SHERIFFDOM OF LOTHIAN & BORDERS AT EDINBURGH

[2023] FAI 16

EDI/B1426/22

DETERMINATION

BY

SHERIFF K J CAMPBELL KC

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

into the death of

ROBERT JAMIESON

Edinburgh, 20 March 2023

The sheriff, having considered the information presented at the inquiry determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") that:

1. In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):

The late Robert Jamieson died at 22.07 on 9 January 2021 in Room 3, Ward 208 at the Royal Infirmary of Edinburgh, Edinburgh.

2. In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

The death did not result from an accident.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

Mr Jamieson's death was natural and was caused by:

1(a). Complications of glioblastoma WHO Grade 4.

4. In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

No finding is made, as the death did not result from an accident.

5. In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

No such precaution has been identified.

6. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

No such defect has been identified.

7. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

There are no other facts relevant to the circumstances of the death.

Recommendations

In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (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):

No recommendations are made.

NOTE

Introduction

[1] This inquiry was held into the death of Robert Jamieson. Mr Jamieson was a remand prisoner within HM Prison Edinburgh, who died on 9 January 2021 at the Royal Infirmary of Edinburgh. Preliminary hearings took place by webex videoconference on 9 January and 6 February 2023. The inquiry took place on 13 March 2023 by webex videoconference.

[2] The following parties were represented: the Crown in the public interest, represented by Ms Dickie, Procurator Fiscal Depute; NHS Lothian, represented by Ms Jardine, solicitor, and the Scottish Prison Service ("SPS"), represented by Ms Johnstone, solicitor. The family of Mr Jamieson elected not to be represented, but have been fully involved in the prior investigation of matters by the Crown, and Mr Jamieson's sister was present on the video conference as an observer.

[3] Parties' representatives had properly and helpfully agreed a significant amount of evidence in a Joint Minute of Agreement, covering provenance of documents and also the key primary facts about Mr Jamieson's illness and treatment, and the circumstances of his death. That enabled parties to present their positions to the inquiry without the need for oral evidence.

[4] A number of productions were before the inquiry and agreed in the Joint Minute. The Crown lodged the following productions:

1. Intimation and certification of death.
2. Final post mortem report.
3. Death in Prison Learning and Audit Review (DIPLAR) report dated 12 February 2021 and 9 June 2021. This type of report is completed by SPS and the relevant National Health Service Board after the death of any prisoner in custody.
4. SPS death in custody documentation.
5. Medical records - Edinburgh Cancer Centre June - November 2020.
6. NHS Lothian oncology records (1).
7. NHS Lothian oncology records (2).
8. GP medical records.
9. NHS All clinical reports - prison medical records 2012-2020.
10. Prison medical records September - 28 December 2020.
11. Prison medical records 2017 & 2018.
12. Prison medical records 16 January 2007-22 February 2017.

13. Witness statement - Wendy Bowman, senior charge nurse.

14. Witness statement - Dr Moray Kyle, consultant clinical oncologist, 25 January 2021.

15. Witness statement - Dr Moray Kyle, consultant clinical oncologist, 8 January 2023.

16. Witness statement - Dr Rebecca Evans, consultant in palliative care.

17. Witness statement - Laura McConnell, senior nurse practitioner.

The legal framework

[5] This inquiry was held in terms of section 1 of the 2016 Act. Mr Jamieson died in legal custody, albeit he was in hospital at the time of his death, and therefore the inquiry was a mandatory inquiry held in terms of sections 2(1) and 2(4) of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"), and was an inquisitorial process. The Crown represented the public interest.

[6] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Jamieson and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules). The

procedure adopted in this case was an appropriate way to present the available evidence in the circumstances.

[7] Section 26 of the 2016 Act sets out what must be determined by the inquiry, and for that reason it is convenient to set out the terms of section 26:

> "Section 26 - The sheriff's determination:
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out -
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1)(a) are -
> (a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to

(a) a participant in the inquiry,

(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[8] In this Note I will, firstly, set out the facts that I have found proved, followed a brief outline of the submissions made by the Crown and the other parties. Finally, I will consider each of the circumstances identified in sections 26(2)(a) to (g) of the 2016 Act and explain, with reference to the information before the inquiry, the conclusions I have reached.

[9] Because parties had reached agreement about the key facts and recorded these in a Joint Minute, that obviated the need for oral evidence. Parties' submissions to the inquiry were based on the Joint Minute and accompanying documents, and it is therefore convenient to set out the agreed facts.

Findings in fact

[10] Robert Jamieson was born on 18 January 1971 and died on 9 January 2021, aged 49.

[11] At the time of his death, Mr Jamieson remained in the lawful custody of Her Majesty's Prison (HMP) Edinburgh.

[12] On 11 April 2020, Mr Jamieson appeared on Petition at Edinburgh Sheriff Court and was remanded in custody for various alleged offences. On 17 April 2020,

Mr Jamieson was fully committed and detained until liberated in due course of law. Mr Jamieson entered a plea of guilty at a Preliminary Hearing on 4 September 2020 at Glasgow High Court and was sentenced to 12 months imprisonment backdated to 11 April 2020. Mr Jamieson was released from prison on 9 October 2020.

[13] At the time of his death, Mr Jamieson was an untried prisoner within HMP Edinburgh having been remanded on 17 November 2020 by Edinburgh Sheriff Court for an alleged breach of a Sexual Offences Prevention Order which had been imposed upon him on 18 March 2020 at Edinburgh Sheriff Court. On 25 November 2020, at Edinburgh Sheriff Court, Mr Jamieson was fully committed and detained until liberated in due course of law.

[14] On 1 June 2020, whilst on remand at HMP Edinburgh, Mr Jamieson completed a Self-Referral Form to the Prison Medical Team complaining of suffering from sharp painful headaches. At the consultation, Mr Jamieson recounted to a practice nurse an incident whereby he had bumped his head on a mantelpiece at his home in April 2020 and thought that the headaches may be related to that. He told the nurse that the headaches had started approximately 2 weeks prior to his self-referral. Mr Jamieson was offered advice from a nurse at HMP Edinburgh with regards to dehydration and to cutting down caffeine intake. He was also advised to re-refer himself to the medical team within the prison should there be no improvement throughout the week.

[15] On 11 June 2020, Mr Jamieson had a further consultation with a practice nurse. Mr Jamieson complained again with regards to sharp pains in his head. A review of medication with an Advanced Nurse Practitioner was scheduled.

[16] On 17 June 2020, Mr Jamieson was reviewed by an Advanced Nurse Practitioner with regards to his complaint of daily headaches. He again described hitting his head off a mantlepiece at his home in April 2020 and that the headaches started approximately 4 weeks after that. Mr Jamieson described the headaches as a daily occurrence and that co-codamol did not relieve the pain. Mr Jamieson was prescribed ibuprofen to see if that medication helped him.

[17] On 22 June 2020, Mr Jamieson was referred to the Prison Healthcare Team by Prison Officers within HMP Edinburgh. Officers were concerned because Mr Jamieson was lying in bed and not able to get up. He was seen by a practice nurse within his cell and complained of having a sore head and nausea. His observations were taken and were reasonable and it was decided to review him in the morning.

[18] On 23 June 2020, Mr Jamieson was reviewed by an Advanced Nurse Practitioner due to concerns raised by a Prison Officer that Mr Jamieson was unable to get up. Mr Jamieson appeared weak and was unable to follow simple commands. An ambulance was called to take Mr Jamieson to hospital for assessment.

[19] On 23 June 2020 at the Royal Infirmary of Edinburgh, due to reduced consciousness levels, Mr Jamieson underwent CT and MRI scans of his head which revealed a right temporal lobe mass. The radiographical diagnosis was that Mr Jamieson was suffering from a primary high grade cancerous tumor, likely Glioblastoma (GBM) and was transferred to the Department for Clinical Neurosciences at the Royal Infirmary of Edinburgh and thereafter to the Intensive Care Unit (ICU).

[20] Mr Jamieson received aggressive treatment and his consciousness levels returned to normal. Mr Jamieson was adamant that he did not want surgery in relation to the tumor. He was stepped down from ICU on 25 June 2020 and discharged back to HMP Edinburgh on 26 June 2020.

[21] On 29 June 2020, Consultant Clinical Oncologist Moray Kyle met with Mr Jamieson. At that time, Mr Jamieson reiterated that he did not want surgery. Palliative radiotherapy was discussed. Mr Jamieson was aware that he had an incurable primary brain tumor which was likely to be a Glioblastoma; pathological analysis would be the only way to be sure. Dr Kyle described this as an aggressive type of brain tumor that would continue to grow and without any treatment, Mr Jamieson's survival would likely be measured in weeks to months. With palliative radiotherapy this may be extended to a larger number of months, but Mr Jamieson was made aware that there was no guarantee of that. Mr Jamieson decided to proceed with palliative radiotherapy treatment.

[22] When a patient presents with symptoms of Glioblastoma it would be expected that the tumor would have been present no longer than a couple of months.

[23] By 24 July 2020, Mr Jamieson had completed 6 rounds of radiotherapy treatment which had been on alternate days over a period of 2 weeks.

[24] Following completion of radiotherapy and having elected not to have surgery, and therefore no pathological tissue to examine, there were no further active treatment options available to Mr Jamieson and the focus shifted to best supportive care with

Dexamethasone and other medications for symptom control. He was thereafter referred to the community palliative care team.

[25] On 5 November 2020, whilst at liberty, Mr Jamieson underwent a post-radiotherapy MRI scan of the head which showed a mixed response - with reduced oedema but increase in right temporal cystic enhancing tissue consistent with disease progression.

[26] On 22 November 2020, Mr Jamieson attended at the Accident and Emergency Department of the Royal Infirmary of Edinburgh due to a worsening headache, slurred speech, dizziness and confusion. Mr Jamieson was reviewed and at that time was given the results of the MRI scan of 5 November 2020 which showed disease progression. Mr Jamieson asked to be returned to prison. His medications were increased as a result of hospital advice.

[27] On 23 November 2020, a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) was put in place due to the likelihood of CPR being unsuccessful due to Mr Jamieson's condition.

[28] On 25 November 2020, Mr Jamieson was admitted to the Western General Hospital, Edinburgh as his symptoms were not improving despite an increase in medication over the preceding 3 days. His medications were increased again, and he was given treatment for a urinary tract infection.

[29] On 8 December 2020, a Marie Curie Nurse Specialist visited Mr Jamieson in HMP Edinburgh. They discussed his potential move to a hospice when it was appropriate but

agreed that it was not necessary at that time. Mr Jamieson was commenced on oral liquid morphine for pain at that time.

[30] On 14 December 2020, Mr Jamieson was assessed by a trainee Advanced Nurse Practitioner because he had been refusing to attend for prescribed medication for several days. He was offered a 3 wheeled mobilator at this time as he was feeling 'off balance' but he refused this. He was provided with an air mattress topper as he was feeling uncomfortable in bed. Mr Jamieson was seen and assessed every 2 to 3 days by nursing staff from that point.

[31] On the morning of 27 December 2020, Mr Jamieson was reviewed by nursing staff; he was found sitting on the floor of his cell. He had been incontinent of urine, was unable to move unaided, and was unable/ unwilling to take oral fluids. He was responsive to voice, but unable to speak or stand and was aided back to bed. The on-call oncologist was contacted for advice, an ambulance was called and Mr Jamieson was later transferred to the Royal Infirmary of Edinburgh. Mr Jamieson did not return to HMP Edinburgh.

[32] Mr Jamieson was transferred to Ward 108 where he was regularly reviewed by the Palliative Care Team and his symptoms were managed in line with Scottish Palliative Care guidelines. He initially became more responsive on 29 December 2020, and a trial of increased steroids was commenced, however his function did not improve significantly. On 30 December 2020, Mr Jamieson expressed a wish to self-discharge and return to prison. At that point, following discussion with the medical team looking after him, it was decided that he did not have capacity to make that decision. Mr Jamieson

continued to be cared for by the medical team with input from the palliative care team to manage his pain and agitation. Moving Mr Jamieson to the Marie Curie Hospice was considered, but he was not stable enough and a move was deemed inappropriate.

[33] On 9 January 2021 at 22:07 hours, Mr Jamieson's life was pronounced extinct by Dr Joanna Higson, in room 3 Ward 208, Royal Infirmary of Edinburgh.

[34] A single doctor post-mortem examination was instructed at the instance of the Procurator Fiscal, and was carried out on 19 January 2021 by Consultant Forensic Pathologist Dr Kerryanne Shearer of Edinburgh City Mortuary, Cowgate, Edinburgh.

[35] The cause of Mr Jamieson's death was initially recorded as '1a. Brain tumor (pending investigations)'

[36] Dr Shearer thereafter produced Final Post-Mortem Report dated 10 March 2021, which includes a Neuropathological Report produced by Professor Colin Smith, Consultant Neuropathologist of The University of Edinburgh. Neuropathological examination confirmed an extensive right partial Glioblastoma WHO Grade 4 which extended across the corpus callosum into the left cerebral hemisphere. Associated with that tumor there was a right sided subfalcine hernia. The reports concluded that Mr Jamieson's death was principally due to natural causes, from complications of Glioblastoma WHO Grade 4 which resulted in swelling and ultimately death.

[37] The cause of Mr Jamieson's death was therefore amended to and certified as '1a. Complications of Glioblastoma WHO Grade 4' by Dr Shearer.

Parties' submissions

[38] On behalf of the Crown, the Procurator Fiscal Depute directed me to the revised Joint Minute, agreed by parties and tendered prior to the hearing. She explained that the Crown intended to rely on that, together with the underlying documents, as the evidence in the inquiry. She did not propose to lead oral evidence from any witnesses. The other parties indicated they were content to proceed in this way.

[39] Having read the Joint Minute into the record, the Procurator Fiscal Depute invited me to make findings under sections 26(2)(a) and 26(2)(c) of the 2016 Act only. As to the first of those, she invited me to find that Mr Jamieson died within Room 3, Ward 208 at the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh. His life was formally pronounced extinct on 9th January 2021 at 22:07 hours, by Dr Joanna Higson, Ward 208, Royal Infirmary of Edinburgh. As to the second of those, the cause of death, she invited me to find that, as set out in the joint minute of agreement and final post mortem report, the cause of death for Mr Jamieson was certified as: '1a. Complications of Glioblastoma WHO Grade 4'.

[40] Those findings were, she submitted, vouched by the material referred to in the Joint Minute.

[41] As the Crown's position was that Mr Jamieson's death was not the result of an accident, the Crown had no submissions to make under sections 26(2)(b) or 26(2)(d) of the 2016 Act.

[42] Having regard to Dr Shearer's conclusion that Mr Jamieson's death was principally due to natural causes, namely from complications of Glioblastoma WHO

Grade 4, which resulted in swelling and ultimately death, the Crown made no submissions under sections 26(2)(e) to 26(2)(g) of the 2016 Act. At a preliminary hearing, the Crown had advised the court that family members had raised concerns about aspects of the management of Mr Jamieson's care with the Crown. In particular that he had been handcuffed to his bed, that hydration was at times inadequate, that his fluids were at times not well managed, and that information was not always readily available to family members. At the hearing on 13 March, the Procurator Fiscal Depute advised that the Crown had considered these matters, and had concluded that the evidence indicated these matters did not bear on the issues in this inquiry. However, family members had been provided with support and information about alternative routes for raising such concerns.

[43] For SPS, Ms Johnstone adopted her written submission. She too invited me to make findings only under sections 26(2)(a) and (c) of the 2016 Act, and she referred me to the Joint Minute. She agreed with the findings proposed by the Crown in that respect. So far as the other elements of section 26(2) were concerned, Mr Jamieson's death was not the result of an accident, and accordingly there were no reasonable precautions which might have prevented his death. Nor was there evidence of any defects in any system of work which contributed to his death. There were no other facts and circumstances relevant to his death.

[44] For NHS Lothian, Ms Jardine also referred me to the Joint Minute. She too invited me to make findings under sections 26(2)(a) and (c) of the 2016 Act only. She

agreed with the findings proposed by the Crown. Mr Jamieson's death was not the result of an accident, and accordingly there were no other issues to be explored.

Findings and discussion

In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):

[45] There was no dispute about when and where Mr Jamieson died. I therefore find that the late Robert Jamieson died at 22.07 on 9 January 2021, in room 3 ward 208 at the Royal Infirmary of Edinburgh. That is documented in the notification of death (Crown Production 1).

In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

[46] It was a matter of agreement that Mr Jamieson's death did not result from an accident. On the evidence before me, that is correct. It is therefore unnecessary for me to make a finding under this head.

In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

[47] There is no dispute about the cause of death. Mr Jamieson's death was natural and in terms of the final post-mortem report was certified as:

1(a). Complications of Glioblastoma WHO Grade 4.

I therefore determined that the cause of death was as documented in the medical certification of death.

In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

[48] It was a matter of agreement that Mr Jamieson's death did not result from an accident. I have already indicated I agree with that. It is therefore unnecessary for me to make a finding under this head.

In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

[49] No such precaution has been identified by the Crown. On the basis of the material before the inquiry, I agree with that assessment. Mr Jamieson was appropriately referred for medical examination by prison staff. Once in hospital, appropriate clinical investigations were carried out, including X-rays and CT scans. Mr Jamieson was appropriately referred for examination and treatment. Once his diagnosis was confirmed, his clinical treatment was appropriate and timely.

[50] Mr Jamieson's death was not the result of an accident. Further, the Crown had identified no systemic failures in the management of Mr Jamieson's care in his time at HMP Edinburgh, or in the Royal Infirmary of Edinburgh.

[51] Given the medically-certified cause of death, the Crown submitted there were no precautions which could have realistically been made to prevent death. In the course of

medical examination, Mr Jamieson had been found to have advanced brain cancer, with a terminal diagnosis. I agree with that assessment.

In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

[52] No such defect has been identified by the Crown. On the basis of the material before the inquiry, I agree with that assessment. As I have already indicated, Mr Jamieson was appropriately referred for examination and treatment. Once his diagnosis was confirmed, his course of treatment was appropriate and timely.

In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

[53] From the matters agreed in the Joint Minute, and the supporting evidence before the court, I do not consider there are other facts relevant to the circumstances of the death.

In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (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):

[54] Against the background of the facts I have found, I do not consider there are any recommendations to be made.

[55] At the outset of the inquiry, I extended my condolences to Mr Jamieson's family, and I wish formally to repeat my condolences to them in this determination.