SHERIFFDOM OF SOUTH STRATHCLYDE, DUMRIES & GALLOWAY AT AYR

[2022] FAI 11

AYR-B231-21

DETERMINATION

BY

SUMMARY SHERIFF SIOBHAN CONNELLY

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

into the death of

DAVID LINDSAY NEILL

Ayr 20 January 2022

The Sheriff, following the hearing of unchallenged evidence, having resumed consideration of the cause, determines that in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"):

1) **In terms of Section 26(2)(a) of the Act (when and where the death occurred)**:

David Lindsay Neill, date of birth 21 May 1944, died on 7 December 2020 at the Ayrshire Hospice, 35-37 Racecourse Road, Ayr.

2) **In terms of Section 26(2)(b) of the Act (when and where any accident resulting in death occurred):**

The death did not result from an accident.

3) **In terms of Section 26(2)(c) of the Act (the cause or causes of death):**

Mr Neill's death was caused by:-

1a) Hepatocellular Carcinoma with Lung Metastases

4) **In terms of Section 26(2)(d) of the Act (the cause or causes of any accident resulting in death):**

No finding is made as the death did not result from an accident.

5) **In terms of Section 26(2)(e) of the Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death or any accident resulting in death, being avoided):**

No such precaution has been identified.

6) **In terms of Section 26(2)(f) of the Act (any defects in any system of working which contributed to the death or the accident resulting in death):**

No such defect has been identified.

6) **In terms of Section 26(2)(g) of the Act (any other facts which are relevant to the circumstances of the death):**

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

NOTE

Introduction

[1] This inquiry was held into the death of David Lindsay Neill under Section 1 of the Act. It was a mandatory inquiry in terms of Section 2(4) of the Act as at the time of death Mr Neill was a serving prisoner at Her Majesty's Prison Barlinnie ("the Prison") . The death was reported to the Procurator Fiscal on 9 December 2020 and a preliminary

hearing was held by webex video conference on 25 November 2021. The inquiry took place on 20 January 2022 by webex video conference.

[2] Ms Brown, Procurator Fiscal Depute, appeared for the Crown. Mr Devlin, solicitor, appeared for the Scottish Prison Service and Mr Henderson, solicitor, appeared for Greater Glasgow Health Board. There was no other appearance. I was told that Mr Neill's next of kin had been informed of the hearing but did not participate in the proceedings.

[3] No parole evidence was led at the inquiry. A Joint Minute was entered into by parties and at their invitation, I interponed authority thereto.

[4] A number of productions were before the inquiry and agreed in the Joint Minute, namely:-

1. Intimation of Death form.
2. Prison records relating to Mr Neill.
3. Death in Prison Learning Audit and Review (DIPLAR) report dated 26 February 2021.
4. Prison medical records relating to Mr Neill.
5. Copy of NHS discharge letter advising on discharge from Glasgow Royal Infirmary to Ayrshire Hospice.
6. Ayrshire Hospice medical report relating to Mr Neill.
7. Multi-disciplinary team letter to Dr ZS in relation to Mr Neill.
8. Scottish Ambulance Service record in relation to Mr Neill.
9. Glasgow Royal Infirmary medical records relating to Mr Neill.

Parties agreed the statement of CB prison nurse, the precognition of Doctor ZS prison GP and precognition of CH, prison nurse.

Legal framework

[5] This inquiry was held under Section 1 of the Act. The inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules"). The inquiry is an inquisitorial process. The Crown represented the public interest. The purpose of an inquiry is not to establish civil or criminal liability. The purpose of the inquiry under Section 1(3) of the Act was to establish the circumstances of the death of Mr Neill and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. Section 26 of the Act prescribes what must be determined by the inquiry and is in the following terms:

> "**Section 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."

Summary

AGREED FACTS – Parties entered into a Joint Minute of Agreement which I interponed authority to and accordingly I found the following facts to be established:-

1. On 3 February 2020 DAVID LINDSAY NEILL, date of birth 21 May 1944 appeared at the High Court of Justiciary, at Glasgow and was convicted, after trial on four charges of indecent assault. Mr Neill was made subject to registration under the notification requirements under Part 2 of the Sexual Offences Act 2003, which were to continue to apply indefinitely. Mr Neill was remanded in custody to Her Majesty's Prison Barlinnie until 28 February 2020 for the purposes of obtaining a Criminal Justice Social Work Report. On 28 February 2020 Mr Neill was sentenced to a period of 7 years imprisonment, backdated to 3 February 2020. The expiry date of Mr Neill's sentence was calculated as 2 February 2027, with a parole qualifying date of 4 August 2023.

2. Following sentence being imposed Mr Neill was returned to the Prison. On 18 August 2020 the Court of Appeal at Edinburgh refused an appeal against Conviction and Sentence made on behalf of Mr Neill. At the date of his death on 7 December 2020 Mr Neill was a prisoner of the Prison. He was accordingly in legal custody at the time of his death.

Transfer request

3. On 27 August 2020 Mr Neill made a cross border transfer application to be transferred to HM Prison Ashfield near Bristol. In support of this application Mr Neill submitted emails from LT, Mr Neill's sister-in-law and JG a friend of Mr Neill. An email was received from MI, Echo Hall residential Front Line Manager, confirming Mr Neill was an ideal candidate for any establishment and had given the staff no concerns whilst a prisoner. In order to assist the application a medical report was completed on 7 September 2020.

Provision of Healthcare in Scottish Prisons

4. On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the Scottish Prison Service to the NHS. Since then the 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.

Health Issue

5. On 11 May 2020 Mr Neill had a consultation in nurse triage during which he advised that a few weeks prior he had blood in his urine, which seemed to have settled by the time of the consultation. This issue was raised again by Mr Neill when he made a Nurse referral on 19 May 2020 regarding blood in his

urine. A letter, dated 15 May 2020, was received from Mr Neill's brother -in-law, NT the purpose of which was to alert the medical staff at the Prison to the issue of Mr Neill having blood in his urine.

6. Samples of Mr Neill's urine were taken and on receiving the results an appointment was made with Dr ZS. On examination of Mr Neill Dr ZS made an urgent referral to Glasgow Royal Infirmary, Urology Department, dated 29 May 2020, for further investigation. Mr Neill received appointments to attend Stobhill Hospital – Imaging Ultrasound (Kidney) on 4 June 2020 and Glasgow Royal Infirmary on 12 June 2020 at the Urology Department for a Flexible Cystoscopy. The results of the kidney scan revealed a 1.2 centimetre cyst in relation to the left kidney, otherwise there was no evidence of any other issue regarding Mr Neill's kidneys.

7. After consulting with Mr Neill at Glasgow Royal Infirmary, Consultant Urologist Mr RV, wrote to Dr ZS and advised Mr Neill had an ultrasound of his upper tract which was normal. The Flexible Cystoscopy showed significant regrowth of his prostrate that was quite vascular. This was bulging into the previous cavity and further into the bladder. Dr ZS was asked to give Mr Neill Finasteride 5mg once daily to reduce the bleeding.

8. Mr Neill received a follow-up telephone appointment for 21 September 2020. It would appear Mr RV did not hold a telephone contact number for Mr Neill and he therefore wrote to Dr ZS at the Prison, Health Centre for an update on Mr Neill's condition.

9. On 23 July 2020 Mr Neill again complained of blood in his urine.

Circumstances of death

10. On 30 October 2020, at approximately 0830 hours, Nurse CB attended Mr Neill's cell, having been made aware that Mr Neill was feeling unwell. On attendance, Mr Neill told Nurse CB that he had been feeling unwell since the previous day but had not sought medical advice. He complained of feeling dizzy and stated he was not able to get up from his bed. Mr Neill complained of having pain at his left side and upper abdomen. He said he had only taken sips of water and had no food since the previous lunchtime. He told Nurse CB that he had been sweating overnight. On examination Nurse CB noted Mr Neill's blood pressure to be low and his heart rate was slightly raised, all other observations were fine. Nurse CB triaged Mr Neill as requiring to be seen by a doctor and left him in his cell in the care of prison officers.

11. At 0951 hours Dr ZS attended at Mr Neill's cell. On examination Dr ZS noted there was tenderness in the upper left part of Mr Neill's abdomen. Dr ZS held the opinion that Mr Neill required to be assessed at hospital at consultant level and contacted the on-call medical receiving doctor at Glasgow Royal Infirmary to discuss matters. It was agreed that Mr Neill should be transferred to hospital and Dr ZS wrote a referral letter with his findings to go with Mr Neill in the ambulance. On writing the letter Dr ZS contacted the clinical manager to order an ambulance.

12. Dr ZS thought he had asked the clinical manager to request an ambulance within the hour but according to the Scottish Ambulance Service ("SAS") Record, the ambulance was ordered at 1018 hours and allocated at 1325 hours. This would seem to indicate that the SAS allocated a routine, non-emergency ambulance. The ambulance arrived at the Prison at 1331 hours and left the prison at 1425 with Mr Neill accompanied by prison officers, arriving at Glasgow Royal Infirmary at 1434 hours.

13. Nurse CH advised that a one or four-hour ambulance would be requested in a non- emergency, but it is the responsibility of SAS to triage matters and to appropriately allocate an ambulance. When requesting an ambulance from the Prison various information would be passed over, including the patient's clinical presentation, observations, and medical history which SAS would use to determine the level of urgency. SAS then give the person making the phone call a reference number. The record of the nurse handover notes "D Neil 46823 E1/20 – unwell, abdo pain, seen by GP non-emergency ambulance ref 6916890". Had there been deterioration in Mr Neill's condition a call would have been made to SAS to escalate matters.

14. Mr Neill was registered at Glasgow Royal Infirmary Accident and Emergency Department ("A&E") at 1444 hours on 30 October 2020. A thorax/abdomen/pelvis CT scan was carried out whilst Mr Neill was within A&E. The scan revealed a large heterogeneous mass lesion of the liver with capsular disruption involving most of segment 2, 3, 4, 7 and 8. This measured

over 20 cm in maximal dimension. Multiple bilateral presumed lung metastases were shown predominately on both lower lobes.

15. Mr Neill was admitted to Ward 65 of Glasgow Royal Infirmary at 1800 hours. Mr Neill's case was discussed at the Multidisciplinary Team at the Glasgow Royal Infirmary with the Team agreeing that Mr Neill was not a candidate for anti-cancer treatment due to the severity of his disease. A referral was made to Palliative Care Team on 3 November 2020 and a review was made by them on 4 November 2020. A further CT scan was carried out on 7 November in order to contrast with the scan obtained on the 30 October 2020. The liver scan noted "new shallow right pleural effusion, lung metastases noted in both bases, confirms presence of a large lesion including most of the left lobe of the liver extending to the right lobe. A large lesion lobe which involves more than 50% of the liver meets diagnostic criteria for HCC" (hepatocellular carcinoma). Mr Neill was to be transferred to Ayrshire Hospice on a bed becoming available. A referral letter was sent to Ayrshire Hospice, dated 6 November 2020 by the Palliative Care Consultant.

16. Mr Neill was transferred, still under guard, to the Ayrshire Hospice on 13 November 2020 for end of life care. Throughout his admission Mr Neill was frail and unable to mobilise out of bed. His main symptoms were breathlessness and at times pain. His symptoms were managed with a combination of morphine and midazolam in a syringe pump and also regular use of oxygen. Mr Neill's deterioration over time was entirely expected and was a gradual

sustained decline, in keeping with someone who had an advanced malignancy, alongside having had an acute bleed as part of his presentation. Around 2000 hours on 7 December 2020 Mr Neill's breathing was noted to be laboured. He was given medication to alleviate breathlessness and distress. Mr Neill's condition deteriorated quickly and he died at 2020 hours. A letter sent from Ayrshire Hospice to Glasgow Royal Infirmary noted the date of death as 7 December 2020 with the cause of death being Hepatocellular carcinoma with lung metastases.

Death in Prison Learning, Audit and Review (DIPLAR)

17. The DIPLAR noted a request for compassionate release was made on 13 November 2020. This was considered by the Parole Board on the 23 November 2020 and a decision was deferred pending receipt of further information requested by the Parole Board. The case was further considered by the Parole Board on 2 December 2020 when a decision was again deferred.

18. The DIPLAR identified good practice in a quick response to requests for assistance from family members when required; the appropriate compassionate request processes were initiated timeously when it was clear that Mr Neill's condition was terminal and an appropriate view was taken of Mr Neill's management in the circumstances of his deteriorating physical condition e.g. access to facilities to maintain contact with his family.

Submissions

All parties were in agreement that the only extant issues were for the court to determine when and where the death occurred in terms of Section 26(2)(a) of the Act and to determine the cause or causes of death in terms of Section 26(2)(c). As the death did not result from an accident there was no requirement to make a finding in terms of Sections 26(2)(b) or (d). All parties submitted that there were no precautions which could have been taken in terms of Section 26(2)(e), defects in a system of working in terms of Section 26(2)(f) or additional facts which were relevant to the circumstances of the death in terms of Section 26(2)(g).

Discussion and conclusions

In terms of Section 26(2)(a) of the Act (when and where death occurred):

There was no dispute about when and where Mr Neill died. Mr Neill died at 2020 hours on 7 December 2020 at the Ayrshire Hospice, 35-37 Racecourse Road, Ayr.

In terms of Section 26(2)(b) of the Act (when and where any accident resulting in death occurred):

Mr Neill's death did not result from an accident and therefore no finding is required in terms of Section 26(2)(b).

In terms of Section 26(2)(c) of the Act (the cause or causes of death):

There was no dispute about the cause of death. Mr Neill's death was natural and was certified as caused by 1(a) Hepatocellular Carcinoma with Lung Metastases. I determined that the cause of death was as documented in the medical certification of death.

In terms of Section 26(2)(d) of the Act (the cause or causes of any accident resulting in death):

Mr Neill's death did not result from an accident and therefore no finding is required in terms of Section 26(2)(d).

In terms of Section 26(2)(e) of the Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in death or any accident resulting in death, being avoided):

Parties were agreed that there were no such precautions identified and on the basis of the information before the inquiry I did not consider that there were any such precautions which could reasonably have resulted in death being avoided. Mr Neill had advanced cancer and was treated appropriately in prison and hospital and subsequently at the hospice. His death was not unexpected from a medical perspective given that he had advanced and substantial malignancy.

In terms of Section 26(2)(f) of the Act (any defects in any system of working which contributed to the death or the accident resulting in the death):

No such defect was identified and on the basis of the material before the inquiry I determined that there were no such defects.

In terms of Section 26(2)(g) of the Act (any other facts which are relevant to the circumstances of the death):

All parties agreed that there were no additional facts which were relevant to the circumstances of the death and from the material before me I determined that there are no such other relevant facts.

In terms of Section 26(1)(b) of the Act (recommendations (if any) as to a) the taking 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):

Having made the finding of facts as outlined above and the determination under Section 26(2)(a) and (c) I do not consider that there are any recommendations that require to be made in terms of Section 26(1)(b).

In concluding this determination I wish to extend my condolences to Mr Neill's family.