SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2018] FAI 30

B1020/18

DETERMINATION

BY

SHERIFF LINDSAY WOOD

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

into the death of

PAUL MATTHEW COWAN

GLASGOW, 27th August 2018.

The Sheriff, having considered the information presented at the Inquiry determines in terms of section 26 of the Act that:

[1] Paul Matthew Cowan, born 25 February 1976, (hereinafter referred to as either Mr Cowan or "the deceased") and residing latterly at HMP Low Moss died at 3.00 am on 10 January 2018 at the Glasgow Royal Infirmary.

[2] In terms of section 26(2)(a), death occurred at the Glasgow Royal Infirmary when the deceased was in custody.

[3] In terms of section 26(2)(c) the cause of death was:

1a complications of end stage liver disease;

1b cirrhosis of the liver.

[4] No findings were sought or are made in respect of section 26(2)(b), (d), (e), (f) and (g).

NOTE:

Introduction

[1] This is a Fatal Accident Inquiry in terms of section 2(4)(a) of the 2016 Act as Mr Cowan was in legal custody at the time of his death.

[2] The deceased's death was reported to the Crown Office and Procurator Fiscal Service on 10 January 2018.

[3] Four preliminary hearings were held on 4 and 12 July and 7 and 14 August all 2018. Late on 16 August 2018 the deceased's widow, Sharon Cowan, who was represented by Ms Rahman, solicitor, withdrew from participation in the Inquiry and as a result withdrew her rule 3.7 note and witness list. As at the preliminary hearing on 14 August, an expert medical report instructed on behalf of Sharon Cowan was still awaited and a further preliminary hearing was assigned for 20 August for it to be lodged together with an amended rule 3.7 note. No such report or note was lodged and in all the circumstances the preliminary hearing on 20 August was cancelled and matters continued to the previously assigned Inquiry hearing on 22 August 2018.

[4] The representatives of the participants were: Ms McRobert, procurator fiscal depute for the Crown, Mr William Henderson, solicitor for NHS Greater Glasgow & Clyde and Mr Ross Fairweather, solicitor for the Scottish Prison Service.

[5] No witnesses were called and the facts relating to the circumstances of death were presented to the Inquiry in a joint minute agreed by all parties.

Legal framework

[6] A Fatal Accident Inquiry was held under section 1 of the 2016 Act.

[7] The Inquiry is governed by the Fatal Accident Inquiry Rules 2017.

[8] In terms of section 1(3) of the 2016 Act, the purpose of an Inquiry is to:

(a) establish the circumstances of the death; and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[9] The matters to be covered in the Determination under section 26 are when and where the death occurred and the cause or causes of the death.

[10] The Crown in the public interest is represented by the procurator fiscal depute. A Fatal Accident Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

[11] The following facts summarise the evidence before the Inquiry:

A On 21 March 2017, Paul Matthew Cowan, date of birth 25 February 1976, appeared from custody on petition at Dumbarton Sheriff Court. Bail was refused and he was remanded to HMP Low Moss.

B On 18 July 2017 at Dumbarton Sheriff Court, the deceased pled guilty to eight charges of theft from a motor vehicle and two charges of theft of a motor vehicle. Sentence was adjourned until 11 August 2017 and the deceased was detained in HMP Low Moss. On 11 August 2017 the deceased was sentenced to 32 months' imprisonment.

C Following upon the imposition of said sentence the deceased was incarcerated in terms of same and as at the date of his death on 10 January 2018 he was incarcerated in HMP Low Moss (also referred to as "the prison"). He was accordingly in legal custody as at the date of his death.

D The deceased had a past medical history of longstanding alcoholic liver disease, personality disorder and alpha-1 antitrypsin deficiency.

E On 29 September 2016 the deceased was offered a new patient appointment at the liver clinic at Glasgow Royal Infirmary following a diagnosis of cirrhosis and portal hypertension. The deceased failed to attend this appointment.

F On 11 October 2016 the deceased's General Practitioner sent him a letter to advise he would be re-referred to the liver clinic.

G The deceased attended at his GP on 23 November 2016 and was advised to attend his next liver clinic appointment due to the diagnosis of cirrhosis.

H On 6 December 2016 the deceased failed to attend an appointment at the liver clinic at the Glasgow Royal Infirmary.

I On 4 January 2017 the deceased's GP re-referred him to the liver clinic.

J On 24 March 2017 the deceased was re-referred to the liver clinic by a prison General Practitioner for management of cirrhosis. It was noted he was clinically jaundiced.

K The deceased was admitted to Glasgow Royal Infirmary on 24 August 2017 due to swelling in his legs with some signs of infection. He was discharged to the prison on 4 September 2017.

L On 7 October 2017 the deceased was admitted to Glasgow Royal Infirmary at the request of Dr Joseph Daly.

M On 8 October 2017 the deceased discharged himself from hospital against medical advice and returned to the prison.

N On 25 October 2017 the deceased was examined by Dr Campbell within the prison. He was jaundiced, very tearful and complaining of abdominal pain. An ambulance was requested and he was admitted to Glasgow Royal Infirmary.

O On 31 October 2017 the deceased was informed of the severity of his diagnosed condition of decompensated liver disease. He was informed that he would be unlikely to recover unless he received a liver transplant. He was advised that he would be referred to the transplant centre if he clinically responded to the management of oedema, ascites and spontaneous bacterial peritonitis.

P On 4 November 2017 the deceased discharged himself from hospital against medical advice and returned to the prison. He was advised that if he proceeded

to discharge himself this would adversely affect his prospects of receiving a liver transplant and posed an immediate risk to his life. He was aware that his bloods were abnormal which put him at high risk of infection. The deceased proceeded to discharge himself.

Q On 12 November 2017 the deceased was found lying on a bed in a cell and it was believed that he may have had a cerebrovascular accident. He was jaundiced due to ongoing end stage liver disease with pitting oedema evident in his legs. The deceased was admitted by ambulance to Glasgow Royal Infirmary.

R On 12 November 2017 the deceased was deemed to be incapable of making decisions relating to all acute medical treatment under Section 47 of the Adults with Incapacity (Scotland) Act 2000. On 18 November 2017 the deceased attempted to discharge himself from hospital. On 24 November 2017 the Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000 was revoked.

S On 22 November 2017 the deceased was admitted to the Gastroenterology ward (Ward 9). He had significant ascites, encephalopathy (brain dysfunction) and acute presentation of likely end stage decompensated alcoholic liver disease.

T On 18 December 2017 the deceased was deemed clinically fit and was discharged from Ward 9 of the Glasgow Royal Infirmary following a 6 week admission to hospital due to ascites and breathlessness on minimal exertion. He returned to the prison on 19 December 2017.

U On 27 December 2017, the deceased was admitted to Glasgow Royal Infirmary. He was cross-matched for 2 units of packed red blood cells. An intravenous cannula was inserted and 2 units were administered with no adverse side effects. His Large Volume Paracentesis operation was postponed until 29 December 2017. The deceased was discharged from hospital.

V At around 09:20 on 29 December 2017, the deceased was admitted to Glasgow Royal Infirmary. It was noted by hospital staff that the deceased was "feeling well". An intravenous cannula was inserted and the deceased underwent Large Volume Paracentesis. 8.1 litres of fluid was drained. The deceased was prescribed with Albumin and discharged.

W On 31 December 2017 there was a "Code Blue" alert and the deceased was found lying on his cell floor. He was reviewed by Mara Fraser, Prison Nurse. He was conscious and stated he had been getting up to make a cup of tea when he collapsed. He stated he felt generally unwell. He had an epistaxis (nose bleed) also. He had never had an episode before. He advised that he had a paracentesis at hospital the previous Friday and they removed 8 litres. He complained of severe back pain and abdominal pain which was sharp in nature. It was noted that he was slightly breathless and had a slight productive cough. It was noted that both legs were oedematous which was not a new issue although he advised they were worse over the past 2 days. An ambulance was requested and the deceased was re-admitted to Glasgow Royal Infirmary believed to be suffering from pneumonia or a pulmonary oedema

secondary to liver failure. He developed respiratory failure and was transferred to the High Dependency Unit.

X The deceased was treated for a respiratory tract infection and decompensated liver disease however he continued to deteriorate. He did not respond to diuresis, his breathlessness worsened and he developed hypotension.

Y The deceased continued to have pneumonia, alcoholic liver disease refractory to treatment, non-cardiogenic pulmonary oedema, worsening renal function, heart failure and possible acute respiratory distress syndrome.

Z No further therapeutic options were available and palliative care was provided.

AA Life was pronounced extinct by Dr Mohammed Haq at 3.00 am on 10 January 2018.

BB Following a post mortem, the cause of death was certified by Dr Sharon Melmore, Forensic Pathologist, of the University of Glasgow as:

1a complications of end stage liver disease

1b cirrhosis of the liver.

Submissions and conclusions

[12] The procurator fiscal depute invited the court to make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act in respect of Mr Cowan's death which submission was adopted by Mr Henderson and Mr Fairweather. Having considered the terms of the joint minute and the productions, I am satisfied that such a formal

determination is appropriate in the circumstances of Mr Cowan's death. No submissions were made in terms of section 26(2)(e) (any precautions which could reasonably have been taken and which might realistically have resulted in the death being avoided) or section 26(2)(f) (any defect in any system of working which contributed to the death). I was satisfied that there was no basis on which to make any finding in terms of either of these provisions. Nor were there any other facts relevant to the circumstances of the death which fell to be included in my determination under section 26(2)(g). Mr Cowan had died of natural causes and nothing could have been done to save his life. He had been treated appropriately throughout his time in HMP Low Moss and at Glasgow Royal Infirmary. There is nothing untoward whatsoever with regard to the circumstances of Mr Cowan's death.

[13] I wish to commend Ms McRobert, the procurator fiscal depute, Mr Henderson, solicitor for NHS Greater Glasgow & Clyde and Mr Fairweather, solicitor for the Scottish Prison Service, for their helpful and professional contributions in agreeing a joint minute which considerably shortened the length of the Inquiry hearing and avoided witnesses having to attend to give evidence and also for their particular assistance at both the Inquiry hearing and at the preliminary hearings.

[14] As is always my practice, I formally express my condolences to the deceased's widow, Mrs Sharon Cowan.