2015FAI18

SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

Inquiry held under s.1(1)(a) under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

DETERMINATION BY Donald S. Corke, Advocate, Sheriff of Lothian and Borders at Edinburgh

In inquiry into the death of KEVIN FYFFE (date of birth 6 August 1965) and late of HMP Edinburgh

EDINBURGH, 25 June 2015

The Sheriff determines as follows.

[1] In terms of s.6(1)(a) of the said 1976 Act that Kevin Fyffe who was born on 6 August 1965 and late of Her Majesty's Prison Edinburgh died at 16:25 hours on 8 September 2012 at Edinburgh Royal Infirmary while a serving prisoner.

[2] In terms of s. 6(1)(b) of the said Act that the cause of his death was:

1a. Coronary atherosclerosis and nefopam toxicity.

[3] In terms of s. 6(1)(c) of the said Act that there were no reasonable precautions whereby the death and any accident resulting in the death might have been avoided.

[4] In terms of s. 6(1)(d) of the said Act that there was no defect in any system of working which contributed to the death or any accident resulting in the death.

[5] In terms of s. 6(1)(e) of the said Act there were no other facts relevant to the circumstances of the death.

Note:

[1] This inquiry relates to the unfortunate death of a 47-year-old prisoner who died while in custody on 8 September 2012. The inquiry took place at Edinburgh Sheriff Court following upon application made by the Crown and after being continued once part heard for the availability of witnesses.

[2] Evidence for the Crown was led by Mr J O'Reilly, the procurator fiscal depute at Edinburgh. Ms L Bowen of Messrs Anderson Strathearn, solicitors, Edinburgh, appeared on behalf of the Scottish Prison Service. The NHS had a watching brief.

[3] A joint minute was tendered agreeing the basic facts, and was in accordance with the productions and other evidence led. The joint minute refers to certain written statements being agreed as true and accurate records of the evidence of the witnesses to which they relate and to be taken as equivalent to oral evidence. There was no problem or issue with the credibility or reliability of any of the witnesses.

[4] As well as appearing in the joint minute, prison officer Grant Hook gave oral evidence. Oral evidence was also led from Detective Constable Nicola Barrett

(formerly Brown), and prison officer William Holgate, in each case supplementing their respective statements.

[5] On 22 November 2002, the deceased was convicted of assault with intent to rape and shameless indecency. He was given a custodial term of eight years with an extension period of six years, for an aggregate sentence of 14 years to date from 3 May 2002. He was in custody at HMP Edinburgh at the time of his death following revocation on 24 July 2009 of a release on licence in terms of s.17 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (pro 1).

[6] The deceased had a history of personality disorder, auditory hallucinations, chest and other pain, high cholesterol, vomiting and diarrhoea, and epilepsy. Prescribed medications at the time of his death included chlorpromazine, procycladine, simvastatin and nefopam. He shared a cell with another and the cell doors would be open for access and visits from other inmates at times. He, like other inmates, was left to take his own medication in accordance with policy. The deceased was prescribed the analgesic drug nefopam due to chronic pain in his back and legs. At the time of his death, he was prescribed 56 30 mg tablets per week to be taken in doses of two, four times a day. He received a weekly supply of nefopam on Friday, 7 September 2012 and by the time of his death should have had 42 left. When his cell was searched after his death, 67 nefopam tablets were found along with empty packaging for the same drug pertaining to prescriptions made up for two other prisoners.

[7] The deceased was pronounced dead at 16:25 hours on 8 September 2012 at Edinburgh Royal Infirmary, having been taken there from HMP Edinburgh for emergency treatment after collapsing at about 14:50 hours on the same date within his cell. He was given all appropriate treatment but nothing could be done to save him.

[8] Dr Clare Bryce is a consultant pathologist and carried out a post-mortem examination of the deceased on 11 September 2012. There was a sworn pathologist's report and toxicology report by her (pro 2). There was a high level of nefopam at 5.2 mg/l, which is consistent with the level associated with seizures and cardiac arrest. It was equally possible that the toxic effects of nefopam or his coronary artery disease could have caused his seizure and death.

[9] Dr Stephen Gilbert, a consultant anaesthetist, was asked to provide an opinion on the appropriateness of prescribing nefopam to the deceased (pro 3), which he defends.

[10] Productions also included medical records pertaining to the deceased's treatment in various prisons between March 2006 and September 2012 (pro 4 and 5); and the SPS "Policy for the Supply of Medicines to Prisoner Patients" dated 25 February 2009 (pro 1 on a separate inventory).

[11] The deceased had been allowed to keep his own medication, and at first sight it may be questioned why policy allows that, given that nefopam toxicity features as a cause of death, and given that even after that he still had more than a week's supply left. It can be seen that there is a balance to be struck between enabling prisoners to exercise personal responsibility and prepare for release against the risks of medicine misuse. The policy indicates that a decision is made by the Medical Officer whether medication should be administered under the supervision of a practitioner nurse or supplied in possession to the patient for self administration. If they are given medicines in possession then the individual signs a patient contract. Quantities are normally dispensed for one week or longer as dispensing in daily quantities is a time-consuming practice with no real benefit, as prisoners could still stockpile medication. On the list of medications normally appropriate for issue for self administration are non-opioid analgesics. Nefopam is a non-opioid analgesic first prescribed to the deceased on 28 September 2009 when his complaint was left leg pain following an old fracture. It is recognised medical practice to prescribe painkillers in this way. Nefopam is included in the safest category of prescribing. There have been very few case reports of death associated with nefopam overdose. Nefopam is a relatively safe painkiller with a lower potential for abuse and overdose than opiate analgesics such as codeine or morphine. It was properly prescribed as being in the safest category of painkillers. Though possibly implicated in the death of the deceased, there is no evidence that this was a deliberate overdose and no reasonable precautions could have been taken to prevent the death.

[12] As well as agreeing the joint minute, the PFD and the SPS solicitor were agreed on the need for formal findings only, as reflected above.

……26 June 2015

Sheriff D S Corke, Advocate