SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2019] FAI 20

EDI-B188/19

DETERMINATION

BY

SHERIFF R B WEIR QC

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

into the death of

LEONARD ALEXANDER WHITEFORD WELSH

DETERMINATION

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 2016 Act") that:

(1) The deceased is Leonard Alexander Whiteford Welsh.

(2) In terms of section 26(2)(a) of the 2016 Act, the death occurred at 17.10 hours on 24 December 2017 within cell 69, Ingliston Hall, HM Prison, Edinburgh.

(3) In terms of section 26(2)(c) of the 2016 Act, the cause of death was metastatic pulmonary adenocarcinoma.

RECOMMENDATIONS

In terms of section 26(1)(b) of the 2016 Act, and having regard to the matters set out in section 26(4), there are no recommendations which, in the circumstances of the instant case, might realistically prevent other deaths in similar circumstances.

NOTE

INTRODUCTION

[1] On 31 May 2019, at Edinburgh Sheriff Court, an inquiry was held into the death of Leonard Alexander Whiteford Welsh ("the deceased") on 24 December 2017. The Inquiry was a mandatory inquiry under section 2(4) of the 2016 Act, the death having occurred in Scotland while the deceased was in legal custody within HM Prison, Edinburgh. The death was reported to the Crown Office and Procurator Fiscal Service, and both the Scottish Prison Service and Lothian Health Board subsequently indicated their intention to participate in the Inquiry, both parties being represented at the preliminary hearing on 17 April 2019.

[2] At the hearing on 31 May 2019 the Crown was represented by Mr Lewis Crosbie, Procurator Fiscal Depute. The Scottish Prison Service was represented by Mr Lewis Shand, Solicitor, and Lothian Health Board was represented by Mr Stuart Holmes, Solicitor. No witnesses were led in evidence. The Inquiry proceeded on the basis of a joint minute of agreement setting out agreed facts that should be admitted as evidence, together with relative productions. The terms of the joint minute having been narrated I heard submissions on behalf of the represented parties, before closing the Inquiry.

The legal framework

[3] The requirements relative to an inquiry under the provisions of the 2016 Act are set out principally in sections 1 and 2, which are in the following terms:

> **"1. Inquiries under this Act**
>
> (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must –
>
> (a) investigate the circumstances of the death, and
>
> (b) arrange for the inquiry to be held.
>
> (2) An inquiry is to be conducted by a sheriff.
>
> (3) 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.
>
> (4) But it is not the purpose of an inquiry to establish civil or criminal liability.
>
> (5) In this Act, unless the context requires otherwise –
>
> (a) "inquiry" means an inquiry held, or to be held, under this Act,
>
> (b) references to a "sheriff" in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.
>
> **2 Mandatory inquiries**
>
> (1) An inquiry is to be held into the death of a person which –
>
> (a) occurred in Scotland, and
>
> (b) is within subsection (3) or (4).
>
> (2) Subsection (1) is subject to section 3.
>
> (3) The death of a person is within this subsection if the death was the result of an accident which occurred –
>
> (a) in Scotland, and
>
> (b) while the person was acting in the course of the person's employment or occupation.

(4) The death of a person is within this subsection if, at the time of death, the person was –

(a) in legal custody, or

(b) a child required to be kept or detained in secure accommodation.

(5) For the purposes of subsection (4)(a), a person is in legal custody if the person is –

(a) required to be imprisoned or detained in a penal institution,

(b) in police custody, within the meaning of section 64 of the Criminal Justice (Scotland) Act 2016,

(c) otherwise held in custody on court premises,

(d) required to be detained in service custody premises...

(6) For the purposes of subsections (4)(b) and (5)(a) and (d), it does not matter whether the death occurred in secure accommodation, a penal institution or, as the case may be, service custody premises.

(7) In this section –

"penal institution" means any -

(a) prison (including a legalised police cell within the meaning of section 14(1) of the Prisons (Scotland) Act 1989), other than a naval, military or air force prison,

(b) remand centre, within the meaning of section 19(1)(b) of that Act,

(c) young offenders institution, within the meaning of section 19(1)(b) of that Act…"

[4] In terms of section 1(3) of the 2016 Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The specific matters to be determined by the court are set out in section 26 of the 2016 Act, which is in the following terms:

"26. The sheriff's determination

(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out –

(a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) 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 –

(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.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur –

(a) if the precautions were not taken, or

(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are –

(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 deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to –

(a) a participant in the inquiry,

(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

SUMMARY

[5] The deceased was born on 27 February 1954. On 13 December 2004, at the High Court in Edinburgh, he was given a 16 year extended sentence, whereof the custodial element comprised a period of 9 years. He was recalled under licence on 2 August 2016 and returned to Scottish Prison Service custody on 3 August 2016. He remained in prison until his death. He was lawfully imprisoned within HM Prison, Edinburgh, at the time of his death.

[6] On 23 March 2017 the deceased attended the smoking cessation advice centre within HM Prison, Edinburgh. At that time he was smoking over 30 cigarettes per day and had been a smoker for 51 years without any real attempts to give up. On 3 April 2017 the deceased withdrew from the smoking cessation advice service.

[7] On 7 April 2017 the deceased complained of having a shooting chest pain. He denied any heaviness in his chest, central chest pains or clamminess, and stated that the pain had eased off quickly. No further action was taken. The deceased was advised to seek further assistance if the pain came back or got worse. On 17 September 2017 the deceased had a nurse consultation after again complaining of chest pain. The nurse noted that the deceased had a history of angina, and that he had a previous crush injury to his chest, having sustained broken ribs in June 2016. The deceased stated that he had stumbled two days previously and had felt pain ever since. The pain was at the bottom of his rib cage where he had sustained his previous fracture. His vital signs were checked and the nurse noted no deformity or bruising to his rib cage. Later that day the deceased was exercising and no further issues were raised by him.

[8] On 10 October 2017 the deceased was seen by a nurse after submitting a self-referral form to the prison health centre. He stated that the Tramadol which he had been prescribed for the past 7 years was no longer controlling his chronic pain and requested alternative pain relief. This request was reviewed by a GP who changed his pain relief to Co-codamol. On 15 October 2017 the deceased was again seen by a nurse after complaining of chest pains. A full history and note of symptoms were obtained. Observations and an ECG were carried out. He was reviewed a further two times on the same day, and listed for a GP consultation the following day. On 16 October 2017 the deceased was reviewed in consequence of worsening chest pain. Observations were carried out and an emergency ambulance was called. The deceased was taken to Edinburgh Royal Infirmary.

[9] On 16 October 2017 the deceased was admitted for assessment at Edinburgh Royal Infirmary. A number of observations and an ECG were carried out, and blood was taken for tests to be carried out. A small circular opacification (a decrease in the ratio of gas to soft tissue in the lung) was seen on his chest x-ray. A CT scan was arranged for a later date, and pain relief was provided. The deceased was thereafter discharged back to HMP Edinburgh.

[10] On 18 October 2017 the deceased was complaining of left abdominal pain. He was examined, and his vital signs were checked and found to be within the normal limits. He was listed for a review the following day. On 19 October 2017 the deceased was reviewed by nursing staff. He complained of worsening chest pain. The GP at the prison arranged for an ambulance to attend and the deceased was conveyed to

Edinburgh Royal Infirmary. Following assessment there, the deceased was diagnosed as having non-cardiac pain likely due to a chest mass. Arrangements were made for the deceased to undergo a CT scan on 30 October 2017, and he was thereafter discharged back to HMP Edinburgh. On 30 October 2017 the deceased underwent a CT scan at Edinburgh Royal Infirmary.

[11] On 23 October 2017 the deceased completed a complaint form regarding medication. Nurse Elaine McAdam provided a response to that complaint form on 25 October 2017. On 12 November 2017 Nurse McAdam reviewed the deceased after he complained of increasing pain. She checked the hospital notes from the CT scan and noted that the deceased had a diagnosis of terminal lung cancer. She arranged for him to be given an urgent GP appointment for the following morning. On 13 November 2017 the deceased was informed that he had a diagnosis of terminal lung cancer.

[12] On 17 November 2017 the deceased was admitted to, and assessed at, Edinburgh Royal Infirmary due to an abnormal chest X-ray and CT scan. He was diagnosed as having stage IV lung cancer. The CT scan showed a 3cm left upper lobe lesion. It was assessed that his chest pain was progressive and related to this malignancy. He appeared to be frail. The consultant advised the prison medical centre of medications that the deceased should be prescribed. The medical centre staff prescribed these medications.

[13] On 21 November 2017 the deceased told Nurse McAdam that the medication was helping with the pain. He was receiving assistance from carers with daily personal tasks. The deceased intimated that he would not wish to be resuscitated. On 24

November 2017 prison medical staff were informed by the deceased's respiratory consultant that the deceased was not suitable for treatment and was to be placed in palliative care. The consultant recommended that medication be prescribed to assist with comfort and pain relief. The prison GP prescribed the recommended medication.

[14] On 24 November 2017 the deceased had a consultation with a nurse from Marie Curie to discuss his diagnosis of terminal cancer. He was offered help and support. On 27 November 2017 the deceased had a consultation with a nurse. He confirmed that he had been provided with a wheelchair. He stated that the medication was assisting with his pain management. On 4 December 2017 the deceased was prescribed a higher dose of Gabapentin to assist with pain at night.

[15] On 10 December 2017 the deceased had a consultation with a nurse as he was complaining of pain in his chest. The nurse carried out a number of observations and advised the deceased that he should attend hospital. The deceased declined to go to hospital and stated that the pain had eased up. Later that day the nurse re-assessed the deceased, who stated that the pain had improved. He was provided with further pain relief in accordance with his consultant's instructions, and advised that should he should seek assistance from nursing staff if the pain increased.

[16] On 15 December 2017 the deceased had a consultation with a nurse from Marie Curie. He explained that his pain was under control. He was noted to be less lethargic, and seemed brighter. Changes were made to his medication to further assist with the deceased's pain management and ease his symptoms of indigestion, caused by his other medications. On 20 December 2017 the deceased had a further consultation with a nurse

from Marie Curie. He was prescribed Gabapentin twice per day to assist with his pain management.

[17] For several weeks preceding his death the deceased was provided with carers to assist him with daily tasks and to provide support when required.

[18] At 15.35 hours on 24 December 2017 prison nursing staff were summoned to attend the deceased's cell, it being reported that the deceased appeared to be unwell. Nurse McAdam and Nurse Allen Beatson attended immediately. By the time they reached his cell the deceased was showing no signs of life. At 17.10 hours on 24 December 2017 the deceased was pronounced life extinct within cell 69, Ingliston Hall, HM Prison, Edinburgh, by Detective Sergeant Sutherland in the presence of Detective Constable McAlinden, the deceased's condition being incompatible with life. A post mortem examination of the deceased was performed by Dr Ralph BouHaidar at the City Mortuary on 3 January 2018, following which Dr BouHaidar certified the medical cause of death as metastatic pulmonary adenocarcinoma.

[19] All parties were content that I should find the facts established as set out in the joint minute of agreement, and also find that the time, place and circumstances of the deceased's death were as set out in those agreed facts and the death certificate issued by Doctor BouHaidar. This I have done.

DISCUSSON AND CONCLUSIONS

[20] From the evidence I conclude that the deceased was a heavy smoker with a smoking habit extending over a period of decades. There was nothing in the agreed

evidence or productions to indicate that earlier treatment in hospital would have had any different outcome. By the time that his stage IV lung cancer was diagnosed the deceased's condition was terminal. The deceased had appropriate access to medical treatment during the course of his illness, and died as a result of metastatic pulmonary adenocarcinoma as identified in the death certificate.