SHERIFFDOM OF GRAMPIAN, HIGHLAND, AND ISLANDS AT PETERHEAD

[2021] FAI 18

PHD-B139-20

DETERMINATION

BY

SHERIFF ROBERT FRAZER

UNDER

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

into the death of

JAMES CONNOR

Peterhead, 1 February 2021

Determination

The Sheriff, having considered the information and evidence presented at the Inquiry, determines, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the Act") the following:

1. In terms of section 26(2)(a) of the Act (when and where the death occurred): That James Connor, born 6 March 1965, died at Ward 111, Aberdeen Royal Infirmary, Aberdeen, on 2 May 2020 at 1050 hours.
2. In terms of section 26(2)(b) of the Act (when and where any accident resulting in death occurred):

That the death did not result from an accident. Accordingly, no finding is made.

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

   That the cause of death was ineffective exacerbation of chronic obstructive pulmonary disease.

4. In terms of section 26(2)(d) of the Act (the cause or causes of any accident resulting in death):

   That the death did not result from an accident. Accordingly, no finding is made.

5. In terms of section 26(2)(e) of the Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

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

6. In terms of section 26(2)(f) of the Act (any defects in any system of working which contributed to the death or the accident resulting in death):

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

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

   There are no other facts relevant to the circumstances of the death.

NOTE

[1] This inquiry was held into the death of James Connor (the deceased) on 28 January 2021 at Peterhead Sheriff Court. The hearing was conducted remotely. Miss Sun, Procurator Fiscal Depute, represented the Crown, Miss Middleton, Solicitor, represented the Scottish Prison Service (SPS) and Miss Waseem, Solicitor, represented NHS Grampian.

[2] At the time of death the deceased was a convicted prisoner serving a life sentence for murder at HMP Grampian, South Road, Peterhead (the prison). He was sentenced on 23 April 2018 with the punishment part of his sentence fixed at 14 years and 11 months. Accordingly he was in legal custody at the time of his death.

[3] The deceased had suffered from long term ill health. This included asthma, Chronic Obstructive Pulmonary Disease (COPD), pleuris, and Hepatitis C. In addition he suffered from chronic back pain which caused mobility problems. Prior to his death he was housed within a disabled cell on Ellon Wing at the prison and confined to a wheelchair.

[4] No oral evidence was presented to the inquiry. Parties had entered into a comprehensive joint minute of agreement in advance of the hearing. In addition, the following Crown productions had been lodged and referred within the joint minute:

1. Post mortem Examination Report;
2. Post Mortem Toxicology Report;
3. Medical Notes for deceased from Aberdeen Royal Infirmary;
4. – 7. Prison Health Centre Healthcare Records for deceased.

[5] The following productions were lodged by SPS and referred to within the joint minute:

1. Death in Prison Learning, Audit and Review (DIPLAR);

2. Prison Escort Report;

3. Rule 41 Order dated 21 April 2020 (re Covid-19 protocol);

4. Rule 41 Care Plan dated 21 April 2020;

5. Rule 41 Revocation Order dated 25 April 2020;

6. SPS Governors and Managers Action Plan dated 9 April 2020;

7. SPS Governors and Managers Action Plan on Revised Rule 40A process dated 1 May 2020;

8. SPS Pandemic Plan dated May 2020.

[6] All documentary productions above referred to in the joint minute were agreed by parties to be true and accurate.

[7] In addition, the following witness statements were lodged by the Crown and referred to in the joint minute:

1. Jacqueline Munchirahondo, Staff Nurse, HMP Grampian;

2. Kenneth Martin, First Line Manager, HMP Grampian;

3. Joshua Cramb, Doctor, Aberdeen Royal Infirmary;

4. Michael Shaw, Doctor, Aberdeen Royal Infirmary;

5. Rachel McKinney, daughter of deceased.

[8] Likewise all statements above were agreed by parties as evidence to be considered as equivalent to the parole evidence for each witness.

Legal Framework

[9] This inquiry was held in terms of section 1 of the Act. As Mr Connor died in legal custody this was a mandatory inquiry under sections 2(1) and (4) of the Act. The inquiry was governed by Act of Sedurent (Fatal Accident Inquiry Rules) 2017

(the Rules) and was an inquisitorial process. The Crown represented the public interest.

[10] The purpose of the inquiry, with reference to section 1(3) of the Act, is to establish the circumstances surrounding the deceased's death and to consider if any steps might be taken to prevent other deaths in similar circumstances. It is not the purpose of the inquiry to establish either civil or criminal liability. The manner in which evidence and other information is presented to the inquiry is not restricted and the inquiry is entitled to find its conclusions based on such evidence and information (Rule 4.1).

[11] Section 26(1) and (2) of the Act sets out the requirements for the Sheriff's written determination following the inquiry:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out —
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> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
>
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1)(a) are —
>
> (a) when and where the death occurred,
>
> (b) when and where any accident resulting in the death occurred,
>
> (c) the cause or causes of the death,
>
> (d) the cause or causes of any accident resulting in the death,
>
> (e) any precautions which—
>
> (i) could reasonably have been taken, and
>
> (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,
>
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death,
>
> (g) any other facts which are relevant to the circumstances of the death."

[12] I will accordingly set out the facts I have found admitted or proved and then explain why I consider it appropriate to make formal findings in terms of section 26(2)(a) and (c) of the Act. Findings in facts 1 to 25 are based on the joint minute of agreement together with the post-mortem and toxicology reports referred to in the joint minute.

Summary

[13] I found the following facts admitted or proved:

1. That the deceased, James Connor, was born on 6 March 1965.

2. That the deceased was sentenced to life imprisonment for murder at the High Court on 23 April 2018, with a punishment part of 14 years and 11 months.

3. That the deceased was a prisoner at HMP Grampian, Peterhead (the prison).

4. That the deceased was accordingly in lawful custody at the time of his death.

5. That the deceased had a history of poor health which included Chronic Obstructive Pulmonary Disease (COPD), pleurisy and Hepatitis C. In addition, he suffered from asthma and chronic back pain.

6. That in April 2020 the deceased was housed within cell E3BO1 on Ellon Wing at the prison.

7. That the deceased was mainly confined to a wheelchair due to COPD.

8. That cell E3BO1 was fitted to accommodate a disabled person.

9. That the deceased required carer assistance.

10. That on 21 April 2020 the deceased was assessed by a prison staff nurse, having displayed symptoms of Covid-19. Swabs were taken from the deceased who was then isolated in line with SPS protocol.

11. That the Covid-19 test was subsequently confirmed to be negative and on 25 April 2020 the deceased was returned to cell E3BO1.

12. That on 30 April 202 prison staff nurse, witness Jacqueline Munchirahondo, was asked by a prison officer to check on the deceased in cell E3BO1 as it was reported to her that the deceased had been feeling unwell during the night.

13. That on assessment, the deceased's oxygen levels were noted to be low and witness Munchirahondo provided him with an aerosol nebuliser containing a 5mg capsule of Salbutamol, a medication allowing the airways in the lungs to be opened up.

14. That the deceased was instructed to use the nebuliser within his cell, due to the on-going concerns at the time regarding the Covid-19 virus.

15. That having consulted a prison doctor, witness Munchirahondo returned to check on the deceased 30 minutes later. His oxygen level was still low and the nebuliser was filled with a second dose of Salbutamol.

16. That on her return to check on the deceased 30 minutes later witness Munchirahondo noted the nebuliser to have been switched off by the deceased and his oxygen levels were still low.

17. That witness Munchirahondo consulted with the prison duty doctor and an ambulance was called. The prison residential manager, witness Kenneth Martin, was notified of the deceased's condition and a member of

staff remained with the deceased whilst awaiting the arrival of the ambulance.

18. That the ambulance arrived at approximately 1316 hours and departed for Aberdeen Royal Infirmary (ARI) at 1350 hours.

19. That on arrival at ARI at 1440 hours, and following initial assessment, a working diagnosis of lower respiratory tract infection (LRTI) was made with a high index suspicion of Covid-19. The deceased was initially treated with oxygen, amoxicillin and doxycycline.

20. That a Covid-19 swab was obtained from the deceased which tested negative.

21. That from 30 April to 2 May 2020 the deceased experienced worsening breathlessness. He was diagnosed as having progressive type 2 respiratory failure and respiratory acidosis. The deceased was intubated and given critical care.

22. That on 2 May 2020 at approximately 1050 hours the deceased was found dead in his private room on the ward at ARI by nursing staff.

23. That the deceased was pronounced dead by witness, Dr Joshua Cramb, at 1055 hours on 2 May 2020.

24. That on 5 May 2020 Dr Tamara McNamee carried out a post-mortem examination of the deceased.

25. That the findings of the post-mortem examination report (as contained in Crown Production 1) were that the cause of death was infective exacerbation of chronic obstructive pulmonary disease.

Submissions

[13] All parties accepted that the deceased died of natural causes and, in the circumstances, simply sought formal findings in respect of section 26(2)(a) and (c) of the Act.

Discussion

[14] From the agreed evidence it was clear that the deceased had long term health conditions, including COPD, from which he had suffered prior to his incarceration. The autopsy report makes clear that this was the cause of death.

[15] The deceased was a heavy smoker with a history of illicit drug abuse. At the time of his admission to hospital he was on a methodone prescription programme of 480ml per day. In addition, he had a previous history of episodes of breathlessness.

[16] Whilst there was an initial suspicion that the deceased may have contracted the Covid-19 virus in April 2020 the appropriate tests showed this to be negative. I am also satisfied from SPS productions 6, 7 and 8 that the appropriate procedures for dealing with a suspected Covid-19 case were followed and the deceased required to self-isolate for the requisite period of time.

[17] I am therefore satisfied that, based on all of the above, the deceased's death was solely attributable to COPD as recorded in the death certificate.

[18] In all the circumstances I consider that the appropriate finding is a formal one in terms of section 26(2)(a) and (c) of the Act. The finding in respect of section 26(2)(a) is based on the agreed evidence and, in particular, findings-in-fact 19 to 23. The finding in respect of section 26(2)(c) is based on the agreed evidence as read with the autopsy report as specified at findings-in-fact 24 and 25.