SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH SHERIFF COURT

[2025] FAI 16

EDI-B874-24

DETERMINATION

BY

SHERIFF O'CARROLL

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

into the death of

DAVID FERGUSON

EDINBURGH, 18 February 2025

Determination

The Sheriff, having considered the evidence presented at the Inquiry, determines in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act") (hereinafter referred to as "the Act") that:

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

David Ferguson died whilst in custody at HMP Edinburgh, under transfer to Edinburgh Royal Infirmary on 4 June 2022. His life was formally pronounced extinct at 15.08hrs.

(2) In terms of Section 26(2)(b) of the 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 Act (the cause or causes of death):

The cause of death was: 1a) acute left middle cerebral artery territory infarct; and 1b) severe cerebrovascular disease.

(4) In terms of Section 26(2)(d) of the Act (the cause of any accident resulting in death):

The death did not result from an accident.

(5) In terms of Section 26(2)(e) of the Act (the taking of precautions):

There were no reasonable precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death being avoided.

(6) In terms of Section 26(2)(f) of the Act (defects in any system of working):

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

(7) In terms of Section 26(2)(g) of the Act (other factors relevant to the circumstances of death):

There were no other factors relevant to the circumstances of death.

Recommendations

AND FURTHER, the Sheriff, having considered the information presented at the Inquiry, makes no recommendations in terms of Section 26(1)(b) of the Act.

NOTE

Introduction

[1] This determination is made following the Fatal Accident Inquiry held under the Act into the circumstances of the death of David Ferguson born on 12 June 1954.

[2] At the time of his death, Mr Ferguson was serving a sentence at HMP Edinburgh and had been transferred to Edinburgh Royal Infirmary, where he then died on 4 June 2022 all as explained below.

[3] Accordingly, the holding of a FAI was mandatory: see section 2(4)(a) of the Act.

[4] The Procurator Fiscal issued a notice of the Inquiry on 28 June 2024. A Preliminary Hearing was held on 28 August 2024 at Edinburgh Sheriff Court. Notices of intention to participate were lodged by the Scottish Prison Service (represented by the Scottish Ministers) and NHS Lothian Health Board. The family of Mr Ferguson were invited to participate but declined to do so and no member of his family was present or represented throughout the Inquiry process.

[5] That Preliminary Hearing was continued to 5 December 2024 to afford the parties further time to prepare including the lodging of further productions and a joint minute. By that date, the parties had concluded the greater part of their preparations. The parties agreed on that date to revise the draft joint minute to take account of certain

issues and ordered the parties to lodge notes setting out their positions as regards the issues that the Inquiry required to consider. That was done by 20 December 2024. The Court fixed a date for the Inquiry to take place being 6 January 2025 at Edinburgh Sheriff Court.

[6] By the date of the Inquiry, the parties had lodged the following:

a. Crown Productions 1 and 2, comprising the Death Certificate and Intimation of Death of David Ferguson completed on 24 June 2022 and 29 June 2022.

b. Crown Production 3, comprising the Final Post-Mortem Report authored by Dr Kerryanne Shearer and Dr Ralph BouHaidar, Consultant Forensic Pathologists, following post-mortem examination of the body of Mr Ferguson.

c. Crown Production 4, comprising the prison medical records of Mr Ferguson.

d. Crown Production 5, comprising the Death in Custody Folder of documentation and records maintained by the Scottish Prison Service in relation to Mr Ferguson.

e. Crown Production 6, comprising the Death in Prison Learning and Audit Review (referred to as the DIPLAR) report carried out at HMP Edinburgh following Mr Ferguson's death.

f. Lothian Health Board productions 1 to 4, comprising Edinburgh Royal Infirmary medical records from Mr Ferguson's admission on 30 May 2022 until his death on 4 June 2022.

[7] It was agreed by all parties that all the documents contained in the productions were true and accurate copies of the originals; and further, that the contents were agreed to be true and accurate.

[8] Also lodged were Crown Productions 7 to 16 comprising witness statements of the following witnesses:

a. Gemma Brown, Nurse;

b. Craig Darling, Prison Officer;

c. Mandy Ferguson, Step-Daughter of Mr Ferguson;

d. Leonie Fraser, Prison Officer;

e. Dean Goulding, First Line Manager;

f. Natalie Grant, Nurse;

g. Simon Hart, Consultant Physician;

h. Josephine Lloyd, Junior Doctor;

i. Robbie Wilson, Prison Officer;

j. Laura McConnell, Senior Charge Nurse.

The parties agreed that these statements were true and accurate and invited the Court to treat them as equivalent to the parole evidence of those witnesses.

[9] The parties also lodged a joint minute agreeing facts which were not, so far as the parties themselves concerned, in dispute. In addition, the parties lodged preliminary submissions setting out their positions as regards the issues which the Inquiry required to consider and their proposals as to the procedure that should be adopted by the Inquiry.

[10] By the date of the Inquiry, 6 January 2025, the Court had considered the productions, joint minute, preliminary submissions and witness statements. At the outset, following discussions with the parties' representatives concerning that material, it became clear to the Court that while that material was substantial, what required additional material by way of clarification was the diagnosis and treatment during the first 24 hours or so after Mr Ferguson arrived at A&E on 30 May 2022, in particular as regards the eventual conclusive diagnosis of the cerebral infarct. The Inquiry was adjourned to 14 February 2025 for that matter to be clarified and additional material to be provided.

[11] Lothian NHS Health Board then obtained and lodged a rather more detailed signed supplementary statement from Dr Hart, a consultant physician in stroke medicine, who had examined Mr Ferguson on the day of admission. That statement set out more clearly his involvement in Mr Ferguson's care as well as a more detailed description and analysis of the treatment and care of Mr Ferguson provided by others on 30 May 2022 and the following day. That statement explained and was consistent with the agreed lodged medical notes concerning Mr Ferguson. That statement too was agreed by the parties to be true and accurate. The Court was invited to treat that statement as Dr Hart's additional parole evidence.

[12] At the hearing on 14 February 2025, the parties submitted that the Inquiry could proceed without oral evidence, relying instead on the statements of the witnesses in lieu of parole evidence, the matters agreed in the joint minute including the agreement of the parties as to the contents of the productions and the agreed facts. I agreed with

that course of action, closed the enquiry and reserved my decision (avizandum). The submissions of the parties are reflected in the formal findings above.

The legal framework of the Inquiry

[13] This Inquiry was held under section 1 of the Act. The purpose of a Fatal Accident Inquiry is set out in section 1(3) of the 2016 Act. It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might have been taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (section 1(4)). A Fatal Accident Inquiry is inquisitorial, not adversarial (rule 2.2.(1) of the 2017 Rules).

[14] Section 1(2) provides that an Inquiry is to be conducted by a sheriff, a sheriff principal, or a summary sheriff exercising the powers of a sheriff. The procedure at an Inquiry is to be as ordered by the sheriff (rule 3.8.(1) and rule 5.1). After the conclusion of the evidence and submissions in an inquiry, as soon as reasonably possible, the presiding sheriff must make a determination setting out certain findings and any recommendations as the sheriff considers appropriate. The section 26 determination must be in Form 6.1 (rule 6.1).

[15] The findings the sheriff is required to make are set out in section 26(2): (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 deaths; (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 and (g) any other facts which are relevant to the circumstances of the death.

[16] The sheriff is not obliged to make recommendations: that is a discretionary power. Those which the sheriff is entitled to make are set out in section 26(4). Any such recommendations must be directed towards: (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. Recommendations may be, but do not have to be, directed to (i) one or more participants in the inquiry; or (ii) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

[17] The procurator fiscal represents the public interest. An Inquiry is an inquisitorial process. The sheriff's determination must be based on the evidence presented at the inquiry. The sheriff's determination is not admissible in evidence and may not be founded on in any judicial proceedings of any nature.

The circumstances of the deceased and his death

[18] On the basis of the foregoing, I find the following established.

[19] Mr Ferguson had a long-standing diagnosis of Chronic Obstructive Pulmonary Disease (COPD). This was an existing diagnosis upon his entry into prison in 2014 and was noted by medical staff at that time. This was treated with inhalers. Mr Ferguson

also suffered from trapped nerves in his shoulders with associated back pain, used a walking stick and mobility chair, had high blood pressure and high cholesterol.

[20] On 30 May 2022 at 0655 hours, Mr Ferguson activated his in-cell intercom requesting assistance from prison staff. Prison Officer Leonie Fraser attended at his cell with another officer and spoke with Mr Ferguson. He was sitting on his mobility chair and advised that he had fallen over whilst getting out of bed. He appeared confused, struggling to catch his breath, and could not say how it happened. Officer Fraser requested nursing staff to attend and check on Mr Ferguson.

[21] Nurse Gemma Brown attended at Mr Ferguson's cell shortly after 0710 hours and assessed Mr Ferguson. He was breathless, had a small laceration to his right wrist which she dressed. There were no signs of a head injury. She thereafter left his cell to attend to other duties, saying she would check on him again later.

[22] At around 0745 hours, another prisoner commented to Officer Fraser that he had been in Mr Ferguson's cell and he looked unwell. Nurse Brown overhead this and returned to the cell. She observed a droop in the left side of his mouth, he was unable to obey commands and unable to raise his arms or pull or push the nurse's hands. Accordingly, an emergency ambulance was requested at 0802 hours, which arrived at 0812 hours.

[23] The ambulance paramedics assessed Mr Ferguson. The ambulance left HMP Edinburgh at 0851 hours to convey him to Edinburgh Royal Infirmary. On arrival at Edinburgh Royal Infirmary, Mr Ferguson was assessed by Dr Gibson, Critical Care Consultant, at 0926 hours. An initial CT scan was carried out around 0938 hours.

Unfortunately however, that resulted in a limited examination due to Mr Ferguson moving around. Despite having been given a sedative, Mr Ferguson was not co-operative with those treating him at the time nor with the procedures associated with a CT scan which require the patient to be still for around 10 minutes. It was not possible to make any reliable diagnosis from that scan.

[24] At 1030 hours, Dr Simon Hart, Stroke Consultant, assessed Mr Ferguson. He noted that Mr Ferguson had intermittent speech and was either unable or unwilling to cooperate with commands. Mr Ferguson was and remained generally uncooperative. At that time, due to Mr Ferguson's lack of co-operation, a further CT scan was not possible. The risk associated with an emergency general anaesthetic to enable a further CT scan to be carried out that day was not clinically justified given Mr Ferguson's clinical conditions. A CT scan was necessary for diagnostic purposes. Dr Hart spoke with staff at HMP Edinburgh to obtain the background details of the patient at around the same time. A chest x-ray was conducted around 1217 hours with no significant result. Mr Ferguson continued to be unwell. So, he was ultimately admitted to the ICU at 1700 hours.

[25] On admission to the ICU, Mr Ferguson was noted to have a fever and IV antibiotics were administered. He was intubated, sedated and ventilated.

[26] On 31 May 2022, it became possible for Mr Ferguson to be CT scanned a second time. That CT scan was done around 1253 hours. It showed that Mr Ferguson had suffered a massive stroke: a large left middle cerebral artery territory infarct. This type of stroke is caused by a blockage in an artery rather than a brain haemorrhage.

It involved several significant areas of the brain. Clinically it was very profound. The stroke was unsurvivable. The only treatment possible from that stage was purely palliative. There is no evidence that the fall was in any way responsible for the stroke.

[27] By the time that the stroke was confirmed, thrombolysis, being the only routinely available treatment for an infarct stroke for this category of patient, was not possible. That was because the window for thrombolysis to be effective had already passed, which is about 4.5 hours following a definite new acute infarct stroke. Thrombolysis involves the administration of drugs by drip to dissolve the clot that has caused the stroke. In any event, even if it had been possible to diagnose the infarct stroke earlier (which for the reasons given had not been possible) Mr Ferguson would not have met the highly selective standard selection measures for such treatment. Only 10 to 15% of acute new stroke patients presenting to hospital A&E meet these selection measures and receive thrombolysis. Furthermore, thrombolysis has been shown to have no overall net statistically significant effect on mortality after new acute cerebral infarction. The procedure is also a risky one which offers a 3% risk of itself causing serious or fatal intra-cerebral haemorrhage, meaning that the risks of such treatment have to be carefully balanced against the potential benefits.

[28] On 1 June 2022, a DNACPR notice (do not attempt cardiopulmonary resuscitation) was put in place for Mr Ferguson due to his very poor medical condition.

[29] On the morning of 2 June 2022, Dr Gibson assessed Mr Ferguson. That assessment was to the effect that Mr Ferguson was approaching the end of his life. Around 1122 hours, Mr Ferguson was reviewed by palliative care consultant,

Dr Abi Wallon. Between 1530 hours and 1618 hours that day, Mr Ferguson was transferred from the Intensive Care Unit to Ward 104 for continued palliative care.

[30] On 4 June 2022 at around 1400 hours Mr Ferguson's breathing had slowed down. He was assessed by a nurse at 1408 hours and was thought to have been deceased. Dr Josephine Lloyd thereafter attended and performed checks for signs of life and found none. Accordingly, Mr Ferguson's life was pronounced extinct at 1508 hours.

[31] On 24 June 2022 a post-mortem examination was conducted by Dr Kerryanne Shearer and Dr Ralph BouHaidar, pathologists. They concluded that the cause of death was 1a) Acute left middle cerebral artery territory infarct and 1b) severe cerebrovascular disease. This was demonstrated by extensive disruption within the area of the brain that would account for his presentation, deterioration and death. This was caused by severe cerebrovascular disease which is a narrowing of the vessels supplying blood to the brain.

Conclusions

[32] On the basis of the evidence presented at the Inquiry I am satisfied that I should make formal findings in terms of sections 26(2)(a) and (c) only. I have set out those formal findings above.

[33] On the available evidence at the Inquiry I have determined that Mr Ferguson unfortunately suffered a massive cerebral stroke, probably while in the prison, on or around 30 May 2022. Those dealing with him in the prison acted appropriately and called an ambulance which arrived swiftly. Mr Ferguson received initial treatment

by the paramedics from the ambulance which arrived swiftly. He was assessed by appropriately qualified medical staff soon after arrival at A&E. Once there, suitable treatment was carried out. Due to Mr Ferguson's presentation, it was not possible to definitively diagnose Mr Ferguson's stroke at that time. Mr Ferguson was admitted to the ICU later on 30 May 2022. The following day, it became possible to carry out a further CT scan which enabled the diagnosis of a massive cerebral infarction. That was untreatable and unsurvivable. Appropriate palliative treatment was administered up to his death on 4 June 2022.

[34] I have not identified any systemic defects arising or precautions that might have been taken to avoid the death. I have not identified any matter that would require a finding beyond the formal findings in terms of section 26(2)(a) and (c) of the Act. I am satisfied that it would not be appropriate to make any recommendations in terms of section 26(1)(b) of the Act.

[35] All the parties at the Inquiry expressed condolences to Mr Ferguson's family on their own behalf and on behalf of those whom they represented and to these I add my own condolences.