SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2026] FAI 13

FAL-B74-25

DETERMINATION

BY

SHERIFF M LABAKI

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

into the death of

ROBERT CARR

FALKIRK, 20 March 2026

The sheriff, having considered the information presented at an inquiry on 17 November 2025 and oral submissions thereon, under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the Act", finds and determines that:

Findings

Section 26(2)(a)

Robert Carr died at around 0705 hours on 12 December 2022 within bed 27 at the Acute Assessment Unit, Forth Valley Royal Hospital, Stirling Road, Larbert.

Section 26(2)(b)

His death was not the result of an accident.

Section 26(2)(c)

The cause of death was:

1a: Malignant middle cerebral artery syndrome;

1b: Left middle cerebral artery infarction;

2: Aspiration pneumonia.

Section 26(2)(d)

His death was not the result of an accident.

Section 26(2)(e)

There were no precautions which could reasonably have been taken whereby his death might have been realistically avoided.

Section 26(2)(f)

There were no defects in any system of working which contributed to his death.

Section 26(2)(g)

There are no other facts which are relevant to the circumstances of Mr Carr's death.

Recommendations

Section 26(4)(a)

I have no recommendations as to the taking of reasonable precautions which might realistically prevent other deaths in similar circumstances.

Section 26(4)(b)

There are no recommendations as to the making of any improvements to any system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(c)

There are no recommendations as to the introduction of a system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(d)

There are no recommendations as to the taking of any other steps which might realistically prevent any other deaths in similar circumstances.

NOTE

Introduction

[1] This was a mandatory inquiry into the death of Mr Robert Carr in terms of section 2(4) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

The proceedings and the parties

[2] Preliminary hearings took place at Falkirk Sheriff Court on four occasions before the inquiry itself, which was held on 17 November 2025. All hearings took place by way of Webex.

[3] Mr McKay, procurator fiscal depute, represented the Crown. Mr Halley, solicitor, appeared for the Scottish Ministers representing the Scottish Prison Service ("SPS"), Ms Templeton, counsel, appeared for Forth Valley Heath Board.

Facts and circumstances

[4] All of the facts were agreed between parties and were contained in an extensive joint minute.

[5] Affidavit evidence was incorporated into the joint minute.

Responsibility for healthcare services

[6] Since 2011, each individual regional NHS health board has been responsible for the delivery of healthcare services within prisons in Scotland, which fall within their geographical ambit for the provision of medical care.

The legal framework

[7] The inquiry was held under section 1 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act"). The purpose of such an inquiry is set out in section 1(3) of the 2016 Act and is to:

> "(a) establish the circumstances of the death, and;
> (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances."

Section 26 of the 2016 Act states, among other things, that:

> "(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."

Background

[8] Robert Carr was born on 25 September 1977. At the time of his death, he was an inmate of HMP Glenochil. Mr Carr was serving a sentence of 10 years imprisonment with a 3-year extension period imposed at Edinburgh High Court on 9 February 2017 for the offences of assault; assault to injury; assault to severe injury, permanent impairment and danger of life; and assault to severe injury, permanent impairment and danger of life.

[9] Mr Carr was initially detained at HMP Perth, however was transferred to HMP Glenochil on 17 December 2015. He was transferred back to HMP Perth on 26 August 2021, before being transferred again, back to HMP Glenochil on 17 December 2021, where he resided in a single occupancy cell, cell 57, situated in Harvieston 4, until being transferred to Forth Valley Royal Hospital ("FVRH") on 10 December 2022. Following Mr Carr's transfer to HMP Glenochil on 17 December 2021, FVRH were responsible for the delivery of healthcare services to Mr Carr.

Underlying health conditions

[10] Mr Carr, from 2015, was prescribed Rivaroxaban which is a blood thinning medication. This was due to a history of blood clots in his legs and lungs. In January 2018, he elected to cease his blood thinning medication having not had any

thrombotic episodes since 2008. Those treating Mr Carr agreed that he could stop taking Rivaroxaban.

[11] From 22 January 2018 until his date of death on 12 December 2022, Mr Carr was not prescribed Rivaroxaban. He did not present for treatment with any deep vein thrombosis or pulmonary embolism episodes following the discontinuation of Rivaroxaban up to 10 December 2022.

Events of 10 December 2022

[12] At around 1150 hours on 10 December 2022, prisoner lock up checks were carried out on The Harvieston Wing, Floor 4, within HMP Glenochil. Mr Carr appeared well in his cell 57 Harviestoun 4, with no injuries before being locked in his cell. No concerns were noted by the prison officer on duty. At around 1330 hours, on the same date, the prison officer attended Mr Carr's cell and observed that he had a facial injury, with blood on his nose, he had difficulty speaking and was unable to move his right arm or leg. A call went out to radio for a nurse to attend. At around 1340 hours, in response to the prison officer's request for assistance, Mr Carr was assessed by the staff nurse. She noticed a superficial cut of around 3cm to the right side of Mr Carr's nose, which was bleeding. She did not observe blood on his clothes, or anywhere else within his cell. She suspected that he had sustained the wound after falling within his cell. She then carried out some basic stroke checks. She undertook a "FAST" assessment ("Face, Arms, Speech, Time"). Mr Carr could not complete these checks. He seemed very confused and could only answer yes. He was unable to fully communicate, and she noted a slight

droop on the right-hand side of his face. She noted that he was very unsteady on his feet. She suspected Mr Carr to be having a stroke and requested an ambulance. The nurse remained with him, carrying out observations until the ambulance arrived.

[13] At around 1340 hours an ambulance was called. It arrived at HMP Glenochil at around 1355 hours and departed around 1419 hours. Paramedics noted on arrival at Mr Carr's cell he was lying on his bed, he could not speak and had no movement down his right side. Paramedics suspected that Mr Carr was having a stroke and conveyed him to the FVRH in a blue light ambulance. He did not improve during the journey to hospital and was still displaying the same symptoms on arrival. At around 1444 hours Mr Carr was admitted to the Emergency Department at FVRH.

[14] On admission to FVRH, Mr Carr presented with right-handed weakness and was diagnosed as having suffered an ischaemic stroke following the handover from the treating paramedics, who advised that Mr Carr had last been seen well at around 1220 hours, but had then been found collapsed in his cell at around 1320 hours. Medical staff took cognisance of the fact that Mr Carr was objectively last seen as being well at 1220 hours, there being a 4.5 hour timeframe for administering blood clot-busting medication, such as Alteplase, in response to an ischaemic stroke via a treatment option known as thrombolysis. Thrombolysis is a treatment option that can be administered to break down and disperse a blood clot that is restricting the flow of blood to the brain. The relevant Forth Valley Health Board guideline for acute stroke, to which medical staff had regard, indicated that Alteplase was the medication to be used for carrying out thrombolysis. The 4.5 hour timeframe is known as the thrombolysis window.

Managing a stroke within the thrombolysis window is a time-critical event. Thrombolysis must be performed within 4.5 hours of the onset of the stroke in order to be potentially effective. The thrombolysis window for Mr Carr was to end at 1650 hours. When Mr Carr was first treated by medical staff at FVRH he was within the thrombolysis window. The timeous administration of thrombolysis can potentially achieve disability-free survival from stroke. There are significant risks and contraindications to thrombolysis. One significant risk is that it may lead to increased intracranial bleeding. The risks increase with the passage of time, so much so that the risks outweigh the benefits when outside the thrombolysis window.

[15] Following assessment of Mr Carr by medical staff at around 1553 hours, Mr Carr was deemed to be an appropriate candidate for thrombolysis. When he was physically examined Mr Carr was found to have a right-sided facial droop, significant weakness and reduced tone in his right arm, and difficulty with expressing his thoughts. Those findings were indicative of Mr Carr having suffered a stroke.

[16] When Mr Carr was physically examined, he was able to follow what was going on in the resus room and answered "yes/no" questions asked of him by shaking or nodding his head. Mr Carr followed conversation appropriately and understood that medical professionals suspected a stroke and needed to rule out an intracranial bleed. Mr Carr consented to a non-contrast Computer Tomography (CT) head scan being carried out.

[17] At around 1500 hours a request was made for Mr Carr to undergo an urgent CT scan of his head to rule out an intracranial bleed. A CT head scan was duly performed

by the duty radiologist. At around 1517 hours, the CT head scan was reported as showing that there was no intracranial bleeding, and that there was a subtle loss of grey-white matter differentiation in the posterior left frontal lobe, which was consistent with an ischaemic stroke. The results of Mr Carr's CT head scan were discussed by those treating Mr Carr and the on-call senior stroke physician at the Royal Infirmary of Edinburgh. It was agreed that the clinical findings and results of the CT scan confirmed Mr Carr was a suitable candidate for thrombolysis treatment. At around 1600 hours, Mr Carr was spoken to with regard to obtaining his consent for treatment for his established ischaemic stroke. It was explained to Mr Carr what had happened to him. The assessment was that Mr Carr was following and understood their conversation. Mr Carr nodded at appropriate junctures during their conversation. It was explained to Mr Carr the potential risks and benefits of thrombolysis, and that the overall potential benefits outweighed the risks. It was recommended to Mr Carr that he should undergo thrombolysis as there was much to be gained by reducing the risks of severe disability or death. Mr Carr responded by repeatedly shaking his head and indicated that he did not provide his consent to undergoing thrombolysis. Mr Carr was asked direct "yes/no" questions to convey the ramifications of his decision not to undergo thrombolysis, and to establish that Mr Carr was orientated to time, place and person; and that he understood the possible or likely consequences of refusing thrombolysis. Mr Carr indicated an understanding of the possible or likely consequences of refusal. Mr Carr further indicated that he did not provide his consent to undergoing thrombolysis.

Medical professionals deemed Mr Carr to have full capacity when he refused the thrombolysis treatment.

[18] At around 1620 hours, it was again explained to Mr Carr the benefits of thrombolysis. Mr Carr continued to refuse thrombolysis treatment. Mr Carr was informed that there was still 50 minutes remaining to administer the treatment. Mr Carr nodded agreement that medical professionals could return before the end of the thrombolysis window and re-discuss the administration of treatment.

[19] Medical professionals treating Mr Carr opined that Mr Carr had capacity to decline the thrombolysis treatment. At around 1620 hours, Mr Carr was spoken to again about receiving the thrombolysis treatment. It was explained to Mr Carr that he remained within the thrombolysis window. Mr Carr again indicated that he did not provide his consent to undergoing thrombolysis treatment. Mr Carr refused any further re-discussion.

[20] Mr Carr was advised that he was able to take aspirin. Aspirin is the first line treatment for a patient who presents with ischaemic stroke outside the thrombolysis window. Mr Carr also refused to take aspirin. Given Mr Carr's refusal to receive treatment he did not receive thrombolysis treatment.

[21] At approximately 2135 hours, Mr Carr was transferred to the Clinical Assessment Unit (CAU). A GEOAmey officer was present. While waiting for a bed space in CAU to be prepared for his admission, Mr Carr waited in a bay known as bed space 2. Mr Carr was asked by a hospital porter if he felt able to transfer to the trolley in the bay. Mr Carr appeared to nod in agreement, swifty swung his legs over the side of

the bed and attempted to stand. He fell to the floor, banging his head on a wall. The fall occurred shortly before 2200 hours. It was recorded and observed that there was no resultant change to Mr Carr's neurological, or other parameters, following the fall. A later CT head scan performed on 12 December 2022 showed no signs of trauma. A post fall assessment was carried out. Medical staff decided no further action needed.

Events of 11 and 12 December 2022

[22] Mr Carr agreed to take aspirin at 1145 hours on 11 December 2022. He could no longer be offered thrombolysis due to the passage of time. Mr Carr remained stable during the course of the day.

[23] At around 0515 hours on 12 December 2022, Mr Carr's condition deteriorated. Mr Carr had been observed making noises and it was found that his airway was compromised, making it difficult to breathe. He was given oxygen, reviewed with further bloods obtained and given IV paracetamol and IV antibiotics. His clothes were removed, and he was given suction treatment which seemed to stabilise his airway. At 0532 hours, he was sent for an urgent CT scan. When he was taken for his scan, his airway dropped again. He was given respiratory support via a bag and mask with an airway fitted. At 0552 hours the resuscitation team were called into CT to assist Mr Carr. Following this, Mr Carr's medical team advised GEOAmey officers that no further resuscitation would be given should he go into cardiac arrest. He did not regain consciousness.

[24] At 0616 hours, neurosurgery at Lothian Health Board were contacted via telephone to consult on Mr Carr's recent CT findings, which showed a significant deterioration in the bleed in his brain. It was concluded that they could offer no surgical input. Mr Carr was transferred to the Acute Assessment Unit for extubating and palliative treatment.

[25] At around 0705 hours at the FVRH, Mr Carr's life was pronounced extinct. A death certificate was issued dated 5 January 2023, with Mr Carr's cause of death listed as 1a: malignant middle cerebral artery syndrome, 1b: left middle cerebral artery infarction and 2: aspiration pneumonia.

[26] In relation to the significance or otherwise of the fall suffered by Mr Carr on 10 December 2022, Forth Valley Health Board instructed a report from a consultant neurosurgeon which concluded that on the balance of probability, Mr Carr's fall in hospital had no impact on the ultimate outcome. The fall had no bearing on an already-initiated separate sequence of events (namely the stroke and subsequent development of malignant middle cerebral artery syndrome). The fall was a consequence of weakness caused by Mr Carr's stroke. There is no evidence, in my opinion, that the fall resulted in any significant additional harm and no evidence that it influenced the patient's course in any way.

A summary of the parties' positions

[27] All of the parties submitted that the court should make formal findings only. No findings in terms of sections 26(2)(e), (f) or (g) were sought, nor any recommendations.

Findings and recommendations

[28] Having considered all of the evidence in this inquiry, my findings are that Mr Carr received proper care and treatment both within HMP Glenochil, when he suffered a stroke, and then at Forth Valley Royal Hospital where he was subsequently treated. There was evidence of all appropriate protocols and procedures followed at HMP Glenochil and at Forth Valley Royal Hospital.

[29] Mr Carr had a history of blood clots in his right leg and lungs. Until 2018 he had been prescribed Rivaroxaban, a blood thinner which is used to prevent and treat blood clots and deep vein thrombosis. It was his wish that he stop taking that medication. The risks were properly explained to him by medical professionals at that time.

[30] Having suffered a stroke within his cell at HMP Glenochil Mr Carr was offered treatment by the medical team at Forth Valley Royal Hospital for thrombosis. This would reduce the risk of disability and death following his stroke. I am satisfied that the medical professionals made every effort to treat Mr Carr but he refused thrombosis and had capacity to understand and refuse said treatment.

[31] There was no evidence to suggest any precautions which could have been reasonably taken whereby his death might realistically have been avoided; nor any defects in any system of working which contributed to his death.

[32] Having considered the evidence and the submissions by parties, I consider that only formal findings in respect of section 26(2)(a) and section 26(2)(c) of the Act should be made. I am grateful to parties for their submissions and preparation in this inquiry.

I am satisfied that there is a proper basis for the findings recorded at the beginning of this determination.

[33] The parties extended their condolences to Mr Carr's family and I would like to join them in expressing my condolences.