

NHS Greater Glasgow and Clyde	Paper No. 25/102
Meeting:	NHSGGC Board Meeting
Meeting Date:	21 August 2025
Title:	FAI Update
Sponsoring Director:	Scott Davidson, Medical Director Elaine Vanhegan, Director of Corporate Services and Governance
Report Author:	Iain Paterson, Corporate Services Manager (Compliance)

1. Purpose

The purpose of the attached paper is to: provide the requested briefing for the NHSGGC Board on the Determination of the FAI into the death of 'TC', published 8 August 2025.

2. Executive Summary

The paper can be summarised as follows:

TC was a 52 year old man, known to Mental Health services, who sadly passed away in a works van as a result of carbon monoxide poisoning in January 2019. The SCI, completed in November 2019, concluded that there were issues identified in the patient's care which may have caused or contributed to the event. Five recommendations were made and all actions were implemented by June 2020.

The paper sets out the issues the Fatal Accident Inquiry was called to examine as well as the determination. The sheriff, having considered the information presented at the inquiry, made no recommendations in terms of section 26(1)(b) of the Act.

3. Recommendations

The NHS Board is asked to note the report.

4. Response Required

This paper is presented for awareness.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- | | |
|------------------------|------------------------|
| • Better Health | <u>Positive</u> impact |
| • Better Care | <u>Positive</u> impact |
| • Better Value | <u>Positive</u> impact |
| • Better Workplace | <u>Positive</u> impact |
| • Equality & Diversity | <u>Positive</u> impact |
| • Environment | <u>Positive</u> impact |

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

N/A

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

N/A

8. Date Prepared & Issued

Prepared on: 13 August 2025

Issued on: 13 August 2025

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1. Introduction

The purpose of the attached paper is to provide the requested briefing for the NHSGGC Board on the Determination of the FAI into the death of 'TC', published 8 August 2025.

The Board is advised that the name of the deceased has been withheld from the published Determination.

The FAI was heard by Sheriff Paul Anthony Reid, with evidence heard on 22 and 23 April 2025.

2. Background

TC was a 52 year old man, known to Mental Health services, who sadly passed away in a works van as a result of carbon monoxide poisoning in January 2019. The SCI, completed in November 2019, concluded that there were issues identified in the patient's care which may have caused or contributed to the event. The recommendations were as follows:

1. All attempts to telephone other teams should be recorded in clinical notes each time a telephone call is attempted.
2. All information should be available on patient's electronic records as soon as possible following the contact or intervention. EMIS was not available at ward level at this time.

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3. The Clinical Risk Screening and Management Tool should be completed at all initial patient assessments.
4. The Crisis Team nurse in charge should make decisions with regards to prioritisation of visits. If a visit or visits cannot be made as planned, as a result of activity, then request for additional staff should be made.
5. Crisis Services should develop standardised written information for patients and families on how to access help and services whilst under their care, which should be given at the initial visit.

All actions were implemented by June 2020.

The Fatal Accident Inquiry was called to examine the following issues:

- Whether TC, having been assessed at both University Hospital Monklands Hospital and Stobhill Hospital in 2019, should have been returned to the care of his family on both occasions rather than being admitted to hospital, and whether this caused or contributed to the eventual outcome;
- Whether there was a failure in facilitating regular follow-up with TC in the community following the decision against hospital admission; and if so identified, whether this caused or contributed to the eventual outcome;
- Whether there was a failure in the sharing and/or recording of information regarding TC between and within University Hospital Monklands, Stobhill Hospital, his local Mental Health Crisis Team and Medical Practice and, if so identified, whether this caused or contributed to the eventual outcome;
- Whether there was a failure in the system of prescribing medication, in this case the medication that TC had sought and was refused on the day of his death, and if so identified, whether earlier administration of medication on that date may have affected the eventual outcome.

3. Assessment

The Determination was as follows:

- In terms of section 26(2)(a) of the Act, TC, born 20 September 1966, died at 1950 hours on 21 January 2019 within Glasgow Royal Infirmary, Castle Street, Glasgow.
- In terms of section 26(2)(c) of the Act, the cause of death was: 1(a) carbon monoxide poisoning.
- In terms of section 26(2)(b) of the Act, no accident took place and accordingly no finding requires to be made under section 26(2)(d) of the Act.
- In terms of section 26(2)(e) of the Act, there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.
- In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death.

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

4. Conclusions

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

5. Recommendations

For awareness