SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT STIRLING

[2024] FAI 24

STI-B157-23

DETERMINATION

BY

SHERIFF M LABAKI

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

into the death of

STEWART CUTHILL

STIRLING, 29 February 2024

The sheriff, having considered the information presented at an inquiry on 11 January 2024 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, finds and determines:

(1) Mr Stewart Cuthill was born on 4 October 1952. He died on 22 January 2022 at Forth Valley Royal Hospital, Larbert. He was pronounced dead at 1640 hours on 22 January 2022.[1]

(2) The cause of death was i) bronchopneumonia and complications of small bowel obstruction due to abdominal adhesions, secondary to previous

[1] Section 26(2) (a)

abdominal surgery for bowel perforation and ii) interstitial lung disease and multiple myeloma.[2].

(3) I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26 (2) of the Act.

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

NOTE

Introduction

[1] This is a mandatory inquiry into the death of Mr Stewart Cuthill in terms of section 4(a) of the 2016 Act.

The proceedings and the parties

[2] The inquiry took place at Stirling Sheriff Court on 11 January 2024. Mr Gregor, procurator fiscal depute, appeared for the Crown. Ms Turner, appeared for the Scottish Prison Service ("SPS") and Mr Craig, appeared for NHS Forth Valley Health Board.

The sources of evidence

[3] A joint minute of agreement was agreed by the parties. It formed the entirety of the evidence. The joint minute detailed the circumstances of Mr Cuthill's death and his care and treatment within HMP Glenochil. Written submissions were submitted. The

[2] Section 26 (2) (c)

result was that evidence and submissions was completed in one day. I am grateful to parties for their assistance in the preparation and conduct of the inquiry.

The legal framework

[4] The inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"). The purpose of such an inquiry is set out in section 1(3) of the 2016 Act and 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."

Section 26 of the 2016 Act states, among other things, that:

> "(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
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> (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—
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> (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) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—

(a) if the precautions were not taken, or

(b) as the case may be, as a result of the defects.

(4)The matters referred to in subsection (1)(b) are—

(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."

A summary of the parties' positions

[5] All parties submitted that the court should make formal findings only in terms of section 26(2)(a) and (c) only.

The circumstances of the deceased and his death

[6] In that connection he submitted that Mr Cuthill was found within his cell on Friday 21 January 2022 by prison officers having been alerted via personal wrist alarm

going off at approximately 06.40am. Mr Cuthill reported vomiting and stomach pain, his hernia having swollen and causing pain. Nurse Tara Stafford attended with Mr Cuthill within his cell and found him to be vomiting. Mr Cuthill was assessed by Nurse Stafford as being constipated, however referred him to the Advanced Nurse Practitioner should conditions worsen. Dr Jack Kildare attended with Mr Cuthill at the request of nursing staff and instead of the Advanced Nurse Practitioner. Dr Kildare reviewed him within his cell. Dr Kildare noted that there was no output in Mr Cuthill's stoma bag. Dr Kildare suspected acute surgical abdomen possibly as a result of a bowel obstruction or ischemic bowel and admission to the surgical receiving unit of Forth Valley Royal Hospital in Larbert was arranged via an emergency ambulance.

[7] Upon admission to hospital, doctors suspected a bowel obstruction to be the cause of Mr Cuthill's pain. A CT scan confirmed an adhesional small bowel obstruction. Dr Elizabeth Canning, Consultant General Surgeon, confirmed that the treatment plan was for conservative management due to his significant co-morbidities and therefore treatment was confined to pain management and intravenous antibiotics.

[8] On 22 January 2022, Mr Cuthill was reviewed by Dr Canning. His treatment was found not to be working. He had low blood pressure, low oxygen saturation and a high temperature. His abdominal pain had worsened and was showing signs of sepsis. He was seen around 11.00am by Dr James Noyes who felt he was not fit for any further treatment and so discussed a DNACPR with Mr Cuthill. This was agreed and put in place. Doctors thought that he had developed peritonitis from a possible perforated bowel, he was not fit enough for surgery and he was dying. Care then moved to stop

treatment and remained palliative only. Mr Cuthill remained on palliative care for the rest of that afternoon and deteriorated further. His life was pronounced extinct at 16.40hrs by Dr Noyes on 22 January 2022.

[9] On 9 February 2022 a post-mortem examination was carried out by Dr Kerryanne Shearer. Cause of death was attributed to 1a) Bronchopneumonia and complications of small bowel obstruction due to abdominal adhesions, these secondary to previous abdominal surgery for bowel perforation and 2) Interstitial lung disease and multiple myeloma.

[10] Mr Cuthill was undergoing chemotherapy for cancer having been diagnosed with multiple myeloma in 2011. Mr Cuthill received various cancer treatments to manage this condition. Around the time of his death, Mr Cuthill's cancer was well managed and he was reviewed 8-weekly by the haematology department to monitor progression. In 2011 he had abdominal surgery for a bowel perforation resulting in an ileostomy which he self-managed.

[11] In 2021 Mr Cuthill was assessed by a consultant respiratory physician and diagnosed with non-specific interstitial pneumonitis. An Anticipatory Care Plan was put in place since 2015. The most recent care plan available is dated 18 September 2020 meaning that Mr Cuthill was being monitored by rehabilitation assistants and all care needs were being met by HMP Glenochil at the time.

[12] It is acknowledged within the care plan that Mr Cuthill's conditions were terminal. The anticipatory care plan was to be continually reviewed every three months.

[13] None of the parties made any criticism of the care which had been provided to the deceased within HMP Glenochil. That on 17 March 2023, a Death in Prison Learning, Audit and Review ("DIPLAR") was undertaken in relation to the deceased's death. The DIPLAR, noted that there was good working practice from all staff involved and that the partnership worked to provide the level of care and support required for Mr Cuthill. From that point I am content there was no cues or clues to indicate any signs of risk.

Conclusion

[14] It was common ground that Mr Cuthill had a number of serious health difficulties. There was no dispute about where and when he died and I am satisfied that there is a proper basis for the findings recorded at the beginning of this determination. I accept the submissions made on behalf of the Scottish Prison Service that there was nothing that could have been done to prevent Mr Cuthill's death. There is no evidence before the Inquiry that indicates a defective system of working which may have contributed to his death.

[15] I accept submissions made by Forth Valley Health Board that there is no evidence of any failing on the part of the Health Board or its employees. Indeed there has been no criticism of them.

[16] Having considered the Joint Minute of Agreement, the productions and the submissions of the parties, I consider that only formal findings in respect of section 26(2)(a) and section 26(2)(c) of the Act should be made.

[17] The parties extended their condolences to Mr Cuthill's family and I would like to join them in expressing my condolences.