SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2024] FAI 33

EDI-B55-24

DETERMINATION

BY

SHERIFF KEVIN McCARRON

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

into the death of

BRIAN JOHNSTONE

Edinburgh 2 September 2024

The Sheriff, having considered the information presented at an inquiry under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act"), determines:

1. In terms of section 26(2)(a) of the Act Brian Johnstone born 5 August 1976 died between 2130 hours on 24 December 2021 and 0730 hours on 25 December 2021 in his cell at HMP Edinburgh.
2. In terms of section 26(2) of the Act the causes of death were

   1a Peritonitis and;

   1b Perforated Duodenal Ulcer.
3. In respect of subsections (b) and (d) of section 26(2) of the Act, no accident took place.

4. In respect of subsections (e), (f), and (g) of the section 26(2) of the Act, no findings fall to be made.
5. In respect of section 26(1)(b) and (4) of the Act, no findings fall to be made.

NOTE

Introduction

[1] This inquiry is held under section 1 of the Act. It was a mandatory inquiry in terms of section 2(1) and (4) of the Act. At the time of his death Mr Johnstone was in lawful custody at HMP Edinburgh. The Procurator Fiscal lodged a Notice of Inquiry on 18 January 2024. There was a preliminary hearing on 7 March 2024 and a continued preliminary hearing on 25 April 2024. The inquiry itself took place on 27 May 2024. Written submissions were lodged by all parties within 28 days of the conclusion of the inquiry.

[2] Four parties were represented at the inquiry. Mr Simon Gregor, procurator fiscal depute, appeared for the Crown. Ms Joanna Arnott, Solicitor, for the Scottish Ministers, on behalf of the Scottish Prison Service (the "SPS"). Mr Stuart Holmes, Solicitor, for the Prison Officers Association. Mr Alan Rodgers, Solicitor, for the Prison Officers Association.

[3] A very detailed joint minute had been prepared by the parties, along with the various Crown productions which were lodged for consideration. In addition parole evidence was led from Doctor Cameron Gracie, General Practitioner, and Doctor Katherine Dixon, General Practitioner. Detailed written submissions were then

lodged on behalf of all parties. All of this greatly assisted in allowing findings to be formed.

Agreed evidence

[4] The following facts were agreed:

1. That Brian Johnstone was born on 5 August 1976. At the time of his death he was 45 years of age and was being held in legal custody at His Majesty's Prison Edinburgh, 33 Stenhouse Road, Edinburgh EH1 3LN;
2. That on 17 July 2008 he was sentenced to an Order for Lifelong Restriction in relation to a conviction of a common law breach of the peace;
3. That in January 2010, Mr Johnstone was sentenced to 204 days imprisonment for breach of section 52A Civic Government (Scotland) Act 1982;
4. That in December 2012 Mr Johnstone was assessed by a medical team from the State Hospital at Carstairs due to ongoing concerns over his poor mental health. He was deemed not appropriate for admission there at that time. In January 2013 he was transferred out of HMP Edinburgh and admitted to the Orchard Clinic over concerns of him being thought-disordered, rambling and bizarre speech;
5. That Mr Johnstone returned to HMP Edinburgh in January 2015 from secure psychiatric care units to be managed within the prison environment;

6. That Mr Johnstone's death occurred between 2130hrs on 24 December 2021 and 0730hrs on 25 December 2021 in his cell at HMP Edinburgh and his life was pronounced extinct at 0740hrs;
7. Mr Johnstone had a long-stranding diagnosis of paranoid schizophrenia which was made after his imprisonment. For this he was prescribed Clozapine therapy and his blood was regularly monitored;
8. Mr Johnstone had a diagnosis of Type-2 Diabetes and placed on the Diabetes register on 19 January 2016;
9. Mr Johnstone received regular mental health reviews and engaged with the mental health team at HMP Edinburgh routinely between 2015 and 2021. In 2020 and 2021, Mr Johnstone received Occupational Therapy to assist him with daily living;
10. On 6 July 2021, during a regular mental health review Mr Johnstone discussed his food intake with staff. He advised he usually ate some breakfast and lunch, but no dinner. Staff noted weight loss between 2015, when he weighed 124kg with a BMI of 44.4 and 2021, which he weighed 64kg, with a BMI of 22.9. Due to this change, the decision was taken to observe his weight monthly and refer him to the GP;
11. On 9 August 2021, during an assessment with the prison GP, his observations appeared normal however the GP made a referral for Mr Johnstone to receive a chest X-ray and ultrasound scan of his abdomen to rule out any other

malignancy. Mr Johnstone advised that he did not wish to have any of these investigations;

12. On 18 August 2021, Mr Johnstone refused to attend hospital for the X-ray and ultrasound scans and the appointment was rebooked;
13. On 27 September 2021, Mr Johnstone refused to attend hospital for the X-ray and ultrasound scans and the appointment was rebooked;
14. On 21 October 2021, Mr Johnstone refused to attend hospital for the X-ray and ultrasound scans and the appointment was rebooked;
15. On 23 December 2021, Mr Johnstone refused to attend hospital for the X-ray and ultrasound scans and the appointment was due to be rebooked;
16. On 24 December 2021, Prison Officers WW and CM carried out the evening number roll call of prisoners around 2030hrs. Officer WW opened the cell door of Mr Johnstone and Officer CM asked Mr Johnstone if he was okay, which they received an affirmative response. The door was thereafter locked for the evening;
17. On 25 December 2021, Prison Officer WW began his shift at 0730hrs. At that time he and Prison Officer RA carried out the morning number roll call of prisoners. Upon opening Mr Johnstone's cell door they received no response from him and the cell light was off. They turned the light on and observed Mr Johnstone lying on the floor on his side, fully clothed. There was fluid around his head and under his bed. He was unresponsive and cold to the touch. Officer RA called a "Code Blue" over his radio to summon medical

staff. A "Code Blue" is an emergency code used in prisons to convey quick and specific information and to initiate a timely and effective response. A "Code Blue" signifies an individual who is experiencing severe breathing difficulties and may or may not be unresponsive;

18. Medical staff arrived shortly thereafter and assessed Mr Johnstone. Nurse Alan Beatson assessed Mr Johnstone and could not find any signs of life and CPR was not initiated. His life was pronounced extinct at 0740hrs;

19. A post-mortem examination of the body of Mr Johnstone was conducted on 6 January 2022 by Forensic Pathologist Dr Ralph BouHaidar. Cause of death was attributed to: 1a) Peritonitis and 1b) Perforated Duodenal Ulcer.

Parole evidence

[5] I heard evidence from Dr Cameron Gracie, now retired, who served as a GP within HMP Edinburgh for 25 years. He saw Mr Johnstone on 9 August 2021. On examination he detected what may have been a small mass in his abdomen. He was confident it was not cancerous, but wanted to rule out the possibility. He referred Mr Johnstone to hospital for an X-ray and an ultrasound. This was a precautionary measure. Mr Johnstone immediately told him he would not to go to a hospital. He referred him for an appointment notwithstanding this. Dr Gracie had no concerns about the mental state of Mr Johnstone. His paranoid schizophrenia was well controlled by medication. He was satisfied in general terms with his mental capacity. Had there been

any concerns he would have recorded them. He was clear Mr Johnstone had capacity to make a decision to refuse to comply with treatment.

[6] I heard evidence from Dr Katherine Dixon. She is a GP with experience of working in prisons. She was appointed by the Crown to review the papers in this case and provide an opinion. She confirmed that while an ulcer is a very common disease, and capable of treatment, if it progresses to perforation this would need immediate surgery. The mortality rate from a perforated ulcer is high. She observed the medical records did not confirm what the status of Mr Johnstone's capacity was at the time of his refusal to attend hospital. She explained the importance of ensuring that all prison staff were trained in the assessment of capacity, that inter-disciplinary meetings were held to enable discussion about prisoner welfare by all interested parties, and that all of this was documented and recorded. She agreed that a prisoner may well have to be respected to make a decision about medical treatment which was unwise. It was conceded even if Mr Johnstone had gone to hospital for the scan and X-ray, neither would have diagnosed his duodenal ulcer.

Submissions

[7] Written submissions were received on behalf of all parties. It was accepted there were no reasonable precautions which could have been taken that might have prevented Mr Johnstone's death. All parties conceded no defects in any system of work contributed to his death. The Crown suggested recommendations to improve systems of work. In summary, it was proposed that (1) multidisciplinary team meetings were

recorded and entered into a prisoners medical records, (2) any assessment of capacity of a prisoner was recorded in his medical records, (3) continuous refusal to attend medical appointments should result in re-referral back to the initiating practitioner and (4) all prison and healthcare staff should have training on identifying signs of mental incapacity.

Conclusions

[8] Mr Johnstone was a 45 year old man who had been in prison since 17 July 2008. He had a long standing diagnosis of paranoid schizophrenia which was well controlled by medication. His mental health was reviewed regularly. Between 2015 and 2021 he lost significant weight. This was deliberate - he had stated he wanted to lose weight. Although his weight was now healthy, it was decided to refer him to the GP. He refused to attend the first GP appointment on 19 July 2021. On 9 August 2021 he did attend the GP, who recommended a scan and X-ray at hospital. He told the GP immediately he had no intention of going to hospital. On 18 August 2021 he refused to go to hospital. On 23 August 2021 he told his mental health nurse he "did not want to go" to hospital and on 21 September 2021 he again stated he "had no intention of going". He refused to attend further hospital appointments on 27 September and 21 October 2021.

[9] In July 2021 it was recorded there were "no observed or reported concerns with his mental health". His mental health was reviewed regularly through till December 2021. Some progress was recorded during this period. On 30 October

he had asked for a shower, and on 1 December 2021 he asked for a haircut. On 23 November 2021 it was recorded there were "no signs of psychotic symptoms". On 25 November 2021 it was noted there was "continued improvement" and he was "regularly asking for a shower". By 3 December 2021 it was noted his self-management (previously very poor) had now improved and "he felt ready to progress to less secure conditions". Unfortunately, he refused to attend his final hospital appointment on 23 December 2021 and died from natural causes within 48 hours.

[10] The records describe Mr Johnstone as being "set in his ways". He had a long history of refusing to engage with others who were trying to assist him. He was clearly determined not to attend hospital, despite repeated opportunities to do so. There was no evidence he had any condition that required urgent treatment. The appointment was for investigation only. His mental health was stable at the time, if anything improving. He had capacity to make his own decisions about his health and welfare, including those that were not necessarily wise.

[11] While submissions have been made about possible improvements to systems of work none of these, if implemented, would have made any difference to the outcome for Mr Johnstone. More extensive evidence and analysis would be required - beyond the confines of this case - before proper consideration could be given to such recommendations being made.

[12] All the parties at the inquiry expressed condolences to the family of Mr Johnstone on their own behalf, and on behalf of those whom they represented. I add to them my own condolences for their loss.