SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT ALLOA

[2021] FAI 15

ALO-B112-20

DETERMINATION

of

SUMMARY SHERIFF CRAIG HARRIS

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC

(SCOTLAND) ACT 2016

in the inquiry into the death of

HUGH FERGUSON

Alloa, 19 February 2021

DETERMINATION

The summary 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 (hereinafter referred to as "the Act"):

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

The late Hugh Ferguson (born 12 July 1959), then a prisoner within Her Majesty's Prison Glenochil, Tullibody, died at 1134 hours on 3 May 2019 within cell 5/61 within the Abercrombie wing of that prison.

(2) In terms of section 26(2)(b) of the Act (when and where any accident resulting in death occurred):

There was no accident. No findings are made.

(3) In terms of section 26(2)(c) of the Act (the cause or causes of death):

The cause of death was 1a Cardiomegaly (cardiac enlargement) and 1b Obesity and possible hypertension.

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

There was no accident. No findings are made.

(5) In terms of section 26(2)(e) of the Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

There were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.

(6) In terms of section 26(2)(f) of the Act (any defects in any system of working which contributed to the death or the accident resulting in the death):

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

There are no other facts which are relevant to the circumstances of the death.

RECOMMENDATIONS

The summary 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 Hugh Ferguson (born 12 July 1959) (hereinafter referred to as "Mr Ferguson") at Her Majesty's Prison Glenochil, Tullibody (hereinafter referred to as HMP Glenochil) on 3 May 2019. At the time of his death Mr Ferguson was in legal custody. Accordingly this was a mandatory fatal accident inquiry in terms of section 2(4)(a) of the Act.

[2] The death of Mr Ferguson was reported to the Crown Office and Procurator Fiscal Service on 7 May 2019.

[3] First notice of the inquiry was given by the Procurator Fiscal on 21 August 2020 in terms of section 15(3) of the Act. I pronounced a first order on 31 August 2020 fixing a preliminary hearing on 13 October 2020 and fixing dates for the inquiry to be held on 24 and 25 November 2020, all at Alloa Sheriff Court.

[4] Two parties provided notification of an intention to participate in the inquiry, namely the Scottish Prison Service and Forth Valley Health Board. The Procurator Fiscal

advised that intimation of the inquiry had been made to Mr Ferguson's nearest known relative who did not wish to participate in the inquiry.

[5] At the preliminary hearing on 13 October 2020 the representatives from the Crown, the Scottish Prison Service and Forth Valley Health Board were all agreed that evidence could proceed by way of Joint Minute of Agreement. After providing my observations on the draft Joint Minute of Agreement that had been lodged, I agreed with parties that the inquiry could proceed without the requirement of parole evidence.

[6] The inquiry was held at Alloa Sheriff Court on 24 November 2020 with all parties participating remotely via Webex. Karon Rollo, Procurator Fiscal Depute represented the Procurator Fiscal; Laura McCabe, solicitor advocate represented the Scottish Prison Service and Nadia Waseem, solicitor represented Forth Valley Health Board.

[7] All parties had entered a Joint Minute of Agreement agreeing facts in relation to the entirety of the evidence that would otherwise have been led at the inquiry. In addition the following productions were lodged and referred to by the Joint Minute:

- Prison records relating to Mr Ferguson;
- A post mortem report dated 22 August 2019 by Dr Robert Ainsworth, Consultant Forensic Pathologist in respect of Mr Ferguson's death;
- A Death in Prison Learning, Audit and Review Report prepared by the Scottish Prison Service (only this production did not have its contents agreed as true and accurate – parties advised this was because it contained opinion evidence); and
- Prison healthcare records relating to Mr Ferguson.

[8] At the inquiry the Joint Minute of Agreement was read out by the Clerk of Court. Written submissions were provided in advance of the inquiry by all parties. The Procurator Fiscal Depute read out her submissions and Ms McCabe and Ms Waseem indicated they adopted those submissions. All parties submitted I should make formal findings only.

Legal Framework

[9] The inquiry was held under section 1 of the Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. References to sections or rules in the following paragraphs refer to the Act and the 2017 Rules respectively.

[10] The purpose of a fatal accident inquiry is to establish the circumstances of the death of a person and consider what steps (if any) might be taken to prevent other deaths in similar circumstances (section 1(3)). It is not the purpose of an inquiry to establish civil or criminal liability (section 1(5)).

[11] A fatal accident inquiry is conducted by a sheriff (section 1(2)). The inquiry is conducted in public unless the sheriff orders the proceedings (or any part of them) to be conducted in private (sections 21(1) and (2)). The inquiry is an inquisitorial, not adversarial, process (rule 2.2(1)). At the inquiry the Procurator Fiscal represents the public interest. Certain categories of persons connected to the person who has died, together with any other person who the sheriff is satisfied has an interest in the inquiry, may also participate in the inquiry (section 11). The Procurator Fiscal must, and a participant may, bring forward evidence relating to the circumstances of the death to which the inquiry relates (section

20(1)). The sheriff may require the Procurator Fiscal or a participant to bring forward evidence about any matter relating to the circumstances of the death (section 20(2)).

[12] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate (section 26(1)). A determination is to be in a prescribed form (rule 6.1).

[13] The findings that must be made in relation to the death to which the inquiry relates are (a) where and when 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, 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 (section 26(2)).

[14] The making of recommendations is discretionary. The 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 (section 26(4)). A recommendation may (but need not) be addressed to (i) a participant 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 (section 26(5)).

Summary

[15] Having regard to the information presented to the inquiry, I found the following facts to be established:

1. Mr Ferguson was born on 12 July 1959. He died on 3 May 2019 within cell 5/61 within the Abercrombie wing of HMP Glenochil. He was 60 years old.

2. On 1 July 1980 at the High Court of Justiciary at Glasgow Mr Ferguson was sentenced to life imprisonment in respect of a charge of murder and to 15 months detention in respect of a charge of housebreaking with intent to steal. On 6 July 1992 Mr Ferguson was released on licence. On 11 October 2004 that licence was revoked causing him to be returned to custody.

3. On 13 June 2008 at the High Court of Justiciary at Aberdeen Mr Ferguson was sentenced to 20 years imprisonment in respect of a charge of rape, 2 charges of assault and 2 charges of sodomy and indecent assault.

4. Mr Ferguson was serving both of his sentences at HMP Glenochil and was in legal custody at the time of his death.

5. Mr Ferguson was located within a single occupancy cell 5/61 with the Abercrombie wing at HMP Glenochil. He occupied this cell alone.

6. Mr Ferguson generally kept good health.

7. During the course of the evening of 2 May 2019 Mr Ferguson was seen by prison officers David Sutherland and Steven Beattie several times. Mr Ferguson appeared

to be in good spirits. At 2100 hours that night Mr Ferguson was locked in his cell for the night. He was seen to be well at that time by the same prison officers and gave them no cause for concern.

8. On 3 May 2019 at approximately 0725 hours prison officer Colin Patterson unlocked Mr Ferguson's cell. Mr Ferguson was lying slumped on the floor in the far left corner of the cell. Officer Patterson attempted to get a response from Mr Ferguson by shaking his shoulder and calling his name. At that point prison officer Sharon Hendry entered the cell. Officer Patterson alerted other staff by calling a code sign over his radio. Another prison officer then entered the cell. Officer Hendry attempted to detect a pulse on Mr Ferguson without success. Two members of NHS nursing staff within the prison immediately attended. No attempt at resuscitation was made. Mr Ferguson appeared to have died several hours beforehand.

9. On 03 May 2019 at 1134 hours Mr Ferguson's life was pronounced extinct by Dr Craig Sayers, a prison doctor for HMP Glenochil.

10. On 9 May 2019 a post mortem examination was conducted upon Mr Ferguson at the City of Edinburgh Mortuary by Dr Robert Ainsworth, Consultant Forensic Pathologist.

11. The cause of Mr Ferguson's death was:

    1a Cardiomegaly (cardiac enlargement)

    1b Obesity and possible hypertension.

[16] The documentary productions agreed as true and accurate in their terms contained information which expanded upon the agreed facts in the Joint Minute of Agreement and which I took account of. The Joint Minute also agreed facts about the circumstances which had led to the revocation of Mr Ferguson's licence in October 2004. I did not consider those circumstances relevant to my determination and have not detailed them in this note.

[17] The Procurator Fiscal Depute submitted that Mr Ferguson had kept reasonably good health. His death appeared to have been sudden and unexpected but was as a result of natural causes. I was invited to only make findings in respect of section 26(2)(a) (where and when the death occurred) and section 26(2)(c) (the cause or causes of the death) of the Act in the terms set out in the Joint Minute of Agreement and the post mortem report. Both Ms McCabe and Ms Waseem adopted the same position.

Discussion and conclusions

[18] Mr Ferguson had generally kept good health. All of the toxicology analyses undertaken after death for alcohol, prescription drugs and drugs of abuse gave negative results. Post mortem examination revealed a marked enlargement of his heart. The post mortem report concluded that Mr Ferguson's death was due to natural causes, as the result of cardiomegaly (cardiac enlargement), the nature of which could have caused "sudden cardiac death" at any time. That report commented that the cause for the disease could to some extent have been related to Mr Ferguson's body size (his body mass index clinically reflected obesity) and that it was also possible that Mr Ferguson was suffering from hypertension (high blood pressure).

[19] Having considered the Joint Minute of Agreement, the productions and the submissions of the parties, I consider that only formal findings in respect of section 26(2)(a) and section 26(2)(c) of the Act should be made.

[20] There was no accident in the present case and so no findings are appropriate under sections 26(2)(b) and (d) of the Act. No submissions were made, nor was there any information to suggest, that any findings should be made in terms of section 26(2)(e) of the Act (regarding any precautions which could reasonably have been taken and which might realistically have resulted in the death being avoided) or in terms of section 26(2)(f) of the Act (regarding any defect in any system of working which contributed to the death).

[21] I am satisfied that there are no other facts relevant to the circumstances of the death which ought to be included as formal findings in my determination in terms of section 26(2)(g) of the Act.

[22] Given the information and submissions before me, I consider it would not be appropriate to make any recommendations in terms of section 26(1)(b) of the Act.

[23] I am grateful to all parties for their preparation for the inquiry, as a result of which evidence was agreed and no witnesses were required.

[24] I conclude matters by expressing my condolences to the family and friends of Mr Ferguson.