SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2024] FAI 16

FAL-B259-22

DETERMINATION

BY

SHERIFF C M SHEAD

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

into the death of

PAUL HOGWOOD

26 MARCH 2024

The sheriff, having considered the information presented at an inquiry on 22 and 23 November 2023 and 8 January 2024 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 finds and determines:

(a) In terms of section 26(2)(a) the late Paul Hogwood died at HMP Perth on 15 January 2021. He was 60 years old. At the time of his death he was a serving prisoner whose earliest date of release was 4 September 2024.

(b) In terms of section 26(2)(c) following a post mortem examination on 19 January 2021 the medical cause of death was determined to be I (a) left lobar pneumonia with empyema (streptococcus pneumonia) and diabetic ketoacidosis and (b) chronic bronchitis and emphysema and insulin-controlled diabetes.

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

(d) In terms of section 26(2)(f) there was no defect in any system of working which contributed to the death.

(e) In terms of section 26(2)(b) and (d) there was no accident on which to base any findings.

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

(g) In terms of section 26(1)(b) I have no recommendations to make.

Introduction

[1] This is a mandatory inquiry into the death of Mr Paul Hogwood in terms of section 2(4)(a) of the 2016 Act.

The proceedings and the parties

[2] A number of preliminary hearings took place before the inquiry itself which was held on 22 and 23 November 2023 and 8 January 2024. Ms Graham, procurator fiscal depute, appeared for the Crown. Ms Iridag, counsel appeared for Forth Valley Health Board, Ms Turner for the Scottish Ministers on behalf of Scottish Prison Service, Mr Rodgers for the Prison Officers' Association Scotland and for Officer CD and Mr Kennedy, counsel appeared for GH.

The sources of evidence

[3] A joint minute of agreement was entered into by the parties. I heard evidence from six witnesses some by video link and some in person. A number of affidavits and documents including witness statements had been submitted in advance of the hearing.

Written submissions were prepared by each party and I heard submissions on 8 January 2024 when each party adopted their written submissions without elaboration. I am grateful to parties for their assistance in the preparation and conduct of the inquiry.

The legal framework

[4] The inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the 2016 Act). The purpose of such an inquiry is set out in section 1(3) of the 2016 Act and 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."

[5] Section 26 of the 2016 Act states, among other things, that:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out –
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> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2)
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> and
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> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers as appropriate.
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> (2) The circumstances referred to in subsection 1(a) are –
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> (a) when and where the death occurred;
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> (b) when and where any accident resulting on the death occurred;
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> (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."

The parties' positions

[6] It was common ground that there was no accident and thus section 26(2) paragraphs (b) and (d) were not applicable. The parties, apart from the deceased's widow, invited the court to make findings only under section 26(2)(a) and (c). By

contrast Mr Kennedy submitted that the court should make findings under section 26(2) paragraphs (e) and (f) for the reasons set out in his written submission.

The circumstances of the deceased and his death

[7] The following findings are based on the terms of the joint minute and the other sources of evidence both written and oral presented to the inquiry by the parties.

[8] At the time of his death Mr Hogwood was serving a 10 year sentence imposed at the High Court of Justiciary sitting at Glasgow on 11 April 2016. His earliest date of release was 4 September 2024.

[9] The deceased was diabetic having been diagnosed with Type 1 diabetes when he was 22. He had a long history of failing to attend medical appointments including while serving the sentence imposed in 2016. The deceased suffered from severe coronary heart disease and an enlarged heart with right sided ventricular hypertrophy which would have substantially increased the risk of sudden cardiac dysrhythmia and cardiac arrest in the context of untreated severe sepsis and diabetic ketoacidosis.

[10] The deceased was friendly with another prisoner AB. Around 9 or 10 January 2021 the deceased told AB that he was feeling unwell. Between 12 and 14 January the deceased had been in bed. During that time, on a couple of occasions, he heard the deceased being asked by prison officers if he wanted to see a nurse and on each occasion he said no. He too had asked the deceased on one or two occasions whether he needed a nurse and the deceased had said no that he was ok. On 14 January the deceased told AB that he was feeling weak and had a sore stomach. The deceased remained in bed for

most of the day. That evening AB noticed that that there was faeces on the floor under the deceased's bed. He told the deceased that he would help him clean it up in the morning.

[11] On 15 January at about 07:45 prison officers CD and EF were carrying out a numbers and welfare check. When they went to the deceased's cell he was in bed. There was vomit visible in the sink. At about 08:45 when all the cells were unlocked CD noticed that the deceased was in bed. Later on at approximately 12:15 CD spoke to the deceased who was still in bed. The officer thought the deceased looked better.

[12] Between 14:15 and 15:30 CD went to the deceased's cell with paperwork. He noticed either vomit or faeces in the toilet. Later that afternoon he saw the deceased and AB in the deceased's cell cleaning up. Shortly after 16:00 the deceased was helped out of bed by AB and left the cell to have a shower. AB noticed that there was faeces on the bedding and he removed the sheets.

[13] CD had four or five interactions with the deceased on the day of his death. On each occasion when asked if he wanted medical attention the deceased declined. In CD's view the deceased was getting better as the day progressed. He would have called a nurse if had thought the deceased needed one. He had not known that the deceased was diabetic.

[14] Sometime shortly after 4pm AB was finishing cleaning the deceased's cell when he heard another prisoner shout that the deceased had taken a turn in the showers. When he got to the shower area he found the deceased conscious and on the floor

propped up against the wall. He told him not to worry and that the nurses were coming. The deceased replied "nah AB forget the nurses."

[15] CD also went to the shower area where he saw the accused lying on his back. He used his radio to summon assistance. When the nurses Ms Oswald and Ms Christie arrived at about 16:19 Mr Hogwood was conscious but not responding to speech. Ms Christie who was aware that the deceased was diabetic checked his blood pressure and blood sugar. The latter was high. Both then saw the colour drain from his face and he lost consciousness. An ambulance was called. Ms Oswald began CPR which continued for about 10 minutes until the paramedics arrived. A defibrillator was used to apply one shock to the deceased. Unfortunately the efforts to revive the deceased were unsuccessful and life was pronounced extinct at 16:46.

[16] Police were called and began their investigations about 18:30. The deceased's cell was searched. During the search, among other items, a box of capped insulin needles, two insulin pens and a ketone sensor were found. All these items had been prescribed for the deceased.

[17] A post-mortem was carried out on the instructions of the Procurator Fiscal on 19 January 2021 by Dr Helen Brownlow consultant forensic pathologist. The examination of the deceased's lungs revealed infection throughout the lower part of the left lung (lobar pneumonia), inflammation of the tissues covering the lungs (pleuritis) and 300mls of heavily pus-stained fluid (empyema) present in the chest cavity. Biochemical markers of ketoacidosis were detected in femoral blood at markedly elevated concentrations.

[18] It was noted that lumbar pneumonia is a severe respiratory infection to which the deceased was pre-disposed in part because of the immunocompromising effects of diabetes mellitus.

[19] Dr Brownlow certified the cause of death as I(a) left lobar pneumonia with empyema (streptococcus pneumoniae) and diabetic ketoacidosis and I(b) chronic bronchitis and emphysema and insulin controlled diabetes mellitus.

Subsequent inquiries

[20] The Procurator Fiscal asked Dr Brownlow to express her view on a number of issues by posing written questions to her. She responded on 1 April 2023. One of those questions was in the following terms:

> "Had the deceased been taken to hospital earlier (assuming of course there was a reason to do so) could any treatment have been given which might have changed the outcome?"

Dr Brownlow responded:

> "Whilst pneumonia and DKA are relatively easy to diagnose and there are treatments available for both conditions it is not possible to predict an individual's response to such treatment or its impact on survival outcome."

A summary of the main points of the evidence

[21] Each of the witnesses adopted an affidavit or statement with the exception of CD. I do not intend to set out in detail the evidence of each witness but rather to concentrate on the main points as they relate to the issues raised in the submissions.

Dr Ken Darzy

[22] Dr Darzy is a consultant diabetologist and endocrinologist. On the instructions of the agents for the next of kin he had had produced a report on the death of Mr Hogwood. He adopted that report as part of his evidence. He had been provided with various documents which he listed at the beginning of his report.[1]

[23] Having reviewed the medical records he concluded that:

> "he could not identify any breaches regarding the required biochemical and clinical monitoring of the [deceased's] diabetes. He was offered multiple appointments with the nurses which he failed to attend. When he wanted an appointment with the GP/doctor this was organised and he failed to attend."[2]

[24] He further observed:

> "He was fully aware of the requirements for diabetes management including self-monitoring of blood glucose and insulin administration and titration. However he was not fully compliant with self-management of his diabetes. This was not related to lack of support but to a personal choice."[3]

[25] Having considered the post-mortem and toxicology reports Dr Darzy expressed his agreement with the causation of the death of Mr Hogwood. He pointed out that the deceased was at risk of chest infections because of his poorly controlled diabetes. The finding, in his blood, of the bacteria responsible for the pneumonia indicated that the deceased may have had septicaemia. If so that would have resulted in symptoms including sickness and/or diarrhoea.

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[1] page 2
[2] Para [43]
[3] Para [44]

[26] Acute infection in patients with poorly controlled diabetes is often complicated by diabetic ketoacidosis ("DKA"). Without timely and effective treatment diabetic ketoacidosis can progress fairly rapidly and result in multi-system failure and death.

[27] Dr Darzy noted that the post-mortem report showed that the deceased had severe coronary artery disease (due to long standing poorly controlled diabetes and smoking) and an enlarged heart with right sided ventricular hypertrophy. In Dr Darzy's opinion "this would have substantially increased risk of sudden cardiac dysrhythmia and cardiac arrest in the context of untreated severe sepsis and DKA."[4]

[28] It was noted that the deceased had gone into cardiac arrest in the shower area. As Dr Darzy put it:

> "In essence the cardiac arrest was multifactorial and caused by hypoxia, severe metabolic acidosis and metabolic derangements, sepsis, respiratory failure and cardiac vulnerability because of severe coronary artery disease."[5]

[29] In his view "nothing could have prevented the death of the deceased once he went into cardiac arrest". However he went on to opine that had the deceased been in hospital up to 30 minutes before the cardiac arrest he would have diagnosed with DKA and had he been provided with the normal treatment in response to that diagnosis that treatment would have prevented his death.

[30] In the last section of his report Dr Darzy raised and discussed the possibility of whether there was a breach of duty of care by virtue of a failure to identify his acute

[4] [6] page 24
[5] [8] page 24

illness. However he acknowledged, as I understood it, that this was an issue which went beyond his area of expertise.

[31] In cross-examination he agreed that the deceased was aware of the requirements for managing his diabetes but he was not "fully compliant with self-management".

[32] He accepted that the deceased might not have appreciated how ill he was even if DKA was established. He had been able to walk to the showers. He had suffered a very sudden rapid decline.

GH (Next of Kin)

[33] GH gave evidence by video link and adopted her affidavit.

[34] The deceased was in good spirits in the weeks before his death and was looking forward to moving to open conditions in another prison. In her experience the deceased was good at managing his diabetes. When necessary he had received hospital treatment in connection with his condition. He would always ask for help if unwell.

[35] Having found out about Mr Hogwood's death she spoke to a prison governor the following day when he told her that the deceased had died of a suspected heart attack. GH disputed this as the deceased had never had concerns about his heart.

[36] She expressed her belief that there were problems in getting the deceased to medical appointments or getting medical staff to see the deceased due to the restrictions brought about by COVID-19.

IJ

[37] IJ is a qualified nurse who worked in that capacity in HMP Perth between 2014 and 2022. In preparation for giving evidence she had reviewed the deceased's medical records which revealed a longstanding difficulty in securing the deceased's co-operation with the management of his diabetes and other medical problems.

[38] Part of her duties involved her acting as a diabetes link nurse. There was nothing in the medical notes to suggest that the deceased lacked capacity and in her experience he had full capacity to take decisions on his own behalf. Had the deceased been a patient in the community he would have been discharged from the service for a persistent failure to engage.

[39] When she worked at the prison nurses were available to be consulted from 7am to 9pm during the week and 8am to 6pm at weekends. In her experience if a prison officer had concerns about a patient they would contact the health centre by telephone asking for a review. If alerted to a health issue by a prison officer a member of the nursing staff would decide whether to attend the hall to see the prisoner or whether the prisoner could be brought to the health centre depending on the urgency of the situation. In the case of concerns expressed about a patient with poorly controlled diabetes a nurse would want to see that patient immediately.

[40] A referral service also operated for non-urgent routine matters where a prisoner could request assistance by completing the relevant form. When the form is received a nurse will triage it.

[41] It would not be unusual if a prisoner with symptoms of diarrhoea and vomiting did not seek help. The Scottish Prison Service could request that such a prisoner be confined to their cell but that would have to be considered and approved by the nursing staff. If a prisoner was confined in this way and the next morning another prisoner in the next cell was displaying the same symptoms this would prompt the nursing staff to consider the possibility of infection. If so that would be reported to the infection control nurse.

[42] From the medical records it was noted that the deceased had been admitted to hospital in Dundee on 2 November 2020 with "coffee-ground" vomit which can be caused by bleeding from the gastrointestinal tract and possibly indicate diabetic ketoacidosis.

[43] On 15 January she was one of the nursing staff who attended after the deceased had collapsed in the shower. She was there when paramedics arrived and used the defibrillator in an effort to revive the deceased but without success.

[44] In cross-examination she explained that if there was an emergency then the nursing staff would attend the hall but otherwise patients would come to the health centre.

[45] She confirmed that prison officers did not have access to medical records. A prisoner can refer himself for medical assistance. It would also be possible for a prison officer to ask for help for a prisoner and equally a prisoner can approach the nursing team on behalf of another prisoner.

[46] If a prisoner had had diarrhoea and vomiting for 24-48 hours that would not be a major source of concern from the nursing staff's point of view.

George Ferguson

[47] Mr Ferguson is employed as the governor at HMP Castle Huntly. He has worked for the Scottish Prison Service for 29 years. In the course of that service he had worked as prison officer.

[48] He acknowledged that prison officers owe a duty of care to prisoners. In relation to health matters prison officers operate as a conduit between the prisoner in question and the health care team. The object is to ensure that prisoners who need medical help receive that help.

[49] Given his understanding of the circumstances he considered that CD had discharged his duty of care towards the deceased. Had he been confronted by the same scenario he would have taken the same course of action.

[50] He confirmed that prison officers are not medically trained. If a prisoner says he does not want medical assistance that should be taken at face value unless there are obvious signs to the contrary. The only occasions on which a prisoner officer could seek medical attention without a prisoner's express consent would be where the prisoner lacked capacity or the officer believed that there was a genuine and immediate threat to the prisoner's health.

[51] He was not aware if there were any specific policies which governed prisoners with health conditions or chronic health conditions promulgated either by the Scottish

Prison Service or HMP Perth. Prison officers are given basic first aid training. In addition they are given training and guidance in relation to Code Blue and Code Red emergencies and the use of self-referral procedures. Code Blue is invoked where a prisoner has stopped breathing and Code Red where the prisoner is bleeding.

[52] In cross-examination he explained that prison officers have discretion as to how they should deal with prisoners who are ill. However he would expect an officer to contact the health centre on a prisoner's behalf if he or she had sufficient concerns about his condition. Had he been confronted with the same scenario as CD he would have taken exactly the same steps. An officer should go against a prisoner's wishes only if the officer thought the prisoner was seriously ill.

[53] He rejected the suggestion that some form of coloured sticker might be applied to a cell door to denote that a prisoner was diabetic. He said that would contravene the principle of medical confidentiality.

CD

[54] CD had been a prison officer since 1999. He had begun work in "C" Hall where the deceased was housed in September 2020. He got to know the deceased and would see him regularly.

[55] He was on shift on 15 January 2021 starting at around 07:30. He was carrying out a welfare and numbers check with a colleague in the course of which he went to the deceased's cell. When he opened the door he noticed a smell of sick and saw some sick in the sink and the toilet. He asked the deceased, who was in bed, if he wanted

assistance but he declined. The deceased said he was fine. He was clear that he did not want to see a nurse.

[56] He recalled speaking to the deceased a number of times in the course of the morning. Each time he asked him if he was ok. He had no concerns about him as a result of these interactions. The deceased was clear in saying he did not want medical assistance.

[57] In the afternoon he saw AB in the deceased's cell. He was helping to clean up the cell. The deceased was out of bed. In all he saw the deceased about four or five times before he went for a shower. He thought the deceased was looking better as the day went on and that he was "on the mend". He had no concerns for his well-being. He would have called a nurse if he had thought the deceased needed one.

[58] Later that afternoon he was called to the showers where he saw the deceased lying on the ground. He radioed for nurses to come immediately. He then returned to other duties. He was shocked to learn that the deceased had died.

[59] He described the deceased as a "great" prisoner who was polite and respectful and he liked to think they had a relationship of mutual respect.

[60] He confirmed that while he had received CPR and first aid training he was not otherwise medically trained. He had no access to a prisoner's medical records and he did not know that the deceased was diabetic.

[61] If he had observed the deceased "going downhill" he would have called for a nurse regardless of the prisoner's wishes.

[62] In cross-examination he said that he was not aware that the deceased had been hospitalised in November 2020. He had not seen any of the deceased's diabetic kit in his cell and he was not aware that the deceased was diabetic.

[63] He had smelt vomit when the cell door was opened but not excrement. The deceased had been in bed each time he saw him in the morning. In his experience the deceased was normally clean and tidy. He could not remember whether he had been working on 14 January.

[64] In response to being asked if the deceased was lethargic he replied that he had sounded normal. He had not noticed the colour of his face because the cell was dark at the time.

[65] He rejected the suggestion that what he had seen was a "red flag" event. The deceased had been emphatic that he did not want to see a nurse. He thought the deceased may have been a bit embarrassed at the state of his cell and that he did not want to make a great fuss of it.

[66] Even with the benefit of hindsight he did not think he should have been told about the deceased's medical condition.

AB

[67] AB adopted his affidavit.

[68] In January 2021 he was a serving prisoner. He had become a friend of the deceased having met him in November 2020. He was aware that the deceased was a diabetic and his impression was that some members of staff were aware of his condition.

[69] The deceased had been unwell for about a week before his death and particularly so during 12-14 January. He had visited him in his cell. The deceased was in bed. His colour changed over time and his pallor became grey. The deceased told him he was feeling unwell.

[70] During the three days that the deceased was ill in bed he heard, on a couple of occasions, prison officers asking the deceased if he wanted to see a nurse and each time the deceased had said no. He was almost bedridden but he still came out of his cell for dinner sometimes.

[71] He had been told by the deceased that he was concerned that reporting sick might have interfered with his chances of parole. The deceased had recently received papers in connection with his parole hearing.

[72] AB had also asked the deceased if he needed to see a nurse on one or two occasions and the deceased had replied that "no he was ok".

[73] On the night before he died he visited the deceased in his cell. He could see that there was excrement all across the floor of the cell and there was a smell which was overpowering.

[74] On 15 January he went in to see the deceased about noon and at that time the deceased was in bed and said to him that he thought he had caught some sort of bug.

[75] He went in again between 3 and 4pm and offered to help clean up the cell. The deceased accepted the offer. As the witness returned with the bucket the deceased was getting out of bed. He asked for a drink and they had a "wee laugh" about a comment made about the state of the cell. The deceased then left his cell to have a shower.

[76] While he was finishing cleaning the cell and changing the bedding another prisoner shouted to him to say that the deceased had taken a turn in the showers. He went there and found the deceased. He told the deceased not to worry as the nurses were on their way to which the deceased replied "nah AB forget the nurses."

[77] The witness felt that it was obvious that the deceased was unwell on the evening before his death and that the staff should have summoned medical assistance. In retrospect he wished he had been insistent with the deceased and the staff that medical help should have been called for.

[78] In cross-examination he agreed that the deceased was a bit embarrassed at the state of his cell and at first was reluctant to accept help.

[79] He also confirmed that the deceased was concerned that reporting sick might interfere with his prospects of parole because he might have been put on observations in relation to possible drug use.

A summary of the submissions

[80] There was no dispute as to where and when Mr Hogwood died or the cause of his death. Dr Darzy did not take issue with the cause of death certified by Dr Brownlow. It was also common ground that Mr Hogwood had repeatedly been asked and declined to see a nurse on the day of his death. Most of the evidence was agreed or uncontentious. The main point of contention raised was whether CD had known whether the deceased was diabetic or not. Otherwise the submissions focused on what conclusions the court should draw from the evidence.

[81] There was no dispute about the law which was to be applied the parties having made submissions on the provisions of the Act and its proper interpretation. As noted the main issue for the court was whether to make the findings in relation to section 26(2)(e) and (f) contended for Mr Kennedy on behalf of GH (next of kin).

[82] The Crown emphasised the repeated interactions between the deceased and CD on 15 January. On each occasion the deceased was able to answer the officer's questions and he appeared to CD to be looking better as the day wore on. In his evidence AB had heard prison officers over the previous 3 days asking Mr Hogwood if wanted to see a nurse to which he replied in the negative. Dr Darzy explained that it is possible for someone with DKA to feel fine.

[83] Mr Ferguson considered that CD had discharged his duty of care to the deceased by offering to call the nurse.

[84] It was submitted that it was not apparent that there was a medical emergency until Mr Hogwood collapsed in the shower.

[85] The Scottish Ministers on behalf of the Scottish Prison Service submitted that there was no evidence to entitle the court to conclude that CD had breached his duty of care towards Mr Hogwood. In this connection I was invited to accept the evidence of Mr Ferguson and CD.

[86] It was emphasised that prison officers are not given information about a prisoner's medical condition since that would represent a breach of the prisoner's right to confidentiality.

[87] In general a prison officer would not override a prisoner's wish not to seek medical attention. The only exceptions would be where there was an immediate threat to the prisoner's well-being or where the prisoner lacked the capacity to make that decision for himself. Neither was relevant in the circumstances of this case.

[88] There were obvious objections to the creation of a system whereby a prisoner's medical history was shared with prison officers. Even if there had been such a system in place there was no evidence to show how it might have proved effective since prison officers were not medically trained. On the face of it there was nothing to alert CD to the true nature of the deceased's condition.

[89] In summary there had been no breach of the duty of care towards Mr Hogwood and CD's actions did not contribute to his death.

[90] In its submissions Tayside Health Board drew attention to the evidence of IJ as to the methods whereby a prisoner might seek medical attention. Referral forms could be completed and deposited in a secure box in the hall. The box was emptied every day. In her evidence IJ explained that the deceased was someone who understood the consequences of poor diabetic management.

[91] Accordingly the deceased was in a position to make an informed decision about whether to seek medical assistance and how to do so if he wanted that assistance. It was clear that the deceased had declined the opportunity to consult with nursing staff on the day of his death.

[92] In responding to the next of kin's submissions it was contended that there was no evidence from which the court could infer that the deceased's mental state was

impaired and no evidence that the deceased was suffering from an infectious disease. Finally Mr Kennedy's submission that prisoners have greater healthcare needs than the general population and that more mature prisoners are more likely to have diabetes was not supported by evidence.

[93] The Prison Officer's Association Scotland and CD lodged a joint submission in which the court was invited to make findings under section 26(2) paragraphs (a) and (c) only. In relation to paragraph (e) it was submitted that there was nothing in the deceased's presentation on the day of his death which would have merited a prison officer seeking medical assistance for him.

[94] CD had given evidence that he and his colleagues had had a good relationship with the deceased whom he described as a "great prisoner". The officer also described his interactions with Mr Hogwood on the day of his death. Shortly after 07:30 he had opened the door of the deceased's cell and had been immediately struck by the smell of vomit. He had seen some vomit in the sink and possibly the toilet as well. He asked the deceased how he was feeling and the reply was "ok". He specifically asked if he wanted medical attention and he said no. He had seen the deceased a number of times in the course of the morning and noted nothing which caused him concern. He spoke to him at about 13:30 and at that time he had not appeared to be unwell. In the course of the afternoon he had seen AB in the deceased's cell helping the deceased to clean it. He thought the deceased had looked better.

[95] In the course of his interactions that day he had asked the deceased on a number of occasions whether he had wanted to see a nurse and on each occasion the deceased

had declined. He had been clear that he would have summoned medical assistance if he thought it had been merited.

[96] The officer had confirmed that he did not know that the deceased was diabetic and that prison officers did not have access to a prisoner's medical files.

[97] Mr Rodgers contended that in all the circumstances CD could not reasonably have known that the deceased was acutely unwell.

[98] In connection with the suggestion that the officer should have alerted the medical team to the possibility that the deceased had some infectious disease he submitted that would place an "impossibly onerous task on the shoulders of officers" who are not medically trained.

[99] He invited the court to conclude that the deceased was unaware that he was acutely unwell. Dr Darzy had explained that the onset of DKA can arise suddenly and without warning. He had noted the fact that the deceased had gone for a shower which suggested he had been feeling relatively well at the time just shortly before his collapse and death.

[100] Mr Kennedy lodged a detailed submission on behalf of GH (next of kin) in which he invited the court to consider making findings under section 26(2)(e) and (f).

[101] In the first place it was submitted that the issue was whether the apparent failure to recognise and treat the deceased's acute illness involved any failure or fault on behalf of the prison officers and in particular CD.

[102] More particularly it was submitted that the prison officers ought to have been aware that the deceased was diabetic and given that he had been experiencing sickness

and diarrhoea in the two days preceding his death they should have felt compelled to seek medical assistance despite the deceased's stated wishes. It was accepted that prison officers cannot be expected to make medical judgements. In relation to CD it was submitted that the court should find that he knew that the appellant was diabetic.

[103] In reliance on Dr Darzy's evidence it was contended that a competent nurse would have recognised that in a diabetic vomiting and diarrhoea could be manifestations of a serious illness. If seen as such a doctor would have been called to make an assessment of the deceased. Had that been done a diagnosis of DKA would have been made and this would have led to the deceased's admission to hospital. Had he been admitted and treated promptly and appropriately his death would have been avoided.

[104] It was against that background that the actions of CD in particular fell to be considered. In assessing his actions it was acknowledged that prison officers should take a prisoner's decision to decline medical assistance at face value unless there were obvious signs to the contrary. As I understood it that meant any obvious signs of illness of a sufficient severity to overcome the prisoner's express wishes. This was characterised as imposing a moral or ethical duty on prison officers.

[105] It was contended that prison officers should be expected to monitor diabetic prisoners and recognise "red flag" diabetic signs or events particularly when dealing

with mature or elderly prisoners with underlying vulnerabilities[6] although it was recognised that vomiting and diarrhoea are non-specific symptoms.

[106] It was also submitted that the officers should have recognised that these symptoms were the "key symptoms" of a potentially infectious or communicable disease.

[107] The court was invited to accept various parts of the evidence which demonstrated that the deceased had been ill for at least two days in the run up to his death and that he had suffered vomiting and diarrhoea sufficient to require prison officers to summon a nurse notwithstanding the deceased's wishes.

[108] It was submitted that the summoning of such assistance would not have involved any challenge to the deceased's bodily autonomy or an interference with his dignity. It was also contended that he was not in a position to make a "fully unemotional, rational and competent decision" about whether to seek medical attention.

[109] Even if he was in a position to make such a decision that decision should not have been respected but overridden because he was suffering the "key symptoms" of an infectious or communicable disease.

[110] Accordingly there was a failure to summon medical assistance to treat his illness. Had that been done his death might have been prevented. The prison officers must or should have known that the deceased was a diabetic. On that basis medical assistance should have been summoned for him in his last two days of life.

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[6] [42] p10

[111] Prison staff should have been informed that the deceased was diabetic. That was a precaution that could reasonably have been taken and if so might have realistically resulted in his death being avoided. Mr Kennedy, for the reasons set out in his written submission, invited me to consider whether CD's evidence that he did not know that the deceased was diabetic should be accepted as reliable.

[112] In any event the absence of a policy, protocol or procedure which would have permitted prison staff to be informed about the deceased's medical condition was a defect in the system of working which contributed to his death.

The submissions considered

[113] The questions raised by the submissions for the next of kin related to sections 26(2)(e) and (f) of the Act. Having considered the evidence and parties' submissions I am not satisfied that I should be make any findings in respect of either of those subsections.

[114] In relation to the question of summoning medical assistance I have concluded that no criticism can be made of the actions of CD on the day of the deceased's death. Having asked whether the deceased wanted medical assistance and having been told no there was, in the circumstances which presented themselves to CD, no obvious reason to disregard his wishes and summon medical assistance. I accepted the evidence which he gave about the assessment he made of the deceased and his stated wish not to seek medical assistance that day. In other words there was nothing in his presentation which suggested he should override the deceased's wishes. Since the point was raised in

submissions I should make clear that I accepted the evidence of CD that he was unaware that the deceased was diabetic. I found his evidence on that point to be given in a clear and straightforward manner.

[115] In considering the scope of a prison officer's duty of care Mr Kennedy had drawn attention to Mr Ferguson's evidence to the effect that prison officers would take at face value a prisoner's statement that he did not want medical assistance unless there were obvious signs to the contrary. It was accepted that while there was no legal duty of care on prison officers there was a moral one to summon medical assistance in appropriate circumstances.

[116] Notwithstanding a lack of legal duty on or medical training for prison officers Mr Kennedy contended that officers should still be expected to monitor diabetic prisoners and recognise "red flag" diabetic signs or events. I do not accept that is a realistic view of a prison officer's duty. He or she does not have the necessary degree of medical training to make that kind of assessment for themselves. That is why there is access to medical assistance for prisoners within the prison itself. That assistance is readily available in various forms including, if need be, in a medical emergency. In this case the evidence showed how quickly the medical staff responded to the medical emergency which occurred.

[117] On the view I have taken of the evidence and in particular the evidence of CD there were "no obvious signs to the contrary" which would have required ignoring the deceased's wishes and the summoning of medical assistance. In simple terms neither the deceased nor the prison staff were aware that the former was seriously unwell on 15

January. In the days leading up to his death the deceased had declined medical assistance. This was despite his condition as a diabetic and his recent admission to hospital.

[118] In respect of any precaution which could reasonably have been taken I accept that in some circumstances summoning medical assistance whether sought by a prisoner or not could be regarded as such a precaution. The need to do so might also extend to cases where a prisoner had expressly declined medical assistance. However in the present case there was nothing in the circumstances which suggested that on the day of his death that such assistance should be summoned. The precaution in question involved a matter of judgement to be exercised in the circumstances in which the officers found themselves. It is important to bear in mind that the court is concerned with a precaution that could reasonably have been taken. Unfortunately nobody was aware of the true state of the deceased's health and there was no obvious reason to override the deceased's wishes not to seek medical treatment given how the deceased was presenting that day particularly in the afternoon when he seemed to be getting better.

[119] As was pointed out in submissions subsection 2(e) refers to any precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided. On the latter point it needs to be borne in mind that had medical assistance been summoned it would have required the nurse who was called to recognise that the deceased was seriously unwell and to have made arrangements for the deceased to be transferred to hospital.

[120] It also assumes that the deceased would have accepted the advice that hospital treatment was needed. In this context it is agreed that the deceased had a long history of not attending for medical appointments and there was no dispute that he had declined the services of a nurse when asked. In addition there was evidence which suggested that the deceased was concerned that seeking medical treatment might have had an impact on his prospects of parole.

[121] On the assumption that the deceased had accepted the advice and gone willingly to hospital the medical staff treating him would have had to make the correct diagnosis and prescribed the necessary treatment.

[122] I accept that Dr Darzy expressed the opinion that had the deceased been in hospital and treatment administered up to 30 minutes before he suffered a cardiac arrest that treatment would have prevented his death. He went on to say that the prospect of survival would have been reduced in the last 30 minutes before the cardiac arrest but had he been monitored and given immediate CPR the prospect of survival would have been reasonable. Although not an expert in this field his evidence on these points was not challenged and no other expert evidence was led to cast doubt on his opinion except to a limited extent by Dr Brownlow in answer to the Procurator Fiscal's inquiry.
Dr Darzy had also drawn attention to the fact that the success rate for CPR outside the hospital environment is very small.

[123] Given the view I have reached in relation to (i) of 2(e) it is unnecessary to express a conclusion in respect of (ii). In this connection I recognise that the court is not to apply the civil standard of proof but rather to consider whether there was a "lively possibility"

the death might have been avoided. In this context there are many variables to be taken into account: for example the time of the request for assistance, when a member of the nursing staff would have attended in response to the request, how long the consultation would have taken, whether the nurse would have recognised the need for urgent hospital treatment, whether the deceased would have accepted that advice, how long it would have taken to organise a transfer to hospital, the correct diagnosis being made in hospital and the correct treatment administered and ultimately, in the event of a cardiac arrest, the successful use of CPR. It is also necessary to bear in mind the opinion expressed by Dr Brownlow that it is not possible to predict an individual's response to such treatment.

[124] In setting out those practical considerations I acknowledge that had it been apparent early that morning that the deceased was sufficiently unwell so as to override his wish not to be seen by a nurse and had a nurse attended promptly it would have been easier to conclude that the death might have been avoided although that would still have depended on getting the deceased into hospital and him being properly treated.

[125] I now turn to consider the other main points made by Mr Kennedy. He submitted, in summary, that the summoning of medical assistance would not have compromised the deceased's bodily autonomy or interfered with his right to medical confidentiality. I accept that submission in so far as it goes but it does nothing to illuminate the basic issue as to whether medical assistance should have been summoned.

I have already expressed my view on the latter point in the context of considering the requirements of 2(e)(i).

[126] The question was also raised of whether the deceased was suffering from an infectious disease and if so whether that might too have been a basis for overriding the deceased's wish not to have medical assistance. The short answer to that point is that there was no evidence to show that the symptoms exhibited by the deceased were sufficiently indicative of an infectious disease to trigger the use of the appropriate procedure for dealing with such disease. In any event the issue of any infectious disease protocol was not adequately explored in evidence to allow the court to conclude that it should have been invoked in the circumstances of this case.

[127] The next of kin also raised the question of whether there should be some system for transmitting confidential medical information about individual prisoners from NHS staff to prison officers. It was accepted that the current position is that such information is not communicated to prison staff for reasons of medical confidentiality. The suggestion that such information should be shared was rejected by Mr Ferguson in the course of his evidence. The submission was also criticised by the Scottish Ministers on the basis that there was no evidence to show how such a policy would operate in practice.

[128] On the limited evidence available to me I can see no reason why the current arrangements should be altered in the way suggested. The present system is designed to maintain medical confidentiality. In any event even if there had been a system of sharing confidential information there is no indication as to how that might have had a

tangible impact on the tragic outcome in this case. I have accepted that there was nothing obvious in the deceased's presentation which should have prompted CD to have summoned medical assistance in spite of the deceased's wishes. There is nothing in the evidence to suggest that that assessment would have altered even if he had been informed that the deceased was diabetic. The officer would have required medical training in that field to have recognised that assistance might have been required.

[129] As was pointed out in submission there was no evidence which suggested that CD or, for that matter, AB had any idea that the deceased was dangerously ill. Had either of them appreciated the true position I am satisfied that they would have summoned medical help.

[130] In response to the points raised at the end of Mr Kennedy's submission I am not persuaded that even if the prison officers (including AB) had known that the deceased was diabetic medical assistance would have been summoned. They lacked the necessary training to alert them to the possible dangers of such a condition. It is submitted that informing prison staff of the deceased's status as a diabetic was a precaution which could reasonably have been taken and if it had been it might realistically have resulted in the death being avoided. Even if providing the information was a precaution that could reasonably have been taken there is no reason to suppose that the fact of that knowledge might realistically have resulted in his death being avoided.

[131] The remaining submission is a criticism that there was no policy or protocol in place to allow the sharing of medical information. This is characterised as a defect in the system of working which contributed to Mr Hogwood's death.

[132] I accept that there is no system for sharing this information for the reason already identified: medical confidentiality. Even if there had been, by itself, the information that the deceased was a diabetic would not have altered the outcome.

Conclusions

[133] There was no dispute about where and when Mr Hogwood died or the cause of death and I am satisfied that there is a proper basis for the findings recorded at the beginning of this determination.

[134] For the reasons given I do not consider that Mr Kennedy's submission was well founded and accordingly I have not made any findings in respect of section 26(2)(e) and (f).

[135] The parties extended their condolences to Mr Hogwood's family and friends and I would like to join them in expressing my condolences.