

SHERIFFDOM OF LoTHIAN AND BORDERS AT EDINBURGH

[2026] FAI 53

EDI-B483-26

DETERMINATION

BY

SHERIFF COLM P DEMPSEY

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

into the death of

BERTIE HALL

EDINBURGH, 2 October 2026

The sheriff, having considered the information presented at an inquiry on 1 October 2026, under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (“the Act”) finds and determines:

1. In terms of section 26(2)(a) of the Act that Bertie Hall, who was born on 20 August 1967, died on 14 March 2024 within cell 2/38, Hermiston Wing North, HMP Edinburgh, 33 Stenhouse Road, Edinburgh. The time of his death was recorded at 0737 hours.
2. In terms of section 26(2)(c) of the Act that the cause of death was:
 - 1(a) Complications of oesophageal carcinoma.
3. I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26(2) of the Act.

4. I have no recommendations to make under section 26(1)(b) of the Act.

NOTE

Introduction

[1] A fatal accident inquiry was held at Edinburgh Sheriff Court on 1 October 2026 into the death of Bertie Hall.

[2] Three parties were represented at the inquiry. Ms Evans, procurator fiscal depute, appeared for the Crown. Ms Shaw, solicitor, appeared for the Scottish Ministers on behalf of the Scottish Prison Service, and Mr Holmes, solicitor advocate, appeared for Lothian Health Board. Intimation of the inquiry was made to Mr Hall's family, who elected not to participate.

[3] For the purposes of the inquiry, the parties tendered a joint minute of agreement covering all the evidence necessary for the determination. Therefore, no oral evidence was heard. All parties invited me to make only formal findings in terms of section 26(2)(a) and (c) of the Act.

The legal framework

[4] This inquiry was held under section 1 of the Act. It was a mandatory inquiry in terms of section 2(4)(a) of the Act as Mr Hall was in legal custody at the time of his death.

[5] In terms of section 1(3) of the Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent

other deaths in similar circumstances. Section 26 requires the sheriff to make a determination, which in terms of section 26(2), is to set out factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These 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 could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided; (f) any defect in any system of working which contributed to the death or to the accident; and (g) any other facts which are relevant to the circumstances of the death. In terms of sections 26(1)(b) and 26(4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate 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; and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances. The procurator fiscal depute represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The determination must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish criminal or civil liability.

Findings

[6] Mr Hall was born on 20 August 1967.

[7] At the date of his death, Mr Hall was serving sentences of imprisonment, having first been sentenced on 12 September 2017 at Glasgow High Court to a period of 8 years' imprisonment. On 21 December 2021, at Edinburgh High Court, Mr Hall was sentenced to a further period of 9 years' imprisonment.

[8] During his imprisonment Mr Hall spent time at His Majesty's Prisons in Shotts, Grampian and Edinburgh. He had been at HMP Edinburgh since 22 February 2019.

[9] On 24 June 2022 Mr Hall was diagnosed as having oesophageal adenocarcinoma (a cancer that begins in the gland cells in the inner lining of the lower part of the oesophagus). CT scans showed no evidence of metastatic disease, and the treating clinicians considered that the condition was amenable to curative surgery.

[10] Mr Hall attended a surgical review meeting on 8 July 2022 and was informed of the outcome of the investigations. Mr Hall stated at that time that he did not wish to pursue surgical or other curative treatment. He was informed of the likely progression of the disease and the possibility of future stenting.

[11] Mr Hall thereafter developed difficulty in swallowing and his weight decreased. During August and September 2022 these difficulties worsened. His pain medication was reviewed and increased and his diet was altered to alleviate the swallowing difficulties.

[12] On 30 November 2022, Mr Hall requested that a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decision be put in place for him. This was subsequently put in place on 18 March 2023.

[13] Throughout 2023 and into early 2024 Mr Hall's condition deteriorated as the disease progressed. He suffered from associated health problems including recurring chest infections and constipation. His mobility was reduced and he became increasingly frail. Throughout this period Mr Hall remained under the care of the prison healthcare team, hospital clinicians and the Marie Curie palliative care team.

[14] At the time of his death Mr Hall was accommodated within a single occupancy cell in Hermiston Wing North at HMP Edinburgh. Mr Hall had established relationships with prison staff and other inmates there.

[15] On 13 March 2024, Prison Officer Bell was on duty and observed Mr Hall to be weak but mobile.

[16] During the evening of 13 March into the morning of 14 March 2024, Healthcare Assistant Kofi Benefo undertook regular observations and care checks in respect of Mr Hall.

[17] At 1900 hours on 13 March 2024 Mr Hall was observed to be in bed within his cell. He was comfortable at this time and advised that he did not require any assistance.

[18] At approximately 2100 hours Mr Hall was again observed to be awake in bed. He did not require any assistance.

[19] Around midnight Mr Hall was assisted to change position in bed to reduce the risk of pressure injuries.

[20] At 0300 hours Mr Hall was observed to be asleep in bed. No concerns were noted at this time.

[21] At 0735 hours Prison Officers Speed and Beveridge carried out a numbers check within Hermiston Wing North.

[22] Numbers checks are used by prison staff to check on the welfare of prisoners and require that the officers obtain both visual and verbal responses from prisoners.

[23] Upon entering cell 2/38 Prison Officers Speed and Beveridge observed Mr Hall to be lying in his bed, however there was no sign of movement or response. Assistance was requested by way of a "Code Blue" call. This is an emergency code to indicate that an individual is having trouble breathing and may or may not be responsive.

[24] Senior Charge Nurse Laura McConnell attended at the cell along with other prison healthcare staff. Mr Hall showed no signs of life and Senior Charge Nurse McConnell formally confirmed his death at 0737 hours on 14 March 2024.

[25] On 25 April 2024, a post-mortem examination was carried out at the Edinburgh City Mortuary by Professor Ralph BouHaidar, consultant forensic pathologist, who found that the cause of Mr Hall's death was due to complications of oesophageal carcinoma.

Conclusion

[26] Mr Hall was a 56 year old man who suffered from oesophageal cancer. He received appropriate medical and palliative care during his time in custody.

[27] Given the circumstances of Mr Hall's death, 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.

[28] Lastly, I express my condolences, along with those of the parties who appeared at the inquiry, to the family and friends of Mr Hall.