

SHERIFFDOM OF LoTHIAN AND BORDERS AT Livingston

2012 FAI 24

DETERMINATION

By Sheriff Grahame Ritchie Fleming Esq Q.C.
Sheriff of Lothian and Borders at Livingston

Following an Enquiry held at Livingston on
26 March 2012 into the
Death of Richard Hugh McGhie

The Sheriff having resumed consideration of the enquiry finds in fact as follows:-

1. Richard Hugh McGhie (hereinafter referred to as “the deceased”) was born on 12 March 1969.
2. On 21 October 2010 at Hamilton Sheriff Court the deceased was sentenced to 3 years imprisonment conform to extract conviction current production no 1.
3. The deceased from an early age suffered from epilepsy.
4. Crown production no 8 is a copy of the deceased’s medical records held by Monklands General Hospital (hereinafter “the hospital”) where he was treated when at liberty.
5. Crown production no 9 of process are the medical records relating to the deceased held by Her Majesty’s Prison, Addiewell (hereinafter referred to as “the prison”) and

cover the period of his incarceration subsequent to 21 October 2010 and the previous period in 2009.

6. Crown productions 8 and 9 are true and accurate records of the notes kept therein.
7. While in the prison the deceased suffered a number of seizures which are noted at pages 6 and 7 of Crown production no 6 a report by Dr John Paul Leach, Consultant Neurologist.
8. On 15 November 2010 at about 10.00am Ms Michelle Buggy, the Prison Officer at the prison checked the deceased's cell no 15 of C Block in Tay wing. The deceased appeared to be asleep in his bed. The curtains of the cell were down.
9. At about 13.45 a prisoner called, Colin Dunsmore looked into the deceased's cell and saw him lying with his head on the bed and his body slumped or down on the floor. He believed the deceased was having a fit. He informed Michelle Buggy of that belief. At the time Dunsmore looked into the cell the curtains in the cell were up.
10. Another prisoner, John McCarrol advised Daniel Mathieson, Prison Officer, that the deceased was fitting. Michelle Buggy called a "code blue" over her radio to summon medical assistance. Code blue is a code for an unconscious or collapsed prisoner.
11. Mathieson and Buggy went into cell 15. The deceased was found lying as described by Dunsmore. He was wearing grey tracksuit bottoms but no top. He did not appear to be breathing. There was no pulse but his body was warm.
12. The deceased did not attend for breakfast or lunch in the pantry. The fact that he did not do so was not unusual. It was not unusual for the deceased to sleep most mornings, all morning.

13. After Buggy and Dunsmore had entered the cell the other prisoners were locked down. An ambulance arrived about 10 minute later.
14. There was no obvious injury to him.
15. Within a minute of the code blue being called Stuart Keenay, a Prison Nurse and other medical staff, including Dr Stephen Karney MBCHB a General Practitioner employed at the prison arrived at cell 15. They moved the deceased onto the floor, his vital signs were checked and Dr Karney commenced CPR and oxygen was administered. Dr Karney continued to monitor the deceased for life signs but these were negative. Dr Karney determined that the deceased was not revivable and pronounced life extinct at 14.10.
16. At 14.20 Detective Sergeant Keith Bendall, who was on duty at Livingston Police Station was informed by DC Kennedy that a prisoner had died at the prison. Bendall and Kennedy went to the prison and found cell 15 locked and they saw the deceased body with obvious signs he had been given medical treatment. The cell door was unlocked and they examined his body in the cell. DC Kennedy arranged for a member of the Identification Branch to take photographs. The deceased's body was subsequently taken to St John's Hospital. Statements were then taken from witnesses.
17. At about 15.40 on the 15 November 2010 Robert Young of the Scottish Police Services Authority Forensic Service Scene Examination Branch photographed cell 15. Production is a book of photographs taken by him. Photograph 1 is a view of the cell with the door open and the deceased lying on the floor next to the bed. Photograph 2-6 are general views of the cell.

18. On 18 November 2010 an autopsy was performed on the deceased by Mr Ralph BouHaider. Crown production no 5 is a report prepared by him of the autopsy and is an accurate account of the matters to which it bears to relate. In particular evidence was found post-mortem of a haemorrhage within the sternocleidomastoid which could be consistent with an epileptic fit.
19. Dr BouHaider instructed a neuropathologist report and toxicology report in respect of the deceased.
20. Crown production no 3 is a report by the neuropathologist. Neurological examination demonstrated no significant abnormality.
21. Crown productions 4 and 5 were the toxicology reports following an analysis of the deceased's blood and urine and blood respectively. No alcohol was found in the blood or urine. None of the drugs listed in production 4 were found. Lamotrigine and Levetiracetam were found in concentrations lying within the range of values following their normal medical use. Lamotrigine is an anti-convulsant drug used for the treatment of epilepsy and Levetiracetam is prescribed for monotherapy and conjunctive treatment for partial seizures.
22. In the absence of any finding of natural disease or other physical cause of death being identified Dr BouHaider concluded by exclusion that the deceased had died of sudden unexpected death in epilepsy.
23. The care received by the deceased at the hospital and in prison was appropriate.

DETERMINES –

1. In terms of Section 6(1)(a) of the Fatal Accident and Sudden Death (Scotland) Act 1976 that Robert Hugh McGhie died in Cell 15 of C Block of Tay Wing of Her Majesty's Prison, Addiewell on 15 November 2010 sometime between about 10.00 hours and 14.10 hours.
2. In terms of Section 6(1)(b) of said act that the cause of death was sudden unexpected death in epilepsy.
3. In terms of Section 6(1)(c) of said act there were no reasonable precautions whereby his death might have been avoided.
4. In terms of Section 6(1)(d) of said act there was no defect in any system of working which contributed to the deceased's death.
5. In terms of Section 6(1)(e) there are no other facts which are relevant to the circumstances of the death.

NOTE –

This Fatal Accident Enquiry was convened in terms of Section 1(1)(a)(ii) of the Fatal Accident and Sudden Deaths Enquiries (Scotland) Act 1976 to enquire into the circumstances of the death of Richard Hugh McGhie who at the time of his death was a prisoner at Her Majesty's Prison, Addiewell.

Mr James O'Reilly, Procurator Fiscal Depute appeared for the Crown.

The Scottish Prison Service were represented by Miss Lorraine Wilkinshaw, Solicitor and Sedexo (who manage HMP Addiewell) and Ace Insurance were represented by Mr Raymond Gribben, Solicitor.

Members of the deceased's family, including his mother were present at the enquiry but did not give evidence.

Parties lodged a joint minute of admissions which inter alia in article agreed at written statements for the persons specified therein were true and accurate records of their evidence and to be taken as equivalent to oral evidence.

The Crown also led the evidence of Dr Ralph BouHaider BSCMSC (Forensic Medicine MD) fellow of the Royal College of Pathologists, Consultant in Forensic Pathology NHS Lothian and in the division of Pathology University of Edinburgh, Dr John Paul Leach MBCHBMDFRCP, Consultant Neurologist in Glasgow with a particular interest in epilepsy and Michelle Buggy, Prison Officer, HMP Addiewell.

The finding in facts I made in respect of the events of 15 November 2010 are based on her evidence and on those statements referred to supra.

Though Ms Buggy had no recollection when giving evidence of checking the deceased cell at 10.00am on the day in question and no memory of what she said to the police when she took a statement from her that day, she accepted she would have told them the truth. Finding

in fact replicates what she told them. She also gave evidence that the curtains in the cell when she saw it were drawn. Ms Buggy inferred that the deceased must have got up after she saw him in bed because the curtains were raised when next she entered his cell with Mathieson and he was wearing clothing at least on the bottom part of his body. That seems to me to be a reasonable inference.

Ms Buggy indicated it was not unusual for the deceased like a number of other prisoners not to attend for breakfast or lunch. She confirmed that the deceased was not breathing when she entered the cell with Mathieson. Dr BouHaider spoke to his performing an autopsy on the deceased and to his report no 5 of process which sets out his finding. He confirmed that he had instructed neuropathological and toxicological investigations and spoke to the findings contained in the relevant reports which are Crown productions no 3, 4 and 7.

He indicated that none of the superficial injuries he had noted externally on the deceased's body would have caused or contributed to his death. The rib and sternum fractures found were consistent with attempts being made to resuscitate the deceased. He had detected no significant abnormalities on internal examination.

A none specific but potentially significant finding was the haemorrhage within the sternocleidomastoid which could be consistent with an epileptic fit.

The neuropathologist report had identified no notable injuries or findings.

In these circumstances by excluding all other possible causes of death he considered by diagnosis by exclusion as he put it that the cause of death was sudden unexplained death in epilepsy. He indicated that there was strong medical evidence that sufferers of epilepsy were at risk of dying suddenly. The deceased gender and age were also risk factors pre disposing him to such a death. A variety of theories and mechanisms for this were referred to in the medical literature but they were uncertain. He had been unable at autopsy to diagnose any or all of the mechanisms postulated as some of these were usually only discovered clinically. Dr Leach spoke to his report crown production no 6 which he had prepared having reviewed the various documents referred to therein. He had concluded *inter alia* “the description from various witnesses would be consistent with the patient having died secondary epileptic seizure. I would defer to the pathologist for details as to whether the post mortem findings were appropriate and commensurate with this diagnosis. Death is a recognised complication of epilepsy.

He was further referred to his second and third conclusions and confirmed that the 2 toxicology reports confirmed that the deceased appeared to have taken the 2 drugs prescribed for his epilepsy. Conclusion 7 of his report explains “SUDEP (sudden unexplained death in epilepsy) is a recognised complication of epilepsy. In patients with severe uncontrolled epilepsy the risk is said to be approximately one per cent per year. This risk is higher in patients who continue to have seizures, who have seizures at night, who are exposed to illicit drugs or alcohol, or whose intake of medication is variable. The best way to prevent SUDEP is to prevent seizures by consistent dosing with optimal anti epileptic drugs. Mr McGhie would appear to have been aware of the importance of such prevention.

Dr Leach also confirmed that the records kept by the prison, crown production no 9 of process indicated that the deceased while in prison had been offered the opportunity to obtain special advice at Monklands District General Hospital but had refused this as was evidenced by a document there dated 21 September 2010.

In his view the deceased's treatment at the hospital had been appropriate with the correct intervals between appointments. He confirmed that it appeared from an entry in crown production no 8 that the possibility of SUDEP had been discussed with the deceased and in this connection referred to a letter from Dr Green to Dr Murphy bearing to be typed on 16 November 2004 and a letter from Dr Gordon McKay to Dr McGarrity bearing to be typed on 7 January 2009. These matters he felt were best raised by the treating specialist rather than medical or non medical staff in a prison.

He also considered the provision of care and offer of care at the prison to be reasonable and in respect of both the hospital and the prison did not feel there had been any particular "gaps" in care.

Although he criticised the keeping of the prescription log in the prison (to which I will return later) he found no evidence that the deceased had not obtained his medication.

I raised with Dr Leach the usefulness of using alarms to detect movement, sound or breathing in epileptics. It was clear that in general he was lukewarm about there usefulness.

They were apparently not very specific on what they could detect and generated false positives and were potentially intrusive for both patient and patient's family. They were not used routinely and only two occasions in 10 years had he directed families towards using them.

In respect of there use for the deceased in particular he observed many of his seizures occurred on awakening or after and an overnight monitor would not have picked up many of these episodes. One of the recent seizures had occurred in the gym not in his cell and not while the accused was asleep.

In so far as to the circumstances of the accused death occur during a day, as I understood him, he was doubtful if anyone (and I assume he included the deceased in this) would be keen to be monitored for 20 or 22 hours a day. Given that the deceased was apparently not optimally compliant with the advice and medication given him I to would doubt whether the deceased would have in fact used such an alarm.

No evidence was led on behalf of the Scottish Prison Service or Sedexo/Ace.

In his submissions the Procurator Fiscal invited me to make formal findings over.

The deceased was fairly healthy in his forties though an epileptic. He was not abusing drugs or alcohol in prison. He went to the gym.

While in prison he had a seizure on 3 August 2010 which he self reported and one on 28 August 2010 in the gym and a further seizure on 19 October 2010 while in the cell awaiting to go to Court. Staff at the prison had made efforts to get him appropriate medication as the toxicology report confirmed. The deceased had not attended for breakfast or lunch but that was unremarkable. The deceased was last seen alive at 10.00am and the Court might conclude he had woken up given the curtains had been raised and he was wearing tracksuit bottoms. What may have occurred did not take place while he was asleep and that was consistent with his two previous seizures.

Dr Leach had offered no particular criticisms of the deceased's care. He was dubious about the use of alarms or monitors because of their intrusiveness and disruptiveness and had rarely prescribed their use himself he invited me to determine in terms of Section 6(1)(a) that the deceased died at about 14.10 hours on 15 November 2010 at HMP Addiewell, thus in terms of Section 6(1)(b) that the cause of death was sudden unexpected death in epilepsy.

He submitted no finding should be made under Section 6(1)(c) or 6(1)(d) because Dr Leach had not suggested anything that might have been done to avoid death.

The criticism made by Dr Leach of the prescription log did not relate directly to the deceased's death who appeared from the toxicology reports to have been receiving the appropriate medication and he seemed to think the overall care of the deceased had been good.

Following the seizure in the gym the prison authorities had sought the advice of Monklands General Hospital and increased the dose of medication following receipt of that advice and had further tried to access specialist care for him so as best to manage his condition (though the deceased had refused this).

He stated that he was not seeking that I should make any findings critical of the prison service.

Miss Wilkinshaw also invited me to make formal findings only and adopt the Procurator Fiscal Deputes submissions.

Mr Gribben similarly invited me to make formal findings only and he too adopted the fiscal submissions.

He stated there had been no evidence critical of the medical or supervisory regime at the prison. He reminded me that Dr BouHaider had stated that SUDEP could be distinguished from epilepsy itself and while various mechanisms may operate in SUDEP these were uncertain and Dr BouHaider had been able to say what these were in this case.

CONCLUSION –

Pretty well all of the evidence before me was unchallenged. Negatively no criticism was offered of the medical or supervisory care at the prison and positively there was evidence

from Dr Leach that the deceased treatment at Monklands District General Hospital and the prison was appropriate.

I am satisfied on the evidence of Dr Leach and Dr BouHaider that by a process of exclusion, the cause of the deceased untimely death has been established as Sudden Unexplained Death in Epilepsy.

There was no evidence to suggest anything which could have been done which might have avoided death. In particular I am satisfied that the provision of alarms would not have done so. In these circumstances I shall make formal findings only.

However there is one matter which I wish to raise albeit does not in my opinion form within any the heads of Section 6(1) of the Act and especially head 6(1)(e) and that is the question of the prescription law contained in crown production no 9 Dr Leach described it as haphazard and difficult to read. Although he modified his view that there was a gap in the record for July he observed that because of the density of the figures and other markings on the log he could not ascertain for that period the discrete record for each prescription. He observed that because of the way the log was recorded it was difficult to track the medications being dispensed. Failure to keep a clear record meant that one could not monitor the drugs which had been previously prescribed. I am satisfied that the log lacked clarity – if an experienced consultant cannot make sense of some of it that in my view is self evident.

I am also satisfied however that the lack of clarity is not been demonstrated to be relevant to the circumstances of death far less play any part in its cause nor if it had been clearer might have avoided death.

However I wish to make it clear to Sedexo that such record keeping is not acceptable and in the case of another prisoner suffering from epilepsy might have disastrous consequences for that prisoners care.

Mr Gibben accepted the note keeping was not of the best order and indicated he had brought this to the attention of Sedexo.

One hopes that appropriate corrective measures will be taken to ensure all such logs are fit for purpose in the future and it may well be that Sedexo should review the prescription logs in respect of other prisoners who suffer from epilepsy.

Sheriff Grahame Ritchie Fleming Esq Q.C.

March 2012