SHERIFFDOM OF GLASGOW AND STRATHEKELVIN AT GLASGOW

[2021] FAI 22

DETERMINATION

BY

SUMMARY SHERIFF LUGTON

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

into the death of

BRIAN HUNTER

Glasgow, 25 March 2021

Determination

The Sheriff, having considered 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 referred to as "the 2016 Act") the following:

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

   That Brian Hunter, born 20 May 1957, died at Ward 6, Glasgow Royal Infirmary, Glasgow, on 8 January 2020 at 12.10pm.

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

That the death was not caused by an accident. Therefore, no finding is made.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

That the causes of death were (i) locally advanced metastatic non-small cell carcinoma; and (ii) lower respiratory tract infection with right pleural effusion.

4. In terms of section 26(2)(e) of the 2016 Act (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):

That there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

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

That there are no other facts which are relevant to the circumstances of the death.

Recommendations

In terms of section 26(1)(b) of the 2016 Act, the Sheriff makes no recommendations.

NOTE

Introduction

[1] This inquiry into the death of Brian Hunter ("the deceased") was held on 9 March 2021 at Glasgow Sheriff Court. The hearing took place in Court 19, with the parties participating by telephone conference call. Mr Faure, Procurator Fiscal Depute, represented the Crown. Miss Thornton, Solicitor, represented the Scottish Prison Service ("SPS").

[2] Mr Hunter died at Glasgow Royal Infirmary ("GRI") on 8 January 2020. At the time of his death Mr Hunter was serving a sentence at HMP Barlinnie. His death was reported to COPFS on the day that it occurred. Prior to the inquiry on 9 March 2021, preliminary hearings were held on 25 January 2021 and 8 February 2021.

[3] No oral evidence was presented to the inquiry. The parties entered into a detailed and comprehensive Joint Minute of Admissions in advance of the hearing. The following productions were lodged:

Crown productions:

(1) Mr Hunter's prison file held by the SPS including the Death in Prison Learning and Review report; and

(2) Mr Hunter's NHS medical records.

SPS productions:

(1) The SPS's Governors and Managers ACTION 054A/16 Early Release on Licence on Compassionate Grounds – Revised Guidance for Submission of Applications dated 9 September 2016; and

(2) The SPS's Governors and Managers ACTION 039A-18, "Role of SPS Parole Unit in the Application for Release on Compassionate Grounds" dated 7 June 2018.

All productions were agreed to be true and accurate.

The legal framework

[4] The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") govern fatal accident inquiries. A fatal accident inquiry is held under section 1 of the 2016 Act and its purpose in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. Conversely, the purpose of the inquiry is not to establish civil or criminal liability. The process is inquisitorial in character. The procurator fiscal represents the public interest at the inquiry. The present inquiry was mandatory in terms of sections 2(1) and (4) of the 2016 Act as Mr Hunter was in legal custody at the time of his death.

[5] In terms of section 26(1) of the 2016 Act as soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination

containing the sheriff's findings as to the circumstances of the death, and such recommendations (if any) as the sheriff considers appropriate.

[6] As regards the circumstances, the sheriff must make findings regarding: (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— (i) could reasonably have been taken, and (ii) 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 or any accident resulting in the death; and (g) any other facts which are relevant to the circumstances of the death.

[7] In terms of section 26(4) the sheriff is entitled to make recommendations regarding (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

Summary

Factual Circumstances

[8] Having regard to the information presented to the inquiry, I found the following facts to be established:

1. Mr Brian Hunter was aged 62 years at the time of his death, having been born on 20 May 1957.

2. Mr Hunter was convicted on 12 June 1989 at the High Court in Glasgow of the offences of rape, assault and robbery and sentenced to life imprisonment. He was released on licence on 5 May 2006 from HMP Noranside. He was then remanded in custody at HMP Barlinnie on 4 January 2008 and convicted at Glasgow High Court on 11 November 2008 of the offence of assault to severe injury and permanent disfigurement and permanent impairment and danger to life. He was sentenced to 4 years and 6 months. He was released on licence on 19 January 2016 from HMP Castle Huntly. On the 13 December 2018 Mr Hunter was returned to custody having breached his licence. He was sent to HMP Barlinnie.

3. While in HMP Barlinnie Mr Hunter had a number of consultations with healthcare professionals working at the prison on behalf of NHS Greater Glasgow and Clyde.

4. On 12 November 2019 Mr Hunter reported chest pain and a dry cough at a consultation with nurse Ms J Carson.

5. On 30 November 2019 at a consultation with nurse Ms K Bell, Mr Hunter reported that he was "coughing up blood clots." A referral was made on his behalf for a GP appointment.

6. On 2 December 2019 at a further appointment with Ms K Bell, Mr Hunter stated that he had been "coughing up blood". It was noted that he was a smoker and that he had been "vaping" while at HMP Barlinnie.

7. On 3 December 2019 Mr Hunter had an arranged GP clinic appointment. He reported a constant tickly cough and occasional chest tightness. On examination Dr Grace Campbell noted reduced air entry in the right side of Mr Hunter's chest. She instructed a chest x-ray.

8. On 6 December 2019 the results of the x-ray were received and reviewed by Dr Sutchi Senthil. A mass of 11 x 9.5cm in the right middle and lower lobe was identified and it was noted that this was "concerning for an intrapulmonary mass". Dr Senthil recommended obtaining an urgent respiratory opinion and that Mr Hunter undergo a CT scan.

9. On the 13 December 2019 Mr Hunter attended GRI for a CT scan.

10. On 16 December 2019 the scan was reviewed and revealed that Mr Hunter probably had a primary right lung tumour. He was placed in the next day's E-Hall clinic to discuss the diagnosis and urgent respiratory follow-up was put in place.

11. On 17 December 2019 Dr Grace Campbell had a consultation with Mr Hunter and made him aware of the result of the CT and x-ray scans.

12. On 18 December 2019 Mr Hunter attended an appointment for respiratory medicine whereby an ultrasound and biopsy were taken. These confirmed the cancer diagnosis.

13. On 26 December 2019 Mr Hunter was transferred from prison to GRI because his condition had deteriorated. While at GRI within ward 6 he received anti-biotics and oxygen therapy.

14. On 8 January 2020 Dr Imane Bekri observed that there had been a further significant deterioration in Mr Hunter's health. After discussion with his brother a palliative care pathway was adopted for Mr Hunter.

15. On 8 January 2020 at 12.10pm Mr Hunter died while an in-patient of Ward 6 at GRI.

16. Dr Bekri certified the cause of death as:

1a: Locally advanced metastatic non-small cell lung carcinoma;

1b: Lower respiratory tract infection with right pleural effusion.

17. On 8 January 2020 at about 3.15pm Police Constable Ailie Frost attended at GRI and conducted a police investigation into Mr Hunter's death. There were no suspicious circumstances. She concluded that Mr Hunter's death was an anticipated event.

18. The Crown did not instruct a post-mortem.

Submissions

[9] The Crown and the SPS both lodged helpful written submissions. Both parties invited me to make formal findings in terms of sections 26(2)(a) and (c) of the 2016 Act and no findings in terms of sections 26(2)(b), (d), (e), (f) and (g). Similarly, the parties invited me to make no recommendations under section 26(4) of 2016 the Act. The parties offered their condolences to the family of Mr Hunter.

Discussion and conclusions

[10] From the information available to the inquiry it appears that Mr Hunter died of locally advanced metastatic non-small cell carcinoma and a lower respiratory tract infection with a right pleural effusion. He first reported symptoms in November 2019, following investigations he was told of his diagnosis on 17 December 2019 and he died in hospital less than a month later, on 8 January 2020. Accordingly, Mr Hunter's death was an anticipated event and resulted from natural causes. In these circumstances I am satisfied that I should make formal findings of the time, place and cause of Mr Hunter's death in terms of sections 26(2)(a) and (c) of the 2016 Act respectively, and that I should make no findings in terms of sections 26(2)(b), (d), (e), (f) and (g). Likewise, I have no recommendations to make in terms of section 26(4) of the Act.

[11] Finally, I offer my condolences to the family of Mr Hunter.