prophylactic reasons, that was not the presentation that was apparent to Doctor Papaconstantinou. I was also referred to the determination by Sheriff Stephen with regard to reasonable precautions that might have prevented death, when dealing with medical interventions and issues. He asked me to consider with regard to the evidence I had heard I should not find that it was a reasonable precaution to administer Clexane as suggested by Mr Farrell. He emphasised that the issue of clinical judgement was a balancing exercise and that whether or not to give Clexane was a clinical judgement and as Doctor Bloomfield said it was a grey area as different doctors may have a different approach.

I gave Mr Farrell an opportunity to give me a brief response as he was concerned that Mr Stewart's approach could be interpreted as the Procurator Fiscal finding fault. He confirmed that that was not his intention but rather that the administering of Clexane was a reasonable precaution. He also reiterated that while Doctor Bloomfield had written his report and given his evidence he was not physically present at the deceased's bedside and therefore his evidence had to be taken in the light of that.

I have listened very carefully to all of the evidence presented in this Fatal Accident Inquiry. It is clear the Scottish Prison Service, with regard to medical care, has well-established protocols to ensure that any prisoner in their care is either given appropriate treatment or alternatively, is transferred to Inverclyde Royal Hospital in the event of an acute episode of ill-health, as happened to the deceased, Mr Brown. Similarly, the Reliance officers who had to been in attendance with Mr Brown have clear instructions as to their responsibility and care in relation to prisoners in their care. For these reasons I have no further comment to make in respect of the steps taken by them in relation to the care of Mr. Brown.

The family have sat patiently throughout this Fatal Accident Inquiry and heard, as I have, the steps that were taken by all those concerned in Mr Brown's care in the lead-up to his death. I have sympathy for the family and the circumstances that they found themselves in leading up to Mr. Brown's death. It must have been very difficult for them to hear of

what had happened. It is apparent, from the documents lodged, that the family had some concerns about the medical interventions leading up to Mr. Brown's death. The Procurator Fiscal has, on their behalf, put a number of questions to the medical witnesses in an effort to try to resolve the questions and queries that they had.

The purpose of a Fatal Accident Inquiry is to determine the cause, place and time of death of the deceased and in this case I have been asked to make a finding in terms of 6(1)(c) of the Act. Mr. Farrell asked me to find that had Clexane been administered or surgical stockings provided that Mr. Brown's death might have been avoided.

Much of the evidence that I have heard, in respect of this case, was in relation to the medical interventions which took place at Inverclyde Royal Hospital prior to Mr Brown's death. He was admitted to hospital on two occasions and I can do no better to describe the background than to quote from the post-mortem report.

"Mr Brown had undergone a heart transplant fourteen years previously as a result developing a Cardiomyopthy. He also suffered from arthritis and had previously been treated for a brain abscess and was prescribed numerous medications including steroids. He was currently in HMP Gateside Prison in Greenock, having recently been charged with homicide, during which incident he had also received a number of injuries including a stab wound to his right hip.

On 6 November 2007, whilst in the prison, he complained of chest pain radiating through to his back following which he was transferred to Inverclyde Royal Hospital and initially diagnosed with "Acute Coronary Syndrome". He was also noted to be paraxial at this time, although an infection investigation of his spleen was entirely negative. Over the next few days his condition appeared to stabilise and he was discharged back to prison on 14 November 2007.

On 19 November he once again complained of shortness of breath and chest pain, and was transferred back to Inverclyde Royal Hospital. There he was once again diagnosed with "Acute Coronary Syndrome" and treated as such, his condition again appearing to stabilise somewhat thereafter. He was also investigated for increasing back pain which is thought to be due to a possible spinal problem. On the morning of 23 November

however, he developed sudden onset severe chest pain before collapsing unresponsive. Cardiopulmonary resuscitation was attempted but this was unsuccessful, and he was formally declared dead at 0700 hours."

Mr. Brown was admitted to Inverclyde Royal Hospital on two occasions and was clearly unwell on both these occasions. He suffered from breathlessness and pain and this was diagnosed at the time by the doctors as probably indicating that he had Acute Coronary Syndrome. He had had a heart transplant fourteen years before and it was a diagnosis that fitted in with that type of background. While I have heard a lot of evidence in relation to what was done by the doctors with regard to medical intervention I do not intend to rehearse what was said by them. In my mind it would serve no purpose. What was done by Doctor Papaconstantinou, the only attending doctor whose evidence I heard, was perfectly appropriate according to the expert evidence of Doctor Bloomfield

The terms of section 6(1)(c) states:-

"the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided."

The apparent immobility of the deceased was mentioned in the evidence as a reason to consider the continued administering of Clexane. Doctor Papaconstantinou was aware of the immobility of the deceased but that immobility did not suggest, from her observations, that he was unable, as some patients are, to actually move about. The evidence from the Reliance Officer confirmed that Mr. Brown was able to move about and go to the toilet and I therefore see no reason to question that observation. Doctor Papaconstantinou's reason for deciding to stop Clexane and Clopidogrel was taken because Mr. Brown's ECG was normal and the troponin level was normal. Furthermore it was her intention to review the matter but as she took ill she did not do that. She expected those who took care of him thereafter to do that in her absence. Mr. Farrell questioned Dr Papaconstantinou about the possibility of a DVT, given that immobility was an issue and therefore continuing Clexane or Clopidogrel. From her observations and clinical judgment however, that was not appropriate and she also said that she had concerns about bleeding which is a side effect of these drugs, given her recollection of his previous admission in relation to infection and pain in the abdominal area. Mr. Farrell

continually probed the fact that Dr Papaconstantinou decided to cease administering Clexane and Clopidogrel, yet Dr Papaconstantinou gives clinical explanations related to her diagnosis of Acute Coronary Syndrome, his normal ECG and his normal troponin level as well as knowledge of recent past medical history of infection and pain in the abdominal area and the concern associated with bleeding. This inquiry is not a blame apportioning matter but rather a fact finding exercise. I have given very careful consideration to the evidence given to the enquiry and I am satisfied that Doctor Papaconstantinou made perfectly appropriate decisions about the presentation and diagnosis in respect of Mr. Brown. She impressed me as being careful and competent in her approach and indeed attending at the hospital while she was unwell and still enquiring about a patient shows a dedication that is to be commended. In my view no adverse issue arises with regard to the care that she gave to her patient. The difficulty that I have with the proposition that I should made a Finding in terms of 6(1)(c) is that I think it is predicated on hindsight. It was only from the postmortem that it was discovered that Mr. Brown had in fact had a pulmonary embolism that was fatal. Doctor Bloomfield had said that the only way in which it could have been discovered was a particular type of MRI scan but that it would not necessarily have shown, at the time prior to his death, that there was a thrombosis that would cause his death. I do not think it is appropriate to make a Finding in terms of 6(1)(c) as the decision made by the doctor at the time was that his presentation was Acute Coronary Syndrome and she was not working on the basis of it being a Pulmonary Embolism. It would not be appropriate for any doctor to continue medication "just in case" when the diagnosis does not justify it. There are side effects and consequences of administering drugs and Dr Papaconstantinou was aware of that for this patient who had a previous admission. It would not be appropriate to suggest that in the field of medicine that when it comes to clinical observations and diagnosis that these should be set aside because at post mortem the cause of death was not the original diagnosis but something that is difficult to detect because it's presentation can be suggestive of something else. It would be a worrying aspect for clinicians if fatal accident inquiries started to suggest medication because following post mortem, something is discovered which was not anticipated given the clinical presentation. It is impossible to say that any doctor having regard to the clinical presentation of Mr. Brown would necessarily have acted any differently. I am firmly of the view that the clinicians in respect of Mr. Brown made the appropriate decision based on their professional judgment and it is not for me, to now decide that there was a reasonable practical

alternative that might have avoided his death. We simply do not know that. Doctor Bloomfield whose evidence I found to be clear and informative with regard to the medical care given, did indicate in his evidence that he may well have come to the same diagnosis as Dr Papaconstantinou and that the steps taken were appropriate. I also accept that although he was not personally present as an expert he is well able to give appropriate consideration to all the documents lodged and the decisions taken and make appropriate comment on them. The fact that he did not see "the immobility" of Mr. Brown does not in my view affect my ability to rely upon his evidence in relation to that, particularly as immobility may mean different things in particular medical context as referred to by Dr Papaconstantinou. I think I can do no better than to perhaps quote from Doctor Bloomfield and I refer to the final paragraph of his letter of 16 October 2009:-

"I think it is important to point out to the family that there are times when an unexpected condition is eventually diagnosed. This was the case with Mr. Brown when Pulmonary Embolism was not at all suspected for the reasons that I have outlined in my report. Medical diagnosis is often the equivalent of working out a puzzle. If the answer is known, then I am looking back over a patent's presentation it may seem obvious that a certain course of action should have been followed. It must be realised that if the final diagnosis is not known then the doctors looking after a patient must have to work on a balance of probabilities. The balance of probabilities in Mr Brown's case were very much in favour of him having an Acute Coronary Syndrome and very little to indicate a Thromboembolism. Furthermore, his condition was not such that I believe anti-coagulant thrombo-prophylaxis should have been used".

The reality is that we can now state from the post mortem that the deceased died of a pulmonary embolism but that was not a diagnosis which could have been made differently at an earlier stage and I do not find it an appropriate response to decide on hindsight that the reasonable precautions might have been to continue with Clexane and Clopidogrel and I therefore decline to make any further findings.

Sheriff Rajni Swanney

Sheriff of North Strathclyde at Greenock