SHERIFFDOM OF LOTHIAN & BORDERS AT EDINBURGH

[2021] FAI 55

EDI-B492/21

DETERMINATION

BY

SHERIFF K J CAMPBELL

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

into the death of

ANGUS ROBB

Edinburgh, 1 November 2021

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 Angus Robb died at 18.30 on 13 June 2020 at Ferryfield House, 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 Robb's death was natural and was caused by:

1(a). End-stage metastatic lung cancer;

1(b). Cancer of right middle lobe of lung (no tissue diagnosis);

2. Emphysema.

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 Angus Robb. Mr Robb was a serving prisoner at HM Prison Edinburgh, who died on 13 June 2020 at Ferryfield House, Edinburgh. A preliminary hearing was held by webex videoconference on 28 July 2021. The inquiry took place on 25 October 2021 by webex videoconference.

[2] The following parties were represented: the Crown in the public interest, represented by Mr Morrison, Procurator Fiscal Depute; NHS Lothian, represented by Mr Holmes, solicitor, and the Scottish Prison Service ("SPS"), represented by Ms Thornton, solicitor. The family of Mr Robb elected not to be represented, but were present on the video conference as observers.

[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. 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, extracted 16 April 2021.

2. Death in Prison Learning and Audit Review (DIPLAR) report dated 10 & 15 September 2020. This type of report is completed by SPS and the relevant National Health Service Board after the death of any prisoner in custody.

3. Death in custody documentation.

4. Prison medical records.

5. NHS Lothian medical records.

SPS lodged the following productions:

1. Draft compassionate release application.

2. Redacted email 2 June 2020, from Mark McLeod.

3. SPS document GMA054A/16, Governors and Managers Action - Early Release on Compassionate Grounds.

4. Affidavit of Mark McLeod, dated 15 October 2021. The Affidavit provides further background information to Mr Robb's care, why the compassionate release application was not progressed and the criteria that have to be met for a compassionate release application to be successful.

The legal framework

[5] This inquiry was held in terms of section 1 of the 2016 Act. Mr Robb died in legal custody 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 Robb 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).

[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:
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> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out -
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> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
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> (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] Angus Robb was born on 1 August 1953 and died on 13 June 2020, aged 66.

[11] Mr Robb died at Ferryfield House, Edinburgh. Ferryfield House is an NHS Lothian community hospital which provides, *inter alia*, end of life and palliative care.

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

[13] On 16 October 2018, Mr Robb was found guilty of a number of historical sexual offences against children including four charges of lewd, indecent and libidinous practices and behaviour after a trial by jury at the High Court of Justiciary sitting at Edinburgh. He was admitted into the custody of HMP Edinburgh pending the preparation of background reports and sentence. He was sentenced at the High Court of Justiciary sitting at Glasgow on 12 November 2018 to a period of imprisonment of six years and six months, backdated to the 16 October 2018. He was conveyed back to HMP Edinburgh to serve that sentence.

[14] On admission to HMP Edinburgh on 16 October 2018, Mr Robb's prison medical notes were updated to reflect his known health and medical issues. The following was noted:

- Suspected asthma
- Physical handicap problem involving his elbows which had necessitated three historical surgeries
- A three year history of Chronic Obstructive Pulmonary Disorder (COPD)
- He had suffered from a heart attack in 2013
- He had suffered from a stroke in 2014
- A five year history of prostatitis

[15] During Mr Robb's incarceration at HMP Edinburgh he was prescribed the following regular medications:

- Alfuzosin (in relation to the prostate enlargement)
- Bisoprolol (for blood pressure)
- Clopidrogel (anti-platelet medication)
- Finasteride (in relation to the prostate enlargement)
- Fultium D3 (for calcium absorption)
- Aspirin
- Lansoprazole (antacid)
- Sertraline (anti-depressant)
- Simvastatin (to lower cholesterol)
- Salbutamol and Duaklir inhalers
- Co-codamol

[16] On 18 April 2020, Mr Robb was seen by a triage nurse at the request of Prison Officers on the basis that he presented with breathlessness and that he appeared vague on conversing with them. On review by the triage nurse it was noted that he was vague on conversing with her and that his monthly medication appeared not to have been used. On examination he was found to have full power in all his limbs, had no deficit in his reactions, and there was no deviation in his tongue movement. A urine sample was arranged and an appointment for further review was booked with the General Practitioner.

[17] On 21 April 2020, Mr Robb was reviewed by Shelley Jones, Advanced Nurse Practitioner, after he had vomited, appeared confused and was yellow in appearance. On review Ms Jones noted that Mr Robb was jaundiced and that his eyes were yellow

with constricted pupils. She noted that his mouth appeared to be drooped on the right side and he appeared very confused. Ms Jones' initial assessment was that this was a medical emergency and that Mr Robb may have suffered from a stroke. Arrangement was made for his immediate transfer by ambulance to the Accident and Emergency Department of the Royal Infirmary of Edinburgh.

[18] Mr Robb was admitted to the Royal Infirmary of Edinburgh on 21 April 2020 where he remained until 20 May 2020 when he was transferred to Ferryfield House, Edinburgh. At the Royal Infirmary of Edinburgh Doctor Iain Macintyre, Consultant, was in charge of Mr Robb's care.

[19] On 22 April 2020, Mr Robb underwent a chest X-ray. Doctor Macintyre notes that the results of the X-ray showed patchy consolidation in the right lower and midzone and he was therefore diagnosed with community acquired pneumonia. He was prescribed antibiotics as treatment.

[20] On 24 April 2020, Mr Robb underwent a Computerised Tomography (CT) scan of his head, instructed against a background of continued confusion and a right-sided facial droop. The scan revealed the presence of numerous hypercellular cerebral and cerebellar tumours. Further CT scans of the chest, abdomen and pelvis revealed presumed primary lung malignancy in the right middle lobe with mediastinal lymphadenopathy, hepatic and cerebral metastases. Doctor Macintyre noted from these results that the larger metastases demonstrated extensive surround perilesional oedema and mass-effect resulting in a frontal midline shift of 4 millimetres. The cancer was categorised as advanced and metastatic, and was terminal. Mr Robb was

prescribed dexamethasone in view of significant oedema surrounding the lesions in the brain.

[21] On 24 April 2020 a "Do Not Attempt Cardio-Pulmonary Resuscitation" (DNA CPR) protocol was initiated and put in place for Mr Robb, on the basis that such a course of action was likely to fail as a result of his multi-faceted health problems. Mr Robb remained at the Royal Infirmary of Edinburgh for on-going care meantime, and Doctor Macintyre notes that it was determined that he would require hospital level care for the remainder of his life. The respiratory team at the Royal Infirmary of Edinburgh determined that palliative chemotherapy was not appropriate in the circumstances and that Mr Robb's prognosis indicated a life expectancy of days to weeks.

[22] A Compassionate Release application was commenced in or around May 2020. SPS Production 1 is said Compassionate Release application. The Compassionate Release application was partially completed by Dr William Smith and dated 5 May 2020. It is there noted that Mr Robb is still a high risk prisoner and the only way to support him in hospital is with continued prison support to supervise him.

[23] SPS Production 3 is Governors and Managers: ACTION GMA 054A/16 dated 9 September 2016 entitled "Early Release on Licence on Compassionate Grounds – Revised Guidance for Submission of Applications". GMA 054A/16 provides guidance to SPS staff on the compassionate release process.

[24] On 20 May 2020, Mr Robb was transferred to Ferryfield House, Edinburgh where he was housed within Room 35. His transfer was to facilitate a more comfortable location for palliative and end of life care.

[25] On 2 June 2020, there was further discussion regarding Mr Robb's Compassionate Release application. SPS Production 2 is an email on 2 June 2020, from Mark McLeod of SPS to various others, providing an update following a telephone call with Dr Andrew Pearson from Ferryfield House. It confirms that Dr Pearson would not support an application for compassionate release as Mr Robb was still able to present a risk.

[26] During Mr Robb's stay at Ferryfield House, Edinburgh his condition was noted to deteriorate. Laura Black, Staff Nurse, was responsible for Mr Robb's care at Ferryfield House. She noted that on first admission Mr Robb was mobile and able to walk with a Zimmer frame, was able to use the shower and bathing facilities and communicated well. Ms Black notes that Mr Robb's condition deteriorated quickly, however. She noted that within two weeks he became confined to his bed, lost his appetite and became less communicative. She further noted that his pain was increasing and that whilst there were times when he was lucid, these periods were becoming "few and far between." In terms of Mr Robb's decline, Ms Black notes that this was not unusual or concerning given the medical picture. A syringe driver was utilised to administer pain relief medication to Mr Robb, including oxycodone and midazolam. Ms Black notes that the primary care function was to make Mr Robb as comfortable and pain-free as possible.

[27] On 13 June 2020, it was noted that Mr Robb had further deteriorated and his family were contacted to attend at Ferryfield House. At around 1800 hours same date, Mr Robb's breathing became laboured and a nurse was alerted. Staff Nurse Louise Black attended and at 1830 hours she pronounced Mr Robb's life extinct.

[28] Mr Robb's death was medically certified by Doctor Rosamund Ring, Ferryfield House, Edinburgh. The cause of death was certified as:

1a – End-stage metastatic lung cancer

1b – Cancer of right middle lobe of lung (no tissue diagnosis)

2 – Emphysema

Parties' submissions

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

[30] Having read the Joint Minute into the record, the PF Depute invited me to make findings as to the birth and death of Mr Robb as follows: Mr Robb was born on 1 August 1953 and died at 1830 on 13 June 2020 at Ferryfield House, Edinburgh. He invited me to find that the causes of death were:

1a – End-stage metastatic lung cancer

1b – Cancer of right middle lobe of lung (no tissue diagnosis)

2 – Emphysema

[31] Those findings were, he submitted, vouched by the material in the Joint Minute.

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

[33] 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 Robb had been found to have advanced metastatic cancer, with a terminal diagnosis. The evidence disclosed a clear explanation of the primary care function, namely to make Mr Robb as comfortable and pain free at end of life. Members of his family had been called on 13 June, and were by his side. His death had been medically certified.

[34] The Crown was therefore not inviting the court to make findings in terms of subsections 26(2)(b), (d), (e), (f), or (g) of the 2016 Act.

[35] For Lothian Health Board, Mr Holmes indicated he did not have anything to add to the submissions on behalf of Crown. He too sought findings only in terms of section 26(2)(a) &(c) of the 2016 Act.

[36] For SPS, Ms Thornton, referred to me to the affidavit of Mark McLeod (SPS production 4). She explained the context of the account there was that Mr McLeod was part of a multidisciplinary team. Following the diagnosis of cancer, there had been discussions about compassionate release. An application had been partly prepared.

That had not progressed because it was thought it would be not successful.

Ms Thornton also sought findings only in terms of ss 26(2)(a) &(c) of the 2016 Act.

Findings and discussion

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

[37] There was no dispute about when and where Mr Robb died. The late Angus Robb died at 18.30, on 13 June 2020 at Ferryfield House, Edinburgh. That is documented in the medical certification of death.

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

[38] It was a matter of agreement that Mr Robb's death did not result from an accident. 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):

[39] There is no dispute about the cause of death. Mr Robb's death was natural and was certified as:

1(a). End-stage metastatic lung cancer;

1(b). Cancer of right middle lobe of lung (no tissue diagnosis);

2. Emphysema.

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):

[40] It was a matter of agreement that Mr Robb's death did not result from an accident. 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):

[41] No such precaution has been identified by the Crown. On the basis of the material before the inquiry, I agree with that assessment. Mr Robb 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 Robb was appropriately referred for examination and treatment. Once his diagnosis was confirmed, his clinical management was appropriate and timely. He was transferred to Ferryfield House, which is a hospital suitably equipped for palliative and end of life care.

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):

[42] 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 Robb

was appropriately referred for examination and treatment. Once his diagnosis was confirmed, his clinical management 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):

[43] 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):

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

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