SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2021] FAI 37

HAM-B490-20

DETERMINATION

BY

SHERIFF LINDA MARGARET NICOLSON

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

into the death of

DAVID WHITELAW

Hamilton, 4 June 2021

DETERMINATION

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

a) David Whitelaw (the deceased), born 18 April 1961, died at approximately 1100 hours on 31 December 2019 at University Hospital, Wishaw, North Lanarkshire. At the time of his death the deceased was in legal custody.

b) No accident occurred which resulted in the death.

c) The cause of death was 1a) myocardial infarction, 1b) ischaemic heart disease, 1c) severe left ventricular systolic dysfunstion, 1d) type II diabetes mellitus.

d) There were no cause or causes of any accident resulting in the death, there being no accident that occurred which resulted in the death.

e) No precautions could reasonably have been taken which might realistically have resulted in the death being avoided.

f) There were no defects in any system of working which contributed to the death.

g) There are no other facts relevant to the circumstances of the death.

RECOMMENDATIONS

No recommendations are made under section 26(4) of the Act.

FINDINGS IN FACT

I found the following facts proved, by way of admission in the joint minute of agreement between the parties who participated in the inquiry, namely the Crown, the Scottish Prison Service and NHS Lanarkshire.

1. At the time of his death the deceased was a prisoner in HM Prison, Shotts following conviction on 25 April 2007.
2. Following his conviction in April 2007 the deceased was recorded as requiring a "high" level of supervision under the Prisoner Supervision System. After a review this was changed to "low" and then raised to "medium" in May 2013 following an assault by the deceased on a member of Prison staff to their injury. Following further review on 19 June 2015 the deceased's level of supervision was again reduced to "low".
3. Throughout his time in HMP, Shotts the deceased was subject to Integrated Case Management Assessments on a regular basis; the deceased was described as

having a "challenging" and "anti-authoritarian" attitude towards staff members within the Prison.

4. On 1 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. Since 1 November 2011 the SPS has been responsible for the provision of personal and social care for prisoners in Scottish prisons.

5. The deceased was known to suffer from multiple long-term medical conditions including Type 2 diabetes, asthma, ischaemic heart disease, and angina. The deceased also had a history of acute kidney injury, severe left ventricular systolic dysfunction, and had suffered from previous myocardial infarction. In addition, the deceased was obese and was registered blind in 2014. The deceased was regularly reviewed by the Diabetic Retinopathy Screening Department and wore special glasses and had magnifying aids. The deceased also suffered from a diabetic ulcer on his left greater toe, which was dressed as required, but twice weekly as a minimum, and he was seen monthly by the visiting podiatrist. This ulcer was a result of the deceased's diagnosis of diabetic neuropathy which were further complications of his poorly controlled diabetes. The deceased also required the use of a zimmer frame when walking.

6. The deceased attended the Department of Diabetes at University Hospital, Wishaw annually. In addition, the Department of Diabetes at University Hospital, Wishaw was accessed by telephone by Lanarkshire Healthcare nursing staff on 24 December 2019, 18 September 2018 and 31 May 2018 regarding the deceased's insulin prescription and blood sugar (BM) recording. All the rest of the deceased's healthcare management was managed jointly between the General Practitioner (GP) and Practitioner Nursing Team within HMP Shotts. A care plan was in place and the deceased was attended to twice daily within his cell by Ailsa Care services, who delivered personal care and hygiene requirements, and was also seen weekly by a GP and daily by a registered nurse.
7. The deceased's medication was issued to him weekly by nursing staff and his insulin was administered daily within his cell. Based on his BM recordings, the nursing staff would alter his prescription accordingly. As the deceased's BM was unstable, his prescription was also reviewed weekly by a GP and amendments made accordingly. This was largely due to the deceased's diabetes being poorly controlled as a result of his poor dietary control and historical non-concordance with his oral hypoglycaemic medication. The deceased was known to eat foods and fluids from the canteen which were not recommended for a patient with Type 2 diabetes.
8. The deceased's compliance with his prescribed medication improved following the use by healthcare staff of a dosette box to administer his medication, however throughout his time in Prison the deceased was regularly recorded as being non-

compliant with some elements of his medical care and treatment. Lloyds Pharmacy dispensing records detail that this dosette box was in place in November 2017.

9. The deceased also had a long history of mental health problems requiring inpatient care both before, and following, his conviction. The deceased is recorded as having been placed on "Act to Care" due to incidences of self-harm within the prison environment which included refusal of medication, food, and fluids.

10. Following a referral received from the SPS Psychology Department regarding concerns about the deceased's possible cognitive impairment, Dr Carlin undertook an ACE assessment on 27 June 2018. Dr Carlin's impression was it was likely vascular cognitive impairment. The deceased was referred to Dr Morris, Consultant Psychiatrist, who assessed the deceased on 12 July 2019 for low mood. The deceased was prescribed anti-depressant therapy and was to be reviewed after two months. The deceased was reviewed on 13 September 2019 by Dr Morris when he described himself as largely unchanged in his mood and that the anti-depressant therapy had not made any difference. Dr Morris' impression was of ongoing depressive type presentation in the context of multiple physical health problems and pre-morbid mixed personality disorder. The plan was to increase his anti-depressant therapy and review again in 3 to 4 months' time. This review was not undertaken as the deceased died on

31 December 2019. Staff did not find evidence that the deceased's mental health caused lack of capacity that would have influenced non-compliance.

11. There was a significant deterioration in the deceased's health throughout 2019, leading to acute hospital admissions on several occasions between May and December that year. The deceased was admitted to hospital on 17 May 2019 having been reviewed by Prison healthcare staff and found to be suffering from a swollen foot and calf. He was returned to HMP Shotts on 20 May 2019 and at that time his medication was adjusted by the Prison GP on the recommendation of the hospital clinician. The deceased was re-admitted on 15 June 2019 as a result of feeling generally unwell and having discolouration of his feet. He was returned to the Prison the following day, again with advice to change to his medication which was actioned by the Prison GP. On 12 December 2019 the deceased was seen by the Prison GP with increased pain in his foot and malodour, which had failed to improve with antibiotics. He was admitted to University Hospital, Wishaw where he was treated for cellulitis and acute kidney injury, prior to being returned to the Prison on 17 December 2019 with further adjustments made to his prescribed medication. During this admission a "do not attempt cardiopulmonary resuscitation" (DNACPR) was put in place by hospital staff following a discussion with the deceased, and this was returned with him to Prison. A discharge summary from the hospital to the Prison was dictated on 19 December 2019. It stated that Dr Reilly had a discussion with the deceased regarding his functional baseline, given his co-morbidities. However, it is

recorded by Prison healthcare staff that the deceased was unhappy with this decision following his return to Prison from Ward 5 on 18 December 2019 and stated to nursing staff that he wished to be resuscitated. Nursing staff then discussed this with the visiting GP, Dr Conroy, who advised the deceased could revoke his DNACPR status. On 18 December 2019, the deceased signed a medical disclaimer and an appointment to discuss this with the GP was arranged for 22 January 2020. The practice would be that on 26 December 2019, when the deceased was being returned to the hospital, the nursing staff would inform the ambulance crew of the deceased's DNACPR status and follow this with a telephone call to the receiving hospital advising of any change to DNACPR status.

12. On 26 December 2019 the Prison healthcare staff were alerted by the deceased's carers and found the deceased to be suffering from an infected toe and rectal bleeding. Following a full set of clinical observations being recorded, it was agreed that, due to the deceased's symptoms and presentation, the deceased required urgent admission to hospital. An urgent ambulance was requested and the deceased arrived at University Hospital, Wishaw around 50 minutes later.

13. On his arrival at University Hospital, Wishaw the deceased was examined by witness Doctor Hessell. The deceased was under the care of Dr Smith, Consultant Physician. All clinical observations were found to be within normal parameters, and he appeared relatively well, but the deceased's toe was swollen, hot, and producing significant exudate. The deceased's foot was x-rayed and he

was admitted to hospital for treatment, including intravenous antibiotics and anti-emetics (anti-sickness drugs). The deceased initially appeared settled following his admission, although his appetite was poor. On 28 December 2019 the deceased was admitted to Ward 6 under the care of Dr Anderson who was the supervising Consultant for the remainder of the deceased's care. During the deceased's admission on Ward 6 he was also seen by Dr D Hill, Consultant, and Dr Tomala, locum Cardiology Consultant. On the evening of 28 December the deceased experienced a rapid decline in blood pressure and developed a severe acute kidney injury. Tests carried out indicated acute myocardial infarction. The deceased's condition continued to deteriorate over the course of the next two days, with worsening hypotension and renal function. Due to the deceased's co-morbidities and severe systolic dysfunction, hospital staff concluded that there were no further acute medical interventions that could be undertaken and, on 30 December 2019 following discussion with clinicians and the deceased's family members, including his sister, it was decided that active management and treatment should cease and the deceased's family confirmed he did not want any interventional treatment. It is recorded in the notes that a DNACPR and a Hospital Anticipatory Care Plan (HACP) were in place on that date. The deceased was moved to palliative care and was made comfortable.

14. At approximately 1030 hours on 31 December 2019, Prisoner Custody Officers present with the deceased noted that he appeared to have stopped breathing. They requested the attendance of medical staff who reviewed the deceased. The

deceased was pronounced life extinct at 1100 hours on 31 December 2019. The persons present at the time of death is not recorded in the medical records.

15. Throughout this final admission to University Hospital, Wishaw the deceased was constantly escorted by Prisoner Custody Officers, who remained within or outside his room at all times. The deceased was never handcuffed whilst in hospital due to his compliance with staff and general good demeanour. The deceased's family were also present with him during his time in hospital and were consulted in relation to the deceased's medical treatment and move to palliative care.

16. A Post Mortem examination was not carried out on the deceased and the cause of death was recorded and registered as:-

    1a) Myocardial infarction

    1b) Ischaemic heart disease

    1c) Severe left ventricular systolic dysfunction

    1d) Type II diabetes mellitus

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

    "Mr Whitelaw was attended twice daily by Ailsa Care services who delivered personal care including hygiene requirements which was arranged by SPS. Although Mr Whitelaw was non-compliant with medication he was supported weekly by a General Practitioner and was seen daily by a registered nurse. All systems and resources were in place to deal with his level of disability"

18. A Briefing Note was also prepared by the Prison healthcare staff the purpose of which was to inform a potential Significant Adverse Event Review. At the Recommendations section of the Briefing Note it is stated:-

> "There is evidence within the records and by talking to nursing staff that Mr Whitelaw received a good level of care and treatment from the healthcare team within HMP Shotts. Emergency care was delivered timely. There were good levels of communication between the carers and nursing staff. There was good evidence of multidisciplinary care planning and delivery. Staff should receive positive feedback regarding this…
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> "An OT assessment could have been undertaken to ensure that Mr Whitelaw had everything that could have helped with his activities of daily living. There is no OT availability. The process for referrals should be reviewed to ensure it is robust and all staff are aware of the process…
>
> "Healthcare records should be updated each time there is an episode of care and treatment in line with NMC and NHSL standards of record keeping. All staff should complete NHSL record keeping learnpro module. Healthcare records should be regularly audited by Clinical Manager to ensure compliance with NMC and NHSL record keeping standards…
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> "A falls risk assessment should have been undertaken as Mr Whitelaw had fallen on a few occasions and his eye sight and mobility was poor".

NOTE

Representation at this inquiry was as follows:

The Crown: Ms Allan, Procurator Fiscal Depute;

Scottish Prison Service: Mr McIntosh, solicitor; and

NHS Lanarkshire: Ms Shippin, solicitor.

[1] The court is grateful to those solicitors for their meticulous preparation of the joint minute. That made the task of the court easier. More importantly, it sets out in

some detail information, repeated in the above findings in fact, which the family of Mr Whitelaw is entitled to know.

[2] The evidence reveals that Mr Whitelaw was in poor health over a number of years. Mr Whitelaw was provided with appropriate medical attention and care at the prison and then at the hospital. When, on 30 December 2019, his condition deteriorated to the point that clinicians concluded that no further acute medical intervention could be undertaken, discussion took place with Mr Whitelaw's family who confirmed he did not wish interventional treatment. It was decided that active management and treatment should cease and Mr Whitelaw was made comfortable with palliative care until, sadly, he passed away on 31 December 2019.

[3] On the basis of the evidence, reflected in the findings in fact, there was no ground for the court to identify any precautions which could reasonably have been taken which might realistically have resulted in the death being avoided. Neither was there any evidence of any defect in any system of working which contributed to the death.

[4] There were no other facts relevant to the circumstances of the death requiring notice and there was no need to make any recommendations.

[5] I, along with the solicitors for the parties represented, extend our condolences to the family of Mr Whitelaw.