SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2024] FAI 28

GLW-B7421-23

DETERMINATION

BY

SUMMARY SHERIFF JONATHAN GUY

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

into the death of

ALISTAIR IAN FINDLAY

GLASGOW, 18 June 2024

The sheriff, having considered the information presented at the inquiry, Determines that in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") the following:

(1) In terms of section 26(2)(a) of the Act, Mr Alistair Ian Findlay ("the deceased"), born 20 May 1959, died in cell E1/20, E Hall, HMP Barlinnie, 81 Lee Avenue, Glasgow, on 12 February 2021, at 16.24 hours.

(2) In terms of section 26(2)(b) of the Act, the death was not due to an accident.

(3) In terms of section 26(2)(c) of the Act, the cause of death was pulmonary thromboembolus, deep vein thrombus and prostatic carcinoma.

(4) In terms of section 26(2)(d) of the Act, the death was not due to an accident.

(5) In terms of section 26(2)(e) of the Act, there were no precautions that might realistically have resulted in the death being avoided.

(6) In terms of section 26(2)(f) of the Act, there were no defects in any system of working that contributed to the death.

(7) In terms of section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

(8) I have no recommendations to make under sections 26(1)(b) and (4) of the Act.

Introduction

[1] This inquiry is governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules"). It is a mandatory inquiry in terms of sections 2(1) and 2(4)(a) of the Act, due to the death occurring whilst the deceased was in legal custody. In terms of section 1(3) of the Act the purpose of the inquiry is to (a) establish the circumstances of the death, and (b) to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The procurator fiscal represents the public interest and is required under section 1(1)(a) of the Act to investigate the circumstances of the death.

The sheriff's determination

[2] Section 26(1) of the Act requires the sheriff to make a determination setting out (a) in relation to the death to which the inquiry relates, their findings as to the circumstances mentioned in section 26(2), and (b) such recommendations (if any) as to

any matters mentioned in section 26(4) as they consider appropriate. The circumstances mentioned in section 26(2) 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.

[3] In terms of section 26(4) of the Act the sheriff is to make such recommendations (if any) as they consider appropriate as to:

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working,

(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

[4] In order to identify precautions that might realistically have avoided the death, or defects in the system of working which contributed to the death, the sheriff must be satisfied on the balance of probabilities that those precautions, or the defects in the

system of working, contributed to the death. In order to make recommendations the sheriff has to be satisfied that there is a reasonable possibility that the recommendations might prevent other deaths in similar circumstances.

[5] Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, and in terms of section 1(4) of the Act, it is not the purpose of the inquiry to establish civil or criminal liability.

The inquiry process

[6] The notice of inquiry and Form 3.1 were lodged with the court by the procurator fiscal on 31 May 2023. Only the Scottish Ministers (acting on behalf of the Scottish Prison Service) initially decided to participate in the inquiry.

[7] The rule 3.7 notes for the procurator fiscal and Scottish Ministers invited the court to make formal findings and submitted that the evidence regarding the death could be adduced by the parties lodging a joint minute of agreement. That was the position at the preliminary hearing on 12 July 2023 when a sheriff continued the inquiry to a hearing on the evidence on 27 September 2023. On 27 September 2023, the parties tendered a joint minute of admissions and invited me to make formal findings under the Act. Neither party had cited any witnesses to appear on this date.

[8] I indicated to the parties that I was not prepared to proceed on this basis. I was particularly concerned by the absence of any information within the joint minute of

agreement concerning what had occurred between 4 and 12 February 2021 (when the deceased died). Against a background of a number of serious medical ailments, paragraph 11 of the joint minute of agreement states:

> "On 04 February 2021, the consultation nurse within the prison received a phone call from the deceased's social worker following an interview with the deceased where he is said to have presented in a physically horrific condition claiming he was struggling to breathe, vomiting every day and urinating himself (as shown at Crown Production 5 page 4 and Crown Production 14 Page 2). The deceased was assessed by a nurse following this phone call. The deceased disclosed that he was urinating himself and using toilet paper as pads, that he was vomiting and feeling unwell. Physical observations were taken, and the deceased was described to be able to articulate well (Crown Production 14 Page 2)".

[9] While this paragraph refers to the deceased being examined by a nurse, it does not explain what (if any) conclusions were reached about his health on this date. Nor does it set out what (if any) treatment was administered to the deceased to address his symptoms prior to his death on 12 February 2021.

[10] Reference is made in the joint minute of agreement to forensic pathologist Dr Julie McAdam's report and her conclusion that the death was caused by pulmonary thromboembolus, deep vein thrombus and prostatic carcinoma. Dr Julie McAdam's report does not, however, state that the medical care provided to the deceased was appropriate and the death was unavoidable. The conclusion that one of the causes of the death was prostatic carcinoma also suggests that there was some interplay between the deceased's medical ailments and his death. This raised a question in my mind as to whether there was a connection between the symptoms that the deceased was

displaying on 4 February 2021 and his subsequent death, so that the death might have been avoided.

[11] A police statement from the deceased's cellmate was contained within the productions that had been lodged with the court. The content of this statement was not addressed in the joint minute of agreement. In this police statement, the deceased's cellmate (who is registered blind) states:

> "In the two weeks running up to his death I remember Alistair going to hospital, maybe more than a fortnight, and he had a procedure…He got an infection which didn't clear up very quickly. Alistair was in a lot of pain when he went to pee. He thought it was urine infection and then it just kept getting worse. He was jumping out of bed wrenching in the week before his death, just wrenching a lot for almost an hour at times…Alistair was getting worse and worse, almost paranoid. He felt like he was being left. He told me he thought they were just leaving him to suffer. In my opinion certain staff members may have thought he was embellishing his symptoms to get a trip out of hospital…Toward the end, in the days before his death, and with hindsight: Alistair was clearly feeling really bad. An officer took him across to see a nurse without an appointment. I think they realised how bad it was, they phoned an ambulance and he died later that day. In this place the nursing staff just don't care. Unless you are dying on the floor in front of them it just doesn't matter. If a blind man can see that Alistair was ill then I don't know how the nurses couldn't."

[12] With reference to this information, I explained to the parties that I considered that there was insufficient information for me to assess whether the deceased had received appropriate medical care shortly prior to his death to determine (amongst other things) whether the death could have been avoided.

[13] Similar to the position that Sheriff Foulis encountered in the inquiry into the death of *Darrell Smith* [2018] FAI 40, there was surprise on the part of the procurator fiscal depute when I indicated that I was not prepared to conclude the inquiry on the

basis of the joint minute of agreement. After initially seeking to persuade me that it was unnecessary to investigate the above matters, the procurator fiscal depute indicated that it may be necessary to instruct a suitably qualified expert to address the appropriateness of the medical treatment provided to the deceased. I said that this seemed appropriate and continued the inquiry to a date to be afterwards fixed to (amongst other things) allow the suitably qualified expert's availability to taken into account when assigning a further date.

[14] The 29th of January 2024 was thereafter assigned as the next date for the inquiry. Prior to this date, I received an email (via my clerk) from the procurator fiscal depute seeking my guidance on the appropriateness of the investigations that she proposed to undertake, including the expertise of the expert that she intended to instruct.

[15] In order to assist the parties, and with a view to ensuring the expeditious progress of the inquiry, I made an order dated 3 November 2023, under rule 2.6 of the Rules, requiring the procurator fiscal to obtain and lodge a report from a suitably qualified skilled witness, or witnesses, within 6 weeks of this date, addressing the following questions:

(i) Whether the deceased received appropriate medical treatment between 4 and 12 February 2021 having regard in particular to: the procedure that he underwent on 29 December 2020; that he was prescribed antibiotics on 14 January 2021; the information concerning his symptoms that he provided to his social worker, Ms Tracey Bissett, on 4 February 2021 and healthcare professionals on or around this date; and cause of his death?

(ii) If the deceased was not provided with appropriate medical treatment between 4 and 12 February 2021, whether this contributed to his death?

(iii) If the deceased was not provided with appropriate medical treatment between 4 and 12 February 2021, if the appropriate treatment had been provided, might this have realistically resulted in his death being avoided?

[16] On 24 January 2024, I received a further email from the procurator fiscal depute (via my clerk) stating that she had instructed Professor Adam Hill (Honorary Consultant Respiratory Physician) to provide a report addressing the above questions, but his report would not be available on 29 January 2024.

[17] When the inquiry called on 29 January 2024, the procurator fiscal depute made a motion for the inquiry to be adjourned to allow Professor Hill further time to prepare his report. This was unopposed by the solicitor for the Scottish Ministers and I continued the inquiry to 25 March 2024.

[18] In advance of 25 March 2024, the procurator fiscal depute lodged a report by Professor Hill dated 7 February 2024. In this report, Professor Hill states that there were omissions in the medical care provided to the deceased on 4 February 2021 that fell below the standard of care to be expected. In his opinion, the death was nonetheless unavoidable unless the deceased displayed symptoms suggestive of a deep venous thrombosis in life. As there is no indication that he displayed any such symptoms, any omissions in relation to the care administered to the deceased prior to his death did not cause or contribute to his death.

[19] In addition to lodging Professor Hill's report, the parties lodged a second joint minute of agreement. This joint minute of agreement stated that various police statements (including the deceased's cellmate's police statement referred to above) are to be treated as being equivalent to the parole evidence of the person that had made the statement. It also addressed Professor Hill's report and stated that, "Said report is a true and accurate copy of the original, the contents of which are agreed in evidence". The parties therefore agreed that the deceased had been provided with inadequate care whilst in custody on 4 February 2021 (8 days prior to his death).

[20] On 25 March 2024, the parties invited me to make formal findings. They did not address Professor Hill's opinion that the deceased had received inadequate care prior to his death. When I inquired as to whether it would be open to me to make a finding under section 26(2)(g) of the Act in relation to this, they accepted that they had not considered the point.

[21] The procurator fiscal depute stated that she would wish to notify the relevant health board if I was considering making a finding under section 26(2)(g) of the Act. I asked whether she had notified the appropriate health board that the procurator fiscal had agreed that the deceased had received inadequate care whilst in custody and she stated that she had not.

[22] I decided to adjourn the inquiry until 10 May 2024 to allow the procurator fiscal depute to make the appropriate health board aware of the discussion at the inquiry and so that I could be addressed on whether it would be appropriate to make a finding under section 26(2)(g) of the Act.

[23] Prior to 10 May 2024, Greater Glasgow Health Board ("the Health Board") lodged a notice to participate in the inquiry together with written submissions. In its written submissions, the Health Board challenge Professor Hill's opinion that deceased was provided with inadequate care on 4 February 2021. This is on the basis that he is not suitably qualified to express an opinion on the adequacy of the care that the deceased received from a nurse whilst in prison. The submissions further contend that the alleged inadequate care is not relevant to a finding under section 26(2)(g) of the Act.

[24] The procurator fiscal and Scottish Ministers lodged a third joint minute of agreement prior to 10 May 2024. This refers to Professor Hill being asked whether the omissions in the care that he identified could have been fatal, which he answers in the negative.

[25] On 10 May 2024, counsel for the Health Board moved its notice to participate in the proceedings, which I granted, albeit late. The parties then moved to amend the second joint minute of agreement so that it no longer reads that Professor Hill's report is agreed in evidence and states that its contents "are to be treated as the parole evidence of Professor Hill". Thereafter, the parties invited me to make formal findings under the Act on the basis of the joint minutes of agreement that had been lodged.

[26] After reflecting on the submissions of the parties I decided that it was unnecessary to require any witnesses to attend the inquiry to give oral evidence and that I would make my determination on the basis of the three joint minutes of agreement (as amended) that had been lodged.

The evidence before the inquiry

[27] The parties tendered three joints minutes of agreement which formed the evidence before the inquiry. The terms of these joint minutes of agreement (as amended) and presented to the inquiry are as follows:

First joint minute

1. At On 12 November 2018 ALISTAIR FINDLAY, date of birth 20 May 1959 (hereinafter referred to as "the deceased"), was convicted following trial at the High Court of Justiciary, Glasgow, before Lord Matthews, in respect of a number of historical sexual offences against children. On 18 June 2019 the deceased was sentenced to an Order of Life Long restriction with a minimum period of imprisonment of 4 years and 6 months. The sentence was backdated to 20 July 2017, the date on which the deceased had first been remanded in custody. The expiry date of the deceased's punishment part was calculated as 19 January 2022 (all as shown at Crown Production 5 page 52).
2. Following sentence being imposed, the deceased was imprisoned within HM Prison, Barlinnie (hereinafter referred to as "the prison") (Crown Production 5 page 52).
3. At the date of his death on 12 February 2021 the deceased was a prisoner of HM Prison, Barlinnie. Accordingly, he was in legal custody as at the date of his death.

Provision of Healthcare to Prisoners

4. On 01 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the Scottish Prison Service (SPS) to the NHS. Since then, individual regional NHS health boards have been responsible for the delivery of health care services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

Medical History and Treatment

5. The deceased was known to suffer from several long-term medical conditions including asthma, bladder cancer and an enlarged prostate for which he was on a waiting list for an operation (Crown Production 2 page 1). The deceased was diagnosed with urinary bladder cancer in October 2013 (Crown Production 14 page 21) and underwent a partial cystectomy operation on 30 July 2014 to remove this (as shown at Crown Production 14 page 19 and Crown Production 15 page 28). At the time his death, the deceased was prescribed with several medications including citalopram, omeprazole, simvastatin, co-codamol and inhalers (Crown Production 2 page 1).
6. The deceased was referred to and reviewed on multiple occasions by both the prison and by specialists in the urology departments at Gartnavel General Hospital, Glasgow Royal Infirmary and Stobhill Hospital over an

extended period for his prostate/urinary issues (all as shown at Crown Production 14 pages 2, 3, 4, 5, 8, 9, 10, 11, 12, 18, 20 & 21, Crown Production 15 pages 16, 20, 21 & 22, Crown Production 19 pages 20, 21, 31 & 34, Crown Production 20 page 3, Crown Production 21 page 25 and Crown Production 22 page 13).

7. The deceased was also subject to a number of diagnostics including regular urine and stool sampling, blood tests, regular cystoscopy, CT scans of the bladder/prostate and multiple sigmoidoscopies since 2014 (all as shown at Crown Production 14 pages 2 - 22, Crown Production 15 pages 10, 20 & 21 and Crown Production 19 pages 6, 7, 17, 20, 21, 23, 29, 37, Crown Production 20 pages 2, 12, Crown Production 22 pages 25 & 26).

8. From 2012 until his death in 2021, the deceased made a number of self-referrals to healthcare both in relation to his bladder cancer (as shown at Crown Production 20 page 13) and other health issues including dental issues, vomiting, productive coughing, constipation, bowel issues, chest infections, joint pain and gout. On each occasion he was assessed by healthcare staff and/or the relevant prison GP and referrals made where appropriate (all as shown at Crown Production 14 pages 2 - 22).

9. The deceased also made several self-referrals in relation to his mental health (as shown at Crown Production 14 pages 7, 10, & 14, Crown Production 18 page 9, Crown Production 21 page 5, and Crown Production 22 page 10). On each occasion, he received a consultation from healthcare staff and relevant

prison GP (Crown Production 14 pages 7, 10, & 14 and Crown Production 18 page 11 & 12).

10. On admission to HMP Barlinnie on 20 July 2017 the deceased's prison medical notes were updated to reflect his known health and medical issues (Crown Production 14 page 11). The following was noted:

    (i) Suspected asthma - asthmatic uses inhalers daily;

    (ii) Registered disabled - ankylosing spondylosis - bladder cancer - restless legs high cholesterol;

    (iii) Hearing loss tinnitus wears hearing aids;

    (iv) Physical handicap problem - obese - walks with two sticks;

    (v) History of psychiatric disorder - PTSD 2004 - Peterhead prison depression.

11. On 4 February 2021, the consultation nurse within the prison received a phone call from the deceased's social worker following an interview with the deceased where he is said to have presented in a physically horrific condition claiming he was struggling to breathe, vomiting every day and urinating himself (as shown at Crown Production 5 page 4 and Crown Production 14 page 2). The deceased was assessed by a nurse following this phone call. The deceased disclosed that he was urinating himself and using toilet paper as pads, that he was vomiting and feeling unwell. Physical observations were taken, and the deceased was described to be able to articulate well (Crown Production 14 page 2).

Events of 12 February 2021

12. Around 1430 hours, Prison Officer David Murphy attended at the deceased's cell, and observed the deceased to be sitting in a chair at the back of the cell. The deceased's cellmate, who is blind stated that the deceased appeared to be in some distress and that he had used the cell intercom to request assistance. Officer Murphy asked the deceased what was wrong, and the deceased stated that he felt unwell, and that his heart was racing.

13. Officer Murphy thereafter contacted the prison health centre, and prison nurse Kirsten Walsh attended at the hall. The deceased was then taken to the nurses' station and examined. As Officer Murphy was returning the deceased to his cell he dropped to his knees and stated he could not make it to his cell. The deceased was placed on oxygen and Dr Senthil attended to examine the deceased. An ambulance was requested to attend to examine the deceased further. Officer Murphy thereafter attended to his duties in the exercise yard and Prison Officers Michael Ingram and Mark Carcary took over. Prison Nurse Christine Campbell attended in her capacity of nurse and took over from Nurse Welsh who returned to the health centre.

14. The deceased was informed that he was going to hospital, and he asked for privacy to change his incontinence pad. Officers Ingram and Carcary assisted in moving the deceased to his cell. Nurse Campbell entered the cell and shouted for help to get the deceased to the ground as he had lost

consciousness. Officers Carcary and Ingram assisted in putting the deceased to the ground within the cell while Nurse Campbell commenced chest compressions. Officer Carcary radioed a "code blue" and requested that a defibrillator was brought to the cell.

15. Prison Officer Jillian Leckie was on duty in her capacity as First Line Manager (FLM) when she heard the "code blue" and immediately attended, observing Nurse Campbell giving chest compressions. Officer James Inglis then attended at the cell with a defibrillator and gave this to Nurse Campbell. At this time, the paramedics attended and took over administering CPR. It was decided that the deceased be moved in the corridor in order to allow more room for the paramedics to work on him. After approximately 40 minutes, CPR had been unsuccessful, the deceased was showing an asystolic rhythm, no pulse was obtainable, and had fixed and dilated pupils. Life was formally pronounced extinct at 16.24 hours by paramedic, Carl Smith.

Cause of Death

16. A Post Mortem examination was conducted on the 12 March 2021 by Forensic Pathologist Dr Julie McAdam, at the Queen Elizabeth University Hospital, Glasgow and the cause of death was recorded as:- 1a. Pulmonary thromboembolus 1b. Deep vein thrombus 1c. Prostatic carcinoma.

17. The conclusion section of the Post Mortem Report is contained at page 4 of Crown Production 2 and state as follows:

> "Post mortem examination revealed pulmonary thromboembolus in the right lung and corresponding deep vein thrombus was identified in the right calf muscle. This is a condition whereby blood clots forming the deep veins of the legs and break away, travelling via the circulation through the heart to become lodged in the pulmonary arterial system where they cause acute cardiopulmonary compromise. There are numerous risk factors for the development of deep vein thrombus and subsequent pulmonary thromboembolus, including malignancy. The prostate gland was grossly enlarged, firm, fleshy and extensively necrotic on gross examination and microscopic examination revealed changes in keeping with a primary prostatic carcinoma, albeit definitive diagnosis would require expert review and immunohistochemistry. There was apparently a history of bladder malignancy and although tumour was seen infiltrating the muscular wall of the bladder, this appeared to arise in the prostate gland. The bladder was grossly distended, the ureters were slightly dilated and there was relatively prominent dilation of the renal pelves, findings which are consistent with a degree of urinary obstruction due to enlargement of the prostate gland. There were no convincing findings to suggest ascending urinary tract infection. The heart was enlarged, showing left ventricular hypertrophy, but there was no other evidence of natural disease. Analysis of post mortem blood revealed levels of paracetamol and codeine, in keeping with therapeutic use of prescribed co-codamol. The presence of morphine in this case is considered to reflect a metabolite of codeine. In summary, the cause of death is regarded as pulmonary thromboembolus due to deep vein thrombus due to prostatic carcinoma. Given the presence of pulmonary thromboembolus, it is considered unlikely that cardiac disease has significantly contributed to death."

Reviews

18. Following the death of the deceased, a Death in Prison Learning, Audit and Review (DIPLAR) was conducted by Scottish Prison Service (Crown Production 3). The DIPLAR identified some elements of good practice and states:

> "The response in the hall and from the health centre at the time of the incident was good, very quick, effective and compassionate- e.g. good attention given to trying to assist Mr Findlay in dressing in fresh clothes in preparation to go to hospital; assistance with pad care; and in providing support generally. The ambulance service responded very quickly and took over when on site. Mr Findlay's medications needs had been considerable and the prison pharmacy had responded to his needs by, unusually, personalising his blister pack arrangements to make his medications self-management as easy as possible" (as shown at Crown Production Number 3 at page 5)

19. The DIPLAR further identified a learning point and states:

> "Mr Findlay's cell mate was provided with support by staff at the time, we need to ensure that we are overt in our attention to cell mates etc, following such an incident. The Risk Management Team continues to be attentive to the need to consult with, and inform external agencies involved in the oversight of higher risk offenders, when such a prisoner dies." (as shown at Crown Production Number 3 at page 5)

Productions

20. Crown Production 1 is a true and accurate copy of the Intimation of Death Form relating to the deceased. Said Production is a true and accurate copy of the original, the contents of which are agreed and admitted in evidence.

21. Crown Production 2 comprises the Final Post-Mortem Report dated 16 April 2021 detailing the findings of a post-mortem examination of the deceased's body, which was carried out on 12 March 2021 by Dr Julie McAdam, Forensic Pathologist at the Queen Elizabeth University Hospital, Glasgow. Said Production is a true and accurate copy of the original, the contents of which are agreed and admitted in evidence.

22. Crown Production 3 is the Death in Prison Learning, Audit and Review (DIPLAR) which took place on 30 March 2021 in relation to the deceased's death. It contains a true and accurate account of the matters considered and the conclusions reached at this DIPLAR, the contents of which are agreed and admitted into evidence.
23. Crown Productions 4 - 13 are a true and accurate copy of Prison Records relating to the deceased. These records contain true and accurate information in relation to the deceased's time within HM Prison, Barlinnie.
24. Crown Productions 14 to 33 are a true and accurate copy of Prison Medical Records relating to the deceased. The information contained therein is a true and accurate record of the deceased's medical history and treatment during the deceased's time within HM Prison, Barlinnie.

Second joint minute (as amended)

1. That Crown Production 34 is a report authored by Professor Adam Hill, Consultant Respiratory Physician. Said report is a true and accurate copy of the original, the contents of which are to be treated as the parole evidence of Professor Hill.
2. That Crown Production 35 is a statement given to police by Michael Ingram on 12 February 2021 at HMP Barlinnie. Said statement is to be treated as the parole evidence of Michael Ingram.

3. That Crown Production 36 is a statement given to police by Mark Carcary on 12 February 2021 at HMP Barlinnie. Said statement is to be treated as the parole evidence of Mark Carcary.
4. That Crown Production 37 is a statement given to police by Jillian Leckie on 12 February 2021 at HMP Barlinnie. Said statement is to be treated as the parole evidence of Jillian Leckie.
5. That Crown Production 38 is a statement given to police by James Inglis on 12 February 2021 at HMP Barlinnie. Said statement is to be treated as the parole evidence of James Inglis.
6. That Crown Production 39 is a statement given to police by David Murray on 12 February 2021 at HMP Barlinnie. Said statement is to be treated as the parole evidence of David Murray.
7. That Crown Production 40 is a statement given to police by Christine Campbell on 12 February 2021 at HMP Barlinnie. Said statement is to be treated as the parole evidence of Christine Campbell.
8. That Crown Production 41 is a statement given to police by Carl Smith on 7 March 2021. Said statement is to be treated as the parole evidence of Carl Smith.
9. That Crown Production 42 is a statement given to police by Amie Wollgramm on 24 March 2021. Said statement is to be treated as the parole evidence of Amie Wollgramm.

10. That Crown Production 43 is a statement from Police Constable Matthew Law taken on 26 February 2021 at London Road Police Station. Said statement is to be treated as the parole evidence of Matthew Law.
11. That Crown Production 44 is a statement from Police Constable Richard Moody taken on 1 March 2021 at London Road Police Station. Said statement is to be treated as the parole evidence of Richard Moody.
12. That Crown Production 45 is a statement given to police by Dr Suchitra Senthil. Said statement is to be treated as the parole evidence of Dr Suchitra Senthil.
13. That Crown Production 46 is a statement given to police by the deceased's cellmate on 11 August 2023 at HMP Barlinnie. Said statement is to be treated as the parole evidence of the deceased's cellmate.
14. That Crown Production 47 is a statement given to police by Tracey Bissett on 11 August 2023 at HMP Barlinnie. Said statement is to be treated as the parole evidence of Tracey Bissett.
15. That Crown Production 48 is a statement given to police by Harry O'Neill on 5 January 2024 at HMP Barlinnie. Said statement is to be treated as the parole evidence of Harry O'Neill.

Third joint minute

1. Kirstie Webb, Procurator Fiscal Depute for the Crown, emailed Professor Adam Hill on 26 March 2024 and asked Professor Adam Hill to comment on the following:

> "If an individual had presented to prison health care with the same symptoms and had received the same treatment as the deceased, were these omissions or failings to provide the correct treatment severe enough to result in the individual's death?"

Professor Hill responded on 27 March 2024 and advised:

> "No, is the short answer. In my opinion, despite omissions between 4.12.2021 and 12.02.2021, this did not contribute to his death as he presented with no symptoms suggestive of a deep venous thrombosis in life and from the records the pulmonary embolism came on suddenly on the 12.02.2021."

Evidence contained within the second joint minute of agreement

[28] I set out above the terms of the deceased's cellmate's police statement. I do not propose to narrate the terms of the various other documents introduced into evidence in terms of the second joint minute of agreement, other than to refer to aspects of Professor Hill's report dated 7 February 2024, which are relevant to the discussion that took place during the inquiry and the submissions of the parties.

Professor Hill's report

[29] Professor Hill states that he is an honorary consultant respiratory physician at the Royal Infirmary of Edinburgh. He refers to the academic material that he considered in preparing his report as well as the relevant medical records of the deceased.

[30] Professor Hill explains that a pulmonary embolism usually arises from a blood clot in the legs that has travelled to the lungs. Symptoms of a pulmonary embolism include difficulty breathing that comes on suddenly, chest pain that's worse when you breathe, cough, or sneeze and on occasions those affected cough up blood. The risk factors of pulmonary embolism for the deceased were his active malignancy (bladder and prostate), a right calf deep venous thrombosis, high body mass index (32Kg/m2) and his age.

[31] As regards the death, Professor Hill states that the deceased had sudden worsening breathlessness with hypoxia and chest discomfort in keeping with a pulmonary embolism on 12 February 2021. A deep venous thrombosis was identified at post mortem, so there might have been pain, redness and swelling in the right calf, but the deceased had not reported these in life.

[32] After detailing the history of deceased's medical treatment, Professor Hill addresses the adequacy of the care provided to the deceased prior to his death and states:

> "On 04.02.2021 it was noted the late Alistair Findlay was unwell with vomiting, struggling for breath and urinating uncontrollably. His observations were a raised blood pressure 158/105, a raised pulse rate 105 beats per minute (normal less than 100) but normal oxygen saturations on room air (97%). There was no recorded temperature measurement. A temperature measurement is needed to exclude sepsis due to a urinary tract infection. There was no recorded clinical examination. There was no recorded urinalysis/mid-stream specimen of urine to check for a urinary tract infection. There was no diagnosis made and no escalation to the GP. In my opinion, these omissions fall below standard care. There should have been further investigations to exclude urinary sepsis. In addition, he had underlying asthma and there was no examination of the chest or peak

> expiratory flow measurements to assess whether the breathlessness was due to worsening asthma or another cause."

[33] In Professor Hill's opinion, the omissions on 4 February 2021 did not cause or contribute to the death. This is because the deceased presented with no symptoms suggestive of a deep venous thrombosis in life and from the records the pulmonary embolism developed suddenly on the day of his death.

Submissions

The procurator fiscal

[34] The procurator fiscal depute invited me to make formal findings under the Act.

[35] As regards section 26(2)(g) of the Act, the procurator fiscal depute submitted that a finding under this section must be relevant to the circumstances of the death. Once this is established, a finding can only be made if it might prevent other deaths in similar circumstances. As such, there is a two-stage test that requires to be met before a finding can be made under section 26(2)(g).

[36] In the procurator fiscal depute's submission, the omissions identified by Professor Hill in his report are not relevant to the circumstances of the death. This is due to the passage of time between the omissions and the date of death.

The Scottish Ministers

[37] The solicitor for the Scottish Ministers invited me to make formal findings under the Act.

[38] In respect of section 26(2)(g) of the Act, the solicitor for the Scottish Ministers referred to paragraph 5-77 of Carmichael, *Sudden Deaths and Fatal Accident Inquiries* (3rd ed) and submitted that there is a requirement for the facts established under this head to be relevant to the circumstances of the death. It does not follow that if evidence was heard at an inquiry that it related to the circumstances of the death. In this death, Professor Hill's report regarding the omissions made on 4 February 2021 falling below the standard of care is not relevant to the circumstances of the death. The deceased had no symptoms suggestive of deep venous thrombosis in life and the pulmonary embolism came on suddenly. The death was therefore unavoidable and unconnected to any failings in the care provided to the deceased.

[39] In the event that I determined to make a finding under section 26(2)(g) of the Act, the solicitor for the Scottish Ministers submitted that the responsibility for the treatment of prisoners rests with the Health Board and not the Scottish Ministers.

The Health Board

[40] Counsel for the Health Board submitted that I should make formal findings under the Act.

[41] Counsel submitted that although findings under section 26(2)(g) of the Act do not require a causative link to the death, they need to concern facts that are relevant to the circumstances of the death. This requires the fact to have a direct bearing on, or at least be connected to the death in some way. The evidence in relation to this death does not support a finding that any omissions in respect of the deceased's medical care had a

bearing on, or were connected to the death. The deceased's previous medical condition and treatment is therefore relevant only insofar as it is part of the general background and context of the death.

[42] It was further submitted by counsel that the treatment that Professor Hill identified as below standard concerned nursing care within a prison environment. As Professor Hill is not a nurse, it would be necessary for an appropriate nursing expert to give evidence in order to support a finding that the care was below standard.

[43] If I was minded to obtain further evidence in relation to the deceased's medical treatment, counsel submitted that the inquiry would be moving into a general assessment of the medical treatment that the deceased received whilst in custody instead of establishing the circumstances of the death and considering what steps (if any) might be taken to prevent deaths in similar circumstances.

Discussion and determination

[44] On the basis of the evidence before the inquiry, and submissions of the parties, I reached the following conclusions in respect of the matters that I am required to determine under section 26 of the Act.

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

[45] I accept the undisputed evidence contained within the joint minutes of agreement, police statements of those present on the day of the death, medical professionals that attended to the deceased, and Dr Julie McAdam's report, that the

death occurred in cell E1/20, E Hall, HMP Barlinnie, 81 Lee Avenue, Glasgow, on 12 February 2021, at 16.24 hours.

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

[46] The death did not result from an accident.

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

[47] In Dr Julie McAdam's report she states that the cause of death was pulmonary thromboembolus, deep vein thrombus and prostatic carcinoma. As a forensic pathologist, Dr McAdam is appropriately qualified to express an opinion on this issue, which is consistent with the other evidence before the inquiry. I accept her evidence and determine that this was the cause of the death.

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

[48] The death did not result from an accident.

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)

[49] The procurator fiscal depute instructed Professor Hill to review the deceased's medical history, and the circumstances of the death, to provide his opinion on (amongst other things) the appropriateness of the medical care provided to the deceased prior to his death and whether the death might have been avoided.

[50] I am satisfied that Professor Hill is suitably qualified to assist the inquiry by providing an opinion on these issues. Professor Hill states in his report that the deceased had no symptoms of deep venous thrombus in life and the pulmonary embolism developed suddenly on 12 February 2021. He is of the opinion that the deceased was provided with appropriate medical care when the pulmonary embolism developed and that the death could not have been avoided.

[51] Although Professor Hill identified failings in the care that was provided to the deceased on 4 February 2021, he does not consider that they caused or contributed to his death. He is therefore unable to identify any precautions that might realistically have avoided the death.

[52] There was no other evidence before the inquiry that caused me to doubt Professor Hill's opinion in relation to this issue. I therefore accept his evidence and determine that there were no reasonable precautions that might realistically have avoided the death.

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)

[53] For the reasons that I provide above, I accept Professor Hill's evidence that the omissions in care that he identified did not contribute to the death and that the deceased was provided with appropriate medical care on the day that he died. I therefore determine that there were no defects in any system of working which contributed to the death.

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

[54] The only fact that I considered might form the basis of a finding under section 26(2)(g) of the Act concerned Professor Hill's opinion that the deceased received inadequate care on 4 February 2021. The parties submitted that this is not a fact (should it be established) that is relevant to the circumstances of the death on the basis of their proposed interpretation of the section. It is therefore necessary to consider how the section should be interpreted.

[55] In *McMillan* v *T Leith Developments Ltd* 2017 SC 642 a full bench of the Inner House considered the principles that the court requires to apply when interpreting a statutory provision. At paragraph 54 of the judgement, Lord President Carloway states:

> "The task of the court was, and is, to seek the meaning of the words used; often described as ascertaining the intention of Parliament expressed in the statutory language in light of the particular context (*R* v *Secretary of State for the Environment, Transport and the Regions, ex p Spath Holme Ltd*, Lord Nicholls, pp 396, 397; citing *Black Clawson International Ltd* v

> *Papierwerke Waldhof-Aschaffenburg AG*, Lord Reid, p 613). Although the courts may employ certain accepted canons of interpretation, 'an appropriate starting point is that language is to be taken to bear its ordinary meaning in the general context of the statute.' (Ibid Lord Nicholls, p 397.) As the defenders submitted, if the terms were legal ones, they will be given their legal meaning. Where there is an apparent ambiguity in the wording, however, reference can be had to certain internal or external aids, many of which were alluded to, and some founded upon, in the submissions to this court."

[56] Approaching the interpretation of section 26(2)(g) with regard to these principles, the starting point is to consider the ordinary meaning of the words used in the section. A finding can only be made if the fact identified is "relevant to the circumstances of the death". This term is not defined within the Act. The word "relevant" is defined in Cambridge English Dictionary as "connected with what is happening or being discussed". The word "circumstance" is defined as "a fact or event that makes a situation the way it is". Therefore, applying the ordinary meaning of these words, I accept counsel for the Health Board's submission that that it is necessary for a fact to be connected to the death in some way if it is to be the subject of a finding under the section.

[57] I do not accept the procurator fiscal depute's submission that a finding can only be made if it might prevent other deaths in similar circumstances. The words used in the section do not make this a necessary prerequisite to a finding and this does not emerge from a wider consideration of the Act.

[58] The purpose of the inquiry in section 1(3) of the Act is two-fold: to (a) establish the circumstances of the death and (b) what steps (if any) might be taken to prevent other deaths in similar circumstances. These purposes are reflected in the matters that

the sheriff requires to determine under section 26 of the Act. While these purposes are connected, it is apparent from the wording in sections 1(3) and 26 that they are distinct and reflect the different stages of the inquiry process.

[59] In my opinion, once it has been established that a fact is relevant to the circumstances of the death, it is open to a sheriff to make a finding under section 26(2)(g). As to when this might be appropriate, I consider that the section provides the sheriff with wide scope to address any matter that comes to light during the inquiry that they deem to be in the public interest.

[60] This construction is consistent with Carmichael's proposed interpretation of the identically worded paragraph 6(1)(e) of The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the statutory predecessor to the Act) in his textbook *Sudden Deaths and Fatal Accident Inquiries* (3rd ed). At paragraph 5-77 of this textbook the learned author states:

> "The wording of this paragraph, though it gives the sheriff wide scope, none the less provides the facts which the sheriff finds established under this head must be relevant to the circumstances of the death. It means, it is submitted, the circumstances of the death as they may affect the public interest. There is a distinction between findings under s6(1)(c) and (d) where there is required to be a causal connection, and under s6(1)(e) where no such connection is required."

[61] In terms of the death in this inquiry, Professor Hill is of the opinion that the deceased died unexpectedly and unavoidably 8 days after the alleged inadequate care. While it is a matter of concern that the deceased may have not have received adequate care on 4 February 2021, on the basis of Professor Hill's evidence, I accept that this is not relevant to the circumstances of the death. I therefore accept the parties' position that I

should not make a finding under section 26(2)(g) of the Act in relation to this, or any other matter.

In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

[62] Against the background of the above findings, I do not consider there are any recommendations to be made.

Final remarks

[63] I wish to conclude by extending my condolences to the deceased's family.