

NHS Greater Glasgow and Clyde	Paper No. 26/71
Meeting:	NHSGGC Board Meeting
Meeting Date:	25 June 2026
Title:	Fatal Accident Inquiry Determinations
Sponsoring Director/Manager:	Scott Davidson, Executive Medical Director
Report Author:	Iain Paterson, Corporate Services Manager (Compliance)

1. Purpose

The purpose of the paper is to provide a summary of the Determinations of three recent Fatal Accident Inquiries that NHSGGC participated in at Glasgow Sheriff Court:

- Michael Charlton – 15 April 2026
- Archie Donald – 27 April 2026
- David Sutherland – 4 May 2026

2. Executive Summary

The paper can be summarised as follows:

- Sheriff Guy, presiding over the Michael Charlton FAI, made 9 recommendations for the attention of Scottish Prison Services and none for the attention of NHSGGC: [SHERIFFDOM OF SHERIFF COURT](#)
- Sheriff Millar, presiding of the Archie Donald FAI, identified precautions that could have avoided the death and system defects that contributed to the death, but, satisfied with the improvements made since, made no recommendations for the attention of NHSGGC: [SHERIFFDOM OF SHERIFF COURT](#)
- Sheriff McDonald, presiding over the David Sutherland FAI, made 3 recommendations for the attention of Scottish Prison Services and none for the attention of NHSGGC: [SHERIFFDOM OF SHERIFF COURT](#)

A brief summary of each case can be found in Appendix 1.

3. Recommendations

- Our deepest condolences remain with the families of Michael Charlton, Archie Donald and David Sutherland for their loss and the distress they have experienced. NHSGGC is fully supportive of the purpose of FAIs and welcomes the opportunity to learn from each case.
- The Sheriff's determination into the Archie Donald FAI acknowledges that all necessary changes have been implemented since Archie's death, and, as a result, makes no recommendations.

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:

- The FAI Determinations were communicated to the Executive and relevant Service leads by the Corporate Services Manager. The Central Legal Office notified Board witnesses of the published findings and support continued to be available from the Witness Support Service.

7. Governance Route

- Inquiries Oversight Sub-Group and Clinical Care and Governance Committee

8. Date Prepared & Issued

Date Prepared: 2 June 2026

Date Issued: 17 June 2026

APPENDIX 1

Michael Charlton FAI

Sheriff Guy's Determination following the death of Michael Charlton, a prisoner in HMP Barlinnie who completed suicide by hanging in 2019, was published on 15 April 2026.

Reasonable precautions were identified that could have realistically prevented the death as well defects in the systems of working that contributed to the death. None of the nine recommendations made by Sheriff Guy were directed at NHSGGC, only to Scottish Prison Services. However, two findings do relate to the prison healthcare services provided by NHSGGC, namely:

- The SPS's planning and implementation of MORS at HMP Barlinnie was defective due to the failure to ensure that Greater Glasgow Health Board (GGHB) would implement aspects of this policy.
- The care plans for prisoners that have been placed on MORS at HMP Barlinnie, have not been completed in accordance with this policy, as healthcare staff have not specified the type of observation that is to be completed in addition to the frequency of observations.

The first recommendation requires SPS to put in place a written system of work at HMP Barlinnie in relation to its Management of Offender at Risk Due to Any Substance (MORS) policy that:

- Requires healthcare staff to specify the type of observation that is to be undertaken for prisoners that have been placed on MORS when completing a prisoner's care plan. This should include the type of observation that requires to be undertaken for prisoners that are sleeping and when it is appropriate to wake them for the purpose of carrying out observations.

The second recommendation requires the SPS to amend MORS so that it:

- Does not include a requirement for another organisation (such as GGHB) to undertake tasks that they have not consented to undertaking.

The Determination notes that the SPS's implementation of MORS was defective insofar as it applied to HMP Barlinnie, as it failed to obtain the Board's consent to undertaking aspects of the policy prior to sending it to this prison with an instruction to implement it fully. It further notes that the Board had communicated to the SPS that it would not undertake particular aspects of MORS Policy.

SPS has convened a working-group to review its MORS policy and NHSGGC managers with responsibility for prison health care are participating to directly influence its content and improvements in its application.

Archie Donald FAI

Sheriff's Millar's Determination following the death of Archie Donald, a 3-year-old boy who died in November 2019 in Ward 3C, Royal Hospital for Children, was published on 27 April 2026.

Archie was living with chronic renal failure due to congenital nephrotic syndrome and sadly died due to subacute bacterial endocarditis with extensive associated myocardial infarction.

The Sheriff identified the following precaution that might have realistically avoided Archie's death:

- The elevated C-reactive protein (CRP) result of 98 on 5 November 2019 should have been identified by the attending consultant, with blood cultures ordered. On balance, cultures would have been positive for *Enterococcus faecalis*, prompting earlier investigation (including echocardiography where clinically indicated), targeted antibiotic treatment and monitoring which might realistically have avoided progression to myocardial infarction and death.

The Sheriff also identified 'system defects' which contributed to Archie's death:

- Failure to follow relevant guidance and Archie's anticipatory care plan (including low threshold for infection specialist input and/or blood cultures) given repeated elevated CRP results between 8 October and 5 November 2019.
- Failure to note and communicate the raised CRP on 5 November 2019 in the discharge letter and to review it through the usual post-admission MDT process (no MDT meeting took place and was not rescheduled; absence of the CRP result at discharge was not noted).

It was also noted that, on 19 November 2019 bacterial endocarditis was correctly suspected at renal clinic and blood cultures were ordered, but ward capacity pressures delayed admission and the timing of cardiology investigations. These delays were found to be regrettable but not causative of the death; the subsequent deterioration could not reasonably have been anticipated.

Nevertheless, Sheriff Millar made no recommendations. The Determination records that the blood test results checking process has been strengthened through an electronic sign-off requiring consultants to acknowledge review of results, alongside updated processes/protocols for:

- I. follow-up of outstanding clinic results,
- II. management of renal patients with central lines and raised inflammatory markers (including cultures and antibiotic cover) and;
- III. timely placement in an appropriate clinical environment for children requiring admission from clinic.

No further action is required from NHSGGC. The Sheriff is satisfied that the Significant Clinical Incident Investigation carried out following Archie's death addressed the system issues and all its recommendations were implemented.

David Sutherland FAI

Sheriff McDonald's Determination following the FAI into the death of David Sutherland, a prisoner at HMP Barlinnie who completed suicide by hanging in 2022, was published on 4 May 2026.

No reasonable precautions were identified that could have prevented the death although findings were made in respect of defects in the system of working. All three recommendations made by Sheriff McDonald were for the attention of Scottish Prison Services:

- SPS should develop a standardised toolkit for auditing cells for ligature anchor points, use it to audit all standard cells at HMP Barlinnie, and then remove or reduce ligature points as far as reasonably practicable.
- The DIPLAR process must examine how the suicide was completed, assess risks in the physical environment, and—where a ligature is used—record the ligature and anchor point in detail and share this information with Estates for action.
- SPS should undertake a national procurement exercise for bedding, explore developing a bespoke product with suppliers, and assess whether in-house manufacture is feasible.