SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2026] FAI 28

EDI-B1683-25

DETERMINATION

BY

SHERIFF GRAEME WATSON

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

into the death of

DAVID JAMES REID

EDINBURGH, 29 May 2026

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") that:

1. In terms of section 26(2)(a) of the Act, David James Reid, born 14 September 1958, died within ward 207 of Edinburgh Royal Infirmary on 23 June 2022, aged 63.

2. The death did not result from an accident so no findings in terms of section 26(2)(b) need be made.

3. In terms of section 26(2)(c) of the Act, the cause of death was 1) acute on chronic lung disease in a man with chronic obstructive pulmonary disease and Covid pneumonitis; and 2) ischaemic heart disease.

4. In terms of sections 26(2)(d), (e), (f) and (g), no findings fall to be made.

5. In terms of sections 26(1)(b) and 26(4), no recommendations are made.

NOTE

The legal framework of the inquiry

[1] Under section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths in similar circumstances. Section 26 requires the sheriff to make a determination which under section 26(2) is to set out factors relevant to the circumstances of the death. These 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 could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided; (f) any defect in any system of working which contributed to the death or to the accident; and (g) any other facts which are relevant to the circumstances of the death.

[2] Under section 26(1)(b) and 26(4), the inquiry is to make such recommendations as the sheriff considers appropriate 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; and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances. The sheriff is not obliged to make recommendations; that is a discretionary power. The procurator fiscal depute represents the public interest. An inquiry is an inquisitorial process. The determination must be based on the evidence

presented at the inquiry. It is not the purpose of an inquiry to establish criminal or civil liability. The sheriff's determination is not admissible in evidence and may not be founded on in any judicial proceedings of any nature.

Introduction

[3] This inquiry was held under section 1 of the Act. It was a mandatory inquiry under section 2(1) and (4) as Mr Reid was in legal custody at the time of his death. The procurator fiscal lodged a notice of inquiry on 5 December 2025. A preliminary hearing took place on 8 January 2026. It was continued to 9 March and then to 15 April 2026 to allow parties further time to prepare, including lodging further productions and witness statements and drafting a comprehensive joint minute of agreement. The inquiry was held on 21 May 2026 at Edinburgh Sheriff Court.

[4] Three parties were represented at the inquiry. Andrew Neilson, procurator fiscal depute appeared for the Crown. Niamh Brett, solicitor, appeared for the Scottish Ministers acting through the Scottish Prison Service. Catriona Robertson, solicitor, appeared for Lothian Health Board. Mr Reid's parents are deceased and on cause shown I dispensed with intimation on his nearest known relative. He had had no contact with any known relative for many years, and none had been willing to act as his next of kin.

[5] No oral evidence was led at the inquiry. All parties entered into a joint minute of agreement. All parties invited me to make formal findings under section 26(1)(a) and (c) of the Act. No party invited me to make any recommendations.

[6] By the date of the inquiry, the Crown had lodged extensive productions, the most significant being:

a. Crown Production 1, the autopsy report in respect of Mr Reid, written by Dr Kerryanne Shearer, pathologist;

b. Crown Production 3, the prison medical records maintained by Lothian Health Board in relation to Mr Reid;

c. Crown Production 4, the hospital medical records maintained by Lothian Health Board in relation to Mr Reid;

d. Crown Production 5, the Death in Prison, Learning, Audit and Review ("DIPLAR") Report in respect of the death of Mr Reid;

e. Crown Production 6, the NHS Local Case Review;

f. Crown Production 22, extract from HMP Edinburgh's vaccination spreadsheet; and

g. Crown Production 29, Department of Health and Social Care press release, dated 15 September 2021.

[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 and should be admitted in evidence.

[8] Also lodged as Crown Production 25 were statements of the following witnesses:

a. Alana Kelly, previously charge nurse, HMP Edinburgh Health Centre;

b. Caitlin Roberston, previously primary care nurse, HMP Edinburgh;

c. Callum Preston, prison officer, HMP Edinburgh;

d. Diane McCabe, senior charge nurse, NHS Lothian;

e. Dr Pauline Jones;

f. Elaine McAdam, advanced nurse practitioner;

g. Keith McLeish, vaccination service manager;

h. Kirstin Sykes, staff nurse;

i. Louse Willington, clinical nurse manager;

j. Michelle Kinnear, previously nurse with NHS Lothian at HMP Edinburgh;

k. Ross Keenan, prison officer, HMP Edinburgh;

l. Sharanne Findlay, head of operational support, SPS;

m. Shelley Jones, advanced nurse practitioner, previously at HMP Edinburgh;

n. Steven McCann, head of operations, HMP Edinburgh;

o. Ted Lamprecht, prison officer; and

p. Toni Govan, staff nurse.

[9] The parties were agreed that the statements were true and accurate copies of the originals, the contents were agreed, and they should be treated as the evidence of those witnesses.

[10] The parties also lodged a joint minute of agreement of facts which were not, so far as the parties were concerned, in dispute. In addition, each party lodged submissions setting out their position on the issues which the inquiry required to consider.

[11] At the hearing on 21 May 2026 the parties submitted that the inquiry could proceed without oral evidence, relying instead on the witness statements in lieu of

parole evidence and on the matters agreed in the joint minute, including parties' agreement as to the contents of productions and agreed facts. I agreed with that course of action, closed the inquiry and reserved my decision. Parties invited me to make formal findings only.

The circumstances of the deceased and his death

Background

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

[13] On 1 November 2011, responsibility for the provision of healthcare to prisoners was transferred from the Scottish Prison Service to the NHS under the Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011. Since then, each individual regional NHS health board has been responsible for the delivery of healthcare services within the prisons in Scotland which fall within their geographical ambit, for the provision of medical care.

[14] On 2 September 2019 at the High Court in Glasgow, Mr Reid received an Order for Lifelong Restriction, with a punishment part of 4 years and 3 months. He was imprisoned at HMP Edinburgh. He resided in Hermiston Hall 2, North Wing, which was for older or unwell prisoners.

Medical history and treatment

[15] Mr Reid had a history of angina pectoris, Type 2 diabetes mellitus, ischaemic heart disease, emphysema and left ventricular systolic dysfunction. He frequently

reported being short of breath to prison medical staff and often refused to attend hospital.

[16] A DNACPR (do not attempt cardio-pulmonary resuscitation) notice was put in place on 29 December 2021. Another DNACPR was signed on 31 December 2021. At this point, clinicians were of the view that although CPR could be successful, the likely outcome would not be of overall benefit to Mr Reid. A final DNACPR form was signed on 3 June 2022. By this point, clinicians were of the view that CPR had no realistic prospect of success.

[17] From December 2021 onwards Mr Reid suffered worsening shortness of breath. On 9 December 2021, he was identified as symptomatic for COVID-19. He was swabbed for testing and placed in COVID-19 isolation as a precaution. The next day, he was confirmed as positive for COVID-19. He remained in COVID-19 isolation until 18 December 2021. Over the following weeks nursing staff carried out regular observations and strongly advised him to agree to attend hospital, which he refused to do. On 27 December 2021, an ambulance was called and paramedics attended to Mr Reid. They advised Mr Reid to attend hospital, but he refused. On 31 December 2021, he did agree to attend hospital and was admitted to Edinburgh Royal Infirmary. His initial chest X-ray showed significant pneumonic changes, due to his prior Covid infection, and extensive emphysema. There was no evidence of a current Covid infection.

[18] On 2 February 2022, following a review from the medical team, Mr Reid was discharged back to HMP Edinburgh. After his return to prison, Mr Reid was reviewed

by nursing staff but did not want any interventions. His condition worsened from 18 February onwards. He also started to refuse clinical observations and continued to refuse readmission into hospital. Mr Reid's condition deteriorated on 4 May 2022. Mr Reid presented as very short of breath and struggling to speak and said he was willing to attend hospital. He was admitted to Edinburgh Royal Infirmary. He initially improved, but on 3 June 2022 he developed escalating oxygen requirement. A chest X-ray showed a right-sided consolidation. This was attributed to a new hospital acquired pneumonia. Mr Reid began to improve, and a plan was out in place to discharge him back to HMP Edinburgh with additional oxygenation, however, by the afternoon of 20 June, he had deteriorated again and was no longer fit for discharge.

Circumstances of death

[19] By 22 June, Mr Reid required to be sustained on 6 litres of oxygen. By the morning of 23 June, he had desaturated to 81%. He was placed on 10 litres of oxygen with little effect.

[20] Mr Reid was seen by Dr Jonathan Bardgett on 23 June because of a further deterioration. His chest X-ray and blood results suggested recurrent infection. Dr Bardgett prescribed antibiotics and continued oxygen treatment but advised that his prognosis was poor and that if he continued to deteriorate, a palliative approach may be needed. Palliative treatment refers to treating symptoms rather than the underlying medical condition. He prescribed anticipatory medications that could be offered for pain, anxiety, sickness, or shortness of breath. All doctors treating Mr Reid

agreed with Dr Bargett's opinion. At no point was Mr Reid's active treatment with antibiotics or oxygen stopped.

[21] Mr Reid died on 23 June 2022, with his death being confirmed at 2243 hours.

[22] A post-mortem examination was carried out by Dr Kerryanne Shearer, consultant forensic pathologist on 5 July 2022. Mr Reid's cause of death was reported as: 1a. Acute on chronic lung disease in a man with chronic obstructive pulmonary disease and Covid pneumonitis. 1b. Ischaemic heart disease.

[23] A DIPLAR report was completed, dated 14 August 2023. The report identified one learning point, to ensure the fitness of the person being discharged from hospital. The associated action plan was for hospitals within Lothian to be provided with an overview of the prison environment and medical services available to patients. NHS Lothian carried out a local case review to assess whether a significant adverse event review was required. The local case review determined that Mr Reid was given appropriate care. No care or service delivery problems were identified. There were no breaches of policy or procedure and no lessons to be learnt.

Submissions

[24] All parties submitted that only formal findings should be made under section 26(2)(a) and (c) of the Act. I was not invited to make any other findings or any recommendations.

Conclusions

[25] On the basis of the evidence presented at the inquiry, including the joint minute of admissions, I am satisfied that I should make formal findings under section 26(2)(a) and (c) only. I have set out those findings above.

[26] On the available evidence at the inquiry, I have determined that Mr Reid died from acute on chronic lung disease. He suffered both chronic obstructive pulmonary disease and Covid pneumonitis. A secondary cause was ischaemic heart disease. He had received appropriate Covid vaccinations. Although he had frequently refused hospital care, staff did persuade him to agree to hospitalisation on 31 December 2021. He was treated appropriately and discharged back to HMP Edinburgh on 2 February 2022. His condition deteriorated and on 4 May 2022 he agreed to attend hospital. He received appropriate treatment following his admission to Edinburgh Royal Infirmary. He deteriorated following a hospital-acquired pneumonia. He received intravenous and oral antibiotics. Active treatment continued until his death on 23 June 2022.

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

[28] All parties expressed their condolences to Mr Reid's family on their own behalf. I add my own condolences for their loss.