SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2018] FAI 8

KIL-B270-17

DETERMINATION

By

SHERIFF PRINCIPAL DUNCAN L MURRAY

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

into the death of

RAYMOND GAVIN

KILMARNOCK, MARCH 2018

The Sheriff Principal, having heard and considered all of the evidence, and the submissions of parties, finds and determines that:

[a] In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

Raymond Gavin, born 18 January 1962, died, at Crosshouse Hospital, Kilmarnock at 2115 on 27 June 2014.

[b] In terms of section 6(1)(b) of the Act:

The cause of the death of Raymond Gavin was: Multiple organ failure due to, intra-abdominal haemorrhage, due to blunt force trauma. This was the cause of death recorded in the post-mortem report Crown Production 3. The cause of the blunt force trauma resulting in the death of Raymond Gavin was an assault by John O'Neil, in the Laundry at HMP Kilmarnock, on the morning of 11 June 2014. Mr O'Neil pled guilty to a charge of culpable homicide on 20 January 2015 and was sentenced to 28 months imprisonment.

[c] In terms of section 6(1)(c) of the Act the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided:

There were no reasonable precautions by which the death might have been avoided.

[d] In terms of section 6(1)(d) of the Act the defects, if any, in any system of working which contributed to the death or any accident resulting in the death:

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

[e] In terms of section 6(1)(e) of the Act any other facts which are relevant to the circumstances of the death:

1. There was inadequate communication about Mr Gavin between Nurse Smith and Dr Henderson on 11 June. Dr Henderson was outwith the prison when Nurse Smith first attempted to contact him shortly after 1130. She could have telephoned him but she did not do so. When she spoke to him at about 1300 Dr Henderson did not appreciate the full picture of Mr Gavin's presentation and he failed to clarify this or clarify with Nurse Smith the actions which she thought he should take.
2. The recording of observations was sub-optimal. The introduction by NHS Ayrshire and Arran of the clinical response form, the SBAR reporting protocol and the National Early Warning Score (NEWS) response form are innovations which should add clarity about when advice from the General Practitioner should be sought and regularise and improve communications between the medical team. The forms will support and assist with the standardisation of the taking and recording of observations when nursing staff are called to a medical response, and the subsequent provision of that information to the General Practitioner.

It is recommended that NHS Ayrshire and Arran should give careful consideration to the requirements for the delivery of General Medical Practitioner services to the prisoners detained within HMP Kilmarnock and to the specification of the required services in the successor to the existing contract.

Representation at the Inquiry:

For the Crown: Ms Adair, Procurator Fiscal Depute
For the family of Raymond Gavin**:** Ms Connelly, Counsel
For NHS Ayrshire and Arran: Ms Watts, Counsel
For Dr Henderson: Mr Mawby, Solicitor Advocate
For Scottish Prison Service: Ms Phillips**,** Solicitor Advocate
For Serco Limited: Ms McDonald, Solicitor

General Legal Framework

[1] This was an inquiry held under section 1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, on the ground that the person who died was, at the time of his death, in legal custody. This was because the application for the inquiry was lodged on 26 April 2017. It will be one of the last enquires to be undertaken in terms of the provisions of the 1976 Act and the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977 made under section 7(1) of the 1976 Act. For petitions lodged after 15 June 2017 the Inquiry will be conducted in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

[2] The purpose of an inquiry held in terms of the 1976 Act is for the sheriff to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction:

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes 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 avoided;

(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

- all in terms of section 6(1) of the Act.

[3] The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the Inquiry. The determination must be based on the evidence presented at the Inquiry and is limited to the matters defined in section 6(1) of the Act. Section 6(3) of the Act sets out that the determination of the sheriff shall not be admissible in evidence or be founded on in any judicial proceedings, of whatever nature, arising out of the death or out of any accident resulting in the death. While this prohibition is intended to encourage a full and open exploration of the circumstances of a death it also reflects the position that a Fatal Accident Inquiry is not a forum designed to establish legal fault.

The Proceedings, Witnesses and Evidence

[4] Preliminary hearings of the Inquiry were held on 6 June and 24 August 2017. The Inquiry heard evidence on 11, 12, 13 and 14 September 2017, 14 November 2017, 22 January 2018, and 5 and 6 February 2018. Submissions were made on 19 February 2018.

[5] Evidence was led principally by the Procurator Fiscal Depute, in accordance with the duty under section 4(1) of the 1976 Act. The Crown witnesses were as follows:

1. Prison Officer Valerie Lorimer

2. Nurse Karen Smith
3. Nurse Graham Trundle
4. Dr Bruce Henderson, General Practitioner
5. Ann Gow, Director of Nursing and Midwives for Healthcare Improvement Scotland
6. Gerard Cronin, Clinical Director Cronin Limited, Registered Nurse
7. Miss Catherine Sharp, Consultant in Upper Gastro-Intestinal, Bariatric and General Surgery Crosshouse Hospital
8. Dr Norman Wallace, General Practitioner
9. Dr Julie Mardon, Consultant in Accident & Emergency Crosshouse Hospital

[6] Evidence was also led on behalf of the Health Board from:

1. Fiona Gordon, Service Manager and Nurse Lead for Prison Healthcare NHS Forth Valley
2. Mr Andrew de Beaux, Consultant in General and Upper Gastro-intestinal Surgery Edinburgh Royal Infirmary
3. Dr Michael J Donald, Consultant in Emergency Medicine Ninewells Hospital
4. Ruth McMurdo, Senior Manager Justice Health Care Services, NHS Ayrshire and Arran
5. Dr Paul McConnell, Consultant in Anaesthesia and Intensive Care Medicine Crosshouse Hospital (agreed statement as per Joint Minute)

Serco Limited called Prison Officer Steven Clark as a witness.

[7] Parties lodged a joint minute and there was substantial agreement in the submissions as to the findings which I should make.

What happened

[8] Raymond Gavin (Mr Gavin) was a 52 year old single man. On 11 June 2014 he was serving a sentence in HMP Kilmarnock. HMP Kilmarnock was and is operated by Serco Limited on behalf of the Scottish Prison Service under contract with Scottish Ministers. From November 2011 onwards prisoner healthcare within HMP Kilmarnock has been

provided by NHS Ayrshire and Arran in terms of an amendment to the said contract between Serco Limited and Scottish Ministers.

[9] General Medical Practitioner services were provided by Arcus Trading Limited under a contract with NHS Ayrshire and Arran (Crown production 11). This contract commenced on 1 June 2012 and continues in force until 31 May 2019, having been extended on two occasions.

[10] On Wednesday 11 June 2014 HMP Kilmarnock was operating on a weekend regime to facilitate the delivery of refresher, suicide prevention training for staff.

[11] On or about 0920 hours on 11 June 2014 Mr Gavin was assaulted within the prison laundry by John O'Neil who was also at the time an inmate at HMP Kilmarnock. In the course of said assault, John O'Neil punched Mr Gavin on the abdomen. Mr O'Neil pled guilty to a charge of culpable homicide on 20 January 2015 and was sentenced to 28 months imprisonment. After the assault the deceased, Mr Gavin, made his way back to his cell on the ground floor of Alpha Wing, within House Block 1, of HMP Kilmarnock.

[12] On 11 June 2014, Dr Henderson was the General Practitioner fulfilling the contractual obligation of Arcus Trading Limited. Prison access records show he entered the prison at 0927, he left again at 1130, entered again at 1259 and left again at 1612. Nurse Smith is a Band 5 Registered Nurse. She was experienced in the specifics of prison nursing having worked in HMP Kilmarnock for 13 years. On 11 June 2014 she was rostered as reception nurse. She commenced work at 1000 hours and was due to finish at 2200 hours. She was working on reception duties with Susan Kerr, a nursing colleague, who was carrying a radio when they received the first alert call.

[13] The radio message reported a prisoner having collapsed in Alpha Wing of House Block 1. Nurse Smith was not rostered to be a first responder on this day but attended the call at the request of Nurse Kerr in an effort to be supportive to her colleague. Nurse Smith arrived at Mr Gavin's cell first at 1018. She found Mr Gavin sitting up with his back against his bed talking, with no obvious sign of injury. Very shortly thereafter she was joined by Nurses Gordon, Trundle and Kerr. She asked Nurse Gordon to get a response bag and went straight to the patient. She asked Mr Gavin what had happened, whether he had taken any illicit substances and examined him. He said that he had been in the laundry, then returned to his cell and became unwell. To try and achieve a degree of privacy she asked him in a low voice whether there was anything else she ought to know. She stressed to Mr Gavin that she was a nurse and she was only there to look after him. Mr Gavin stated there was nothing else she needed to know and Nurse Trundle and Nurse Smith assisted Mr Gavin onto his bed, he showed no sign of discomfort and made no complaint of pain. The observations taken were P 78 R 14 BP 126/70 PERL3mm BM 9.5 which are all within normal limits. These were subsequently recorded by Nurse Smith in the Vision record for Mr Gavin.

[14] Mr Gavin asked for his methadone and Nurse Smith explained that she was not prepared to administer that because he had been unwell. He said that he had fainted because he needed his methadone. Nurse Smith's plan was that he would be reassessed at lunchtime by the nurse working at the House Block and would be given his methadone then unless there were any other concerns. Nurses Smith and Trundle left Mr Gavin's cell at 10.29. (For convenience this is referred to as the "First Incident.")

[15] At approximately 1110 Nurse Smith was in the triage room adjacent to Alpha Wing when she was asked by a prison officer to go and see Mr Gavin. When she entered Mr

Gavin's cell, she saw Mr Gavin lying unconscious on the floor. Nurse Smith approached Mr Gavin speaking to him as she did so. She turned him over and administered a sternal rub which resulted in his regaining consciousness. He did so within 30 seconds of Nurse Smith entering his cell. The observations which Nurse Smith took of Mr Gavin at that time as recorded in the Vision record were BP 105/68 P 70 R 12. (This is referred to as the "Second Incident.")

[16] Nurse Smith determined, on leaving Mr Gavin, that she required to speak to Dr Henderson about Mr Gavin's condition, given this second unexplained episode of collapse. She advised prison officer Clark of her intention to do so and asked him about a wheelchair to take Mr Gavin to healthcare. She collected the Kardex and took that and a post-it note on which she had written her most recent observations (Health Board Production 3) and went to the medical centre to find Dr Henderson. She was advised that Dr Henderson was no longer in the prison but should be returning to provide programmed suicide awareness training at 1300. She left a message with the gatehouse asking Dr Henderson to contact her on his return and advised the other staff in healthcare that she was looking to speak to Dr Henderson as soon as he returned. She remained in healthcare. Prison staff became aware that the doctor was not in the prison.

[17] Nurse Smith met Dr Henderson in the corridor outside healthcare shortly after 1300. Dr Henderson told Nurse Smith he was aware she had been looking for him. She reported that she had seen Mr Gavin twice that morning and that he had collapsed. She gave Dr Henderson the Kardex and post-it note. Dr Henderson understood that Mr Gavin had lost consciousness. Nurse Smith did not make Dr Henderson aware that Mr Gavin did not respond until after she had administered a sternal rub. She explained that Mr Gavin's

methadone had been withheld and that Nurse Trundle was shortly going to review Mr Gavin before administering his methadone. She did not ask Dr Henderson specifically to go and see Mr Gavin. Nurse Smith accepted Dr Henderson's decision to see Mr Gavin at the clinic the following day. Dr Henderson did not have any impression of particular concern about Mr Gavin on the part of Nurse Smith.

[18] At approximately 1348 prison officer Campbell came to the triage room in House Block 1 and asked Nurse Trundle to go and see Mr Gavin in his cell as he was unwell. Nurse Trundle took the response bag with him and found Mr Gavin lying on a mattress on the floor in his cell. He was in obvious distress, pale and clammy, complaining of being unable to breathe and generally unwell. As Nurse Trundle undertook his observations Mr Gavin explained that he had been assaulted. He lifted his shirt and pointed to some red marks on his left flank at the bottom of his ribs. Nurse Trundle was concerned about his condition and oxygen saturation levels. He returned to the triage room to get oxygen and asked for the doctor to be sent. When he returned to the cell Mr Gavin's oxygen saturation had decreased further. Nurse Trundle asked a prison officer to call an emergency ambulance. Nurse Trundle proceeded to administer oxygen to Mr Gavin and continued to monitor him. Shortly thereafter Dr Henderson arrived. Mr Gavin's oxygen saturation was coming up but he remained very distressed. Nurse Trundle had to encourage him to keep the oxygen mask on. (This is referred to as the "Third Incident.")

[19] The ambulance arrived at the prison at 1409 to transfer Mr Gavin to Crosshouse Hospital. The ambulance paramedics believed Mr Gavin suffered a cardiac arrest in the course of the ambulance journey and called a pre-alert to Crosshouse Hospital to advise that Mr Gavin was critically unwell and should be immediately assessed. On arrival at

Crosshouse Hospital Accident and Emergency Department at 1442 Mr Gavin came under the care of Dr Mardon and a multi-disciplinary team. He had a low level of consciousness and did not respond to stimulation. He was recorded as 3 on the Glasgow Coma Scale. A fast scan was undertaken as there was a concern that Mr Gavin was bleeding internally. This identified fluid in the abdomen and surgical intervention was required. The major haemorrhage protocol was initiated. Mr Gavin lost cardiac output and advanced life support was undertaken by the medical staff, heartbeat was regained at 15.04. Mr Gavin received a massive transfusion of blood products and was taken to theatre expeditiously. Surgery was performed by Miss Sharp. Mr Gavin's spleen was removed; the operation notes record a small tear was identified at the back of the spleen heading towards the hilum of the spleen. Post operatively Mr Gavin was transferred to intensive care. His condition did not improve, later that evening Mr Gavin returned to theatre as he had ongoing bleeding. He returned to theatre again over the following days for repacking and dressing and was receiving escalating critical care. The care he received at Crosshouse Hospital was exemplary. On 27 June 2014 it was apparent to clinicians that Mr Gavin was in multiple organ failure and further treatment was futile. With the agreement of his nearest relatives, life support was discontinued. Mr Gavin was pronounced dead at 1930 on 27 June 2014.

Summary of evidence

Prison officer Lorimer

[20] Ms Lorimer is a prison officer employed by Serco Limited and had worked at Kilmarnock Prison for over 18 years. Her duties as a custody officer are to keep prisoners safe and secure from risks that might present to them. As a prison officer she had

undertaken basic first aid training. At about 1000 a prisoner approached her and prison officer West suggesting they go and see Mr Gavin who was said to be staggering about in his cell. She found Mr Gavin sitting on the cell floor with his back against the wall, he did not look well. She put a pillow against his head and asked her supervisor to call for a medical response. She asked Mr Gavin if he had taken any medication and gave him the opportunity to tell her what was wrong. He reported to her that he had not taken anything and had just come out of the laundry.

[21] Nurses Smith and Trundle arrived at the cell within a couple of minutes. There was no change in Mr Gavin's position from when she first observed him to the point at which the nursing staff arrived. She saw them putting Mr Gavin onto the bed to take his blood sugar level but didn't recall them taking his blood pressure or observe his pulse being monitored. She did not recall any equipment being used by the nurses. She did not recall the terms of the conversation between Mr Gavin and the nurses, except she did recall Mr Gavin requesting his methadone. He was told his methadone would be provided when he had seen the doctor, after which he picked himself up and said he was fine. The nursing staff left about 1015.

[22] Prison Officer Lorimer looked in to observe Mr Gavin in his cell three times in the course of her circulation around the floor between the nurses' departure and about 1100. Just after 1100 she was alerted by another prisoner to go and check Mr Gavin. When she went into the cell, Mr Gavin was lying slumped over the toilet bowl. He was conscious and she moved him so that he was sat against the wall of the cell. She asked the nurses in triage to come and see Mr Gavin. They took a few seconds to get from triage to the cell at which point prison officer Steven Clark, her supervisor appeared. She could not recall what the

nurses did on this occasion and did not recall what was said. She subsequently put a duvet over Mr Gavin as he said he was cold. She did not recall instructions to her from the nursing staff. She continued to keep an eye on Mr Gavin as she undertook her rounds on the wing. She assumed that the nurses would get the doctor to see him. She recalled Mr Gavin asking for his methadone, she asked him if he wanted lunch but he said no and she left lunch in his cell.

[23] She did not think Mr Gavin had wet himself. Her initial shift ended at 1300 and at the handover she briefed prison officer Campbell, about the two medical responses to see Mr Gavin. She did not recall any prisoner saying that Mr Gavin had been assaulted. Even if she had been told this she would have taken the same action and called the medical response.

Nurse Smith

[24] Karen Smith is now working in occupational health, based in Glasgow. In 2014 she was employed as a band 5 registered general (staff) nurse and had worked in HMP Kilmarnock for 13 years. Nurse Smith said she was one of the more experienced nurses working at the prison and explained she did the job of an experienced staff nurse.

[25] The work regime for general nurses in the prison was the administration of planned medication and changing dressings, they also responded to addiction and mental health issues, supporting the health and safety of the patients, provided chronic care and the management of those prisoners prescribed methadone. They also undertook unplanned tasks such as reviewing a prisoner who had sustained an injury. The nurses responded to medical response calls where the prison staff required an urgent response. Nursing staff

were based in the Healthcare Centre which was located in a separate building from the various prison wings. A prisoner might come to healthcare for asthma or blood checks. Between breakfast, lunch, teatime and bedtime medication was given in the areas where the prisoners were housed. This was administered in the triage room located in the House Blocks, outside the bubble at the entrance to the wings. Nurse Smith had never worked in a GP practice. In terms of responding to a medical emergency, three staff were allocated as first responders on any day. On 11 June 2014 she was allocated to undertake the duties of reception nurse. This entailed a medical check of prisoners entering and exiting the prison, these duties generally built up in the afternoon when prisoners returned from court. In the morning, therefore, she would generally help the other staff out. At approximately 1015 her colleague, who had the radio, Susanne Kerr, and had been unwell, asked Nurse Smith to assist her in attending a response call to house block A. On arrival at Mr Gavin's cell she asked Nurse Gordon to get the response bag. Nurse Trundle was also there along with another nurse, whom she didn't recall. When she entered the cell she saw Mr Gavin with his back against the wall speaking to prison officers. She went over in front of him and asked what happened. He said that he just felt unwell and woke up on the floor. He was showered, shaved, clean and tidy and gave the impression there was no injury, and nothing else to be concerned about. She asked some of her colleagues to take observations. She questioned Mr Gavin about his medical history, and whether this had this happened before, or had he taken any unauthorised medication. She checked his blood pressure, pulse, respiration, oxygen saturation level, blood sugar, pupil reaction. The readings were as recorded in the Vision record, namely Pulse 78, Respiration 14 Blood Pressure 126/70. She and Nurse Trundle assisted Mr Gavin onto his bed. Nurse Smith decided that despite Mr

Gavin's request his methadone should be withheld and he should be re-assessed by Nurse Trundle after lunchtime, with the likelihood that it would be dispensed unless there were other concerns. It was due to be dispensed about 10.30am, so it would have been delayed by some two to two and a half hours. Following seeing Mr Gavin Nurse Smith checked the Kardex and established that Mr Gavin was prescribed rivaroxaban. She thought this was an anti-coagulant and checked this in the BNF. She had identified on examination that Mr Gavin had ulcers on his legs and assumed that the rivaroxaban was to combat the risk of clotting in his legs.

[26] She was called back to see Mr Gavin again about 1115. At the time she was in the triage room in house block 1. She had been approached by prison officer Lorimer who had asked whether Mr Gavin should be brought to receive his methadone. Nurse Smith confirmed she would keep to the original plan and a decision would be taken following a review by Nurse Trundle at lunchtime. Prison officer Lorimer returned to the triage room shortly thereafter and asked someone to come and see Mr Gavin. Nurse Smith assumed she had told Mr Gavin he was not to receive methadone and was unhappy and had asked for an explanation from Healthcare. It took about 10 seconds to get to Mr Gavin's cell which was close by. Mr Gavin was pale and unconscious lying on the floor, in the recovery positon, between the bunk and the cabinet. As she turned him over, she shook him and gave him a sternal rub. In her oral evidence she stated it took about 10-15 seconds between her entering the cell and Mr Gavin regaining consciousness. In the Vision record (Crown Production 6 page 37), the electronic patient medical record, she had recorded "unresponsive to pain for 30 seconds". On responding Mr Gavin was reasonably alert but a bit groggy. He said nothing about how he had come to collapse. She again took observations: blood pressure,

pulse and oxygen saturation. Although his blood pressure had fallen to 105/68 it remained within normal limits. The pulse reading was 70 which had dropped from 78. In her view a reading of anywhere between 60 and 90 was normal. His respiratory rate was 12 and she was happy with that. She recorded both sets of observations onto Vision at the same time but couldn't say when. She didn't record oxygen saturation and assumed she forgot to put that information on Vision.

[27] She decided to have Mr Gavin seen by the doctor. Following seeing Mr Gavin she spoke to the supervisor, prison officer Clark, to tell him she was going to speak to the doctor and asked about the availability of a wheelchair if the doctor wanted Mr Gavin taken to healthcare. That was just before 1130. She did not have an understanding of the doctor's hours and expected the doctor to see Mr Gavin at the end of the morning clinic. When she got to healthcare she was told the doctor had just left and was returning for training at 1300. The options open to her were to call the doctor who was on call or to call an ambulance. She took the view that given the doctor was to return before 1pm there were no further risks in that timescale and she would consult the doctor on his return to the prison. She called the gatehouse to ask that they ask the doctor to contact her before he went into training so that she would be able to speak to him about a patient. She then updated Nurse Trundle as to what had happened.

[28] Just after 1300 Nurse Smith went to meet Dr Henderson and brought with her the Kardex and a post-it note with her observations. Dr Henderson told her he was aware she had been looking for him. She reported that she had seen Mr Gavin twice that morning and that he had collapsed. She was clear she had used the word collapsed. In using "collapsed" she meant suffered a loss of consciousness. She gave Dr Henderson the Kardex and post-it

note. She did not explain to him that she administered a sternal rub. She did not make Dr Henderson aware of even her qualified 10 – 15 seconds lack of response from Mr Gavin. The post-it note observations did not match the observations on the Vision computer system because she had taken a number of readings and those on the post-it note were the most recent readings.

[29] She told Dr Henderson that Nurse Trundle was going to review Mr Gavin and if he appeared OK to dispense his methadone. Dr Henderson decided that Mr Gavin should be booked in for an appointment the following day. Dr Henderson appeared satisfied with the actions which she had taken. She would have preferred that Dr Henderson had seen Mr Gavin, and had done so prior to commencing the training. She confirmed she had not asked Dr Henderson to do so and had not clearly expressed her concerns to Dr Henderson.

[30] She could have booked Mr Gavin into the clinic the following day herself and did not require Dr Henderson to ask to see him the following day. She denied saying to Dr Henderson that she would herself review Mr Gavin again. Dr Henderson's only offer was to put Mr Gavin on the list to be seen the following day. On being pressed as to whether she could have pushed Dr Henderson harder to see the patient she agreed that she could have but she felt that she simply relied on Dr Henderson to make the decision. She felt that she had given Dr Henderson appropriate information and trusted his decision. Nurse Smith conceded that she did not express to Dr Henderson the change in Mr Gavin's presentation from her first attendance on Mr Gavin's collapse to her attendance at the Second Incident when he appeared to have deteriorated. With the benefit of hindsight she recognised that she should have been more assertive to have the patient assessed and could have been more robust with the GP. Dr Henderson did not say to her he would see Mr Gavin if required.

Nurse Smith recalled being reassured by Dr Henderson's decision to review Mr Gavin the following day.

[31] In relation to the clinical review undertaken by Ann Gow, Nurse Smith was unaware of any apparent mechanism for a blood loss to occur. Normal blood sugar was between 4 and 8. She would not have reached the conclusion which Anne Gow, a band 8 nurse, reached that the elevated blood sugar might be an indication that Mr Gavin was possibly in a compensatory stage of shock. Nurse Smith would have taken Mr Gavin's recovery from fainting as an explanation for his increase in blood pressure. Nurse Smith had received first responder training but that was principally involved with cardiac resuscitation and the use of a defibrillator.

[32] Nurse Smith confirmed when she was working at the prison SBAR was not used. She was aware of it as an NHS communication tool which stood for: situation, background, assessment and recommendation. She had used this working for NHS 24 after she had left the prison. She accepted that the SBAR template produced as Production 35 would have been of some assistance to her in transmitting the information to Dr Henderson and in her decision making. Likewise completion of the initial assessment form which was introduced and seen in the appendix in the Patient Assessment and Escalation Procedure Process Local Operating Procedure (NHS Ayrshire and Arran Production 9) and its presentation to Dr Henderson would have avoided the miscommunication or at least the inadequate communication and discussion which took place between her and Dr Henderson. At the time, however, she was satisfied that she had passed the necessary information to the GP. She believed he was better placed to make the decision as to the urgency of his seeing Mr Gavin and accepted his view. With the benefit of hindsight she recognised that she could

have done more. Nurse Smith disputed that the entry at the top of page 6 of the Critical Incident Report (Crown Production 8) that she was unaware of the signs of shock was a valid or fair comment. In the absence of any sign of injury and no report from Mr Gavin of an assault it did not occur to her that loss of blood was a factor. She recognised that when Mr Gavin disclosed he had been assaulted the symptoms fitted together with a blood loss arising from the assault. After the First Incident when she looked at the Kardex she confirmed she was aware that Mr Gavin was on rivaroxaban. She conceded that as stated in Mr Cronin's report that she had a considerable degree of concern for Mr Gavin after her second visit to his cell, and she agreed with Mr Cronin's conclusion that following the Second Incident it was reasonable that he should have been presented for urgent medical review.

Nurse Trundle

[33] As at 11 June 2014 Nurse Trundle was a Band 5 Registered Nurse, and had been qualified for five years. He began work at HMP Kilmarnock in May 2013. That day he was working a shift which commenced at 0700. His tasks that day included the provision of medication and in particular prescription methadone to prisoners. Methadone in general was dispensed between 1000 and 1200 with lunchtime medication dispensed after 1200. He was also required to attend medical response calls. Nurse Trundle could not recall if he was particularly allocated to undertake medical response on that day although his police statement taken on 12 June (Production 1 for Mr Gavin's family) recorded him as "having had radio yesterday." He believed in his oral evidence he was allocated to work in House

Block 2 but his police statement records his having been: "allocated to House Block 1 which covers A, B, C and D wings."

[34] He was carrying out the morning medication and had signed for the methadone when the first emergency call came through. He responded to the call at about 1010. He arrived with nurses James Gordon and Susan Kerr and found Nurse Karen Smith already there. Mr Gavin was leaning against the wall. Mr Gavin appeared orientated and was making complete sense. He looked pale and was leaning to one side. One of the other nursing staff handed over the response bag and went away. He supported Mr Gavin as blood pressure, temperature and other observations were taken. He could not recall anyone apart from Nurse Smith taking the observations. Nurse Trundle did not remember relaying observations to Nurse Smith, nor did he recall how she was recording the observations she was taking. Nurse Trundle was aware of Nurse Smith asking Mr Gavin what had happened to him. He thought Mr Gavin said that he had a faint. When Nurse Smith finished taking the observations from Mr Gavin she said she would speak to the doctor on his behalf and would withdraw his methadone until around lunchtime in case the doctor wanted to undertake a further assessment.

[35] Medical response calls were a routine event which occurred once or twice a week and he had a poor recollection of events. He said the decision to withhold the methadone was entirely sensible, as it was possible Mr Gavin's medication had been mismanaged or he had taken some other substance which had caused some form of seizure or faint. He believed that these were the possibilities that Nurse Smith would present to the doctor. As far as he could recall Nurse Smith told him the observations were normal. Nurse Trundle said it was general practice to go and speak to the doctor following a medical response. If

the doctor was not available he would make his own plan for ongoing treatment but generally he would go and speak to a doctor, if available. He could not recall there being a particular plan to review Mr Gavin and could not recall any suggestion that it was he who would review Mr Gavin. Nurse Trundle estimated that he spent about 10 or 15 minutes in the cell with Mr Gavin. He didn't have any particular worries on leaving the cell as Mr Gavin was mobile and got onto his bed pretty much on his own with minimal assistance and wasn't complaining of any pain. On leaving the cell he continued to undertake methadone dispensing duties in House Block 2.

[36] For the rest of the morning he had no more interaction with Mr Gavin, but heard at lunchtime that Mr Gavin was to get his methadone after all. He could not recall where this information had come from, although he thought it was most probably from Nurse Smith and that it would have been between 1230 and 1330. Nurse Trundle therefore proceeded to organise methadone for Mr Gavin. He checked the Kardex was still valid and asked one of the Addiction Care Workers to assist him to dispense the methadone. He requested that Mr Gavin be brought to the triage room for his methadone to be dispensed. While he waited for Mr Gavin to arrive prison officer Campbell came and asked him to go and see Mr Gavin in his cell as he was unwell. He took the response bag. Mr Gavin was lying on a mattress on the floor. He was in obvious distress, pale and clammy. He was complaining he was unable to breathe, and generally unwell. Nurse Trundle asked him what was wrong and applied a pulse oximeter to his finger. It didn't give a reading straight away, his extremities were very cold. Blood pressure was difficult to make out and appeared to be very low. Nurse Trundle was seriously concerned about Mr Gavin's condition; his oxygen saturation was 84 - 86%. Mr Gavin explained that he had been assaulted. He lifted his shirt and pointed to some red

marks on his left flank, at the bottom of his ribs, which, as far as Nurse Trundle could tell, were recent. Mr Gavin did not appear tender on examination, but was upset and asking to be taken to hospital. Nurse Trundle returned to the triage room to get oxygen and asked for the doctor to be sent for. When he returned to Mr Gavin's cell his oxygen saturation had decreased further to 70 - 80% and Nurse Trundle asked a prison officer to arrange an emergency ambulance. Nurse Trundle proceeded to administer oxygen to Mr Gavin and continued to monitor him, at this point Mr Gavin's oxygen saturation had dropped to 74%, his respiration rate was 60 and temperature 34. Nurse Trundle believed Mr Gavin's condition was life-threatening. By the time Dr Henderson arrived, which was within about ten minutes, about five minutes before the paramedics, Mr Gavin's oxygen saturation was coming up, but he remained very distressed and Nurse Trundle had to encourage him to keep the oxygen mask on. Nurse Trundle reported the position to Dr Henderson when he arrived and explained that Mr Gavin said he had been assaulted. Mr Gavin seemed healthy at the First Incident compared to his appearance at the Third Incident.

[37] Nurse Trundle did not recall his having any specific training as a first responder. He had undertaken basic life support training when he started and annual refresher training on CPR. More recently he had undertaken training on acutely unwell patients. This involved the assessment of people in shock and he found it to be a useful addition to his knowledge base, beyond that which he had when treating Mr Gavin.

[38] In terms of other changes since June 2014 they now have a handover meeting at one o'clock to discuss what has happened in the various parts of the prison. The prison staff now use a Code Red or Blue to try and indicate what is wrong in order for the appropriate equipment to be taken. "Code Red" tends to indicate bleeding or self-harm, and Code Blue

cardiac arrest or epileptic seizure. Nurse Trundle would now expect a person with Mr Gavin's response to be described as "Code Blue". SBAR reporting is now used, this assists in ensuring all important information is conveyed and nothing is missed. It is used to inform the doctor over the telephone when leaving a message or when giving information to him. It is not just used in emergency situations and is also used in the context of changes to medication. It gave a better structure for the passing-on of information. At the time of Mr Gavin's death information was written down on a piece of paper or the back of a glove. The initial assessment form had also been introduced, as part of the new protocol and blank copies are kept in the response bags. This also promoted better recording and transfer of information. Once the information was conveyed to the doctor the forms would be scanned onto Vision. It was a more formal structured system which everyone follows.

Mr Cronin

[39] Mr Cronin is the Clinical Director of Cronin Limited and is a registered nurse. He qualified in 1993. In twenty five years his career had taken him from staff nurse to modern matron in an emergency care division. He had extensive clinical experience. He gained further experience within South East Essex Primary Care Trust in 2009 in a management role, leading on commissioning and quality management of urgent care. He also led on prison healthcare and worked clinically with the health care team of HMP Bullwood Hall Prison in improving and monitoring standards of healthcare. He had been in the prison on a regular basis while undertaking his responsibilities in that regard. He did work clinically with prisoners, but did not personally deliver nursing services to prisoners. In 2013-2014 he was employed as a quality and patient safety manager working at a strategic level within

NHS England Essex Area Team. Mr Cronin retains his clinical expertise through working as a nurse in the emergency department of Basildon Hospital. He is currently substantially employed by the Nursing & Midwifery Council as a registered case examiner and makes decisions on fitness to practice matters.

[40] In his report Mr Cronin identified a number of conflicts of evidence which I require to resolve. Mr Cronin was not critical of the actions of Nurse Smith or the other nurses who interacted with Mr Gavin at the First Incident. In his opinion the nursing care provided to Mr Gavin during the First Incident did not fall below the standard of care required. None of the conflicts of evidence would have affected this view. If Mr Gavin had felt able to disclose that he had been assaulted that might have changed the course of events as the fact he was prescribed rivaroxaban might have further heightened concerns.

[41] Mr Cronin concluded that the nursing care provided to the deceased during the Second Incident was neither reasonable nor responsible given that this followed within about an hour of the First Incident. By this time Nurse Smith was aware that Mr Gavin was taking rivaroxaban and found him to be unresponsive for at least 10 to 15 seconds. He considered that finding a patient who failed to respond to a sternal rub for even 10 to 15 seconds would be viewed with concern by any nurse. It would have been reasonable and responsible for a nurse to have had such a patient reviewed by a medical practitioner as soon as possible. He considered that Nurse Smith's failure to seek a review by Dr Henderson urgently after the Second Incident fell below what should be expected of a reasonable staff nurse. He was critical of Nurse Smith's decision to defer speaking to Dr Henderson until his return to the prison. She should have sought an urgent medical review and physical examination of Mr Gavin by Dr Henderson. The correct course would have

been for Nurse Smith to make contact with Dr Henderson. She should have called him on the telephone to seek his advice if he was not in the prison. Mr Cronin did not consider that an ambulance call was appropriate as he considered Mr Gavin appeared haemodynamically stable at the time of the Second Incident. Mr Cronin was of the view that if Dr Henderson was contracted to be present within the prison at the time of the Second Incident he should not have left but would defer to the GP expert and others in this regard. In relation to the Third Incident the healthcare team had all done their best for Mr Gavin.

[42] Mr Cronin was clear that prison healthcare is primary care focused. Mr Cronin accepted that SBAR and NEWS are evidence-based aids to clinical decision-making. He observed that they are not decision-making tools that replace clinical judgment, but they can act as a useful prompt. He was not asked to comment on the NEWS response form which was not available at the time he gave his evidence.

[43] Mr Cronin was critical of the mental health services clinical records review report dated 12 September 2014 (Crown production 8) which he considered to be poorly structured, applied hindsight to factual matters, often mixed fact with opinion and made numerous assumptions. He said the report overall was of a poor quality. He could not determine why the report authors had assumed that Nurse Smith was of the view that during the Second Incident the deceased was in a post-ictal phase and or had an episode of hypo-glycaemia. He noted the report to be critical of the lack of systems to allow healthcare staff to identify patients on high-risk medication. He did not endorse this concern given in the instant case Nurse Smith had herself identified that Mr Gavin was prescribed rivaroxaban and had made Dr Henderson aware of this. He supported the findings: that there were training issues for prison nurses in the identification of the acutely unwell adult, a systematic approach needed

to be developed and implemented in relation to patient history taking, assessment and escalation, and that standardised reporting tools such as SBAR be introduced.

Dr Henderson

[44] Dr Henderson received his medical degree from Dundee University in 1996 and became a member of the Royal College of General Practitioners in 2001. He undertakes forensic medical work for Health Boards and provides healthcare and forensic services to Police Scotland. He is a director of Arcus Trading Limited and started working in 2012 at HMP Kilmarnock under the contract between Arcus Trading Limited and NHS Ayrshire and Arran. He generally works at the prison all day on a Tuesday and on a Friday morning. He did not recall exactly when he arrived at the prison on 11 June, but accepted the timings of the prison staff movement record (Crown Production 32) that he arrived at the prison at 0927 and left again at 1130.

[45] Dr Henderson's position was that the contract only required a GP to be in the prison when patients required to be seen and consultations took place between 0930 and 1130. On 11 June, according to his usual practice, he left the prison when his surgery concluded which was at approximately 1130. It normally took about 10 to 15 minutes to move between healthcare and the main gate and his home was some 15 minutes away from the prison. He usually did paperwork at home at lunchtime as the only place he could find a computer to work at was to go home. There were only two consulting rooms available at the prison and they were often used by the mental health nurses and their use was timetabled. It would normally take about 25 minutes to see a patient if he was called at home. When out of the prison at lunchtime his contact number was available and he was treated as being "on-call"

and was fully available to see patients if required. If called to see a patient, his preference was for the prison staff to take the patient to healthcare. It would be uncommon for him to see a patient in his cell. On occasion if called at home he might suggest he would see the patient in forty five minutes, to allow time for arrangements to be made for the patient to be taken from a cell block to healthcare.

[46] He returned at about 1300. He was not aware of any concerns while he was outwith the prison. On his return one of the prison guards may have asked him to contact healthcare but that did not particularly register as he was heading to healthcare in any event as the training was to be held in the training room/chaplaincy adjacent to healthcare. He believed he was met by Nurse Smith in the corridor adjacent to the healthcare centre. Nurse Smith told him there was a patient, Mr Gavin, whom she had seen twice that morning. On the first occasion he seemed fine, he was thought to have fainted, or collapsed and had fully recovered. She did not discuss the First Incident in any more detail. On the second occasion she attended Mr Gavin's cell, Nurse Smith told him Mr Gavin had again collapsed but recovered quickly and he did not form the impression that Nurse Smith was greatly concerned. She gave him the drug Kardex and discussed he was on methadone. The Kardex only showed rivaroxaban and methadone. She said she had not given him methadone and was going to review him again and give him his methadone if he was feeling better. Nurse Smith wanted to know what else could be done for the patient. He did not recall his having any impression of particular concern on the part of the nurse and he felt that she would have contacted him by telephone if she were more worried about Mr Gavin. He did not ask her anything further about the patient. He knew Mr Gavin was shortly to be reviewed and instructed Nurse Smith to list Mr Gavin for the next morning's surgery, which

he was to cover. He believed he had intended to ask if there were any problems before he left the prison that night. He thought that was sufficient and a reasonable treatment plan. He was comfortable with the level of information which he had been given by Nurse Smith, but did accept with hindsight that he might have asked her if she was worried and wanted him to see Mr Gavin, whether she had any particular concerns and why she had sought his advice. From the information given to him by Nurse Smith and her demeanour he concluded there was no need for him to immediately see the patient. A safety net was in place as Mr Gavin was shortly to be reviewed by the nursing staff. A further safety net was that he would review Mr Gavin the following morning. Dr Henderson relied on the nurses and believed they were very capable. The observations taken were within a normal range.

[47] It was only recently that he understood that Nurse Smith had tried to contact him at about 1130. Had he been telephoned shortly after 1130 and the same information conveyed by Nurse Smith he did not consider there to be any particular degree of concern. That was a time when there was restricted prison movement and lockdown, so he would not have gone back immediately in any event. Dr Henderson did not recall being advised as was recorded in the Vision record that Mr Gavin had been unresponsive to pain for some thirty seconds. He explained that would have suggested a more serious condition than that stated by Nurse Smith, but even then his treatment plan may not have changed. He could understand that Mr Gavin may have minimised his symptoms in the interests of getting his methadone. Absent any indication of an assault, Dr Henderson thought he would have carried out a neurological examination, pupils, balance, co-ordination, heart, and chest, but he would not necessarily have examined Mr Gavin's abdomen. He did not recall Mr Gavin as having been described as pale and clammy at the Second Incident. Dr Henderson considered that it

was common for prisoners not to reveal they had been assaulted, and to minimise any injury in order to ensure they got their methadone. When he did see the bruising it was subtle and difficult to see. Those on rivaroxaban may get light bruising. If he had been consulted earlier and seen Mr Gavin the probability is he would have ordered an urgent ambulance, not a "blue-light" ambulance and probably had some discussion with the hospital in advance of admission. If Nurse Smith had told him about having a wheelchair ready to take him to the surgery he might have been more concerned about the difficulties of Mr Gavin being able to walk.

Ms Gow

[48] Ann Gow is Director of Nursing and Midwifes at Allied Health Professionals for Healthcare Improvements (Scotland) which is an oversight organisation inspecting nursing in the NHS and Private Sector. In 2014 her position was as Associate Nurse Director for Primary Care with responsibility for Community Nurses, District Nurses, Health Visitors and General Nurses for NHS Ayrshire and Arran. She had no direct experience of working within a prison. She qualified in 1989 as a Registered General Nurse and worked as a Registered Nurse in an acute hospital environment for three years. She qualified as a midwife in 1991, and as a Health Visitor in 1992 and then worked as a heath visitor for 7 years. She was a Nurse Consultant in Greater Glasgow and then in Ayrshire and last provided patient care in 2000 as a Health Visitor. She was the author, assisted by Barbara Cowley, an advanced nurse practitioner, of the Mental Health Services Clinical Review Report dated 12 September 2014. She confirmed that she had received training in the preparation of such reports and in root cause analysis. She had previous experience of

preparing such reports across a number of areas. She indicated that this report was slightly different to normal, as she had been guided not to do anything which might interfere with the criminal prosecution. She obtained access to staff statements taken at the time, Mr Gavin's medical records and also interviewed Nurse Smith and Nurse Trundle. She also took advice from a senior GP. She explained the purpose of the report is not to deal with competency or HR issues. If something like that arose it would be dealt with separately. The function of the report was to identify the root causes of the event. The report explores what might have been the underlying issue which has triggered the event not necessarily the direct cause but something which has created the circumstances which allowed the event to occur. It will explore systems and process and seek to identify learning points. This could be seen as the action plan contained within the report. She had left NHS Ayrshire and Arran prior to steps being taken to implement the action plan.

[49] Barbara Cowley was highly specialist in the treatment of acutely unwell adults and provided significant input, the report reflected her explanation of what had probably been going on. It was accepted that some of the conclusions were reached because when the report was completed it was known that Mr Gavin had been bleeding internally. Ms Gow accepted that the report could be read as being very critical of the action taken. It was put to Ms Gow that the tone of the report was highly critical of Nurse Smith and she conceded that she could understand why Nurse Smith might be upset by the report, but this had not been her intention. This may have arisen as a result of the way the report was phrased given the criminal proceedings, but she thought this had backfired. She also accepted that there were factual conclusions in the report which were not well founded.

[50] The key outcomes of the report were however to identify the root causes and action which could prevent repetition. Those were set out in the action plan. One issue which was easily identified was that there was no standard operating practice and no written procedure to regulate recording procedures following a medical response.

Mr de Beaux

[51] Mr de Beaux has been a consultant upper gastro-intestinal surgeon at the Royal Infirmary, Edinburgh since March 2001. This post includes responsibility for the care and management of general surgical emergencies, including major trauma and day-case surgery.

[52] With the recorded clinical observations when Mr Gavin was first seen by Nurse Smith: heart rate of 78, respiratory rate 14 and blood pressure of 126/70 given the patient denied any substance misuse or trauma, there was no indication to arrange hospital transfer. Mr de Beaux attributed the second collapse to be the result of insufficient blood and oxygen getting to the brain. He interpreted the clinical readings as disclosing a degree of hypovolemia (reduced blood in the circulation) and a vasovagal response from standing compounding the effect of hypovolemia which resulted in collapse. Mr de Beaux was again of the view that at the Second Incident the clinical findings and the denial of any history of trauma with no obvious signs of injury, gave no indication for transfer of Mr Gavin to hospital. Mr de Beaux concluded that Nurse Smith was concerned but not concerned enough to require immediate action and she properly attempted to speak to the doctor. He considered those actions to be reasonable and appropriate in the circumstances.

[53] Mr de Beaux described Mr Gavin's injury as not a particularly bad stomach injury. He assessed Mr Gavin to have suffered a Grade 3 splenic injury from which Mr Gavin was

probably slowly losing blood. Mr de Beaux would not necessarily expect the loss of blood to have been consistent throughout the period from the assault until Mr Gavin's arrival at hospital. His best estimate was to suggest that it was likely that Mr Gavin would have lost a litre of blood by 1130. He does not use blood-loss calculations as it was non-clinical practice and he believed the calculations made in the Mental Health Services Clinical Records Review Report to be a "guesstimate" at best.

[54] Mr Gavin who was reported as having been a smoker for most of his life, had liver impairment probably as a result of hepatitis C infection and was prescribed rivaroxaban was given the best chance of survival by what he considered to have been exemplary treatment at Crosshouse Hospital.

[55] Often there is a very rapid turnaround after surgery, but in Mr Gavin's case bleeding continued post-surgery and there was no material improvement. Mr Gavin's response to active resuscitation in hospital was poor. He went into a condition described as multiple organ failure. This is an idiosyncratic response and not all patients will respond in this way. Such a response is unusual and most often associated with a huge bacterial load from for example a severe infection or a perforated ulcer. Mr Gavin had none of those features. His underlying physiology was poor. His BMI suggested he was not particularly well nourished, he was a smoker, he already had a degree of inflammatory process going on he had hepatitis C and his liver was diseased. That his liver was struggling might account for the BMI of 9.5 when first measured after the assault. He concluded that Mr Gavin developed a systemic inflammatory response. He anticipated that even if Mr Gavin had been treated earlier the same response may have happened and the outcome for him would have been the same.

[56] Mr de Beaux also gave evidence of his expectations of what would have happened

had Mr Gavin been admitted as an emergency to the Royal Infirmary of Edinburgh. I do not repeat this evidence which is not relevant to the determination. Focusing on the hypothetical outcomes had Mr Gavin been transferred to hospital at an earlier stage, Mr de Beaux recognised that such hypothetical scenarios are, by their very nature, speculative and accepted that the transfer into a gurney and then transportation by ambulance to hospital, which occurred after 1400, may have resulted in an increase of Mr Gavin's bleeding and he suffered a cardiac arrest in the course of that transfer and it was impossible to state categorically whether there would have been a similar deterioration in Mr Gavin's condition had he been transferred to the hospital in an earlier stage.

[57] Mr de Beaux did not however think that surgery two hours earlier would have made any difference. Intuitively and logically having regard to Mr Gavin's lack of response to surgery he probably didn't have a material chance of recovery even if operated on three hours earlier.

Dr Wallace

[58] Dr Wallace had been a principal in a GP practice since 1980 and retired in 2001. He acted as a police-surgeon for nine years from 1986 until 1995. This gave him some experience of the care of prisoners in custody. Since his retirement from practice he has undertaken medico-legal work as a medical adviser. In this context he had been asked to visit a prisoner who had a complaint about his care in prison. He also had dialogue with colleagues working in a prison setting and had given evidence in four or five fatal accident inquiries, at least two of which had involved a death in custody. In general terms health services in a prison should be as far as possible equivalent to GP services in the community.

[59] The recorded observation on the Vision medical record and the post-it note fell within a normal range. He was critical that the Vision record for 11 June 2014 narrated "no significant medical history." Mr Gavin had hepatitis C and was prescribed rivaroxaban and methadone. That reflected significant medical history.

[60] Dr Wallace had no concerns about the actions of Nurse Smith during or following the First Incident. With the benefit of hindsight Mr Gavin had played down his symptoms and failed to disclose the material information that he had been assaulted. Following the Second Incident a more significant assessment was required. He accepted that Nurse Smith was competent to examine Mr Gavin. It would have been preferable if Nurse Smith had telephoned Dr Henderson after seeing Mr Gavin after the Second Incident and in a clear and structured way given him information on Mr Gavin's condition and requested that he see Mr Gavin. This would have allowed the doctor to undertake a more comprehensive examination. He noted that the blood pressure recorded on the post-it note was higher than the blood pressure recorded in the prison records and could not explain the reason for this.

[61] There had not been a good level of communication between Nurse Smith and Dr Henderson. There was some confusion about what was communicated, by definition that meant communication was inadequate. He would have expected that Dr Henderson would have seen a patient who had collapsed twice over the course of a morning, rather than delay matters until the next day. He was also surprised that Nurse Smith hadn't requested that Dr Henderson see Mr Gavin. He considered that Dr Henderson should have made more enquiry of Nurse Smith clarifying her assessment of the patient and specifically asked her what she wished him to do.

[62] In terms of improvements to the system he suggested an important action would be to highlight patients who were on anti-coagulant medication within the prison. He believed that the pro-forma clinical assessment tool (NHS Ayrshire and Arran production 9) which had been introduced and was now available in the response bag would assist in supporting the recording of observations of patients. He thought that, particularly in combination with a SBAR report, might have overcome the difficulties created by the apparent reassurance to Dr Henderson that the nurse had not sought him more urgently. Dr Wallace considered that there was vulnerability in the system if the doctor was off-site which might require consideration of the level of training for nurses given a disproportionate amount of pathology may be present in the prison population. Dr Wallace thought bruising might have been visible on Mr Gavin's flank after the Second Incident. If Dr Henderson had examined Mr Gavin shortly after 1130 and found him to be stable and not deteriorating he may well have summoned a one-hour ambulance and that would have been an acceptable clinical judgment. He accepted that a staff nurse is not necessarily unsatisfactorily qualified but where this leads to some escalation it would be helpful to the GP if they had confidence in their own clinical skills. Dr Wallace believed Nurse Smith should have been comfortable in seeking advice from Dr Henderson.

[63] In response to cross-examination by Mr Mawby, for Dr Henderson, Dr Wallace conceded that that given the information provided by Nurse Smith he might have acted in a similar way to Dr Henderson, particularly given the suggestion that Mr Gavin was shortly to be reassessed by another nurse, additionally as there had been no reference to a sternal rub having been administered nor clarification of the period of loss of consciousness, and the

lack of pressure from Nurse Smith for Dr Henderson to see Mr Gavin, he accepted that many GPs would have proceeded as Dr Henderson had done.

Dr Mardon

[64] Dr Mardon had worked as an A & E Consultant at Crosshouse Hospital since 2005 and was the on-call consultant in charge of the unit on 11 June 2014. She recalled a pre-alert had been issued by the ambulance warning of Mr Gavin's imminent arrival. This advised Mr Gavin should be immediately assessed and was critically unwell. On arrival Mr Gavin had a low level of consciousness and did not respond to stimulation, he was recorded as 3 on the Glasgow Coma Scale. He was barely able to breathe without the help of a bag mask. A fast scan was undertaken as there was a concern that he was bleeding internally. Very shortly after arrival in A & E Mr Gavin lost cardiac output which she believed resulted from not enough blood flowing through his system and the team proceeded to undertake a well-rehearsed procedure for advanced life support. Heartbeat was regained at 1504. Mr Gavin was taken to theatre very quickly. Dr Mardon felt it was impossible to give a trajectory for Mr Gavin's decline following his having been assaulted.

[65] Dr Mardon also gave evidence on the arrangements for the care of patients who were not brought in in such a critical condition. I don't rehearse this evidence however as it was not relevant for the determination.

Dr Donald

[66] Dr Donald is consultant in emergency medicine at Ninewells Hospital in Dundee. He also undertakes sessional air ambulance duties for NHS Glasgow and Clyde as a primary

responder at the scene of incidents and supporting critical care transfers. He was not prepared to speculate what Mr Gavin's condition might have been around 1230. The variability in the trajectory of a patient's deterioration from normal to catastrophic decline was such he could not express an informed view. He recognised that reactive transfer can give rise to significant problems for those patients with internal bleeds and even in the most gentle, careful transfer there can be a precipitous decline, which some medical experts associate with clot dislodgement. It was also possible at the time of his transfer to hospital there was deterioration in Mr Gavin's condition as it evolved and that the movement had no significant impact.

[67] The A & E staff at Crosshouse Hospital undertook substantial intervention very quickly in what he described as "an exemplar of excellence in modern trauma care". Dr Donald was of the view that Mr Gavin's prospects were poor given the nature of his coma, his extensive liver disease, having hepatitis C, and being prescribed rivaroxaban. He agreed that the instance of cardiac arrest in the ambulance and on arrival at A & E also prejudiced his prospects of survival. He agreed with Mr de Beaux that Mr Gavin would have been unlikely to have survived even if he had been admitted to Crosshouse Hospital some two hours earlier. He also gave evidence in relation to different scenarios on Mr Gavin's arrival to A & E which are not specifically relevant to the determination.

Ms Gordon

[68] Fiona Gordon is Service Manager and oversees prison nursing for NHS Forth Valley. This involves responsibility for three national prisons Polmont, Glenochil and Cornton Vale

and 75 – 80% of her work is on prison healthcare. She is operationally and strategically responsible for prison healthcare in the Forth Valley.

[69] Ms Gordon accepted the care which was given by staff to Mr Gavin at the First Incident to have been appropriate. In relation to the Second Incident, given this was a second incident of collapse, it would have been appropriate for Nurse Smith to have sought medical advice. Nurse Smith could have telephoned the doctor whilst he was out of the prison. This was not a situation where she considered an ambulance should have been called. She considered that a doctor when called should be able to see a patient within about an hour and a half. Thus given Dr Henderson's planned return to the hospital she could accept it was a reasonable clinical judgement for Nurse Smith to decide to wait to speak to Dr Henderson on his return to the hospital at 1300. Nurse Gordon did not agree with Mr Cronin's report at paragraph 20.01 where he states: "The nursing care provided to the deceased during the second event was neither reasonable or responsible." There were good reasons for Nurse Smith to accept the denial of any assault by Mr Gavin and in the absence of any suggestion of assault no prompt for her to fully examine Mr Gavin. That may have been an option for an advanced nurse-practitioner, with greater diagnostic knowledge and it would have been more appropriate to have Dr Henderson undertake an in-depth physical examination, but that was not the role of a band 5 nurse. She considered more options were open to Nurse Smith following the Second Incident and disagreed with Mr Cronin that the only reasonable option was to have immediately sought the advice of the doctor.

[70] HMP and YOI Polmont has a GP in the prison most of the day. In HMP Cornton Vale the GP undertakes clinics and advanced nurse-practitioners undertake some diagnostic

work. In relation to ambulance calls, a blue-light ambulance would be summoned in the circumstances of attempted suicide or an assault where there was visible injury; the ambulance would come quickly. An ambulance dispatched as an urgent ambulance might take an hour and a half.

[71] Nurse Gordon explained that in the prison setting there can be difficulty in getting an accurate history and patients can often "over-egg" their symptoms. In this case it appeared that Mr Gavin had played down his symptoms. Nurse Gordon thought that NEWS was not widely used in a primary care setting. In terms of record-keeping Nurse Gordon thought the salient points from the observations were recorded on Vision.

[72] If the GP was contracted to be in a prison for set hours she would expect them to be there during such hours. Nurse Gordon did not see a benefit for every nurse in a prison setting to become an advanced nurse-practitioner. She thought in the circumstances as she understood them it would have been appropriate for the doctor to have gone to see the patient following the discussion with Nurse Smith at 1300.

Miss Sharp

[73] Miss Sharp has been a Consultant undertaking upper gastro-intestinal, bariatric and general Surgery at Crosshouse Hospital for nine years. On 11 June she was called down to Accident & Emergency to see Mr Gavin. He was clearly very unwell. She recalled Mr Gavin was unconscious and had been ventilated and a consultant from ICU was already in attendance. Her first impression was that Mr Gavin was not going to survive the day. A fast scan ultrasound to the abdomen which doesn't show a lot of detail gave a picture of fluid in the abdomen. Mr Gavin required surgery to explore the source of what was

probably bleeding. Mr Gavin was taken for surgery about 1500. The posterior spleen had been damaged and was the source of the bleeding. Crown Production 7, page 200 showed some 4 litres of blood having been gathered as recorded by the ICU trainee.

[74] Mr Gavin was coagulopathic. The ability of his blood to clot was impaired. Following the removal of his spleen the bleeding would have been expected to stop as it has been disconnected from the blood supply. She surmised that the fact that he was receiving rivaroxaban, had liver disease, and the massive transfusion of blood products which he had received all contributed to his blood not clotting properly and made stopping the bleeding more problematic despite surgical intervention. As a result of continued bleeding, Mr Gavin was returned to theatre on the evening of 11 June and again on a number of occasions over the next few days. She observed Mr Gavin to have developed multiple organ and system failures. The treatment he had received at hospital gave him the best opportunity to survive but he had to be viewed in relation to the factors as applied to him as an individual. Given his underlying morbidity, she agreed with Mr de Beaux Mr Gavin would have on the balance of probabilities not have survived even if he had been operated on some two hours earlier. Accordingly she qualified the view she had previously expressed in a statement to the Crown that Mr Gavin might have survived had he been admitted earlier.

Ms McMurdo

[75] Ruth McMurdo has been Senior Manager for Justice Healthcare Services for NHS Ayrshire and Arran since November 2011. She qualified as a nurse in 1994 at Gartnavel Hospital and had worked there until 2001 before becoming a ward sister in Crosshouse Hospital until she took up a management position. She was aware of the circumstances of

Mr Gavin's death, although not involved in the clinical review of his death which was completed at a time she was absent. Medical services in HMP Kilmarnock were and are provided by a mix of registered nurses, registered mental nurses and general practitioner cover under a contract between the Health Board and Arcus Trading Limited, a consortium of general practitioners providing sessional cover and out-of-hours cover. The average number of nursing staff on day duty was six. There are no in-patient beds where patients could be monitored or observed in the prison. If monitoring and observation was required a prisoner would be transferred to hospital. NHS Ayrshire and Arran did not employ advanced nurse-practitioners at HMP Kilmarnock. Ms McMurdo was aware that some other prisons had explored and used advanced nurse-practitioners. It was her understanding that the vast majority were used in lieu of General Practitioners. In HMP Kilmarnock a nurse would generally be the first line of contact with the prisoner to determine if a GP appointment is required.

[76] Ms McMurdo explained changes which had been introduced as a result of the action plan proposed in the clinical review report prepared following Mr Gavin's demise. A training and competency review of the nursing staff had been undertaken. This had identified a need for greater skills in clinical assessment and re-enforcing the A, B, C, D, E approach (Airway, Breathing, Circulation, Disability, Examination). SBAR had been implemented to improve communication with the General Practitioners through the clarity and consistency of the information shared with them. As a tool to support clinical assessment, clinical assessment forms are now kept in the response bag. The form had been designed to assist in the recording of information and observations and the communication of that information to the General Practitioner. This information can either be telephoned

through to the GP or e-mailed through a secure e-mail service. New incident report forms had been introduced. A trial of a NEWS response chart which are intended to provide further guidance to nursing staff and assist their decision-making and improve communication had been commenced on Monday 4 February 2018. This was bespoke for use in the prison setting and was produced (NHS Ayrshire and Arran Production 12). The form identified parameters for when a patient should be reviewed by the GP. Applying the instructions of the NEWS response chart would have resulted in a single red score as Mr Gavin had been unconscious, which mandated that the General Practitioner be contacted by telephone advice with a view to reviewing the patient.

[77] It was also a recommendation that there should be a follow-up of all new admissions to the prison within 14 days of coming to the prison but she understood this two-week timetable was not always achieved. These practices and in particular the most recent innovation, the NEWS response chart, will be monitored by the Deputy Clinical Innovations Manager.

[78] It was not appropriate to ask prison staff to monitor prisoners who were unwell and there is no protocol about this. In any case the prison staff should inform the medical staff of any matters which could impact on the condition of a patient. There had been changes in practice in terms of those patients under anti-coagulant therapy but that was not routinely shared with prison staff and was a matter of patient confidentiality.

[79] In terms of the contract a GP is expected to provide cover between 9 and 12 but they should be flexible in coming in further times. Nurse McMurdo did not consider the GP should be within the hospital between 9 and 12 in terms of the contract as long as they were contactable by telephone. She conceded that the contract was not as efficient as it might be

and accepted that it had been extended on two occasions during her responsibility for the contract, without the operation of the contract being looked at in any detail.

Mr Clark

[80] Mr Clark was the prison officer in charge of House Block 1 on 11 June 2014. That day he was working an early shift commencing at 0630. HMP Kilmarnock has four wings, A, B, C and D each with 60 prisoners. All prison staff are first-aid trained. On 11 June there was a regime exemption as that day there was programmed staff training on suicide awareness. This made no difference to security provisions but the prisoners were in hall rather than at work. About 1000 a medical response was called in on the radio. He was in Alpha wing and he recalled observing the nurses at Mr Gavin's cell about 1015. He believed Mr Gavin was thought to have had a fit as he was lying on the floor of the cell. He recalled prison officers Lorimer and West being on the wing that day but could not recall the nurses who were in attendance. His recollection was that a nurse had asked Mr Gavin what was wrong, if he had any injuries. He got the impression that Mr Gavin said he didn't know what had happened but was asking for his methadone. He determined that the wing should be locked up while the nurses dealt with Mr Gavin in the cell. He also explained that when an ambulance was called to transfer a patient to hospital the wing had to be locked up. Prisoner officer West told him another prisoner had said that Mr Gavin had been assaulted and he went to speak to the prisoner to ask where this information had emanated from. The prisoner denied anything had happened and said he hadn't seen anything. He used his experience as a prison officer to seek out the truth from the prisoner. He said the prisoner was normally truthful but on this occasion it transpired he did not want to say anything

about what may have happened. He had also spoken to the civilian hairdresser who was cutting hair in the hall outside Mr Gavin's cell and she was unaware of any assault. Mr Gavin had not caused any difficulties since his recent arrival in the prison and Mr Gavin was not the sort of prisoner he would expect to get into the type of situation where he would be assaulted. He didn't pass any information about this to the nurses, as there was nothing to say.

[81] His impression was that the nursing staff thought Mr Gavin had taken a fit prior to his being found on the floor which coincided with the opinion of prison staff on the wing. A prison officer's role was to generally keep an eye on the prisoners. He had no specific instructions to watch Mr Gavin. At the Second Incident a nurse came from the triage area to Mr Gavin's cell and he followed. Mr Gavin was lying on the floor and was unresponsive, he didn't look well. The nurse put her knuckles on his chest and started speaking to Mr Gavin. He was moved to the middle of the cell with the nurse moving around him and taking observations from him. Mr Clark believed he had wet himself and was embarrassed. The nurse wanted to get Mr Gavin onto the bed in the cell but he said he preferred to stay on the floor and prison officer West gave him a pillow, moved the mattress to the floor and covered him with a duvet. Prisoners who fit are often happy to remain on the floor. Mr Gavin was asked again if he had been injured and he said no, and he did not know what had happened. He looked poorly as he did the first time, but was again asking for his methadone. The nurse said to him she would go and speak to the doctor and said she would let the prison staff on the wing know what was to follow. The prison officers were starting to get prisoners locked up for lunch and undertake a roll count. Mr Clark instructed prison officer Lorimer to leave Mr Gavin's cell open as leaving his cell open would allow them to watch

out for Mr Gavin and to get medical help more quickly than if the cell was locked. Mr Clark finished his shift at 1330 and did not see Mr Gavin again. Medical response calls to Mr Gavin would have been discussed at the handover.

[82] Prison officers would generally know those prisoners on methadone because they would be taken to the triage room for this to be dispensed. Prison officers generally don't know what other medications prisoners are on. The prison record system, PR2, does have medical markers to update their healthcare and some prisoners will tell the staff about medication they are on. An assault may occur within the prison about once a month. He completed a record about the incident about three days after the incident. Mr Clark stated he did not expect the nursing staff to make special requests for prison officers to observe a prisoner and if a prisoner required observation on health grounds he anticipated they would be moved to hospital. Regarding Mr Gavin's second collapse Mr Clark said he was about three or four steps behind Nurse Smith and it might have taken ten seconds to get from the triage area to the cell. It took about 30 seconds before Mr Gavin responded to the nurse rubbing his chest. Mr Gavin had responded within a minute of his arriving in the cell.

[83] In response to questions from Ms Connelly he did not think he could have done anything differently. He made enquiries of the prisoner whom he would have thought would have been truthful and he provided no information. He felt his response was appropriate and that included the instruction to keep Mr Gavin's cell door open after the Second Incident.

Submissions

[84] All parties to the Inquiry were agreed as to the findings which I should make in

terms of Section 6(1)(a) and 6(1)(b). They were also in agreement that I should not make findings under Section 6(1)(c) although their reasons differed. The Crown submitted that no finding should be made under section 6(1)(c) because the evidence did not establish a causal link between the exercise of a reasonable precaution and the death. However, the Crown did consider that there were various reasonable precautions for which there was satisfactory evidence. In particular, it was a reasonable precaution for Karen Smith to have summoned Dr Henderson after Mr Gavin's second collapse. The extent of her concern about Mr Gavin should have been made clearer to Dr Henderson. Dr Henderson could have made more inquiry of Nurse Smith about Mr Gavin's condition and the reasons for Karen Smith's concern, and Dr Henderson could have arranged to see Mr Gavin when approached by Karen Smith.

[85] For the Health Board Ms Watts submitted that section 6(1)(c) had two essential elements which required to be present in order to justify a finding. First, the precaution had to have been identified which would be reasonable to deploy in the whole circumstances of the case, and secondly, it had to be established that deployment of such a precaution would have given rise to a real and lively possibility that the death in question may have been avoided. Mr de Beaux's evidence which was supported by Miss Sharp and Dr Donald should be accepted by the Inquiry. None of the actions proposed by the Crown would have prevented Mr Gavin's death, and as a result no finding could be made under section 6(1)(c).

[86] Submissions were made on behalf of the Crown, Health Board and Dr Henderson regarding hypothetical times at which Mr Gavin might have arrived at Crosshouse Hospital and undergone surgery. Given my conclusions on the evidence about causation and finding

that Mr Gavin could not have undergone surgery more than some two hours before he did, I do not address these speculative issues in the determination.

[87] In relation to Section 6(1)(d) parties were agreed that there was no evidence to the Inquiry which identified a defect in the system of work that contributed to Mr Gavin's death.

[88] In relation to Section 6(1)(e) the Crown submitted that there were differences in the patient-clinician dynamic compared to that which could be expected in the community. It was submitted patients who are prisoners necessarily have much less power to direct their own healthcare than would be the case in the community.

[89] For NHS Ayrshire & Arran it was submitted that the contract for GP services operated in a flexible and permissive way. The health board did not consider that Dr Henderson was required to be in the prison after he had concluded his morning surgery.

[90] For the family it was submitted that I should consider the following facts as relevant to the circumstances of Mr Gavin's death: the failure of prison officers to alert the nursing staff attending Mr Gavin that a fellow prisoner notified the prison staff that Mr Gavin had been assaulted; that there was a lack of training and knowledge for Nurse Smith to enable her to properly assess and examine Mr Gavin and that following the Second Incident she should have identified that an acceleration of care was required which would have assisted Mr Gavin at that time; that there was no formalised system whereby an ill patient who remained in their cell was monitored by prison staff; there had been conflicting evidence over whether prison officers had been requested to keep an eye on Mr Gavin, but the evidence demonstrated that the nursing staff did not remain with Mr Gavin in his cell and monitoring such as it was done by prison officers was done in an unstructured way whilst

carrying on other duties; the system used to record observations was inadequate, not all observations appeared to have been recorded in writing and full information was not passed to Dr Henderson; Dr Henderson had failed to identify that injury may have been sustained during collapse, with the possibly of internal bleeding that necessitated immediate medical review; communication between prison and nursing staff attending ill patients was sub-optimal and communication between Nurse Smith and Dr Henderson was sub-optimal.

[91] No submissions were made on behalf of Dr Henderson in terms of section 6(1)(e). For Serco Limited it was submitted there were no other facts which were relevant to the circumstances of Mr Gavin's death and for the Scottish Prison Service that no finding under this subsection should be made against them.

Observations on the factual evidence

[92] Much of the evidence was not in dispute, but I mention certain aspects where there was a conflict of evidence. Prison officer Clark's evidence was that at the Second Incident he observed Mr Gavin to have been incontinent. Prison officer Lorimer stated she was not aware of Mr Gavin having been incontinent. Nurse Smith did not recall Mr Gavin as having been incontinent. I believe she would have noticed had Mr Gavin been incontinent while she was with him at the Second Incident. Nurse Trundle identified that Mr Gavin had been incontinent at the Third Incident; I conclude that although he was not present Mr Clark must have become aware of this subsequently and confused his evidence in assuming he had observed this at the Second Incident. I therefore preferred the evidence that Mr Gavin had not been incontinent at the Second Incident. That corresponds with the evidence of prison officer Lorimer. I did not however find her to be entirely reliable, she often appeared

rather vague in her recollection and where her evidence conflicted with other evidence I generally preferred the other evidence.

[93] I found Nurse Smith's evidence to the Inquiry to be honest and forthright. She for example was prepared to accept that she could have been better in conveying information to Dr Henderson and pressed him to see Mr Gavin. There were however some aspects of Nurse Smith's evidence which I did not accept. I concluded that Nurse Smith was mistaken when she said she asked colleagues to undertake Mr Gavin's observations at the First Incident. I consider on the balance of probabilities she did so herself, Nurse Trundle had no recollection of doing so, she took the lead in the assessment of Mr Gavin and she subsequently recorded the observations on Vision. In her oral evidence to the Inquiry she stated that Mr Gavin he had only been unconscious for some 10 to 15 seconds before a response was elicited from him. I considered it was more likely that her original estimate, as recorded in the contemporaneous notes, of 30 seconds was more accurate. That was also more consistent with prison officer Clark's evidence. I also considered Nurse Smith to be incorrect in her recollection of by whom and in what circumstances she was asked to see Mr Gavin immediately prior to the Second Incident. The CCTV shows her bringing a bag to Mr Gavin's cell, which does not accord with her evidence that she thought she was going to see him to explain that he was not going to have his methadone.

[94] The evidence about the arrangements for Mr Gavin to be reviewed before his methadone was dispensed was inconsistent, Dr Henderson believed Nurse Smith was about to review Mr Gavin, Nurse Smith said this was to be undertaken by Nurse Trundle, Nurse Trundle said that he had been advised that Mr Gavin should receive his methadone. I found Nurse Smith's evidence to be the most probably accurate as Nurse Trundle was

rostered to dispense methadone, so it would be reasonable to expect that she agreed with Nurse Trundle that he should review Mr Gavin before dispensing his methadone prescription. She would have no reason to change that instruction between 1130 and seeing Dr Henderson. She was not asked about what she did following speaking with Dr Henderson. Dr Henderson whose recollection was vague may simply have misunderstood that Mr Gavin was to be reviewed by the nursing staff before his methadone was dispensed and assumed that Nurse Smith was going to do this herself. That was less likely given other staff were dealing with methadone prescriptions that day. Nothing turned on this as Mr Gavin's deterioration occurred shortly prior to when Nurse Trundle was to see him with a view to dispensing his methadone.

[95] Nurse Trundle had poor recollection. I considered that his police statement taken on 12 June was more likely to be accurate than his oral evidence. In the statement he accepted he was a carrying a radio and allocated medical response duties on 11 June 2014. I also concluded he was more probably allocated duties in House block 1 than House block 2 as he stated in his oral evidence. That was again reflected in his police statement, by his being in the triage room with Nurse Smith around 1100 and that he was preparing to dispense Mr Gavin's methadone around 1330. I preferred Nurse Smith's evidence that he was to review Mr Gavin before dispensing his methadone as he appeared to be the obvious person to do so as he was dispensing methadone on 11 June and it would be logical that he should make the assessment. I am unable to resolve the position as to whether Nurse Trundle was subsequently advised that Mr Gavin could receive his methadone.

Conclusions

[96] The time, place of death and cause of death were agreed in the joint minute and accordingly are uncontroversial.

[97] The most significant factor which resulted in this death was the fact that Mr Gavin was assaulted by Mr O'Neil and that Mr Gavin failed to disclose that assault to Nurse Smith, or to anyone else before doing so to Nurse Trundle at 1350 or thereby. This was compounded by the fact that Mr Gavin was prescribed anti-coagulant medication namely rivaroxaban: he had liver disease, hepatitis C, and was a smoker. These comorbidities reduced his prospects of surviving the assault.

[98] I accept that Nurse Smith did all that she reasonably could to encourage Mr Gavin to make a disclosure. In particular she is to be commended for endeavouring to speak confidentially to him to reassure him that she was a nurse, and to have him engage and be open with her. I observe that had Mr Gavin disclosed his assault at the earliest opportunity the trajectory of his treatment would have been entirely different although the Inquiry had no evidence that it would have changed the ultimate outcome. The Inquiry had evidence from Mr de Beaux, Dr Donald, Miss Sharp and Dr Wallace that as a general proposition the earlier bleeding was stopped the better chance of survival. Mr de Beaux also told the Inquiry that the shorter the period between an event and admission to hospital in general the better the outcome achieved. Thus earlier disclosure of the assault, which may have resulted in earlier surgical intervention, would have given Mr Gavin the best possible chance of survival.

[99] There was no criticism of Nurse Smith in relation to the First Incident. The only observation might be that her note-keeping could have been better. In relation to the Second

Incident, again I do not have any concerns about Nurse Smith's actions. She was clearly concerned about Mr Gavin and determined to seek medical advice. It is at this point that matters could have been better dealt with. While it was a matter of clinical judgement on the evidence before the enquiry I consider she should have made contact with Dr Henderson after the Second Incident. That was the view of Mr Cronin and Dr Wallace. It also reflects Ms Gordon's initial expression that it would have been appropriate for Nurse Smith to have sought medical advice, to her subsequently more qualified position. It can only be speculation and runs contrary to the evidence which Dr Henderson himself gave, but given he only left the prison at 1130 had he been telephoned immediately by Nurse Smith he may have returned directly to see Mr Gavin. That because he was being contacted immediately following Nurse Smith having seen Mr Gavin and in his decision not to see Mr Gavin at 1300 he indicated that he was reassured by Nurse Smith not having called him and by the fact that further review was imminent.

[100] Had Nurse Smith made contact with Dr Henderson immediately following the Second Incident, there would have been a passage of time before Dr Henderson examined Mr Gavin. I therefore find that the earliest point at which an ambulance might have been summoned to take Mr Gavin to Crosshouse Hospital was around 1200. Much evidence was directed at how quickly surgical intervention might have followed Mr Gavin's arrival at Crosshouse Hospital on hypothetical scenarios. It certainly could not have been more expeditious than the time which passed between the emergency ambulance being summoned and Mr Gavin actually being operated on. Thus at the very least surgery would not have taken place sooner than some two hours before it did. Indeed with the variables of when the ambulance was called; whether the ambulance call was for an emergency

ambulance or a one hour ambulance; and how Mr Gavin might have been triaged and examined on admission, that period of two hours may have been considerably reduced.

[101] The expert medical evidence from Mr de Beaux and Dr Donald was that such a two hour period would most probably not have resulted in Mr Gavin having been treated successfully and allowed his life to have been saved. It was clear that Miss Sharp had in an earlier statement to the Crown been more optimistic about Mr Gavin's prospects had earlier surgical intervention taken place. However I preferred her oral evidence to the Inquiry in which she agreed with Mr de Beaux's conclusion which I accept. I am therefore unable to make any determination under section 6(1)(c) as on the evidence I do not accept that there was a real and lively possibly that Mr Gavin's death might have been avoided even if Nurse Smith had immediately sought advice from Dr Henderson following the Second Incident. Given that finding it clearly follows that there cannot be said to be a causal connection between the subsequent interaction between Nurse Smith and Dr Henderson at approximately 1300 and Mr Gavin's death. At 1300 even if Dr Henderson had immediately arranged to see Mr Gavin and on seeing him summoned an ambulance it most probably would not have reduced the time before Mr Gavin was in surgery by more than thirty minutes.

[102] Expert medical evidence was led from Mr de Beaux, a consultant at Edinburgh Royal Infirmary and Dr Donald, a consultant at Ninewells Hospital. This evidence was all to the effect that Mr Gavin had received exemplary care at Crosshouse Hospital.

[103] No party to the inquiry invited me to make a finding in terms of 6(1)(d) and I made no finding under that subsection.

[104] I make the following observations in terms of section 6(1)(e) in relation to circumstances relevant to the death.

[105] There was clearly a breakdown in communication or miscommunication between Dr Henderson and Nurse Smith. Nurse Smith omitted to advise Dr Henderson of the administration by her of a sternal rub. Dr Henderson appeared to have been reassured by the fact he was not called, but Nurse Smith had awaited his return to the prison before discussing the patient with him. There was a lack of clarity about the intention to the review of Mr Gavin prior to getting his methadone and who this was to be undertaken by. Nurse Smith does not appear to have adequately expressed to Dr Henderson the extent of her concern about the patient. I also agree with Mr Cronin's observation that Dr Henderson was "inadequately curious" and could have taken more steps to clarify with Nurse Smith the reason why she wished to consult with him and what actions she thought he should take. I therefore consider both Nurse Smith and Dr Henderson could have communicated better to ensure Dr Henderson had a clear picture which would enable him make a proper assessment as to whether or not to see Mr Gavin. I also identify some sub-optimal aspects of the recording of observations. Nurse Smith accepted she had omitted to record oxygen saturation. A number of observations were taken as is clear from the difference between the figures on the post-it note and on Vision.

[106] I agree with the submission on behalf of the family that the system for noting and recording observations could have been improved. I also recognise that steps have been taken following the Critical Incident Review to improve this. I welcome the introduction of the clinical incident form within the response bag as an aide-memoire to nurses when a recording is to be taken. This will act as aide-memoire for a nurse and provides a more

satisfactory place for observations to be recorded than on a post-it note or the back of a glove. It also facilitates the recording of a number of readings and observations over the course of the examination. That may not have been material in the instant case, but it may be of benefit in others. I also endorse and support the introduction of the SBAR forms which give more structure to a report and should provide a fuller picture when advice is sought from the General Practitioner. Had Dr Henderson had access to this more comprehensive information he would have been better placed to make a decision whether to see Mr Gavin.

[107] I further welcome the introduction of the NEWS response form which seems to be a sensible adaption of the NEWS system for use in the prison, highlighting the situations in which nursing staff are mandated to contact the General Practitioner. These are, I think, all steps which will enhance the provision of healthcare in HMP Kilmarnock in future.

[108] The clinical review report is not an impressive document and I found there to be substance to Mr Cronin's criticism of the report. It was conceded by Ms Gow that conclusions had been drawn with the benefit of hindsight and it contained a number of factual errors and inaccuracies. I also note that Mr de Beaux was dismissive of the blood loss calculation narrated in the report. He believed such a calculation to be unreliable and that little store could be placed on it. He was of the view which was supported by Dr Donald and Miss Sharp that it was not possible to determine the speed of blood loss which Mr Gavin had sustained and whether that was consistent from the injury being inflicted or was irregular from that time until he underwent surgery. The report also failed to identify the confusion about arrangements for Mr Gavin to be reviewed. Having made these criticisms of the report, as will be noted I have endorsed improvements proposed in the action plan contained within the report.

[109] In relation to the other matters raised by Miss Connolly on behalf of the family of Mr Gavin, I do not accept it to be a valid criticism that prison officers did not advise the nursing staff that a fellow prisoner had made reference to Mr Gavin having been assaulted. Prison Officer Clark followed this up and the prisoner denied anything had happened. Nor do I find that there were material failings in the communication between nursing staff and prison staff. I accepted Mr Clark's evidence that he made enquiries of the prisoner who then denied to him there had been an assault. I do not conclude that it was reasonable to expect that a vague reference to an assault to another officer, which was subsequently denied, warranted that this should be brought to the attention of the nursing staff.

[110] It is appropriate that there is a degree of patient confidentiality and I find no evidence to suggest there was any deficiency in the information passed between the nurses and prison staff. I do accept that there was some confusion in the evidence as to what had been said, but I consider this is attributable to poor recollection over the ensuing two and a half years rather than any problem with the communication per se.

[111] I do not accept that Nurse Smith was inadequately trained to undertake her duties, nor that further training would have taken her any further in ascertaining the position. As I have found, she considered that she should raise the matter with the GP for further assessment and I consider that was the proper course. Further training would not have changed that from being the proper course for her to have adopted.

[112] I do not consider there to be any substance in the suggestion that Dr Henderson should have given consideration to injuries sustained during collapse.

[113] I also reject the suggestion on behalf of the family that there was a material failure of the prison staff in monitoring Mr Gavin following the incidents or that he should have been

monitored by nursing staff following the incidents. I found no evidence to suggest this was necessary after the First Incident and after the Second Incident as narrated above I consider that Nurse Smith should have made contact with Dr Henderson to seek advice. I also accept the evidence that there was no facility for monitoring patients within the prison and a prisoner would be admitted to hospital where further monitoring was required. I consider it to be a matter of common sense that the prison staff would act as prison officer Lorimer did and "keep an eye on Mr Gavin" and I consider that was a reasonable approach.

[114] The sessional requirements of the contract between NHS Ayrshire and Arran Health Board and Arcus Trading Limited (Crown production 11) are not clearly specified. The Clinical Schedule is not well expressed and is open to interpretation. I refer in particular to page 533 which provides:

> "Day services will be 10 sessions per week. Due to the nature of the Prison environment, patient contact can be between 9am – 12noon and 2.30pm – 5pm, Monday to Friday. It is anticipated that these sessions would commence from 8.30am; one of the sessions will be required either on Friday evening until 10pm or on a Saturday morning to medically assess new or transferred prisoners who arrive into the prison on Friday afternoon."

[115] Crown Production 32, which showed staff movements between 3 June and 27 June involving Dr Henderson, shows that there was only one occasion when he arrived before 9am: on 3 June at 8:59:13. His general time of arrival was around 9.30. Given the time taken on his own evidence to get from the prison gates to healthcare he was thus rarely available for consultations before 9.45. I note the Health Board considered that the contract should be viewed flexibly and in a permissive way. It was however surprising that Ms McMurdo appeared uninformed about the operation of the contract, given she accepted it had been her responsibility to manage the contract over the period when it was twice renewed. The evidence to the Inquiry, not least Ms McMurdo's own statement that the contract was not as

"efficient as it could be" leads me to recommend that NHS Ayrshire and Arran should give careful consideration to specification of the required services in the successor to the existing contract.

[116] I should thank parties for their assistance in the conduct of the Inquiry.

In conclusion I would reiterate and join with parties in offering my sincere condolences to Mr Gavin's family and friends for their loss.