SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2020] FAI 33

EDI-B756-20

DETERMINATION

BY

SHERIFF CHRISTOPHER DICKSON

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

into the death of

WILLIAM MCCRAE

Edinburgh, 30 September 2020

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 (hereinafter referred to as "the 2016 Act"):

1. In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):

That the late William McCrae, born 2 March 1946, died between 02.00 hours and 02.28 hours on 6 September 2019 in room L of Ward 54 at the Western General Hospital, Crewe Road South, Edinburgh.

2. In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

The death did not result from an accident. No finding is made.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

That the cause of death was ischaemic and valvular heart disease.

4. In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

That death did not result from an accident. No finding is made.

5. In terms of section 26(2)(e) of the 2016 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 are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

6. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in 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 2016 Act (any other facts which are relevant to the circumstances of the death):

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

Recommendations

1. In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

There are no recommendations made.

NOTE

Introduction

[1] This inquiry was held into the death of William McCrae. At the time of his death Mr McCrae was a convicted prisoner serving a sentence at HM Prison, Edinburgh. He was known to have chronic heart failure and was admitted to the Western General Hospital, Crewe Road South, Edinburgh on 28 August 2019. Mr McCrae passed away in the early hours of 6 September 2019 in Room L of Ward 54 at the Western General Hospital. The death of Mr McCrae was reported to the Procurator Fiscal (hereinafter referred to as "the Crown") later in the day on 6 September 2019.

[2] The inquiry took place over a single day on 28 September 2020. Mr Motion, Procurator Fiscal Depute, represented the Crown, Mr Holmes represented Lothian Health Board and Mr Milne represented the Scottish Prison Service (hereinafter referred to as "SPS").

[3] No oral evidence was presented to the inquiry. Instead, the parties had responsibly agreed almost all the evidence in a joint minute of agreement. Also before the inquiry was the following information:

1. Post mortem report by Dr SallyAnn Collis, Consultant Forensic Pathologist, dated 4 November 2019 (hereinafter referred to as "the pathologist's report");
2. Death in custody report prepared by the SPS, undated;
3. Medical records for Mr McCrae; and
4. Death in Prison, Learning, Audit and Review (DIPLAR) report, dated 30 September 2019.

The legal framework

[4] This inquiry was held in terms of section 1 of the 2016 Act. Mr McCrae died in legal custody, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2(1) and (4) of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter "the 2017 Rules") and was an inquisitorial process. The Crown represented the public interest.

[5] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr McCrae and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted.

Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules).

[6] Section 26 of the 2016 Act sets out what must be determined by the inquiry. Section 26 of the 2016 Act 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."

[7] In this Note I will, first, set out the summary of the facts that I have found admitted or proved, and second, briefly explain why it is only appropriate to make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act. Findings in fact 1 to 25 are based on the joint minute of agreement. Findings in fact 26 and 27 are based in the joint minute of agreement as read with the pathologist's report.

Summary

[8] I found the following facts admitted or proved:

1. That William McCrae was born on 2 March 1946.
2. That Mr McCrae was found guilty after trial at Lanark Sheriff Court of the following offences:
   (1) lewd, indecent and libidinous practices and behaviour;
   (2) acting contrary to section 5 of the Sexual Offences (Scotland) Act 1976 (indecent behaviour towards a girl between 12 and 16);
   (3) acting contrary to section 39 of the Criminal Justice and Licensing (Scotland) Act 2010 (stalking); and
   (4) acting contrary to section 27(1)(b) of the Criminal Procedure (Scotland) Act 1995 (breach of bail conditions).
3. That on 20 April 2016 Mr McCrae was sentenced at Lanark Sheriff Court for the offences set out in finding in fact 2. Mr McCrae was sentenced to 5 years

and 6 months imprisonment (which was backdated to a date in February 2016), together with a 3 year extended sentence. On being sentenced Mr McCrae was admitted into HM Prison, Addiewell.

4. That at the time of his death, Mr McCrae was in lawful custody in respect of the offences set out in finding in fact 2.

5. That prior to being imprisoned, Mr McCrae had an extensive past medical history which included a history of atrial fibrillation, myocardial infarction (heart attack) in 2012, cardiomyopathy, hypertension, a pacemaker being fitted, mixed aortic disease, mild mitral stenosis and B12 deficiency.

6. That on 27 September 2018 Mr McCrae was considered for parole but was deemed to be at a high risk of reoffending and his application for parole was refused. Mr McCrae was entitled to be reconsidered for parole around 27 September 2019.

7. That on 8 March 2019 Mr McCrae was transferred from HM Prison, Addiewell to HM Prison, Edinburgh in order to allow him to undertake the 'Moving Forward Making Changes' programme, which was not available at HM Prison, Addiewell. The Moving Forward Making Changes programme is a programme designed to reduce the risk of persons convicted of sexual offences from reoffending.

8. That on 19 March 2019 Mr McCrae engaged with the Moving Forward Making Changes programme at HM Prison, Edinburgh.

9. That Mr McCrae was prescribed regular medications which were dispensed at the medication counter daily by prison custody nurses at both HM Prison, Addiewell and HM Prison, Edinburgh.

10. That one of his medications was an anticoagulant medication known as "warfarin". As a result, Mr McCrae was required to routinely provide blood samples to determine the correct dosage of the medication being administered.

11. That on 15 April 2019 Mr McCrae requested that he be provided with his medication in order that he could take his medication whilst within his cell. However, this was refused due to previous issues with his memory impacting on his ability to take his medication correctly.

12. That on 29 May 2019 Mr McCrae was assessed by physiotherapy as he was increasingly struggling with mobility due to his cardiac issues. It was noted that he had been house bound prior to imprisonment. He was issued with a four wheel walking frame which he was assessed as being safe and independent to use.

13. That on the 19 July 2019 Mr McCrae was de-selected from the Moving Forward Making Changes programme due to concerns surrounding his physical health.

14. That on 28 August 2019, at approximately 1530 hours, Mr McCrae was seen by a prison custody nurse and he was noted to be lethargic, weak and vomiting.

15. That on the 28 August 2019 Mr McCrae was transferred to the Western General Hospital, Crew Road South, Edinburgh, and was admitted for observation for possible worsening of congestive cardiac failure.

16. That Mr McCrae was initially admitted to a general medicine ward prior to being moved to a cardiology ward on 31 August 2019.

17. That it was noted on his admission that he had a past medical history of ischemic heart disease, atrial fibrillation and cardiomegaly and that he had recently been treated for right basal pneumonia. His breathlessness was worse on exertion and when lying flat.

18. That a CT chest x-ray was carried out which showed pulmonary oedema with appearance in keeping with biventricular heart failure and an echocardiogram showed overall severe impairment of systolic function with moderate to severe aortic stenosis.

19. That on 3 September 2019 Mr McCrae's case was discussed at a cardiology multidisciplinary team meeting at the Western General Hospital who considered his recurrent presentation with heart failure and it was noted that Mr McCrae may be a candidate for cardiac resynchronization therapy (CRT), although it was recognised that treatment may not lead to clinical improvement standing his poor cardiac health.

20. That throughout his admission at the Western General Hospital, Mr McCrae was accompanied by GeoAmey prison custody guards.

21. That during the early hours of 6 September 2019, prison custody guards Norma Scott and David Souness were with Mr McCrae in room L of Ward 54 at the Western General Hospital.

22. That at approximately 0200 hours on 6 September 2019 Mr McCrae was lying in his bed dosing when he started to shake like he was having a fit. In the circumstances the prison custody guards immediately sought the assistance of a hospital nurse.

23. That when the nurse immediately attended she checked on Mr McCrae, initiated the hospital CPR procedures and summoned the assistance of other medical staff, including the hospital CPR team on duty.

24. That Doctor Mirian Duncumb responded, along with others, to the emergency call from Mr McCrae's hospital room and started to administer chest compressions, whilst other medical staff in attendance started resuscitation care.

25. That at 0228 hours it was determined by a senior registrar and anaesthetist that resuscitation efforts had not been successful and pronounced life extinct at 0228 hours on 6 September 2019. Mr McCrae was 73 years old when he died.

26. That on 10 September 2019 Dr Sally Ann Collis, Consultant Forensic Pathologist, conducted a post mortem examination of Mr McCrae at the Edinburgh City Mortuary and subsequently prepared a report. The conclusion of Dr Collis, following said examination, was as follows:

> "The aetiology of the cardiac enlargement (cardiomegaly) was thought likely to have been due to the combination of underlying ischaemic heart disease and valve disease. The degree of cardiac enlargement in combination with coronary artery disease and myocardial fibrosis could have resulted in a sudden fatal cardiac dysrhythmia and death at any time. The clinical history provided indicated that William McCrae's heart was failing and the presence of splenic and hepatic congestion would support this…
>
> Taking all of the findings into consideration it is my opinion that William McCrae's death was due to ischaemic and valvular heart disease which had resulted in cardiac enlargement (cardiomegaly) and ultimately cardiac failure."

27. The medical certificate of cause of death was completed as follows:

> "1a. Ischaemic and valvular heart disease"

Submissions

[9] All parties accepted that Mr McCrae had died of natural causes and, in the circumstances, simply sought formal findings in respect of section 26(2)(a) to (c) of the 2016 Act.

Discussion

[10] It was clear from the agreed evidence that Mr McCrae had a history of heart problems prior to being imprisoned for the offences set out in finding in fact 2. Mr McCrae's medical condition worsened whilst he was in HM Prison, Edinburgh, which resulted in him being admitted to the Western General Hospital on 28 August 2019. Mr McCrae was given appropriate care at the Western General Hospital but passed away in the early hours of 6 September 2019. The pathologist's report makes

clear that the cause of his death was ischaemic and valvular heart disease. In the circumstances I consider, on basis of the agreed evidence and other information before the inquiry, that Mr McCrae's death was attributable solely to natural causes which are accurately described in the death certificate. In all the circumstances I consider that it is only appropriate to make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act. The finding I have made in terms of section 26(2)(a) is based on the agreed evidence (see, in particular, findings in fact 21 to 25). The finding I have made in terms of section 26(2)(c) is based on the agreed evidence as read with the pathologist's report (see findings in fact 26 and 27).