SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2024] FAI 37

FAL-B124-24

DETERMINATION

BY

SUMMARY SHERIFF ALISON MICHIE

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

into the death of

JAMES McCAFFERTY

FALKIRK, 15 AUGUST 2024

DETERMINATION

The summary 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 ("the 2016 Act") (hereinafter referred to as "the Act") that:

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

   James McCafferty, born on 12 March 1946, died on 19 November 2022 at Abercrombie Hall, Cell 3.39, HM Prison Glenochil, King O Muir Road, Tullibody, Clackmannanshire FK10 3AD.

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

   The death did not result from an accident. No findings are made.

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

   The cause of death was 1(a) Complications of Atherosclerotic Cardiovascular Disease.

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

   The death did not result from an accident. No findings are made.

5. **In terms of section 26(2)(e) of the Act (the taking of precautions):**

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

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

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

7. **In terms of section 26(2)(g) of the Act (other factors relevant to the circumstances of death):**

   There were no other factors relevant to the circumstances of death.

RECOMMENDATIONS

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

NOTE

Introduction

[1] This determination is made following the fatal accident inquiry held under the Act into the circumstances of the death of James McCafferty, born on 12 March 1946 (hereinafter referred to as "Mr McCafferty"). The Procurator Fiscal issued a notice of the Inquiry on 23 May 2024. A preliminary hearing was held 30 July 2024 and the Inquiry was held on 15 August 2024, both at Falkirk Sheriff Court.

[2] Two parties provided notification of an intention to participate in the inquiry, namely the Scottish Ministers acting through the Scottish Prison Service and Forth Valley Health Board. The Crown advised that intimation of the inquiry had been made to the nearest known relative of Mr McCafferty. They did not participate in the inquiry.

[3] At the preliminary hearing on 30 July 2024 the representatives for the Crown, Scottish Ministers and Forth Valley Health Board were all agreed that the evidence could proceed by way of a Joint Minute of Agreement and a draft Joint Minute was lodged with the court. The statements of the Crown witnesses were agreed within the Joint Minute and the representatives for the Scottish Ministers and Forth Valley Health Board indicated that they did not intend to call any witnesses.

[4] The inquiry was held at Falkirk Sheriff Court on 15 August 2024. There were the following participants to the Inquiry: Alasdair MacLeod, Procurator Fiscal, represented the Crown. Chloe Johnstone, Solicitor, represented the Scottish Ministers acting through the Scottish Prison Service and Caroline Watson, Solicitor, represented Forth Valley Health Board.

[5] A Joint Minute of Agreement was formally entered into evidence on 15 August 2024. The following productions were lodged and referred to within the Joint Minute:

- Final Post Mortem report by Dr Amanda Paton, Pathologist;
- The "Death in Custody Pack" of documentation and records held by the Scottish Prison Service in relation to Mr McCafferty;
- Prison Medical Records in relation to Mr McCafferty;
- A Death in Prison Learning, Audit and Review (DIPLAR) Report;
- 37 photographs produced by Scottish Police Authority, showing cell 3.39 and the deceased within;
- Medical Certificate of Cause of Death signed by Dr Amanda Paton, Pathologist.
- Intimation of Death from Registrar in relation to Mr McCafferty;
- Assessment and Care Plan Booklet pertaining to James McCafferty;
- Deaths in Prison Custody NHS Support Toolkit

The Procurator Fiscal read out the Joint Minute of Agreement. Written submissions had been provided in advance by all three parties to the inquiry. Parties read out their

submissions at the inquiry. All parties submitted that I should make formal findings only.

The legal framework

[6] The Inquiry was held under section 1 of the 2016 Act. The relevant procedural rules are found in the Act of Sederunt (Fatal Accidents Inquiries Rules 2017) ("the 2017 Rules"). The purpose of the Inquiry is defined by section 1(3) of the 2016 Act, and is to:

(a) establish the circumstance of the death, and:

(b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

It is not the purpose of the inquiry to establish civil or criminal liability (section 1(4)).

[7] Section 26 of the 2016 Act requires the Sheriff to make a determination in relation to the circumstances of the death (section 26(1)(a)) and recommendations on certain matters (section 26(1)(b)). Section 26(2) sets out the factors that the Sheriff must consider as to what constitutes the circumstances of the death, including the causes of any accident and the precautions that might have been taken, defects in the system of working and any other factors relevant to the death. Section 26(4) sets out the issues for consideration as to whether any recommendations could be made which might realistically prevent other deaths in the future.

[8] This was a mandatory inquiry in terms of section 2(4)(a) of the 2016 Act as, at the time of his death, Mr McCafferty was a serving prisoner within HM Prison Glencohil.

Summary

Background

[9] On 14 May 2019 at the High Court at Edinburgh Mr McCafferty pled guilty to a number of offences which included; indecent assault, lewd, indecent and libidinous practices and behaviour and breach of the peace. On 14 May 2019 Mr McCafferty was sentenced to 6 years and 9 months imprisonment.

[10] On 19 November 2021 Mr McCafferty was transferred from HM Prison Addiewell to HM Prison Glenochil. At the date of his death, 19 November 2022, Mr McCafferty was in legal custody at HM Prison Glenochil.

Medical History

[11] Mr McCafferty had an extensive medical history. At the time of his death he suffered from several ongoing health conditions which included;

- Dementia which was diagnosed as moderate to severe in September 2021. Mr McCafferty was awaiting a formal diagnosis of vascular dementia.
- Hypertension
- Paroxysmal Atrial Fibrillation
- A 27mm meningioma (benign tumour) to left frontal lobe

[12] Mr McCafferty also had a background of significant health issues including;

- myocardial infarction with percutaneous coronary intervention
- multiple strokes including a right posterior occipital circulatory stroke in February 2021
- pulmonary embolism in February 2021
- frequent falls
- multiple hospital admissions for sepsis
- fracture to C1 vertebrae in 2001
- bilateral knee replacements and a hip replacement

[13] When Mr McCafferty was transferred from HMP Addiewell to HM Prison Glenochil on 19 November 2021 he was assessed as being in very poor health and having significant care needs.

[14] The statement of Dr Kildare indicates that on arrival at HMP Glenochil Mr McCafferty's mobility was "incredibly poor" and within around eight weeks of transfer he was bed bound.

[15] Between 20 November and 30 November 2021 Mr McCafferty was admitted to Forth Valley Royal Hospital for treatment for urinary sepsis.

[16] Within HMP Glenochil McCafferty was assessed as requiring the following care measures;

- twenty four hour care from two members of staff;
- Two hourly input from social care staff;
- Daily input from NHS primary care nursing team;
- Weekly input from NHS rehabilitation support worker;

- Full assistance with activities of daily living;
- Some assistance with eating and drinking;
- Supervised medications;
- Catheter care;
- a pressure relieving mattress;
- a disabled cell;

[17] On 2 December 2021 a Do Not Attempt Cardiopulmonary Resuscitation "DNACPR" notice was put in place by Dr Kildare in respect of Mr McCafferty.

[18] On 7 December 2021 a Certificate of Incapacity in terms of section 74 of the Adults with Incapacity (Scotland) Act 2000 was completed in respect of Mr McCafferty by Dr Kildare.

[19] Between 8 June and 10 June 2022 Mr McCafferty was admitted to Forth Valley Royal Hospital due to concerns that he may have suffered a cerebral vascular accident, due to the presence of a left sided droop and suspected urinary sepsis.

[20] On 21 July 2022 Dr Kildare reviewed Mr McCafferty due to his worsening health. Dr Kildare assessed Mr McCafferty to be approaching end of life and that it was no longer in his best interests to be treated acutely. It was agreed that he should not be admitted to hospital for further intervention. All non-essential medication was withdrawn and measures put in place to prioritise comfort and pain management. Advance care planning palliative medication was prescribed.

Circumstances of Death

[21] At the date of his death on 21 November 2022 Mr McCafferty was subject to checks every two hours by carers accompanied by prison officers. These checks would include positional changes. Mr McCafferty was within cell 3.39 which was single occupancy cell.

[22] At around 2000 hours on 18 November 2022, a Prison Officer conducted final numbers check of Abercrombie Hall. This check requires the officer to obtain a response from every prisoner. The officer noted Mr McCafferty to be in bed and they wished each other good night.

[23] Thereafter two Prison Officers accompanied by two Healthcare Assistants checked on Mr McCafferty at 2200 hours on 18 November 2022 and at 0000 hours and 0200 hours on 19 November 2022. On each occasion Mr McCafferty was sleepy but alert and made no complaint of feeling unwell.

[24] The same four witnesses checked on Mr McCafferty at 0400 hours on 19 November 2022 and at that time he was found to be deceased. Mr McCafferty was not breathing, was cooler to the touch and slight mottling was observed on his right forearm. No medical procedures were attempted due to the existence of the DNACPR notice in relation to Mr McCafferty.

[25] At that time of day there was no member of staff within the prison who was qualified to pronounce life extinct.

[26] One of the Prison Officers alerted his First Line Manager to the death. The First Line Manager called NHS 24 to ask for someone to attend at the prison to confirm the

death. He was advised to call the Scottish Ambulance Service and was directed by the Scottish Ambulance Service back to NHS 24. He was "on hold" on these calls for some time. He was then advised that no one would be sent to confirm the death.

[27] At 0752 hours on 19 November 2022 a Nurse Practitioner entered cell 3.39 and pronounced life extinct.

[28] On 24 November 2022 at Forth Valley Royal Hospital, Dr Amanda Paton, Pathologist, carried out a View and Grant post mortem examination of Mr McCafferty.

[29] The cause of Mr McCafferty's death was;

1(a) Complications of Atherosclerotic Cardiovascular Disease

Submissions

[30] All parties 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.

Discussion

[31] The death of Mr McCafferty was discovered by prison staff at 0400 hours. Due to the DNACPR notice, no ambulance had been called. I noted from the evidence that in such circumstances there was some lack of clarity about the process for having the death confirmed by a suitably qualified medical professional. The First Line Manager required to call both NHS 24 and then the Scottish Ambulance Service before being advised, after a considerable delay, that no person would be sent to the prison to certify the death.

Mr McCafferty's death was confirmed at 0752 hours when a nurse practitioner came on duty.

[32] The DIPLAR noted the following learning points:

> "Clearer instruction about contact with Ambulances, NHS 24, Out of Hours Doctors. More nurses expected to be qualified to confirm death."

The DIPLAR Action Plan thereafter stated that;

> "Death in custody flow chart waiting to be approved with NHS actions to follow and SPS actions to follow. This will then be circulated to relevant staff."

[33] Forth Valley Health Board lodged as a production the Deaths in Prison Custody; NHS Support Toolkit which was published on 26 October 2023. This document includes (at page 11) an NHS, SPS and Police Scotland Initial Response Flowchart with the stated aim; "to ensure all partners are aware of roles and responsibilities following a death in prison custody". Chapter 4 of that document is entitled "Confirmation of Death Guidance" and has a specific section on out of hours processes and situations where there is a DNACRR in place.

[34] It appears that this Toolkit addresses the learning point identified in the DIPLAR and provides clarity as to the processes to be followed for confirming a death in circumstances where there is a DNACPR in place, no medical professionals attend the prison and the death occurs at a time when there are no staff on duty who are qualified to confirm death.

Conclusions

[35] On the evidence there is no difficulty in making the formal findings in terms of sections 26(2)(a) and (c). I have set out those formal findings above.

[36] Mr McCafferty suffered from complex health needs which had been of long standing. In light of his deteriorating health, a DNACPR had been put in place in December 2021. In July 2022 Mr McCafferty had been assessed as approaching end of life and it was agreed that he should not be admitted to hospital for any further intervention.

[37] Mr McCafferty was bed bound and required assistance with all aspects of daily living. There was a package of measures in place to deliver the high level of care that Mr McCafferty required. The evidence discloses that Mr McCafferty received the appropriate care and medical treatment.

[38] I have not identified any matter that would merit a finding in terms of section 26 of the Act.

[39] I am satisfied that it would not be appropriate to make any recommendations in terms of section 26(1)(b) of the Act.

[40] I conclude by offering my condolences to the friends and family of Mr McCafferty.