SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2018] FAI 15

2B 433/17

DETERMINATION

by

SHERIFF KENNETH J MCGOWAN

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

GORDON DALRYMPLE (d.o.b. 9.7.35)

Edinburgh, 12 December 2017

The Sheriff, having considered all the evidence, FINDS and DETERMINES

(i) in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") that Gordon Dalrymple, date of birth 9 July 1935, who was lawfully detained in custody, died at 11:00 hours on 13 April 2015 at Cell 1/55, Ingliston House, at HMP Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3L;

(ii) in terms of section 6(1)(b) of the 1976 Act the cause of his death was:

1a ruptured aortic aneuryism;

(iii) in terms of section 6(1)(c), there were no reasonable precautions whereby the death might have been avoided;

(iv) in terms of section 6(1)(d) there were no defects in any system of working which contributed to the death;

(v) in terms of section 6(1)(e) there were no other facts which were relevant to the circumstances of the death.

NOTE

Introduction

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") into the circumstances of the death of Gordon Dalrymple ("the deceased) who died at HMP Edinburgh on 13 April 2015. As the deceased was in lawful custody at the time of his death this Inquiry is mandatory under section 1(1)(a)(ii) of the 1976 Act.

[2] The public interest was represented by Ms Daly, Procurator Fiscal Depute; the Scottish Prison Service was represented by Ms Thornton, solicitor; and NHS Lothian was represented by Mr Holmes, solicitor.

[3] The deceased's family was not represented. However, the deceased's sister, Mrs Anderson, was present in court and observed the whole proceedings.

[4] A Joint Minute of Agreement had been entered into and was lodged. The only oral testimony came from Dr Angela Maxwell. In terms of the Joint Minute, the written statements of the following witnesses were agreed to be equivalent to the parole evidence:

(i) Alan Cameron, Prisoner, HMP Edinburgh, dated 14 April 2015

(ii) Lesley Clark, Prison Officer, HMP Edinburgh, dated 13 April 2015

(iii) John McLean, Prison Officer, HMP Edinburgh, dated 13 April 2015

(iv) David McAdam, First Line Prison Manager, HMP Edinburgh, dated 14 April 2015

(v) Gordon Mann, Prison Officer, HMP Edinburgh, dated 14 April 2015 (the reference in this statement to cell "151" should in fact be cell 1/55 as indicated on page 7 of Crown Production 7 Prison Custody File)

(vi) Katriona Patterson, Senior Charge Nurse, HMP Edinburgh, dated 13 April 2015

(vii) Allison Crone, Staff Nurse, HMP Edinburgh, dated 13 April 2015

(viii) Angela Maxwell, GP, HMP Edinburgh, dated 13 April 2015, 30 May 2017 and 26 June 2017.

[5] Relevant parts of the various Crown productions were also agreed.

[6] Section 6(1) of the 1976 Act requires the Sheriff to make determinations on the following matters:

(i) where and when the death took place;

(ii) the cause of such death;

(iii) the reasonable precautions, if any, whereby the death might have been avoided;

(iv) the defects, if any, in any system of working which contributed to the death; and

(v) any other facts which are relevant to the circumstances of the death.

[7] At the conclusion of the evidence, written submissions were lodged on behalf of the Crown by the Procurator Fiscal Depute. These were adopted by the solicitors for the Scottish Prison Service and NHS Lothian.

[8] I was invited by all representatives to make a formal determination not to find it appropriate or necessary to make any determination in respect of subsections 6(1)(c), (d) or (e).

Circumstances

[9] On 6 January 2012, the deceased was advised that a scan, undertaken in relation to another issue, showed an abdominal aortic aneurysm ("AAA") and that the opinion of the vascular surgical doctors at Edinburgh Royal Infirmary would be sought: Crown Production 4/7. At that stage, the AAA measured 3.9cm: Crown Production 4/9.

[10] On 8 May 2012, the deceased was remanded in custody at HMP Edinburgh.

[11] On 12 June 2012, the deceased was convicted of two contraventions of Section 6 of the Criminal Law (Consolidation) (Scotland) Act 1995, a contravention of Section 5(3) of the Criminal Law (Consolidation) (Scotland) Act 1995 and assault at the High Court of Justiciary. The deceased was sentenced to 5 years imprisonment backdated to 8 May 2012: Crown Production 2.

[12] On 24 March 2012, the deceased was placed on the Aneurysm Surveillance Programme: Crown Production 4/22.

[13] On 21 August 2012, the deceased felt unwell. He attended at Edinburgh Royal Infirmary where a CT aortogram indicated that the AAA measured 5cm: Crown Productions 5/3 and 5/8.

[14] On 4 January 2013, following the deceased's aneurysm surveillance appointment, the AAA was recorded as having a maximum diameter of 4.9cm. It was recorded that:

> "There is emerging evidence that statins help to slow the progression of aortic aneurysms, so perhaps you would kindly consider starting Mr Dalrymple on a statin of your choice, unless otherwise contraindicated. He is aware that continuing to smoke is likely to have a detrimental effect on the aneurysm, but he has no plans to stop at the moment".

A further appointment was to be arranged in 6 months: Crown Production 5/3.

[15] On 4 January 2013, Dr Cameron Gracie noted this recommendation in relation to statins: Crown Production 3/15. Dr Gracie arranged an appointment for the deceased to see the GP in order to discuss this recommendation.

[16] Due to a failure in communications, this recommendation was never discussed with the deceased and he was never prescribed a statin.

[17] If the recommendation had been discussed with the deceased, it is likely that he would have been prescribed a statin as there were no contra-indicators.

[18] Statins can produce a number or side effects which mean that patients are reluctant or unwilling to continue with such treatment. It is not possible to say whether any side effects would have manifested themselves or, if they had, the deceased would have continued with the treatment.

[19] In December 2012, the deceased again underwent aneurysm surveillance. The ultrasound showed that the AAA had a maximum diameter of 5.3cm. A further appointment was to be arranged in 6 months: Crown Production 5/2.

[20] In July 2014, the deceased again underwent aneurysm surveillance. The ultrasound showed that the AAA had a maximum diameter of 5.3cm. A further appointment was to be arranged in 6 months: Crown Production 5/1.

[21] In January 2015, the deceased again underwent aneurysm surveillance during which the ultrasound showed the aneurysm had a maximum diameter of 5.5cm. Following discussion with the consultant it was decided that:

> "in light of his co-morbidities, age and continued smoking the safest thing to do, for now, is to continue with the surveillance scans until the aneurysm reaches 6cm in diameter".

A further appointment was to be arranged in 3 months: Crown Production 6/1.

[22] The deceased died on 13 April 2015 at 11:00 hours in Cell 1/55, Ingliston House, HMP Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN.

[23] At the date and time of his death, the deceased was lawfully detained in custody at HMP Edinburgh.

[24] On 20 April 2015 a post mortem examination was carried out on the deceased by Doctor Robert Ainsworth BSC(Hons) MBChB FRCPath DipFMS, Consultant Forensic Pathologist; the cause of death was found to be: 1a. Ruptured abdominal aortic aneurysm: Crown Production 1.

Submissions

[25] On behalf of the Crown, the Procurator Fiscal Depute submitted that the purpose of a Fatal Accident Inquiry is not to apportion fault or blame. It is very much an exercise in applying the wisdom of hindsight.

[26] The court was invited to find that the following were established in terms of the 1976 Act:

(i) Where and when the death and any accident resulting in the death took place: the deceased died at 1100 hours on 13 April 2015 in Cell 1/55, Ingliston House, HMP Edinburgh, 33 Stenhouse Road, Edinburgh.

(ii) The cause or causes of such death and any accident resulting in the death: the cause of death for Mr Dalrymple was: 1a ruptured abdominal aortic aneurysm.

[27] No submissions were made in respect of the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided; the defects, if

any, in any system of working which contributed to the death or accident resulting in the death; and any other facts which are relevant to the circumstances of the death.

[28] For their parts, Ms Thornton and Mr Holmes adopted the Crown's submissions.

Comments and conclusion

[29] Plainly it is regrettable that the deceased was not prescribed a statin as had been recommended. Nevertheless, there are a number of other variables which must be borne in mind.

[30] First, the recommendation to prescribe a statin is couched in qualified terms: "…emerging evidence that statins help to slow the progression of aortic aneurysms..." So whether, if prescribed, a statin would have had any effect appears to be a moot point. In addition, the deceased's AAA was stable. Accordingly, it cannot be said that even if prescribed, a statin would have had any beneficial effect. It would not have prevented the AAA from rupturing.

[31] Second, even if prescribed, it cannot be said with any degree of probability that the deceased would have continued to take a statin. Statins can produce side-effects which because of their unpleasant nature dissuade patients from continuing to take them.

[32] Third, the deceased suffered from other significant health problems and continued to smoke. Continued heavy smoking was likely to have detrimental effect on the deceased's AAA. As Dr Maxwell put it, if there was a choice, in the deceased's case, between stopping smoking and having a statin, the former would outweigh the latter in terms of likely health benefits.

[33] Given the foregoing, the formal findings made above are appropriate.

[34] May I take this opportunity to thank the Procurator Fiscal Depute, Ms Thornton, and Mr Holmes for their work in agreeing so much of the evidence before the hearing, thus allowing it to proceed efficiently.

[35] May I also extend to the deceased's family and in particular his sister, Mrs Anderson, who attended the hearing, my condolences.