SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2017] FAI 27

B2093/17

DETERMINATION

BY

SHERIFF LINDSAY WOOD

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

into the death of

GORDON LAMONT CLARK

GLASGOW, November 2017.

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

[1] Gordon Lamont Clark, born 5 August 1955 and residing latterly at Her Majesty's Prison, Barlinnie, 51 Lee Avenue, Glasgow died at 05.38 am on 25 December 2016 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 Sepsis with multiple organ failure due to

1b sigmoid stercoral perforation with faecal peritonitis requiring surgery (laparotomy and Hartmann's resection)

2 Progressive cavitating lung disease, ischaemic heart disease.

[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 Clark 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 28 December 2016.

[3] No preliminary hearing was held.

[4] The representatives of the participants were: Ms McRobert, Procurator Fiscal Depute for the Crown and Mr R 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 both 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 5th September 2013, at Edinburgh High Court, GORDON LAMONT CLARK, date of birth 5th August 1955 (hereafter referred to as "the deceased" or "Mr Clark"), was found guilty following trial of a charge of assault to injury and rape and a charge contravening Section 1 of the Sexual Offences (Scotland) Act 2009. On 26th September 2013, the deceased was sentenced to eight years imprisonment in respect of both charges.

B Following sentence, the deceased was incarcerated in terms of same and as at the date of his death on 25th December 2016, he was incarcerated in HMP Barlinnie (hereinafter referred to as "Barlinnie"). He was accordingly in legal custody as at the date of his death albeit in hospital.

C The deceased had a history of Chronic Obstructive Pulmonary Disease following his admission to Barlinnie. A scan taken in October 2015 suggested a cavitating

lesion of the lung. Sufferers of such have a tendency to cough up blood from time to time and the deceased was prescribed medication for this.

D On 12th October 2016, the deceased underwent a Bronchoscopy at Glasgow Royal Infirmary to look inside his lungs. Following the procedure, he was prescribed Itraconazole to treat cavitating lesion of the lung.

E On 19th December 2016, the deceased was examined by Dr Khoda Buksh at Barlinnie after complaining that it was difficult to pass urine. It was noted that he had no temperature and observations were normal. No temperature suggested that there was no infection however Dr Buksh recommended blood tests to exclude any hidden signs of infection. The deceased was advised to drink more fluids and the doctor requested blood tests to be carried out.

F On 20th December 2016, the deceased was seen by a nurse at which time he appeared bright and conversed well. He advised that he had been drinking more and was now passing urine. He was advised to continue to drink more fluids.

G On 21st December 2016, the deceased provided a urine sample for analysis. A dipstick test was undertaken and was negative.

H On 22nd December 2016, a blood sample was obtained from the deceased and sent for analysis.

I On the morning of 23rd December 2016, prison officers became concerned about the deceased's health. The deceased had activated his emergency light at approximately 10.45 am. When prison officers attended at his cell, he was

vomiting at the sink. Traces of blood were noted in his vomit and he was complaining of stomach pain. The deceased said he required medical assistance. He was examined by a prison doctor, Dominique Van Der Meersschaut who observed him to be pale and grey with an irregular pulse. An ambulance was requested.

J At 11.30 am that same day the ambulance attended and conveyed the deceased to Glasgow Royal Infirmary.

K At the hospital the deceased was administered intravenous fluids. A CT scan showed signs of bowel perforation and he was taken to theatre. A laparotomy was performed which revealed there was perforated colon associated with long standing constipation. There was faecal contamination throughout the abdomen. The perforated sigmoid colon was resected, washed out and Hartmanns procedure was performed.

L Following the operation, the deceased was transferred to the Intensive Care unit. He remained very unwell and deteriorated despite all supportive care. He was noted to have an infection. At 05.38 am on 25th December 2016, life was pronounced extinct.

M A post mortem examination was carried out on 29th December 2016 and the cause of death was recorded as:

1a Sepsis with multiple organ failure due to

1b Sigmoid stercoral perforation with faecal peritonitis requiring surgery (laparotomy and Hartmann's resection)

2 Progressive cavitating lung disease, ischaemic heart disease

Submissions and Conclusions

[12] The procurator fiscal depute invited the court to make a formal determination in respect of Mr Clark's death which submission was adopted by 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 Clark's death. He had died of natural causes and nothing could have been done to save his life. He had been treated appropriately throughout his time in Barlinnie and at Glasgow Royal Infirmary. There is nothing untoward whatsoever with regard to the circumstances of Mr Clark's death.

[13] I wish to commend Ms McRobert, the procurator fiscal depute and Mr Fairweather, Solicitor for the Scottish Prison Service for their helpful and professional contributions to this Inquiry.