**SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH**

**[2018] FAI 4**

EDI-B1293-17

DETERMINATION

BY

SHERIFF ROBERT D M FIFE

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

into the death of

**WILLIAM MAILER**

Edinburgh, 31 January 2018

[1] The Sheriff, having considered all the evidence and submissions presented at an inquiry on 22 January 2018, determines as follows.

[2] In terms of section 26(2)(a) of the 2016 Act William Mailer, born on 8 August 1943, died at the Accident and Emergency Department of the Royal Infirmary of Edinburgh at around 14.45 on 22 January 2015 when the deceased was in custody.

[3] In terms of section 26(2)(c) of the 2016 Act the death was caused by:

1(a). Ischaemic heart disease

1(b). Coronary artery atheroma

2. Chronic obstructive pulmonary disease

[4] In terms of section 26(2)(e) of the 2016 Act there are no precautions which could reasonably been taken and had they been taken might realistically have resulted in the death being avoided.

[5] In terms of section 26(2)(f) of the 2016 Act there are no defects in any system of working that contributed to the death.

[6] In terms of section 26(2)(g) of the 2016 Act there are no other facts which are relevant to the circumstances of the death.

**Note**

**Introduction**

[7] This Inquiry was held in terms of section 2(4)(a) of the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 ("the 2016 Act") into the death of William Mailer who was in legal custody at the time of his death. There was a preliminary hearing on 18 December 2017. Evidence was led at the Inquiry on 22 January 2018.

[8] At the conclusion of the evidence and submissions in an Inquiry, the Sheriff is required to make a determination setting out:

(1) when and where the death occurred;

(2) the cause or causes of the death;

(3) any precautions which (a) could reasonably have been taken and (b) had they been taken, might realistically have resulted in the death being avoided;

(4) any defects in any system of working which contributed to the death;

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

[9] The Inquiry is inquisitorial. It is not the purpose of the Inquiry to establish civil or criminal liability.

**Representatives**

[10] The participants to the Inquiry were Mr Crosbie Procurator Fiscal Depute for the Crown in the public interest, Mrs Thornton solicitor for the Scottish Prison Service and Mr Holmes solicitor for NHS Lothian Health Board. The family of the deceased were not represented. The Procurator Fiscal informed the court that he would arrange for a copy of the Determination to be provided to the deceased's son Scott Mailer who was unable to attend the inquiry.

**Summary of Evidence**

[11] Three witnesses were called by the Crown to give evidence: Alison Crone, Caroline Kenny and Dr William Smith. No other witnesses gave evidence.

[12] Alison Crone was a nurse who worked at HMP Edinburgh ("the prison") for about 4 years from November 2013 until January 2018. Ms Crone now worked for NHS Forth Valley. Her general duties included being a primary care nurse practitioner. Ms Crone spoke to the terms of a witness statement which she herself had noted on the afternoon of 22 January 2015 (Crown production 9). Ms Crone only met the deceased for the first time on 22 January 2015. Ms Crone did not know the deceased before then. It

was relatively easy for a prisoner to get access to/see a nurse if unwell. The procedure was for a prisoner to complete a triage form. The prisoner would see the nurse either the same day or the following day. Ms Crone arranged to meet with the deceased on the morning of 22 January 2015 at around 08.30. The deceased complained of feeling "a wee bit wheezy." Ms Crone asked about the deceased's general health and medical condition. Ms Crone did not see the deceased's medical records. The deceased told Ms Crone he had chronic obstructive pulmonary disease ("COPD"). It was the evidence of Ms Crone that being wheezy was quite a common symptom for someone with COPD. The deceased did not complain of chest pains or any other symptoms during their meeting. The deceased had explained the wheeziness was a regular occurrence for him and that he was usually prescribed prednisolone which was a steroid that reduces inflammation. The usual prescription was a five day course. In the absence of any other symptoms Ms Crone did not examine the deceased. The prednisolone had to be prescribed by a GP. According to the witness statement Ms Crone told the deceased she would speak to the GP. That was her usual practice. The general procedure for obtaining a prescription was for the nurse to contact the GP during his morning clinic. The medication would be prescribed. If the medication was in the medicine cupboard the prisoner would receive the medication straightaway. If not, the medication would be ordered and would come at night-time. According to the witness statement the deceased was happy Ms Crone was going to speak to the GP; the deceased then left the room; the meeting room was some distance from the deceased's cell; had the deceased been cardiac Ms Crone thought the deceased would not have managed to walk to the meeting

room. Ms Crone met the deceased again at around 12.00 noon when she gave him the prednisolone. The deceased had no other concerns or complaints at that time. According to the witness statement Ms Crone asked one of the prison officers to keep an eye on the deceased and to let her know if there were any problems. Ms Crone had no issues with the deceased. The deceased had been quite easy to get on with. Ms Crone told the deceased that if he had felt unwell just to let one of the nurses know. The deceased had appeared quite content when Ms Crone left him. Ms Crone then carried on with other duties.

[13] At around 13.00 later the same day, 22 January 2015, a call was received at the health centre from a prison officer that there might be a "Code Blue" – where someone is not breathing – but this had not been confirmed. Ms Crone went to investigate with another nurse Caroline Kenny. A health care assistant Paula Dornan went to get the emergency equipment including a defibrillator, oxygen and oxygen masks. Ms Crone and Ms Kenny arrived at the cell area within a couple of minutes. It was quite a short walk from the health centre to the cell. Ms Crone found the deceased lying on the ground at the doorway. Prison officer Peter Dunne was carrying out CPR (cardiopulmonary resuscitation). Ms Kenny took over carrying out CPR. Ms Crone contacted the Emergency Control Room (ECR) to advise there was a "Code Blue" and for an ambulance to be called. Other nurses came to assist following the "Code Blue". Standard procedures were carried out. Paramedics arrived within about 25 minutes. The paramedics took over treating the deceased. Ms Crone left the cell area a short time later as there were sufficient other staff present.

[14] Caroline Kenny was a nurse who worked at the prison from 2012-2016 as a practitioner nurse then as a charge nurse. Ms Kenny was now a staff nurse at Western General Hospital. Ms Kenny spoke to the terms of a witness statement which was noted by police officers on the morning of 24 November 2015 (Crown production 10).
Ms Kenny's duties included managing the primary care nursing team within the prison and treating prisoners as a nurse. Ms Kenny had no personal dealings with the deceased. Ms Kenny described the procedure for initial medical assessment for any new prisoner in 2015. There was a nurse in reception who would meet with the new prisoner to cover the prisoner's general health and past medical history. The prisoner's blood pressure and pulse would be checked. GP details would be obtained from the prisoner in order to access information on any drugs prescribed. If the prisoner was on drugs a drugs test would be carried out. Crown production 1 was the prison medical records for the deceased. At page 5 of the medical records there was a kardex recording all prescriptions. There were also results records. All medical staff had access to these records. Every medical consultation was noted in the medical records. Following the initial medical assessment of a new prisoner by a nurse on arrival at the prison in reception the prisoner would be seen the following day by one of the GPs.

[15] If a prisoner had a medical issue they would complete a triage form and put that in a triage box. A nurse would then see the form. The prisoner would be seen by a nurse the following morning but if the matter was urgent the prisoner would be seen without delay/the same day. All prisoners would be aware of the procedure for obtaining medical advice. There were leaflets in reception; the nurse who carried out the initial

medical assessment with a new prisoner would give that prisoner a leaflet; all the prison officers were familiar with the leaflet. There were nurse referral forms kept in boxes (triage boxes) readily available for prisoners at all levels of the halls within the prison. An example of a nurse referral form completed by the deceased was shown at page 20 of the medical records (Crown production 1). Ms Kenny gave an example of when a nurse referral form might be completed by a prisoner such as having a complaint of not receiving medication. Nurses would open the boxes each morning then prepare and give a list of names to prison officers. A nurse then arranged to see each of the prisoners individually in a room. The nurse would then document what happened and any action taken. The medical records for the deceased noted a number of entries for SFRs (self referral forms) filled in by the deceased. Looking at the medical records for the deceased Ms Kenny confirmed that during the period from 21 October 2014 – 22 January 2015 the deceased had seen the GP and nurses on a number of occasions which indicated the deceased was familiar with the procedure for getting help if needed.

[16] Ms Kenny explained medication for prisoners could be supervised or unsupervised. If the medication was of high value or the prisoner was either vulnerable or at risk then the medication would be supervised. Where general medication could not be used as currency then the medication would be handed out to prisoners either weekly or monthly and the prisoner would be unsupervised to take the medication himself. The deceased was prescribed a number of medications. None of his medications had a currency value in prison. All his medications were prescribed monthly. The deceased had been on these medications for the long term. The deceased would know

how to take the various medications. There was nothing to indicate the deceased was a vulnerable person in any way.

[17] Ms Kenny gave evidence that panic alarms were just being introduced within the prison when Ms Kenny was working there. These panic alarms were intended for any prisoner who, for example, might have medical issues including a risk of falling. There were two alarms/buzzers: one for a prison officer to go direct to the cell; and (2) to speak to the front desk. Ms Kenny had no detailed knowledge of panic alarms but on the basis of the information she had about the deceased Ms Kenny did not think the deceased required a panic alarm. The deceased had no risk of falling and there was no risk of a panic attack. Yes, the deceased had a number of medical conditions but Ms Kenny expected the deceased to have had weekly or monthly prescriptions and to have managed all medications himself.

[18] Dr William Smith was a GP in Lothian NHS covering Edinburgh and Addiewell prisons. Dr Smith had been a GP for about 24 years and a prison doctor for about 19 years. Dr Smith was the lead GP for the two prisons. Dr Smith confirmed a new prisoner would be seen by a nurse on the day of arrival at the prison and would be seen by a GP the following day. It was important to ascertain if the prisoner had any real medical issues and what, if any, medication was to be prescribed. Some prisoners were aware, others were not aware of their medication. Generally there were two ways to check what medication was prescribed: (1) a centrally held online system known as emergency care summary (ECS) where medical professionals could access what medication had recently been prescribed; and (2) send a fax to the GP who should revert

quickly with details of all medication recently prescribed. At pages 10 and 11 of the medical records was a copy of the ECS for the deceased. That summary of medication was accessed online on 14 October 2014 then printed off and placed with the medical records. The deceased arrived at the prison on 21 October 2014 when an initial medical assessment was carried out by a nurse. The deceased was seen by a GP Dr Revill the following day 22 October 2014. Dr Revill would have made some clinical judgement about the medication required by the deceased having discussed the deceased's medical condition with him and to make sure the deceased was taking his medication. That was recorded in an entry in the medical records for 22 October 2014 at page 2. The medications prescribed to the deceased were what Dr Smith would have expected. On 14 November 2014 the kardex at page 5 of the medical records for the deceased showed that the deceased was prescribed amoxicillin which was an antibiotic for the chest infection recorded on page 1 of the records:

> "14/11/2014 Consultation SRF: states has chest infection, sputum bottle given. william states he normally gets prednisolone and antibiotic. due to recurring chest infection. is COPD. sounds wheezy. kardex to GP"

According to Dr Smith the prednisolone would help to settle down the infection. The prescription would not have been for the longer term but to treat an acute infection on top of a standard condition (e.g. COPD).

[19] Dr Smith confirmed HMP Edinburgh would never be without the medications required for heart conditions and type 2 Diabetes. The deceased would never have been without any of the medication prescribed for him. The medical records disclosed the deceased had attended regular consultations while in prison and had had some blood

tests done in relation to his general health. The deceased had had his liver and kidney function checked (see page 18 of the medical records) and his diabetes was under reasonable control. In the opinion of Dr Smith the deceased's results generally were not bad for someone of his age.

[20] All three witnesses who gave evidence were credible and reliable, Ms Crone having to rely to some extent on the witness statement she herself noted on 22 January 2015, given the passage of time.

**Joint Minute of Agreement**

[21] A Joint Minute of Agreement was entered into by parties and received by the Inquiry. For the purpose of this Determination the following facts were agreed.

[22] In 2005 the deceased was diagnosed as suffering from unstable angina (a medical condition where the heart does not receive enough blood flow or oxygen), hypertension (high blood pressure) and hyperlipidaemia (elevated levels of lipids or lipoproteins in the blood; this condition can increase a person's risk of having a heart attack or stroke). The deceased informed a doctor at the Royal Infirmary of Edinburgh he suffered from chest pains and confirmed he was a smoker.

[23] The deceased was a smoker up until 2006.

[24] The deceased suffered an acute myocardial infarction (heart attack) in 2006; he was also diagnosed as having ischaemic heart disease in the same year.

[25] On 5 April 2006 the deceased underwent a coronary artery bypass graft operation at the Royal Infirmary of Edinburgh following his heart attack. While within

the ward and after the operation the deceased developed atrial fibrillation (irregular heart rate) and was provided medication for this. He was deemed fit to be discharged home on 12 April 2006.

[26] The deceased was diagnosed as having renal artery stenosis (narrowing of the arteries that carry blood to one or both of the kidneys) in April 2006.

[27] The deceased was seen at the Cardiology Department at the Royal Infirmary of Edinburgh in 2009 when it was confirmed that the deceased suffered from significant COPD, peripheral vascular disease, renal impairment, hypercholesterolemia (the presence of high levels or cholesterol in the blood), anaemia, inferno-renal aortic aneurysm, and type 2 Diabetes.

[28] The deceased was prescribed a number of different medications by his GP in relation to his heart disease and COPD. This was in conjunction with recommendations made by specialist doctors.

[29] On 21 October 2014 the deceased was sentenced at Edinburgh High Court to eight years' imprisonment for two charges of indecent assault, one charge of assault and attempted rape, and three charges of assault and rape.

[30] The deceased was in lawful custody at the time of his death usually residing in the prison.

[31] The deceased was seen by a nurse at the prison on his admission on 21 October 2014. The deceased informed the nurse that he had been diagnosed with type 2 respiratory failure and tachycardia (a heart rate that exceeds the normal resting rate), and angina.

[32] On 22 October 2014 the deceased was assessed by a GP Dr Revill at the prison. It was noted that the deceased suffered from ischaemic heart disease, severe chronic obstructive pulmonary disease, type 2 Diabetes mellitus, nasal polyps, and that he had undergone a coronary artery bypass graft. The deceased was given advice regarding how to use an aerochamber with salbutamol and how to seek emergency help.

[33] On 22 October 2014 the deceased was prescribed the following medication in prison:

- Salbutamol inhaler and nebuliser
- Symbocort inhaler
- Tiotopium inhaler
- Montelukast 10mg tablets
- Carbocisteine tablets 750mg
- Amlodipine 5mg
- Clopidogrel 75mg
- Simvistatin 20mg
- GTN (Glyceryl Trinitrate) spray
- Metaformin 1g
- Sitagliptin 100 mg
- Omeprazole 20mg
- Folic acid 5mg
- Alendronic acid 70mg
- Citrizine 10mg

[34] Production number 6 was a statement written by a fellow prisoner John Ikhine. This statement was written in relation to comments made on a sympathy card (production number 7). In his statement Mr Ikhine stated the deceased had told him at some point after 17 November 2014 but at some time before 22 January 2015 that he (the deceased) was stable when he spoke with him but that he required close monitoring and essential medication. Mr Ikhine suggested that the deceased should speak to medical

centre staff at the prison about this and ask the prison to provide him with a wrist panic alarm. Mr Ikhine stated that the deceased said in reply that he did not get medication on time, and he had only been supplied with amoxicillin once. Mr Ikhine also noted in the statement that the deceased further stated to Mr Ikhine that he had mentioned a panic alarm to health staff and they stated that they would speak to SPS (Scottish Prison Service) staff about this. Soon after that conversation with the deceased Mr Ikhine ceased to share a cell with the deceased and only saw him around the prison from time-to-time.

[35] Production number 7 was a sympathy card sent by a number of prisoners to the next of kin of the deceased. In the card Mr Ikhine stated that in his opinion the deceased had been failed by prison services and the HMP Edinburgh health centre.

[36] At the time of his death the deceased shared a cell with fellow prisoner Cihan Ergisi. Cihan Ergisi provided a statement to an officer of the Police Service of Scotland on 22 January 2015. It was agreed that this statement should be accepted as equivalent to parole evidence from Cihan Ergisi.

[37] Peter Dunne worked as a prison officer at the prison on the 22 January 2015. Mr Dunne provided a statement to the Police Service of Scotland on the same date. It was agreed that this statement should be accepted as equivalent to parole evidence from Peter Dunne.

[38] At 14.38 hours on 22 January 2015 the deceased was checked in at the Accident and Emergency Department at the Royal Infirmary of Edinburgh after being brought in by emergency ambulance from the prison. While en-route Scottish Ambulance staff

administered 11 x 1mg of adrenalin but return of spontaneous circulation had not lasted for more than one or two minutes. Upon arrival at hospital the deceased was treated by medical staff overseen by Dr Douglas Murray, consultant in emergency medicine. The deceased was provided with mechanical CPR and ventilation and was given 100% oxygen via endotracheal tube. The deceased was provided with a further 2 x 1mg of adrenalin which initially resulted in a palpable pulse but this lasted less than one minute and a repeat of ECHO (echocardiography) reading showed cardiac standstill with an asystolic rhythm on the ECG (echocardiogram) scan. Because of the prolonged downtime resuscitation efforts were stopped with no signs of life. Dr Murray pronounced life extinct at 14.45 hours on 22 January 2015.

[39] On 26 January 2015 a post mortem examination was carried out on the deceased at the Edinburgh City mortuary by Dr Ian H. Wilkinson, Consultant Forensic Pathologist. The medical cause of death was certified as:

1(a). Ischaemic heart disease

1(b). Coronary artery atheroma

2. Chronic obstructive pulmonary disease

The pathologist noted that internal examination identified enlargement of the heart with pale discolouration of the main chamber of the heart indicating probable scarring. The pathologist found severe coronary artery disease of the native coronary arteries. Microscopic examination confirmed the presence of scarring of the wall of the main chamber of the heart indicating previous episodes of ischaemia (heart attack) secondary to severe coronary artery atheroma. Microscopic examination also identified chronic

damage of the lungs, in keeping with the history provided of COPD. The pathologist noted that given the absence of an acute exacerbation of this process and in view of the severe cardiac disease seen during post mortem, it was not thought likely that complications of chronic lung disease were the proximate cause of the deceased's death. However the history of the deceased complaining of breathlessness in the hours prior to death was noted by the pathologist, who commented it was possible that chronic lung disease played some contributory role in his death. The presence of ischaemic heart disease was considered by the pathologist to be the most likely cause of the deceased's death, the fatal event possibly being cardiac arrhythmia. Production number 4 was a true and accurate copy of the post mortem report. The pathologist confirmed that the deceased's heart disease, from a pathological perspective, was very severe. In general terms the deceased's heart disease was of a severity which could have caused his sudden death at any time.

**Submissions**

[40] At the conclusion of the evidence I heard submissions from the participants. There was agreement among the participants over the circumstances and cause of death. The Crown submitted there should be formal findings in relation to the circumstances and cause of death and that while the issue of smoking was not proximate to the cause of death, the court might consider it appropriate to make a finding under section 26(2)(g) of the 2016 Act that any non-smoking prisoner should not be placed in a cell with a prisoner who did smoke and in particular a prisoner with COPD. On behalf of

Scottish Prison Service and NHS Lothian Health Board it was submitted by their representatives that only formal findings should be made.

**Determination**

[41] The issues for the Inquiry were:

- The procedures in prison for issuing out medications to prisoners.
- Whether Mr Mailer was provided with appropriate access to heart medication.
- The systems available in HMP Edinburgh for prisoners to summon emergency help if they feel unwell.

[42] I have made formal findings in this Determination.

[43] As I indicated at the conclusion of the Inquiry on 22 January 2018 I was not persuaded on the basis of all the evidence before the Inquiry that any finding under section 26(2)(g) of the 2016 Act can be made in relation to the sharing of cells by a smoker and a non-smoker, an issue not raised in advance of the Inquiry. The Joint Minute of Agreement records the following facts were agreed by all participants.

[44] The rules regarding smoking within Scottish prisons are currently contained within Rule 36 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011 which states:

36. – (1) Prisoners may only smoke in the following areas of a prison-

(a) In a cell or room in which a single prisoner is accommodated;

(b) Subject to paragraph (2), in a cell or room in which two or more prisoners are accommodated; or

(c) In the open air, in any place specified in a direction by the Scottish Ministers.

(2) Prisoners must not smoke in a cell or room which-

(a) accommodates two or more prisoners; and

(b) has been designated by the Governor as a non-smoking cell or room in accordance with a direction given by the Scottish Ministers.

(3) No person may smoke in the facilities provided in a prison for mothers and babies.

[45] The Scottish Prison Service (SPS) has publicly announced intentions for all prisons in Scotland to be smoke free by the end of 2018. The SPS website contains a quote from the Chief Executive of the SPS stating 'The sale of tobacco will cease in 2018 and the SPS will seek to make changes to the Prison Rules to make smoking in Scotland's prisons illegal'.

[46] The only other evidence on the sharing of a cell by a smoker and a non-smoker came from Dr Smith when asked by the Crown for his views, to which Dr Smith replied: "It's not ideal to be in with a smoker." That line of enquiry was not followed up any further. The Crown did not pursue the matter with any further evidence. The sharing of a cell by a smoker and a non-smoker was not a cause of death of the deceased. There was no other evidence which would entitle the court to make the finding proposed by the Crown. In any event there was evidence to the contrary being the evidence agreed in

the Joint Minute of Agreement about the rules regarding smoking within Scottish prisons, contained within Rule 36 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011, see para [43] of this Determination. The making of any such finding under section 26(2)(g) of the 2016 Act as proposed by the Crown would have been speculative and was not supported by the evidence in this Inquiry.

[47] The Inquiry addressed the concerns raised by John Ikhine, see paras [33] and [34] above. There was no evidence the deceased required a panic alarm. There was no evidence the deceased did not receive his medication. Indeed all the evidence was to the contrary. The procedures in prison for issuing out medications to prisoners were canvassed fully in the course of the Inquiry. The evidence which I have accepted is that the deceased was prescribed and received timeously all the prescribed medication which he required.

[48] Ms Crone did not see the medical records for the deceased when she saw the deceased on 22 January 2015. I have had regard to Ms Crone's account of her meetings with the deceased on 22 January 2015, the nature of the deceased's complaint of feeling "a wee bit wheezy" and no other complaint or symptoms, the contemporaneous medical records, the terms of the Joint Minute of Agreement and all the circumstances of what happened on 22 January 2015. I have concluded the fact that Ms Crone did not see the medical records for the deceased on 22 January 2018 had no bearing on the death of the deceased and was not a relevant factor.

[49] The deceased did not raise any concerns about his medical treatment or his medication with any nurse or GP in the course of a number of consultations at any time during his period of incarceration.

[50] The systems for a prisoner obtaining medical assistance when unwell were canvassed fully in the course of the Inquiry. There was no evidence the deceased had been failed by prison services and/or HMP Edinburgh health centre.

[51] For all these reasons I am satisfied that a formal determination is appropriate in all the circumstances of the death of Mr Mailer. Mr Mailer died of natural causes. Mr Mailer had very severe heart disease and nothing could have been done to save his life. Mr Mailer received appropriate medical treatment at all times while in legal custody in HMP Edinburgh.

[52] Finally, I wish to express my sympathy to the family of Mr Mailer for their loss.