SHERIFFDOM OF GLASGOW AND STRATHKELVIN

[2020] FAI 41

GLW-B844-20

DETERMINATION

BY

SUMMARY SHERIFF SHONA C GILROY

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

into the death of

MICHAEL LONGWELL

Glasgow 19 October 2020

DETERMINATION

The Summary Sheriff, having considered all the information presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter 'the Act') that:

A. In terms of section 26(2)(a) of the Act Michael Longwell, born 3 December 1959, then a prisoner within HMP Barlinnie, Lee Avenue, Glasgow died at about 1357 hours on 29 May 2019 within ward 65 of Glasgow Royal Infirmary.

B. In terms of section 26(2)(c) of the Act, the cause of death was (1a) complications of oesophageal rupture.

C. In terms of section 26(2)(b) of the Act no accident took place and accordingly no finding requires to be made under section 26(2)(d) of the Act.

D. In terms of section 26(2)(e) of the Act there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.

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

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

Recommendations

The Summary Sheriff having considered the information presented at the inquiry makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE

Introduction

[1] This determination is made following the fatal accident inquiry held under the Act into the circumstances of the death of Michael Longwell, who died whilst a prisoner of HMP Barlinnie, Glasgow on 29 May 2019.

Procedural history

[2] A Notice of the Inquiry was given by the Procurator Fiscal under section 15(1) of the Act on 2 July 2020. I pronounced a first order on 6 July 2020, assigning a preliminary hearing for the inquiry which was heard on 19 August 2020. Amanda Allan, procurator fiscal depute, represented the Procurator Fiscal, Ms R Wallace, solicitor, represented the Prison Officers Association, Mr Milne, solicitor, represented the Scottish Prison Service and Ms Cargill, solicitor, represented the Greater Glasgow Health Board. Mr Longwell's next of kin, Ms Angela Mills, did not participate in the inquiry itself however Ms Mills did liaise with the procurator fiscal depute throughout the inquiry process and was present at the hearings convened at court.

[3] All parties entered a joint minute agreeing the inquiry's evidence in its entirety. In addition the following productions were lodged:

a. Mr Longwell's Intimation of Death Form.
b. A Post Mortem Report prepared by Dr Julie McAdam on 11 June 2019 in respect of Mr Longwell.
c. Photographs of the cell occupied by Mr Longwell.
d. Mr Longwell's Prison Records.
e. Mr Longwell's Prison Medical Records.
f. Medical Records in relation to Mr Longwell's admission to Glasgow Royal Infirmary on 26 May 2019 and treatment between 26 and 29 May 2020.
g. 'Talk to Me' paperwork in respect of Mr Longwell.
h. DIPLAR (Death in Prison Learning, Audit and Review).

[4] In light of the joint minute of agreement and the productions lodged, which I reviewed, I agreed with parties that the inquiry could proceed without the requirement for witnesses to attend.

[5] The inquiry took place on 18 September 2020 within Glasgow Sheriff Court. The joint minute of agreement was read to the court by the procurator fiscal depute, Ms Allan. Written submissions were provided to the court in advance of the inquiry by all parties. I was asked by all parties to make formal findings only.

The legal framework

[6] The inquiry was held under section 1 of the Act and the procedure was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The inquiry was a mandatory inquiry. It was held in accordance with section 2(4)(a) of the Act because although Mr Longwell died whilst in hospital, he remained a prisoner of HMP Barlinnie throughout that time meaning that at the time of his death he was in legal custody.

[7] Section 1(3) of the Act sets out that the purpose of a fatal accident inquiry is to establish the circumstances of the death and consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The inquiry itself is an inquisitorial process. It is not the purpose of an inquiry to establish civil or criminal liability. The matters which should be considered in a determination are contained within section 26 of the Act and have been set out above. Section 1 also sets out the requirement that the procurator fiscal, who represents the public interest in a fatal accident inquiry, must investigate the circumstances of death and arrange for the inquiry to be held.

Summary

Circumstances of the deceased

[8] Mr Longwell was born on 3 December 1959. He was 59 years old at the date of his death. The deceased had previously spent periods in prison with his most recent admission being at HMP Barlinnie between 20 February 2019 and 25 March 2019. On 25 April he appeared at Glasgow Sheriff Court in relation to a contravention of section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010 with a statutory domestic aggravation. He pled not guilty and was refused bail. He was remanded in custody pending trial, which was assigned for 29 May 2019. The deceased was placed on remand in HMP Barlinnie, Lee Avenue, Glasgow.

[9] At the date of his death on 29 May 2019 Mr Longwell remained a prisoner of HMP Barlinnie and therefore died whilst in legal custody.

Medical history and treatment of the deceased

[10] On his arrival at HMP Barlinnie on 25 April 2019 the deceased was subject to an assessment as part of the prison admission process. During this assessment the deceased was noted by staff to be dependent on a wheelchair, and to have hip pain and poor mobility. He was also recorded as having been previously diagnosed with paranoid schizophrenia and to be receiving assistance for this in the community. As a result a referral was made to the prison's mental health team for the deceased to be further assessed. The deceased was also subject to a Talk To Me risk assessment as part

of the Scottish Prison Service's suicide prevention strategy - he was recorded as having no thoughts of deliberate self-harm and to be of no apparent risk of suicide, although it was noted that the deceased had attempted suicide by overdose approximately 4 years earlier. The deceased's prescribed medication was confirmed with the deceased's own General Practitioner and he was allocated to a single-occupation disabled cell on the ground floor within the prison's B Hall.

[11] On 26 April 2019 the deceased was seen by one of the prison's General Practitioners for a routine physical examination and medical assessment. At this time the deceased stated that he had previously been dependent on alcohol, he had ongoing mental health problems, and that he required use of a wheelchair due to hip pain and poor mobility. The deceased requested to be moved to D Hall which was known to be used as a high dependency unit and was a generally smaller and quieter section of the prison.

[12] The deceased was assessed by the prison's mental health team on 29 April 2019. This assessment was carried out in the deceased's own cell due to his mobility issues. Following this assessment it was recorded that the deceased had a historical diagnosis of schizophrenia, but was not currently receiving any medication for this and was last seen by the Community Mental Health Team (CMHT) in 2018. The deceased was recorded as showing no evidence of mental illness at that time. It was noted that a referral had been made for the deceased to be moved to the high dependency unit (HDU) and a further referral had been made for the deceased to receive care assistance from Ailsa Care Services as a result of his physical difficulties.

[13] On 5 May 2019 the deceased was seen in his cell by a prison nurse for a consultation. During this consultation the deceased was recorded to be a falls risk as he was struggling to mobilise independently and was unable to get up out of his chair unaided. It was noted that Ailsa Care Services were attending at the deceased's cell twice daily to assist him with self-care. A Care Plan was created for the deceased and the deceased was prescribed with incontinence pants as a result of him being incontinent of both urine and faeces. It was also noted that the deceased's bed was too high and that he would benefit from a larger disabled cell with a lower bed, however no larger cells were available at that time and so the nurse arranged for a new, lower bed to be installed with the First Line Manager within the prison.

[14] The deceased was subject to a review by a Consultant Forensic Psychiatrist on 21 May 2019. During this review it was recorded that the deceased had difficulties mobilising, was reliant on a wheelchair since being remanded in custody due to longstanding pain in his leg, and that he was incontinent of both urine and faeces. The deceased was described as appearing thin, extremely dishevelled and unkempt, but with no apparent deterioration in his mental state. It was noted that there was no obvious psychiatric reason for his incontinence and poor mobility and it was recommended that a medical opinion be sought to exclude physical causes for the deceased's difficulties.

Events of 26 May 2019

[15] In the early hours of 26 May 2019, at approximately 0220 hours, the deceased activated his 'call bell' within his cell. Prison Officer, witness Francis Hunston, initially spoke to the deceased via the call bell and then attended at the deceased's cell and spoke to him through the cell door viewing panel. At this time the deceased was sitting up on his bed. The deceased complained of pain in his back and Prison Officer Hunston could see the deceased pointing to his back. The deceased asked for a nurse to attend. Prison Officer Hunston returned to the main desk area within B Hall and contacted the nurse's station by telephone. The nurse on duty, witness Lauren McCloskey, confirmed that she would attend at the deceased's cell. Prison Officer Hunston then contacted witness Paul McTaggart, the First Line Manager on duty that evening, to advise him of the foregoing and then returned to the deceased's cell to await the arrival of witnesses McTaggart and McCloskey.

[16] At approximately 0235 hours, nurse witness McCloskey arrived at the deceased's cell, escorted by witness McTaggart, and permission given for the cell door to be opened. At this time the deceased was still sitting up on his bed and communicating, but was seen to be sweating heavily. Witness McCloskey entered the deceased's cell and noted there to be 'coffee ground vomit' throughout the cell, including on the deceased's clothing, his bed, and the area around him. The nurse noted that the deceased appeared to be distressed and in a lot of pain; he was leaning forward with his chest towards his knees and his arms wrapped around his abdomen area, and was breathing quickly. Witness McCloskey obtained some clinical observations and asked the deceased for

some medical history and details of his current medication. She also asked whether the deceased had suffered a recent fall or injury, or if he had taken anything other than his prescribed medication. The deceased denied suffering from a fall or injury and also denied taking any other medication or illicit drugs.

[17] Witness McCloskey noted that the deceased's oxygen levels were low and so began administering oxygen to the deceased at 15 litres per minute, the highest flow rate available from the portable canister. Throughout this time the deceased was verbally aggressive and abusive towards the prison staff and was becoming increasingly agitated. He was also non-compliant with the medical treatment being provided, persistently removing both the oxygen probe from his finger and the oxygen mask from his face which made it difficult to monitor any improvement or deterioration in his condition. Witness McCloskey requested an ambulance to attend which was immediately arranged. Due to the deceased's continued hostility towards staff witness McCloskey exited the deceased's cell but continued to monitor his condition from the cell door, intermittently returning to the deceased to check on his welfare and oxygen levels.

[18] Witness McCloskey initially requested that the ambulance service was re-contacted to advise that the situation was not improving and that there were concerns that the deceased's condition would deteriorate further. However, there was subsequently an improvement in the deceased's presentation and he was successfully weaned from the oxygen and appeared more stable and comfortable prior to the attendance of paramedics. The ambulance service arrived at the prison at approximately

0416 hours and conveyed the deceased to Glasgow Royal Infirmary, arriving at approximately 0506 hours accompanied by staff.

Admission to Glasgow Royal Infirmary

[19] The deceased continued to be agitated, aggressive towards staff, and generally uncooperative and non-compliant following his admission to Glasgow Royal Infirmary. He was initially noted to be suffering from chest pain and shortness of breath and the deceased stated to staff that he had fallen out of bed the previous day. Due to his non-compliance the deceased was required to be sedated in order for further medical assessments to be carried out. A drain was inserted into the deceased's chest to help inflate his left lung and a CT scan was carried out which showed he had fluid within the chest cavity. Further tests established that the deceased was suffering from a ruptured oesophagus and that this would require surgical intervention to repair. However following consultation with surgical staff and staff within the Intensive Care Unit (ICU) within Glasgow Royal Infirmary the decision was taken that the deceased was unlikely to survive the surgery, which was known to be a high risk procedure.

[20] The deceased had initially been treated conservatively, with intravenous antibiotics and fluids, however due to the significant deterioration in his condition since his admission to hospital the decision was taken on the evening of 26 May 2019 that active management should cease and that staff should move to palliative care. As a result the deceased was moved to Ward 65 within Glasgow Royal Infirmary on the

evening of 26 May 2019 and a 'do not attempt cardiopulmonary resuscitation' (DNACPR) was put in place.

[21] The deceased's condition continued to deteriorate over the following days and he appeared confused and agitated. At approximately 1248 hours on 29 May 2019 the prisoner custody officers on duty within the deceased's room noticed that the deceased's breathing had changed and alerted nursing staff. A nurse attended at the room and thereafter requested attendance of a Doctor. The deceased was pronounced life extinct at 1357 hours on 29 May 2019.

Post Mortem

[22] A post mortem examination was conducted on 11 June 2019 at the Queen Elizabeth University Hospital, Glasgow, by Consultant Forensic Pathologist, Dr Julie McAdam and the cause of death was recorded as:

1a. Complications of oesophageal rupture.

[23] The conclusions section of the Post Mortem Report describes oesophageal rupture as "a condition with a high mortality rate and which would account for this man's symptoms and subsequent death" and states as follows:

> "Oesophageal rupture is unusual, but common causes would include chronic inflammation (oesophagitis) and malignancy. Oesophageal rupture due to trauma would be extremely unusual and any traumatic cause would almost certainly involve more significant trauma than that sustained as a result of a simple fall from bed. Of note, no significant injury to the body was identified at post mortem".

Submissions

[24] Written submissions were lodged on behalf of all parties. All parties agreed that only formal findings should be made in this inquiry.

Discussion and conclusions

[25] In light of the evidence before the inquiry and the submissions made I am satisfied that the medical care provided to Mr Longwell within both hospital and prison as is relevant to the remit of this inquiry was appropriate. There was no evidence to suggest that any alternative form of medical treatment, supervision or intervention would have prevented his illness or changed the outcome of it. I agree therefore with the submissions made by all the participants that only formal findings should be made.

[26] I am grateful to parties for their preparation for this inquiry, as a result of which all evidence was agreed and no witnesses were required to attend.

[27] I wish to conclude this determination by expressing my sympathies to Mr Longwell's next of kin.