SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2019] FAI 8

PER-B139-18

DETERMINATION

BY

SHERIFF W M WOOD

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

into the death of

THOMAS ANGUS
(born 4 February 1948)

At Perth, 25 October 2018

DETERMINATION

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

1. The deceased is Thomas Angus, born 4 February 1948. He died at 1240 hours on 11 March 2016 at the High Dependency Unit within Perth Royal Infirmary. At the time of his death, he was serving a life sentence at HM Prison Perth.
2. In terms of section 26(2)(a), the death occurred at 1240 hours on 11 March 2016 at the High Dependency Unit at Perth Royal Infirmary.
3. In terms of section 26(2)(c), the causes of death were: I(a) Decompensated Left Ventricular Systolic Dysfunction; (b) Ischaemic Heart Disease; and II Peripheral Vascular Disease.

RECOMMENDATIONS

In terms of section 26(1)(b), there are no recommendations to be made which might realistically prevent other deaths in similar circumstances regarding the matters set out in subsection (4).

NOTE

Introduction

[1] An inquiry was held into the death of Thomas Angus, born 4 February 1948, at Perth Sheriff Court on 23 October 2018. The inquiry is a mandatory inquiry under section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act"), the death having occurred in Scotland while the deceased was in legal custody. The death was reported to the Crown Office and Procurator Fiscal Service on 14 March 2016. Following advertisement of the preliminary hearing and inquiry hearings, notifications of intention to participate were received on behalf of the Scottish Prison Service and Tayside Health Board. Both were represented at the preliminary hearing on 2 August 2018.

[2] At the inquiry hearing on 23 October 2018: the Crown was represented by Mr Mohammed Sadiq, procurator fiscal depute; the Scottish Prison Service by Ms L Thornton, solicitor; and Tayside Health Board by Ms G Hogwood, solicitor. No witnesses were led and the inquiry proceeded on the basis of a Joint Minute of Agreement setting out agreed facts that should be admitted as evidence, and the available productions. I then heard submissions on behalf of the represented parties, before closing the inquiry.

The legal framework

[3] The requirements to hold an inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 are principally governed by sections 1 and 2, which are in these terms:

> "**1 Inquiries under this Act**
>
> (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—
>
> (a) investigate the circumstances of the death, and
> (b) arrange for the inquiry to be held.
>
> (2) An inquiry is to be conducted by a sheriff.
>
> (3) 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.
>
> (4) But it is not the purpose of an inquiry to establish civil or criminal liability.
>
> (5) In this Act, unless the context requires otherwise—
>
> (a) 'inquiry' means an inquiry held, or to be held, under this Act,
> (b) references to a 'sheriff' in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.
>
> **2 Mandatory inquiries**
>
> (1) An inquiry is to be held into the death of a person which—
>
> (a) occurred in Scotland, and
> (b) is within subsection (3) or (4).
>
> (2) Subsection (1) is subject to section 3.
>
> (3) The death of a person is within this subsection if the death was the result of an accident which occurred—
>
> (a) in Scotland, and

(b) while the person was acting in the course of the person's employment or occupation.

(4) The death of a person is within this subsection if, at the time of death, the person was—

(a) in legal custody, or
(b) a child required to be kept or detained in secure accommodation.

(5) For the purposes of subsection (4)(a), a person is in legal custody if the person is—

(a) required to be imprisoned or detained in a penal institution,
(b) in police custody, within the meaning of section 64 of the Criminal Justice (Scotland) Act 2016,
(c) otherwise held in custody on court premises,
(d) required to be detained in service custody premises.

(6) For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.

(7) In this section—

"penal institution" means any—

(a) prison (including a legalised police cell within the meaning of section 14(1) of the Prisons (Scotland) Act 1989), other than a naval, military or air force prison,
(b) remand centre, within the meaning of section 19(1)(a) of that Act,
(c) young offenders institution, within the meaning of section 19(1)(b) of that Act,

'secure accommodation' means accommodation provided in a residential establishment, approved in accordance with regulations made under section 78(2) of the Public Services Reform (Scotland) Act 2010, for the purpose of restricting the liberty of children,

'service custody premises' has the meaning given by section 300(7) of the Armed Forces Act 2006."

[4] The inquiry into the circumstances of the death of Thomas Angus is, therefore, a mandatory inquiry in terms of section 2(4) of the Act. In terms of section 36 of the Act the inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules").

[5] In terms of section 1(3) of the Act the purpose of the inquiry is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The specific matters to be determined by the court are set out in section 26 of the Act, which is in these terms:

> "**26 The sheriff's determination**
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
>
> (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.

(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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[6] It will be evident from the above that it is not the purpose of an inquiry to establish civil or criminal liability. The nature of the inquiry hearing is that it is part of an inquisitorial process, in which the procurator fiscal represents the public interest and other interested parties can participate to assist the court in reaching its findings.

Summary

[7] Thomas Angus was born 4 February 1948. At the time of his death, he was serving a life sentence at HM Prison, Perth. He was wheelchair-bound due to a number of health difficulties, which included: unstable angina; peripheral vascular disease; bowel cancer; and he was awaiting palliative angioplasty for triple vessel vascular disease (this is the term

given to the presence of narrowing or blockages in all three of the major coronary arteries that supply blood to the heart).

[8] On 17 February 2016, Scottish Prison Service Officers noted that the deceased was suffering from breathlessness. As a result of their concerns, they contacted Health Centre nursing staff to carry out an assessment. On 4 March 2016, health staff saw Mr Angus again, and prescribed and administered steroids and antibiotics. On 9 March 2016, Mr Angus was seen by the prison GP in his cell. It was noted that his physical condition had deteriorated significantly since being seen on 4 March 2016. The GP recommended that Mr Angus should be admitted to hospital, but Mr Angus declined to go.

[9] A plan for "enhanced care" was put in place by the primary care nursing team within the prison and "Do Not Attempt Cardiopulmonary Resuscitation" ("DNACPR") documentation was completed. It was recorded that he had told staff that he had fallen out of bed the evening before and that he had resorted to sleeping in his wheelchair to prevent further falls. He was noted to have a bruise on his forehead from falling out of bed. Around 1600 hours on 9 March 2016, it was noted by the GP that he was struggling to speak in full sentences. Later that day, he agreed to be admitted to hospital and arrangements were made for him to be taken there the following day.

[10] About 1435 hours on Thursday, 10 March 2016, Mr Angus was admitted to Ward 4 at Perth Royal Infirmary. He was assessed as being terminally ill. His son, Mr Thomas Cantwell, visited and he agreed that "Do Not Resuscitate" ("DNR") documentation was appropriate. Overnight, Mr Angus's condition deteriorated and he was transferred to the High Dependency Unit. On the morning of 11 March 2016, Mr Angus's family were contacted and invited to attend at Perth Royal Infirmary as it was clear that he was in the final stages of life. With the agreement of the family, it was decided to remove Mr Angus's ventilator in order to

allow him some dignity and he passed away about 1240 hours. Life was pronounced extinct by Dr Kristi McKeown, who granted the death certificate. The causes of death were recorded as:

"I(a) Decompensated Left Ventricular Systolic Dysfunction

(b) Ischaemic Heart Disease

II Peripheral Vascular Disease."

[11] In light of Mr Angus' extensive history and the circumstances of his passing, there was no requirement for a post-mortem examination or a toxicology investigation.

[12] At or about 0900 hours on Monday, 14 March 2016, the police were informed of Mr Angus' passing. At or about 1000 hours the same day, Detective Constables Donnan and Stewart attended at Perth Royal Infirmary and made arrangements for Mr Angus' remains to be conveyed and lodged at the police mortuary in Dundee, as well as advising the Crown Office and Procurator Fiscal Service.

[13] The medical records were made available to me. It is clear that Mr Angus was suffering, shortly before his passing, from a number of chronic health difficulties. He had a history of renal cancer and he subsequently developed radiation proctitis. Although he had a "positive" bowel screen test, follow-up investigations had not been performed due to his significant cardiac and respiratory co-morbidity. When seen on 9 March 2016, he was noted to have appeared "tired and had difficulty communicating in sentences". He had been unable to sit upright in the wheelchair independently. As far back as April 2013, in a letter from the Cardiology Department at Perth Royal Infirmary to the medical officer at the prison, Mr Angus was noted to suffer from: triple vessel coronary artery disease with left main stem involvement; impaired left ventricular systolic function; unstable angina; obesity; wheelchair-bound; peripheral vascular disease; peptic ulcer disease; rectal carcinoma; and radiation

proctitis. It was noted then that there was a "significant risk of mortality" should he have been admitted for cardiac surgery.

[14] The submissions on behalf of all participating parties were very brief. In summary, all parties were content that I should find the facts established as set out in the Joint Minute of Agreement and to find the time, place, cause and circumstances of Mr Angus' death are in accordance with the conclusions of the Joint Minute and the death certificate.

Discussion and conclusions

[15] From all the evidence that I have heard and considered, it is clear that Mr Angus had been in a state of declining health for some considerable time. The nature and number of his diagnosed conditions clearly indicate that further cardiac surgery – even three years prior to his passing – carried unacceptable risks. Although Mr Angus declined admission to hospital on 9 March 2016, it seems unlikely that his earlier admission would have resulted in a different outcome. I find that he died as a result of the natural causes identified by Dr McKeown in her death certificate.