SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT STIRLING

[2022] FAI 33

STI-B50-22

DETERMINATION

BY

SHERIFF KEITH O'MAHONY

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

into the death of

ANDREW CROALL HUTCHESON

10 August 2022

Determination

1. The Sheriff, having considered the evidence presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 that:

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

At 2115 hours on 17 January 2021, Andrew Hutcheson, born 16 October 1967, died at Ward 7D, Queen Elizabeth University Hospital, Glasgow.

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

Mr Hutcheson's death did not result from an accident.

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

1 (a) Right Heart Failure

(b) Chronic Thromboembolic Pulmonary Hypertension

2 Paroxysmal Atrial Fibrillation.

1.4 In terms of section 26(2)(d) of the Act (the cause of any accident resulting in the death):

Mr Hutcheson's death did not result from an accident.

1.5 In terms of section 26(2)(e) of the Act (the taking of precautions):

There were, on the available evidence, no precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death being avoided.

1.6 In terms of section 26(2)(f) of the Act (defects in any system of working):

There were, on the available evidence, no defects in any system of working which contributed to the death.

1.7 In terms of section 26(2)(g) of the Act (any other facts relevant to the circumstances of death):

There were, on the available evidence, no other facts relevant to the circumstances of death.

Recommendations

2. In terms of section 26(1)(b) of the Act, there are, on the available evidence, no recommendations to be made.

NOTE

Introduction

Representation:

Procurator Fiscal: Sadiq, Procurator Fiscal Depute.

Scottish Prison Service ("the SPS"): Considine, Solicitor, Anderson Strathern LLP.

Tayside Health Board: Sargent, Solicitor, NHS National Services, Scotland.

[1] This is an inquiry into the death of Mr Andrew Croall Hutcheson. Mr Hutcheson died at the Queen Elizabeth University Hospital, Glasgow on 17 January 2021. The death was intimated to the Procurator Fiscal on 21 January 2021. At the time of his death Mr Hutcheson was a serving prisoner at HMP Castle Huntly. This is, accordingly, a mandatory inquiry in terms of section 2(4)(a) of the Act.

[2] A preliminary hearing was held on 20 June 2022.

[3] The inquiry was conducted virtually with participants appearing by video conference on 8 August 2022. All evidence was agreed by way of a Joint Minute of Agreement lodged on 21 July 2022. The sister of Mr Hutcheson observed the inquiry.

[4] I have found that Mr Hutcheson died of natural causes and, on the evidence, there are no systemic defects arising or precautions that might have been taken to avoid the death. I undernote a narrative of the facts which I find established.

Summary

Background

[5] Mr Hutcheson was convicted at Dundee Sheriff Court on 16 May 2017 and Forfar Sheriff Court on 14 June 2017 of a number of criminal matters. He was sentenced to a period of imprisonment which was backdated to 18 April 2017. He had an earliest date of release of 15 October 2021. He served the earlier part of his sentence at HMP Perth and was transferred to HMP Castle Huntly on 27 October 2020.

Medical History

[6] Mr Hutcheson had an extensive medical history. An analysis of the medical notes reveals, *inter alia*, the following:-

- Pulmonary embolism
- Chronic thromboembolic pulmonary hypertension
- Bronchial embolisation for haemoptysis
- Paroxysmal atrial fibrillation

[7] In 2014 he was found to have thrombus occluding lower left lobe of lung with chronic thromboembolic pulmonary hypertension. On 10 February 2014 he underwent a pulmonary endarterectomy operation. The clinicians involved describe a very good outcome from the procedure with good clearance of the disease and improved haemodynamics.

[8] Since his incarceration on 18 April 2017 Mr Hutcheson had attended 28 separate hospital appointments. On around 8 further occasions Mr Hutcheson had been admitted to hospital following medical assessment. He was regularly seen by the occupational therapist.

[9] On 7 November 2020 Mr Hutcheson was admitted to the Acute Medical Unit at Ninewells Hospital, Dundee where he was diagnosed with fluid overload. He was commenced on diuretic medication. On 9 November 2020 he was discharged back to HMP Castle Huntly.

[10] On 20 November 2020 Mr Hutcheson again attended Ninewells by way of a planned admission where he underwent a diagnostic electrophysiological test. The procedure was stopped due to the presence of an IVC (inferior vena cava) filter. The IVC had been fitted in 2016. Ultimately a further appointment was scheduled for 23 December 2020 at the Pulmonary Vascular Unit, Golden Jubilee Hospital, Glasgow.

[11] Mr Hutcheson attended the appointment on 23 December 2020 where he was assessed by a consultant. He was noted as being in poor health due to right sided heart failure. He was noted as being hypotensive and retaining fluid. His blood levels were noted as abnormal. He declined to be admitted for treatment even with encouragement from the Nurse at HMP Castle Huntly. The reason Mr Hutcheson gave for declining admission was that he would not be able to have any supplies brought to him due to the logistics of the prison service. The consultant explained the risks to Mr Hutcheson, including the possibility of death. Mr Hutcheson stated he was willing to accept these risks. Mr Hutcheson did, however, agree to be admitted at a later date.

[12] A plan was developed to have Mr Hutcheson admitted to ward 7D of the Queen Elizabeth University Hospital on 29 December 2020 where it was intended he would remain for 2-4 weeks. The intention was that Mr Hutcheson would undergo intropic therapy for heart failure.

[13] On 26 December 2020 Mr Hutcheson was assessed by the Senior Charge Nurse at HMP Castle Huntly. His pallor was noted to be good and respiration rate within the normal range.

[14] On 27 December 2020 he was again assessed by the Senior Charge Nurse to monitor his blood pressure. His colour was noted as having deteriorated and he had shortness of breath. His respiration rate had increased and oxygen levels had decreased. Oxygen therapy was commenced and an ambulance was requested via 999.
Mr Hutcheson was taken to the Emergency Department at Ninewells Hospital. He was later transferred to the Acute Medical Unit as an inpatient.

[15] On Tuesday 29 December 2020 Mr Hutcheson was admitted to ward 7D of Queen Elizabeth University Hospital, Glasgow. He was noted to have signs of right heart failure including worsening breathlessness and peripheral oedema. He had associated hyponatraemia. He was treated with intravenous diuretics.

[16] On Tuesday 5 January 2021 Mr Hutcheson was transferred to the Golden Jubilee National Hospital for further investigations. These comprised a CT pulmonary angiogram, right heart catheterisation and invasive pulmonary angiogram. Investigations were completed without any complication. The results were discussed at the Scottish Pulmonary Vascular Unit Multi-Disciplinary Team meeting on 7 January

2021. It was concluded the results were consistent with ongoing severe pulmonary hypertension due to chronic thromboembolic disease.

[17] Mr Hutcheson was returned to Queen Elizabeth Hospital, Glasgow on 7 January 2021 where he continued with IV diuretics and additional drug therapy for pulmonary hypertension. He developed a degree of acute kidney injury and diuretics were temporarily stopped. His kidney function showed rapid improvement, but he developed worsening signs of right heart failure which required the reintroduction of diuretics.

[18] On 15 January 2021 Mr Hutcheson began to exhibit signs of general deterioration with worsening breathlessness and hypoxia. A chest x-ray showed marked pulmonary congestion. There were no particular infective symptoms and a Covid-19 screen was negative.

[19] On 16 January 2021 Mr Hutcheson began to develop associated cardiorenal failure with rising creatinine and anuria. His case was discussed between the on-call registrar and Scottish Pulmonary Vascular Unit staff. It was agreed that the prognosis was very poor and there were no other treatment options. The Palliative care team was involved to help manage symptoms.

[20] Mr Hutcheson died at 2115 hours on 17 January 2021. The cause of death was certified as: 1(a) Right Heart Failure (b) Chronic Thromboembolic Pulmonary Hypertension and 2 Paroxysmal Atrial Fibrillation.

Death in Prison Learning, Audit and Review

[21] On 18 February 2021 the Scottish prison Service carried out a review of the circumstances surrounding Mr Hutcheson's death. Their report was produced to the inquiry as Crown Production number 4.

[22] The review noted Mr Hutcheson had complex health needs. Some concerns were raised by the next-of-kin with the review group regarding the health care he received whilst within the prison estate. On admission to hospital in December 2020 it was not considered that Mr Hutcheson was near death and so no consideration was given to compassionate release.

[23] At the conclusion of the review two 'learning points' were noted, only one of which is relevant to this inquiry: it was noted that on initial arrival at HMP Castle Huntly, staff were given no information regarding Mr Hutcheson's health care needs. The situation was rectified the following day and an appropriate care plan put in place.

Adverse Event Review

[24] NHS Tayside carried out an Adverse Event Review and produced a report dated 14 July 2022. The report was made available to the inquiry as Production Number 1 for NHS Tayside.

[25] The review noted that following discharge on 20 November 2020 no post-operative discharge information made available and could not be immediately obtained as the relevant unit at Ninewells was closed. Ultimately, on 23 November,

telephone contact was made between the prison GP and the consultant within the unit at Ninewells and post-operative care was discussed.

[26] The review made a number of recommendations including: the Risk Management Team NHS representative to communicate to relevant HMP Perth clinical staff regarding any patient discussed who has complex health care needs and has been approved for transfer; where patients are discharged from hospital following an episode of care a timely discharge letter/plan will be sought and contact made directly with discharging ward to establish care and treatment needs.

[27] The review notes that both of these recommendations are complete and processes embedded.

Submissions

[28] The Crown submitted that formal findings should be made in terms of sections 26(2)(a) and 26(2)(c) and that no findings should be made in respect of the other elements of the section.

[29] The solicitor for NHS Tayside mirrored the position of the Crown in inviting formal findings only. She further submitted that Mr Hutcheson died of natural causes and that no reasonable precautions had been identified which might result in the death being avoided, nor had any defect been identified in any system of working which contributed to the death.

[30] Similarly, the solicitor for the Scottish Prison Service invited formal findings only made substantially similar submissions to the other participants.

Conclusions

[31] On the evidence there is no difficulty in making the formal findings noted above in terms of sections 26(2)(a) and (c).

[32] Mr Hutcheson had suffered from complex health needs for some time. The medical records disclose an intense health management regime both before and after incarceration. He was assessed regularly and substantially engaged well with the medical and prison staff administering treatment.

[33] There are learning points for those involved in his care: principally the absence of information provided to HMP Castle Huntly on initial arrival and the absence of post-operative discharge information on 20 November 2020. Both of these elements have been considered by those involved and processes strengthened to prevent repeat. There is no evidence to suggest that these elements led to a deficiency of care that contributed to the death some weeks later.

[34] I have not identified any substantive matter that would merit a finding in terms of section 26. The evidence discloses that the medical and general treatment of Mr Hutcheson was adequate and appropriate. Mr Hutcheson's deteriorating presentation on 27 December 2020 was reacted to appropriately with immediate transfer to hospital. Thereafter, investigations were carried out with a view to establishing appropriate management but these were frustrated by Mr Hutcheson's unexpected and rapid deterioration commencing on 15 January 2021.

[35] There is accordingly no basis on which to make any substantive findings in terms of section 26 or make any corresponding recommendations.

[36] Finally, at the conclusion of submissions all parties offered their condolences to Mr Hutcheson's family. The court joins in that expression of sympathy.