SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2020] FAI 9

EDI-B599-19

DETERMINATION

BY

SHERIFF DONALD CORKE ADVOCATE

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

into the death of

MARK HENRY DILLON

Determination

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:-

1. Mark Henry Dillon was born on 21 September 1978 and was resident at HM Prison, Edinburgh when he died.

2. In terms of section 26(2)(a), the death occurred at 15:37 hours on 10 December 2017 at the Intensive Care Unit of the Western General Hospital, Edinburgh.

3. In terms of section 26(2)(c), the cause of death is:

    1a) Acute bacterial meningitis (likely Streptococcus pneumoniae infection) and associated complications

    2. Viral Hepatitis C infection

Chronic drug misuse

Chronic excess alcohol use

4. In terms of section 26(2)(b), (d), (e), (f) and (g), no findings are made.

Recommendations

The death was due to natural causes as appears from the findings of Dr Ian Wilkinson, Consultant Forensic Pathologist, who undertook the post mortem examination of the deceased's body on 19 December 2017. No recommendations are appropriate on the evidence.

NOTE

Introduction

[1] This inquiry was held under the Act into the death of Mark Henry Dillon.

[2] The appearances were Ms Bell, procurator fiscal depute, for the Crown; Mr Holmes, solicitor, for NHS Lothian; and Ms Middleton, trainee solicitor, for the Scottish Prison Service. The family was not involved and no members of the public attended.

[3] The death was reported to COPFS soon after it occurred.

[4] There was a preliminary hearing on 29 July 2019 and a hearing on 28 October 2019.

The legal framework

[5] The inquiry was held under section 1 of the Act and governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[6] The purpose of an inquiry under section 1(3) of the Act is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[7] It was a mandatory inquiry in terms of section 2(1) and (4) of the Act as the deceased was in legal custody at the time of his death.

[8] In terms of section 26 of the Act, the determination requires to set out the findings of the sheriff and any appropriate recommendations.

[9] In the inquiry, the procurator fiscal depute represents the public interest. The inquiry is an inquisitorial process and (under section 1(4) of the Act) it is not its purpose to establish civil or criminal liability.

Summary

[10] No oral evidence was led at the inquiry. A joint minute was entered into by the parties and I was invited to make only formal findings in terms of section 26(2)(a) and (c) of the Act.

[11] At the date of his death, the deceased was in lawful custody at HM Prison Edinburgh, having been remanded for trial in respect of an alleged assault and robbery,

and contravention of Section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. He was remanded on 28 November 2017.

[12] At the date of death, the deceased was accommodated within Cell 108, Glenesk Remand Wing, at HM Prison Edinburgh. He had shared the cell with another prisoner until 6 December 2017, but he was thereafter the sole occupant until his admission to hospital.

[13] The deceased had a history of drug and alcohol misuse, and a positive diagnosis of Hepatitis C. He also had a history of dental abscesses and over-use of antibiotics.

[14] On 4 December 2017 the deceased completed a triage form raising issues relating to his methadone prescription and complaining of earache. The said triage form was assessed on 5 December 2017 by a Staff Nurse who then attended at his cell. Due to his aggressive behaviour, the deceased was not examined at that time.

[15] At around 09:30 hours on 6 December 2017 the deceased had a consultation with the same Staff Nurse, within the medical treatment room at Glenesk Wing. At that time, he complained of left ear pain and flu-like symptoms, and requested antibiotics. The Staff nurse explained that she would require to undertake standard observations (blood pressure, pulse, temperature, oxygen saturations and respiratory rate) but he refused consent therefor.

[16] Upon examination, the deceased's left ear was found to be filled with wax, and the eardrum could not be seen. He was prescribed almond oil to soften the wax and ibuprofen for his headache and sore ear. Antibiotics were not prescribed. He was listed to see the prison General Practitioner on 7 December 2017.

[17] Around 0800 hours on 7 December 2017, he attended at the medication dispensing hatch demanding to go to hospital. He allowed the nurse on duty, a different Staff Nurse, to take his pulse before requesting his methadone and returning to his cell. When she attended at his cell at around 0915 hours that day to complete standard observations, the deceased refused to be examined. Prison Custody Officers were aware of the situation, and were asked to contact the prison health centre if they had any concerns for his welfare.

[18] On 7 December 2017 the deceased declined to attend at the prison health centre to see the prison General Practitioner.

[19] At around 1830 hours on 7 December 2017, Prison Custody Officers contacted the Staff Nurse on duty (another different individual) and asked for the deceased to be examined. On examination he was found to be lying curled up on his bed, with his eyes open. He appeared disorientated and was not speaking coherently. He was suspected of being under the influence of a substance, and was to be managed in terms of the Substance Misuse Policy, as documented at Crown Production number 3: Observation Referral for an Offender at Risk Due to a Substance. That is a form completed at the time, requiring him to have half-hourly visual observations until midnight and hourly observations thereafter.

[20] The deceased was listed for Court on 8 December 2017. That morning, he was examined by a doctor, who found him to be poorly responsive and unable to move or stand. He was groaning incoherently. The doctor deemed him unfit to attend Court and provided a soul and conscience certificate to that effect. The doctor's advice was that

observations were to be maintained and that he might need sending out to A&E if there was no improvement in his condition.

[21] The deceased was thereafter observed every 30 minutes. On his final examination within Glenesk Wing, a fourth Staff Nurse noted that his condition had deteriorated significantly. His conscious level was GCS4 (responsive to pain and voice, but not verbally communicating). He was incontinent of faeces. His blood pressure had increased; oxygen saturations had dropped; and his temperature was recorded at 39.9. As a result, an ambulance was called at approximately 11:30 hours on 8 December 2017.

[22] The deceased was taken by ambulance to the Accident and Emergency department of the Royal Infirmary of Edinburgh where he was assessed. At that time, he was administered IV fluids and antibiotics, sedated and ventilated. A CT scan of his head was completed which showed high intracranial pressure and fluid surrounding his brain. Meningitis was suspected at that stage. His presentation was discussed with a Consultant Neurologist and the decision was taken to transfer him to the Intensive Care Unit at the Western General Hospital (Ward 20) for specialist care.

[23] The deceased arrived at Ward 20 at around 1800 hours on 8 December 2017 and his care was overseen by a Consultant in Anaesthetics and Intensive Care. At that stage his condition had deteriorated further and his pupils were fixed and unresponsive bi-laterally. He was given pharmaceutical treatment and ventricular Access Device (VAD) was inserted to relieve the high pressure in his brain.

[24] The fluid drained by the VAD was indicative of an infection and a clinical diagnosis of Pneumococcal Meningitis (streptococcus pneumoniae) was confirmed by microbiology testing.

[25] A repeat CT scan on 9 December 2017 showed "multi focal bilateral low itenuation" suggesting that the deceased had suffered an unsurvivable brain injury. He was extubated at 2220 hours that day, and was kept comfortable with morphine and midazolam.

[26] He died at 1537 hours on 10 December 2017 and life was pronounced extinct by a doctor.

[27] The body of the deceased was taken to Edinburgh City Mortuary, Cowgate, Edinburgh and was examined by a Consultant Forensic Pathologist on 19 December 2017. A true and accurate Post Mortem Examination Report dated 16 February 2018 was prepared and has been produced.

[28] A separate Medical Report concerning the deceased was prepared, dated May 2019. That is Crown Production number 8 and it is true and accurate in its terms.

Discussion and conclusions

[29] Given the circumstances of the death of the deceased, I am satisfied, as submitted by all parties, that only findings in terms of paragraphs (a) and (c) of section 26(2) of the Act should be made in this case. The death was due to natural causes, as described in the post mortem examination report. No other findings are appropriate on the evidence.