SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON SHERIFF COURT

[2024] FAI 40

LIV-B96-24

DETERMINATION

BY

SHERIFF V MAYS

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

into the death of

GORDON FRASER

Livingston, 23 September 2024

Findings

The sheriff, having considered the information presented at the fatal accident 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) In terms of section 26(2)(a) of the 2016 Act, Mr Gordon Fraser (born on 22 February 1943), died on 5 June 2022 in cell – C-01, HMP Addiewell, 9 Station Road, West Lothian at 15:54 hours.

(2) In terms of section 26(2)(c) of the 2016 Act, the cause of Gordon Fraser's death was :

1.a. complications of pulmonary thromboembolism, chronic obstructive pulmonary disease and ischaemic heart disease;

2. Cerebral palsy.

(3) Makes no findings in terms of section 26(2)(b), (d), (e), (f) and (g) of the 2016 Act.

Recommendations

AND FURTHER, the sheriff having considered the information presented at the inquiry, in terms of section 26(1)(b) of the 2016 Act, makes no recommendations.

NOTE:

[1] This determination is made following a fatal accident inquiry into the death of Mr Gordon Fraser (hereinafter referred to as "Mr Fraser").

[2] At the time of his death Mr Fraser was in legal custody as he was serving a custodial sentence in HMP Addiewell. Accordingly, this was a mandatory fatal accident inquiry, in terms of section 2(4) of the 2016 Act.

[3] The inquiry was held in Livingston Sheriff court on 9 August 2024.

[4] The following parties participated in the enquiry: (i) the Crown (represented by Ms Irwin, procurator fiscal depute, Livingston); (ii) Sodexo Justice Services (represented by Ms Clark); (iii) the Scottish Prison Service (represented by Mr Halley) and Lothian Health Board (represented by Mr Homes). No other persons appeared at the inquiry or intimated an interest in the inquiry. Mr Fraser's family were not present or represented having indicated that they did not wish to take part in or observe the proceedings.

[5] Fatal accident inquiries are now governed by the 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (“the 2017 Rules”). The form of a Determination is prescribed by rule 6.1 (i.e Form 6.1) of the 2017 Rules which requires

the inclusion of certain information within the Determination. In this Determination, I have set out much of this information in the attached Appendix.

[6] I am grateful to all those appearing in the inquiry for their professional contributions, and for the assistance they gave to me during the course of the inquiry. All of the evidence in the inquiry was agreed by parties in a joint minute. This included parties undertaking further investigations and agreeing additional matters which I wished to be addressed for example what advice Mr Fraser was given by medical professionals on his last hospital admission. As a result of the evidence agreed in the detailed joint minute I did not require to hear oral evidence from any witness.

Procedural history

[7] On 22 January 2024 a notice of an inquiry was given by the procurator fiscal under section 15(1) of the 2016 Act.

[8] A preliminary hearing was assigned at Edinburgh Sheriff Court on 13 March 2024. On that date on Crown motion, there being no opposition, the case was transferred to Livingston Sheriff court and a further preliminary hearing was assigned on 19 April 2024. That hearing was continued to 16 May 2024 for productions to be received and for Sodexo to, at my request, clarify how observation checks in prison were carried out and recorded and for medical records relating to Mr Fraser's last admission to hospital to be provided. A date for the hearing of the fatal accident inquiry was assigned, this being 9 August 2024. On 10 July 2024 the court ordered that the finalised joint minute be lodged with the court by 28 July 2024 and continued to the inquiry

hearing assigned for 9 August 2024. Parties were appointed to provide the court with written submissions at the inquiry.

Information made available to the enquiry

[9] On 9 August 2024, the inquiry was convened.

[10] A joint minute of agreement between the Crown, Sodexo, the Scottish Prison Service and Lothian Health Board was lodged in process. In terms of the joint minute the following documents and other material were admitted in evidence (comprising volumes 1 and 2 of the Crown's productions and labels and production number 1 for Sodexo);

i. Death certificate
ii. Autopsy report
iii. Toxicology report
iv. Death in custody folder
v. Death in Prison Learning Audit and Review (DIPLAR)
vi. Medical records
vii. NHS case review
viii. Pronunciation of Life Extinct (PLE)
ix. Do not attempt cardiopulmonary resuscitation (DNACPR) form
x. Witness statement – Craig Connell (1)
xi. Witness statement – Craig Connell (2)
xii. Witness statement – Natalie Dyer (1)

xiii. Witness statement – Natalie Dyer (2)

xiv. Witness statement – Laura Kettings.

xv. Additional witness statement - by Craig Connell.

[11] On 9 August 2024 written submissions having been received from each party and each party having adopted their written submissions and indicating that they did not wish to make any further oral submissions, I made avizandum.

Written Submissions for the Crown

[12] The Crown invited me to make mandatory formal findings under section 26(2)(a) and (c) of the 2016 Act in relation to the date and cause of Mr Fraser's death. There were no precautions which could reasonably have been taken or had they been taken which might realistically have avoided Mr Fraser's death (section 26(2)(e). There were no defects in any system of working which contributed to Mr Fraser's death (section 26(2)(f). The Crown did not invite me to make any findings under section 26(2)(g) or any recommendations under section 26(1)(b) of the 2016 Act.

Submissions for Sodexo Limited

[13] On behalf of Sodexo Ms Clark invited me to make mandatory formal findings under section 26(2) (a) and (c) of the 2016 Act. There were no precautions which could reasonably have been taken and had they been taken which might have realistically resulted in Mr Fraser's death being avoided. There were no defects in the system of working which contributed to Mr Fraser's death.

Submissions on behalf of the Scottish Prison Service

[14] On behalf of the Scottish Prison Service Mr Halley invited me to make formal findings in relation to the date and cause of Mr Fraser's death (section 26(2) (a) and (c) of the 2016 Act). There were no precautions which could reasonably have been taken and had they been taken which might have realistically resulted in Mr Fraser's death being avoided. There were no defects in any system of work which contributed to Mr Fraser's death. No findings should be made under section 26(2)(e), (f) or (g) of the 2016 Act. No recommendations were appropriate in terms of section 26(4) of the 2016 Act.

Submissions for Lothian Health Board

[15] On behalf of Lothian Health Board Mr Holmes submitted that I should make formal findings in relation to the date and cause of Mr Fraser's death. There were no precautions which could reasonably have been taken and had they been taken which might realistically have resulted in Mr Fraser's death being avoided. There were no defects in any system of work which contributed to Mr Fraser's death. No findings were required in terms of section 26(2)(e), (f) or (g) of the 2016 Act and no recommendations required to be made.

Factual Circumstances

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

(1) Gordon Fraser was born on 22 February 1943.

(2) On 25 October 2021, Mr Fraser was sentenced to 7 years imprisonment after being found guilty of 2 charges of lewd and indecent and libidinous practices and behaviour, and one charge of rape.

(3) On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the Scottish Prison Service to the National Health Service (NHS). Since that date individual regional NHS health boards have been responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

Medical history and treatment

(4) On admission to HMP Addiewell Mr Fraser had a number of health conditions. On admission an admission profile form was completed and Mr Fraser's prison medical notes were updated to reflect his known health issues and his current medication prescriptions.

(5) Mr Fraser was registered disabled. He was unable to stand or weight bear and required his mobility scooter to mobilise. Additionally, Mr Fraser had slurred speech due to cerebral palsy and was suspected of suffering from chronic obstructive pulmonary disease (COPD).

(6) Mr Fraser was initially incarcerated at HMP Addiewell in Cell C-02 and then was moved to Cell C-01 on 28 November 2021. Both cells were sole occupancy and classed as "disabled cells" within the mainstream residential

wing. Due to his medical conditions, Mr Fraser was housed in a disabled cell throughout his incarceration. These cells differ from standard cells in that they have more space within to allow for wheelchair access. Additionally, the in-cell intercom is located above the bed and the bathroom and shower area has hand railings and a seat.

(7) There are no disabled cells within any of the protection wings at HMP Addiewell. Due to the nature of his offences, Mr Fraser was secured in a cell for his own protection for the duration of his time in custody. Throughout the duration of his time in HMP Addiewell there were no reportable incidents with any of the other prisoners.

(8) Mr Fraser had assigned carers who came into the prison on a daily basis to assist him with daily living activities such as personal hygiene, dressing and eating.

(9) On 9 November 2021 a "do not attempt cardiopulmonary resuscitation" (DNACPR) was implemented for Mr Fraser due to his frailty. On 1 June 2022, Mr Fraser was assessed at St John’s Hospital, Livingston and a further DNACPR form was put in place.

(10) Prior to his death, Mr Fraser had had repeated admissions to St John’s Hospital ("St John’s"), Livingston to receive treatment for his poor health.

(11) On 22 February 2022 Mr Fraser was admitted to St John’s and was treated for a urinary tract infection and a chest infection.

(12) On 23 March 2022, Mr Fraser was admitted to St John's and was treated for shortness of breath and an infective exacerbation of COPD. He was discharged the following day.

(13) On 5 April 2022, Mr Fraser was admitted to St John's due to an increased oxygen requirement and presumed pneumonia. He was treated and discharged on 7 April 2022.

(14) On 16 April 2022, Mr Fraser attended St John's due to recurrent aspiration pneumonia and sepsis. He was admitted on 16 April 2022 and provided with oxygen and medication. He was deemed medically fit for discharge on 20 April 2022.

(15) On 22 April 2022, Mr Fraser was admitted to St John's due to abdominal pain and shortness of breath. He was diagnosed with aspiration pneumonia. He was treated with antibiotics and oxygen and was discharged on 25 April 2022.

(16) On 28 April 2022, Mr Fraser attended at St John's due to difficulty breathing. He was diagnosed with a lower respiratory tract infection and was discharged the following day.

(17) On 1 May 2022, Mr Fraser attended St John's and was diagnosed with aspiration pneumonia. He was treated with antibiotics and oxygen and was discharged on 4 May 2022.

(18) On 14 May 2022, Mr Fraser attended St John's and was diagnosed with aspiration pneumonia. He was admitted onto a ward whereby he refused to have a percutaneous endoscopic gastrostomy (PEG) inserted. A PEG is a feeding

tube which allows nutrition to be delivered through the tube. The risks of such refusal were explained to Mr Fraser. He was deemed to have capacity to refuse to have the PEG fitted. Thereafter he was discharged to HMP Addiewell on 31 May 2022. Mr Fraser's medical notes include that Mr Fraser indicated that he did not wish to be readmitted to hospital and wished to pass away in HMP Addiewell.

(19) On 3 June 2022, Mr Fraser was transferred by ambulance to St John's due to poor saturations. On attendance, Mr Fraser was presenting with shortness of breath and difficulty breathing. Mr Fraser declined admission to hospital and self-discharged without treatment. Prior to being discharged, Mr Fraser was advised that he had aspiration pneumonia and was informed that by self - discharging he was likely to get more unwell and there was a possibility of death. Dr Andrew Saunders prescribed antibiotics and Mr Fraser was discharged on 4 June 2022. This was Mr Fraser's last admission to hospital.

(20) On 5 June 2022 at around 10.30am, Mr Fraser was assessed by Crown witness Natalie Dyer who is a Charge Nurse. In her assessment she noted that Mr Fraser appeared frail and had poor saturations. Mr Fraser refused to attend hospital. He was given pain relief medication.

Circumstances of Death

(21) On 5 June 2022, Mr Fraser was being checked within his cell by staff at half-hour intervals as part of his care plan. This was recorded on an observation record.

(22) When completing observations, the door hatch can either be opened by the prison custody officer carrying out the observation or the prison custody officer can physically go into the cell. The purpose of the observation is to get visual confirmation that the prisoner is alive and there is no threat to their well-being. If movement is heard or observed, then the observation is complete.

(23) Following the observation there is an observation monitoring record checklist which requires to be completed. The checklist comprises of whether visual and/or verbal signs were noted during the observation. Comments are normally only noted down if there was something out of the ordinary observed which required to be logged, or if there were special measures in place requiring prison custody officers to provide comments following observation. If the box is ticked on the observation monitoring checklist, then it is inferred that there was no cause for concern.

(24) On 5 June 2022 prison officer, Craig Connell, was conducting observations. He observed Mr Fraser to be alive at 14:30 hours within his cell. During this observation Mr Fraser was lying in his bed looking peaceful. He was breathing and his chest was moving up and down quite gently.

(25) At 14:58 hours on 5 June 2022, Craig Connell re-attended at Mr Fraser's cell. Upon looking through the observation hatch he noted there were no signs of movement from Mr Fraser. Craig Connell opened the cell and entered the cell. He approached Mr Fraser but did not observe any movement. He then called a "code blue", an emergency alarm to summon healthcare staff.

(26) At approximately 15:02 hours on 5 June 2022, Charge Nurse, Natalie Dyer responded to the emergency alarm. On her arrival she noted Mr Fraser appear to have died. Natalie Dyer and another nurse, Laura Kettings, conducted checks for pulse and breathing and found no signs of life. At the time of Mr Fraser's death the DNACPR was still in place. As a result no attempts to resuscitate Mr Fraser were made.

(27) An ambulance was contacted to attend HMP Addiewell. Alex Stewart, Scottish Ambulance Service, pronounced Gordon Fraser's life extinct at 15:54 hours on 5 June 2022.

Postmortem examination

(28) on 29 June 2022 at the instance of the procurator fiscal, Dr Ralph BouHaidar, Consultant Forensic Pathologist, carried out a post-mortem examination of Gordon Fraser.

(29) On internal examination both Mr Fraser's lungs were markedly congested and oedematous. There was fresh pulmonary thromboembolism noted.

(30) Following examination, the cause of death was attributed to pulmonary thromboembolism, pending laboratory studies.

(31) Samples of blood and urine were retained for toxicology. Said samples were examined and a report of the findings was produced. The toxicology report contained no unexpected or unexplained findings.

(32) The histological examination of the main organs confirmed that there was fresh thromboembolism and prominent ischaemic heart disease. Pneumonia was also noted on microscopy.

(33) Following toxicology and histology results Dr BouHaidar recorded that the cause of death should be amended to, 1a), complications of pulmonary thromboembolism, chronic obstructive pulmonary disease and ischaemic heart disease and 2): cerebral palsy.

(34) Mr Fraser was 79 years old at the date of his death.

[17] From information available to the inquiry it appears that at the date of Mr Fraser's reception into custody he was an individual who had a number of underlying health conditions. He was registered disabled and his mobility was significantly compromised as a result of his medical conditions. He was unable to weight bear or to mobilise without using his mobility scooter. He was able to transfer himself from his mobility scooter to bed and to the toilet. During his time in custody he received care from carers who assisted him with daily living activities such as washing, dressing and eating. He received medical care from healthcare professionals based in

hospital. He received care from healthcare professionals based in Addiwell prison including Charge Nurse, Natalie Dyer and other nurses.

[18] From the findings in fact I have made it can be seen that during his time in prison Mr Fraser's health continued to deteriorate. During the period 22 February 2022 to 3 June 2022 Mr Fraser was admitted to St John's Hospital on 9 occasions. On those occasions he was provided with care and treatment in relation to persistent chest infections, aspiration pneumonia and symptoms related to his COPD.

[19] On 14 May 2022 Mr Fraser attended at St John's Hospital in Livingston and was diagnosed with aspiration pneumonia. He was admitted onto the ward but refused to undergo surgery to have a percutaneous endoscopic gastrostomy (PEG) fitted. The risks of Mr Fraser refusing to have the PEG fitted were explained clearly to Mr Fraser by the treating clinicians. Doctors were satisfied that he had capacity to make the choice not to undergo the procedure. Despite the risk of aspiration leading to further chest infections Mr Fraser was of the view that he would rather be able to eat a small amount of food for a short time than not be able to eat food again and be fed via the PEG.

[20] After his admission on 14 May 2022 Mr Fraser advised the medical practitioner treating him that he did not wish to have any further hospital admissions for chest infections brought on by aspiration. He was advised of the risks of this, namely that there was a risk of death. Mr Fraser was clear in his interactions with the medical practitioner treating him that he understood that he would not be able to receive intravenous antibiotics in prison but still wished to remain in prison and be managed by prison healthcare and his carers.

[21] Mr Fraser and prison healthcare staff were aware that if he became unwell in prison and he did not respond to oral antibiotics which could be prescribed in prison that his care may become palliative.

[22] During his time in prison carers and prison staff were concerned about Mr Fraser's ill-health and acted appropriately as is evidenced by the number of times he was taken to hospital for care and treatment over a short period. As a result of the concerns of prison staff Mr Fraser was taken to hospital for the final time on 3 June 2022 presenting with shortness of breath and difficulty breathing. Mr Fraser declined admission to hospital. It was reiterated to him by a medical practitioner that he had aspiration pneumonia and that by self-discharging he was likely to get more unwell and there was a possibility of death. With that knowledge Mr Fraser chose to refuse medical treatment in hospital and to self-discharge and return to HMP Addiewell. He had the capacity to make that decision.

[23] Mr Fraser appears to have had positive relationships with his carers, prison staff and the prison healthcare team and to feel comfortable in prison. He was provided with personal care by his carers and was also seen regularly by NHS staff for personal care and help with feeding. Mr Fraser chose to return to prison knowing that it was likely that he would die as he felt supported there. In addition to the support offered by his carers and the prison staff it appears that he also had some support from the prison chaplaincy team.

[24] Mr Fraser was subject to welfare observations every 30 minutes when he returned from hospital. In his last hours he looked peaceful and was observed to be

breathing. He was last seen alive at 14:30 hours. At 14:58 hours when Craig Connell carried out a welfare check he noted was no signs of movement from Mr Fraser. A nurse was summoned very quickly and noted that there were no signs of life. Mr Fraser had died. An ambulance was called and Mr Fraser was pronounced dead by one of the paramedics who attended.

[25] There was no evidence before me that the medical care or the prison care afforded to Mr Fraser was in any way substandard. To the contrary, Mr Fraser was provided with a high level of care and treatment during his time in prison. No criticism can be made of his carers or the health professionals and other prison staff involved in his care and treatment. As a result of the positive relationships Mr Fraser had with carers, health care professionals and other prison staff and the care and treatment they provided to him, Mr Fraser chose to return to prison to die rather than remain in hospital. He was supported by his carers and other members of prison staff and died with as much dignity as possible given the circumstances.

[26] I am satisfied on the evidence before me that, as submitted by those representing the various parties in the inquiry, there is no need to make any findings other than the formal findings in relation to place and cause of death. Mr Fraser died of natural causes and received appropriate care and treatment for his health conditions during his time in prison. I make no recommendations in terms of section 26(1)(b) of the 2016 Act.

[27] All of the parties at the inquiry expressed condolences to Mr Fraser's family on their own behalf and on behalf of those whom they represented and to these I add my own condolences.

APPENDIX

The legal framework

[A1] The purpose of a fatal accident inquiry is set out in section 1(3) of the 2016 Act. It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (see section 1(4)). A fatal accident inquiry is inquisitorial, not adversarial (see rule 2.2.(1) of the 2017 Rules).

[A2] Section 1(2) provides that an inquiry is to be conducted by a sheriff. An inquiry can be conducted by a sheriff principal, a sheriff or a summary sheriff exercising the powers of a sheriff. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1).

[A3] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate. A determination under section 26 is to be in Form 6.1 (see rule 6.1)

[A4] The findings the sheriff is required to make are set out in section 26(2), namely, (a) when and where the deaths occurred; (b) when and where any accident resulting in the deaths occurred; (c) the cause or causes of the deaths; (d) the cause or causes of any accident resulting in the deaths; (e) any precautions which (i) could reasonably have been taken; and (ii) had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided; (f) any defects in any system of

working which contributed to the deaths or any accident resulting in the deaths; and (g) any other facts which are relevant to the circumstances of the deaths.

[A5] The making of recommendations is discretionary. The recommendations which the sheriff is entitled to make are set out in section 26(4). 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. Recommendations 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.