SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2017] FAI 30

2B434/17

DETERMINATION

BY

SHERIFF DONALD CORKE

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

GORDON MCBRIDE MELROSE (d.o.b. 21.09.47)

EDINBURGH, 8 November 2017

The Sheriff, having considered all the evidence, FINDS and DETERMINES

(i) in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") that Gordon McBride Melrose, date of birth 21 September 1947, who was lawfully detained in custody at HMP Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN, died at 1950 hours on 2 April 2014 at Marie Curie Cancer Centre, Frogston Road West, Edinburgh;

(ii) in terms of section 6(1)(b) of the 1976 Act the cause of his death was:

1a Metastatic Colon Cancer;

(iii) in terms of section 6(1)(c), there were no reasonable precautions whereby the death might have been avoided;

(iv) in terms of section 6(1)(d) there were no defects in any system of working which contributed to the death;

(v) in terms of section 6(1)(e) there were no other facts which were relevant to the circumstances of the death.

Note

Introduction

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Gordon McBride Melrose ("the deceased") who died at the Marie Curie Hospice in Edinburgh on 2 April 2014. Mr Melrose was at the time of his death in legal custody and an Inquiry was thus mandatory under section 1(1)(a)(ii) of the 1976 Act.

[2] Ms Daly, Procurator Fiscal Depute, represented the public interest and Mr Flannigan, solicitor, represented the Scottish Prison Service. Ms Gormley, solicitor, represented the National Health Service Forth Valley. The family of the deceased were not represented and I was informed that although they wished to be informed of the outcome, they did not wish to appear or be represented at the Inquiry. The Scottish Prison Officers Association appeared at the preliminary hearing but had no wish or need to be represented at the Inquiry.

[3] A Joint Minute of Agreement was entered into by parties and received by the Inquiry. No parole evidence was led. The practice has developed under the 1976 Act for evidence to be considered in this manner and for facts to be treated as proved by joint minute, especially where the findings which can be made are not controversial. I exercised due caution in proceeding without hearing oral evidence, given that the family of the deceased were not represented and he died in the custody of the state.

[4] Statements of the following witnesses were appended to the joint minute and have been taken as equivalent to parole evidence. There are no adverse issues around credibility or reliability.

1. Dr Neil Graham MacRitchie, GP at HMP Grampian dated 19 May 2017
2. Dr William Smith, GP at HMP Edinburgh and Addiewell dated 28 March 2017
3. Rachel Kemp, Senior Medical Director at Marie Curie Hospice dated 20 March 2017
4. Linda Stark, Health Centre Manager at HMP Edinburgh dated 9 April 2014
5. Alistair McMillan, Prison Custody Officer for G4S dated 2 April 2014
6. Mark Gregory, Prison Custody Officer for G4S dated 2 April 2014
7. Nicola MacKay, Staff Nurse at Marie Curie Hospice dated 3 April 2014
8. Brian Donlevy, Fiscal Officer at COPFS dated 9 April 2014
9. Police Constable Aideen McElhinney, Police Scotland dated 12 June 2014
10. Dr Craig Sayers, Clinical Lead Prison and Forensic Medicine, FVHB, dated July 2017
11. Lesley McDowall, Health Strategy & Suicide Prevention Manager at SPS dated 2 November 2017

[5] Crown productions 1-11 were agreed within the joint minute.

[6] Section 6(1) of the 1976 Act requires the presiding sheriff to make determinations in the following matters (a) where and when the death took place; (b) the cause of such death; (c) the reasonable precautions, if any, whereby the death might have been avoided; (d) the defects, if any, in any system of working which contributed to the death; and (e) any other facts which are relevant to the circumstances of the death.

[7] Written submissions were lodged on behalf of the Procurator Fiscal Depute. These were adopted by the solicitors for the Scottish Prison Service and the NHS Forth Valley. Brief oral submissions were also made. I was invited by all representatives present to make a formal determination and not find it appropriate or necessary to make any determination in respect of section 6(1)(c) (d) or (e).

Circumstances

[8] On 17 April 2007 the deceased was convicted of assault with intent to rape at the High Court of Justiciary. On 1 October 2007 the court made an Order for Lifelong Restriction under section 210F of the Criminal Procedure (Scotland) Act 1995. In terms of section 2(2) of the Prisoners and Criminal Proceedings (Scotland) Act 1993, the court ordered that a period of 12 years imprisonment commencing from 8 November 2006 be served by the deceased. The deceased had, for previous offending, been placed on a Sex Offenders Order in April 2004 in terms of the Crime and Disorder Act 1998. He was a registered sex offender and schedule 1 offender, for an indefinite period.

[9] The deceased was diagnosed with inoperable colorectal cancer in October 2011 at the age of 64. He died on 2 April 2014 at 1950 hours at the Marie Curie Cancer Centre in Frogston Road West, Edinburgh. The cause of death as recorded on the death certificate (production number 7) was metastatic colon cancer. No post mortem was required or done.

[10] When he was diagnosed, the deceased was a long-term prisoner in HMP Glenochil. He had been transferred from HMP Peterhead on 3 December 2010.

[11] The GP expert report (production number 10) by Dr R G Neville, based on a review of the records, is of particular value in considering the circumstances surrounding the diagnosis, treatment and death of the deceased. In the course of that report, Dr Neville

expressed concerns (para 6.6-6.11; para 7.4) about the system of handwritten medical record keeping in HMP Glenochil in 2011, at a time when almost all Scottish general practices had converted their records to modern computer systems from 2004. There is no reason to suppose that this perceived deficiency, corrected in May 2012, had any bearing upon the time at which the deceased's colorectal cancer could have been diagnosed. An explanation based on procurement of, and migration to, a new computerised system is provided in the statement of Lesley McDowall, Health Strategy and Suicide Prevention Manager within the SPS. In any event, it is not relevant for present purposes.

[12] Likewise, although Dr Neville comments (report para 6.12) about the desirability of continuity of care generally within the NHS and particularly within prisons, there is no indication that a lack of continuity of care contributed to a late diagnosis of the deceased's cancer.

[13] Dr Neville also queried (report para 6.34) how a GP request for urology assessment had been handled. I am satisfied that the reported problem was of urinary flow and the deceased was appropriately referred to a PAC clinic and not for rectal examination, which in any event would not have made a difference coming as it did a month before ultimate diagnosis.

[14] When he was received into HMP Glenochil he was under the care of the SPS, who had the responsibility for the provision of health care to prisoners in Scotland until 1 November 2011, when that responsibility passed to NHS Forth Valley. A medical history with medication was recorded.

[15] From December 2010, when the deceased was admitted to HMP Glenochil, until his diagnosis with colorectal cancer on 13 October 2011, he had various episodes of unresponsiveness, abdominal discomfort and diarrhoea, spasms of abdominal pain and pain

when attempting to pass urine, lack of bowel movement, pain on defaecation, constipation and difficulty with urine flow, haemorrhoids and prostate pain, together with hip pain. Various tests and treatments were undertaken until his condition was ultimately diagnosed.

[16] This culminated in him being found collapsed in his cell on 11 October 2011 and admitted as an emergency to the Forth Valley Royal Hospital in Larbert. He underwent an emergency laparotomy on 13 October 2011 and was found to have a colorectal cancer with extensive localised spread into the bladder creating a colovesical fistula, and tumour invasion into the omentum. He was returned to HMP Glenochil on 1 November 2011.

[17] He attended the Beatson Cancer Centre for management of his locally advanced and inoperable colorectal cancer. At the end of his life he was transferred to Edinburgh for Marie Curie Hospice care. When he died the deceased was lawfully detained in custody at HMP Edinburgh.

[18] The conclusion of Dr Neville was that: "…I would be surprised if Mr Melrose's colorectal cancer could have been diagnosed at a 'curable stage' when one takes account of the atypical nature of his symptoms in the context of unusual health seeking behaviour." I have no reason to disagree with that view. The deceased's treatment was appropriate in the circumstances.

[19] As pointed out by Dr Neville, the duration of last illness was two years and six months from diagnosis to death, not one year and three months as recorded on the death certificate (production number 7).

[20] All this leads to formal findings as already made.

[21] I am grateful to the various representatives appearing for their careful presentation of the evidence and submissions, and for agreeing a joint minute.