SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2020] FAI 46

EDI-B340-20

DETERMINATION

BY

SHERIFF DONALD CORKE

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

into the death of

DAVID BEATSON STENHOUSE SCOTT

Edinburgh, 23 November 2020

Determination

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

1. David Beatson Stenhouse Scott (hereinafter "David Scott"), in legal custody at HM Prison Edinburgh at the date of his death, was born on 1 March 1953.
2. In terms of section 26(2)(a), his death occurred at 18:42 on 7 March 2019 at Ward 204, Royal Infirmary of Edinburgh.
3. In terms of section 26(2)(b), no finding is made as the death did not result from an accident.
4. In terms of section 26(2)(c), the cause or causes of death were:

1a.) Complications of a presumed seizure in a man with epilepsy

2.) Chronic obstructive pulmonary disease

5. In terms of section 26(2)(d), no findings are made as the death did not result from an accident.

6. In terms of section 26(2)(e), there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

7. In terms of section 26(2)(f), there were no defects in any system of working which contributed to the death.

8. In terms of section 26(2)(g), there are no other facts relevant to the circumstances of the death.

Recommendations

In terms of section 26(1)(b) of the Act, as regards such recommendations (if any) 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, (d) the taking of any other steps which might realistically prevent other death in similar circumstances, no such recommendations are made.

Note

Introduction

[1] This Inquiry was held under the Act into the death of the deceased, David Scott. At the time of his death, he was a convicted prisoner serving a sentence at HMP, Edinburgh. He was known to have pre-existing conditions and was admitted to the Edinburgh Royal Infirmary on 24 February 2019. Mr Scott passed away in the early evening of 7 March 2019 in Ward 204 of the ERI.

[2] The death was then reported to COPFS.

[3] A preliminary hearing was set down for 4 May 2020. In view of the fact that there was nothing in dispute, it was continued administratively to this one-day inquiry in formal terms held on 30 October 2020.

[4] Ms Graham, Procurator Fiscal Depute, appeared for the Crown; Mr Holmes, Solicitor, for NHS Lothian; and Ms Middleton, Solicitor, for the Scottish Prison Service. No other party was represented and no members of the family were present.

[5] The productions include the following:

a. post-mortem examination report;

b. death in custody file containing records held by HMP Edinburgh;

c. medical records from ERI;

d. medical records from HMP Edinburgh.

[6] In addition, there were witness statements from a prison custody officer, a sister of the deceased, and the deceased's cellmate.

[7] Parties were able to very helpfully agree almost all the facts in the form of a joint minute of agreement and that document is the basis of the findings in fact in this determination.

The legal framework

[8] This inquiry was held under section 1 of the Act. It was a mandatory inquiry under section 2 as the deceased was in legal custody in Scotland at the time of his death.

[9] The inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[10] In terms of section 1(3) of the Act, the purpose of an inquiry 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.

[11] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. It is not the purpose of an inquiry to establish civil or criminal liability (section 1(4)).

[12] The following matters required to be covered in the determination in terms of section 26:

(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.

Summary

Facts

[13] I find the following facts admitted or proved:

1. That David Scott was born on 1 March 1953 and died on 7 March 2019 at Ward 204, Royal Infirmary of Edinburgh. He was 66 years old.
2. That at the date of his death, David Scott was in legal custody at HM Prison Edinburgh. He was sentenced at Edinburgh High Court on 30 November 2018 to 10 years' imprisonment following his conviction on 23 October 2018 in respect of a number of historic sexual offences.
3. That at the date of his death, David Scott was accommodated within Cell 51, Hermiston Level 2, at HM Prison Edinburgh. He shared that cell with another prisoner, who subsequently provided a statement.

4. That Crown Production number 2: Death in Custody File contains records held by HM Prison Edinburgh relating to David Scott.

5. That David Scott had a complex past medical history. He had been diagnosed with epilepsy and chronic obstructive pulmonary disease (COPD). He also had poor mobility as a result of a previous hip fracture, and had some hearing loss.

6. That Crown Production number 4: Prison Medical Records is a copy of the records maintained by healthcare staff within HM Prison Edinburgh in relation to David Scott.

7. That David Scott was prescribed the following medications upon arrival at HM Prison Edinburgh on 23 October 2018:

    a. Colecalciferol (vitamin D3);
    b. Calcium Carbonate;
    c. Tiotropium Bromide;
    d. Alendronic Acid;
    e. Levetiracetam; and
    f. Epilim Chrono 500.

8. That medications e. and f. above are used in the treatment of epilepsy in adults.

9. That David Scott was required to attend at the medication hatch on a weekly basis to collect his prescribed medication for the week ahead.

10. That during lock-up overnight on 13-14 February 2019, David Scott suffered an epileptic seizure in the presence of his cellmate. Prison

nursing staff were asked to review him at around 1700 hours on 14 February 2019. He had stayed in bed all day, and on examination he was very shaky and lethargic. He reported having been passing urine and complained of feeling cold. He was about to eat dinner when the nurse attended.

11. That an appointment was arranged with Prison nursing staff for David Scott's medication to be reviewed on 15 February 2019. At that appointment, it became apparent that he was no longer able to collect his prescribed medication from the medication hatch. As a result, the decision was taken to allow his medications to be administered as individual supervised doses within his cell.

12. That David Scott was the subject of a care package from 26 October 2018 which required carers to support his personal care needs like washing and dressing. He was capable of eating and drinking independently. Daily notes on his condition were recorded by carers as part of that care package until his transfer to the Royal Infirmary of Edinburgh on 24 February 2019.

13. That on Saturday, 23 February 2019 prisoners were locked in their cells at around 1630 hours as per normal weekend procedure. David Scott sat on his bunk watching television while his cellmate read a book.

14. That at around 1900 hours on 23 February 2019, David Scott's cellmate noted that he was poorly responsive and used the emergency call button

within the cell to summon assistance. Prison staff attended and spoke with David Scott for a short while and took the view that he did not require medical attention at that stage. A carer attended shortly thereafter, and he appeared to be more responsive and engaged in conversation with her. He did not want to be assisted into bed at that time.

15. That at around 20:30 hours on 23 February 2019, David Scott fell onto the cell floor while attempting to stand up from his bunk. He was conscious, but appeared disorientated. His cellmate checked him over for obvious injury and helped him into bed. He fell asleep quickly, and was still asleep when his cellmate went to bed at around 2330 hours.

16. That at around 07:10 hours on 24 February 2019, David Scott's cellmate awoke to find him lying on the floor. Drawers had been opened; a bottle of fizzy juice had been opened and he had urinated on the floor. He was lying asleep underneath the counter beside the heating pipes. His cellmate pressed the emergency call button.

17 That Prison staff attended at the cell and woke David Scott at around 07:30 hours on 24 February 2019. He was very confused and disorientated at that time, and a nurse was asked to attend. He was found to be cool to touch, his oxygen saturation was low, and his blood pressure was unrecordable due to increased tremor. He indicated that he

may have suffered a seizure. An ambulance was called immediately and he was given blankets to keep warm.

18 That David Scott was taken to the Accident and Emergency Department at the Royal Infirmary of Edinburgh by ambulance. He arrived there at approximately 10:21 hours and was assessed immediately. He was found to be peripherally cool and clammy, with oxygen saturation of 88%, and was breathing fast. He remained confused. An ECG confirmed that he was suffering from sinus tachycardia (accelerated resting heart rate).

19. That a chest x-ray showed focal consolidation of the right mid to lower zones in keeping with infection. The working diagnosis was that he had suffered aspiration pneumonia and acute kidney injury, resulting from his seizure. He was started on intravenous antibiotics and fluids, and admitted to the Combined Assessment Unit.

20. That between 24 and 28 February 2019, David Scott was the subject of an Adults with Incapacity Certificate which allowed medical staff to provide treatment to him as they deemed necessary.

21. That a DNACPR certificate was in place from 28 February 2019. It stated "CPR will not be successful and is not a treatment option for this patient". The reason provided was David Scott's "significant co-morbidities and underlying lung disease".

22. That on 1 March 2019, it was apparent that David Scott's condition was worsening despite escalation of intravenous antibiotic therapy. He was

becoming increasingly hypoxic. He was the subject of a Critical Care Referral Review and the decision was taken that escalation to a High Dependency Unit would not be in his best interests. Ward level care was to continue.

23. That due to his continued deterioration, on 3 March 2019, David Scott was moved to Ward 204 for increased oxygen support. He appeared more comfortable and alert, but complained that he was "feeling rubbish" and showed no clinical improvement.

24. That between 3 and 5 March 2019, David Scott's condition worsened. He was deemed to be in Type 1 Respiratory Failure. At around 1940 hours on 5 March 2019 the Consultant in charge of his care opined that he was dying, and initiated end of life care.

25. That the Scottish Prison Service began an Application for Early Release on Compassionate Grounds in respect of David Scott on or around 6 March 2019. The relevant paperwork was completed on 6 March 2019 by the Consultant in charge of his care, and by the Prison Social Work Department and the Governor on 7 March 2019. Early Release had not yet been granted at the time of his death.

26. That David Scott died peacefully on the evening of 7 March 2019. Life was pronounced extinct at 18:42 hours.

27. That the body of the said David Scott was taken to Edinburgh City Mortuary, Cowgate, Edinburgh and was examined by a Consultant

Forensic Pathologist on 13 March 2019. A report of those findings was prepared. Crown Production number 1 is the said Post Mortem Examination Report dated 25 June 2019. The said Report is true and accurate in its terms, and is treated as the credible and reliable evidence of the pathologist.

28. That the medical cause of the said David Scott's death was:

1a) Complications of a presumed seizure in a man with epilepsy

2) Chronic obstructive pulmonary disease

Submissions

[14] The Crown supplied written submissions, with which the other parties concurred. As he was lawfully imprisoned at HMP Edinburgh, an inquiry was required to be held into the circumstances of his death. All parties accepted that he had died of natural causes and simply sought formal findings under the 2016 act. Submissions were restricted to section 26(2)(a) and (c), that is to say where and when the death occurred and the causal causes of the death. The joint minute, to which reference was made, took account of a significant number of documents that were produced. It was submitted that there was no evidence that anything could have been done differently to avoid the death of Mr Scott. There were therefore no submissions under sections 26(2)(b) and (d) to (g) of the Act.

[15] All parties expressed their condolences to Mr Scott's friends and family.

Discussion and Conclusions

[16] From the agreed evidence, it is clear that Mr Scott had a history of epilepsy and COPD prior to being imprisoned for the offences set out above. Over the period from the evening of 13-14 February 2019, his medical condition worsened while in HMP Edinburgh. That resulted in him being admitted to the ERI on the morning of 24 February 2019, where despite being given appropriate care he passed away on 7 March 2019. It is clear from the pathologist's report that he died as a consequence of complications of a presumed seizure in a man with epilepsy and COPD. On the basis of all the evidence before me at the inquiry, I consider that Mr Scott's death was attributable solely to natural causes as accurately described on the death certificate. It is in the circumstances that I have made formal findings only, in terms of sections 26(2)(a) and (c) of the Act, all as based on the agreed evidence which includes the pathologist's report.