SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2018] FAI 38

PER-B138-18

DETERMINATION

BY

SHERIFF W M WOOD

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

into the death of

WILLIAM CARLIN GLATLEY MILLAR
(born 19 September 1952)

At Perth, 25 October 2018

DETERMINATION

The sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

1. The deceased is William Carlin Glatley Millar, born 19 September 1952. At the time of his death at 1818 hours on 2 March 2017, he was a prisoner at HM Prison Castle Huntly.
2. In terms of section 26(2)(a), life was pronounced extinct at 1818 hours within the corridor adjacent to room 3 within section 1 of Wallace Wing at HM Prison Castle Huntly, Longforgan, Angus.
3. In terms of section 26(2)(c), the cause of death was hypertensive and ischaemic heart disease.

RECOMMENDATIONS

In terms of section 26(1)(b), there are no recommendations to be made which might realistically prevent other deaths in similar circumstances regarding the matters set out in subsection (4).

NOTE

Introduction

[1] An inquiry was held at Perth Sheriff Court on 22 October 2018 into the death of William Carlin Glatley Millar, born 19 September 1952. The inquiry is a mandatory inquiry under section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act"), the death having occurred in Scotland while the deceased was in legal custody. The death was reported to the Crown Office and Procurator Fiscal Service, which subsequently instructed a post-mortem examination that was carried out on 6 March 2017. Following advertisement of the preliminary hearing and inquiry hearing, notifications of intention to participate were received on behalf of the Scottish Prison Service, Tayside Health Board and the Prison Officers Association. All three were represented at the preliminary hearing on 2 August 2018.

[2] At the inquiry hearing on 22 October 2018: the Crown was represented by Mr Mohammed Sadiq, procurator fiscal depute; the Scottish Prison Service by Ms Sarah Philips, solicitor; and Tayside Health Board by Mr David James. Despite inquiries having been made of the agents who had represented the Prison Officers Association at the preliminary hearing, and despite delaying commencement of the inquiry until 11.30 am, there was no appearance by or on behalf of the Prison Officers Association. No witnesses were led and the inquiry proceeded on the basis of a Joint Minute of Agreement setting out

agreed facts that should be admitted as evidence, and the available productions. I then heard submissions on behalf of the represented parties, before closing the inquiry.

The legal framework

[3] The requirements to hold an inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 are principally governed by sections 1 and 2 of the Act, which are in these 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)(a) of that Act,
(c) young offenders institution, within the meaning of section 19(1)(b) of that Act,

'secure accommodation' means accommodation provided in a residential establishment, approved in accordance with regulations made under section 78(2) of the Public Services Reform (Scotland) Act 2010, for the purpose of restricting the liberty of children,

'service custody premises' has the meaning given by section 300(7) of the Armed Forces Act 2006."

[4] The circumstances of the death of William Carlin Glatley Millar is, therefore, a mandatory inquiry in terms of section 2(4) of the Act. In terms of section 36 of the Act the inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules").

[5] In terms of section 1(3) of the Act the purpose of the 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 Act, which is in these 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."

[6] It will be evident from the above that it is not the purpose of an inquiry to establish civil or criminal liability. The nature of the inquiry hearing is that it is part of an inquisitorial process, in which the procurator fiscal represents the public interest and other interested parties can participate to assist the court in reaching its findings.

Summary

[7] William Carlin Glatley Millar was born on 19 September 1952. At the time of his death, he was 64 years of age and a prisoner in HM Prison Castle Huntly. At the time, he was serving a sentence of 4 years in prison in relation to mortgage fraud and proceeds of crime offences. His earliest release date was 21 April 2017. He had a well-documented

history of heart problems, high blood pressure and type 2 diabetes as well as prostate and bladder issues. He had recently been passed for release by the Parole Board.

[8] Between 15 and 22 February 2017, Mr Millar had a period of home leave with his daughter. On his return to prison he was interviewed as part of a risk assessment, but reported no outstanding issues or concerns and the prison officer carrying out the assessment concluded that there was nothing in Mr Millar's manner or appearance to give any cause for concern. At the time of his death, he was prescribed an anti-depressant (Citalopram) and medication (Atenolol) for his high blood pressure. He was allocated a single cell at room 3 within section 1 of Wallace Wing at the Castle Huntly prison. When CCTV footage was reviewed, he was seen entering his cell at 1329 hours on 2 March 2017 and thereafter he did not leave his cell until discovered by prison staff.

[9] At or about 1740 hours on 2 March 2017, prison officers Neil Thomson and Simon Miller were carrying out "lock down" and number checks within Wallace Wing. They noted that Mr Millar's cell door was closed. On opening the door, they saw Mr Millar lying on his bed, fully clothed, on top of the covers. They noted that he was pale in colour and unresponsive, prompting the witnesses to call a "code blue" which requires an immediate response. The charge nurse, Fiona Scott, attended but could find no sign of a pulse. The clinical pharmacist, David Morrison, operated the bag valve mask while Fiona Scott and prison officers William Ritchie and Simon Miller carried out CPR. Fiona Scott attached a defibrillator to the deceased, but there was no shockable rhythm.

[10] At or about 1751 hours, paramedics arrived. They found the deceased within his cell, being worked on by the said witnesses. They attached the defibrillator, showing that he was "asystole" (that is, his heartbeat had stopped, with no cardiac output), and took over CPR. A further ambulance crew attended to assist and Mr Millar was moved into the corridor outside

his cell in order to allow those witnesses more space to work on him. Although they continued with CPR and administered adrenaline, there was no response and the witness Paul Rae pronounced life extinct at 1818 hours.

[11] Crown production 6 is a book of photographs taken by the scenes of crime officer, with the deceased in place. Mr Millar's body was subsequently recovered and lodged at the Dundee Mortuary. On 6 March 2017, at the instance of the procurator fiscal, Dundee, Drs David William Sadler and Tamara MacNamee carried out an autopsy examination and certified the cause of Mr Millar's death as hypertensive and ischaemic heart disease, as recorded in the post-mortem examination report dated 6 March 2017 (Crown production 3).

[12] Toxicology analyses were performed on Mr Millar's body fluids, which detected therapeutic levels of his prescribed medication. The results of those analyses were accurately recorded in the toxicology report dated 31 March 2017 (Crown production 4).

[13] The Crown productions include a copy of Mr Millar's prison file as well as copies of his prison medical records. It would appear that Mr Millar's recent medical complaints concerned abdominal pain. The post-mortem examination report confirms that Mr Millar's heart was enlarged (weighing 662 grams) compared with the expected range for his body weight (of between 293 grams to 511 grams), with one of the coronary arteries narrowed by at least 80 per cent by fatty plaque deposits. Mild scarring within the heart indicated previous ischaemic injury. His right lung was heavy and fluid-filled – which, although a non-specific finding, is one that can be seen in deaths associated with heart disease. The kidneys showed scarring and granularity of their surfaces – features commonly seen with systemic hypertension. Taken with the described narrowing of the coronary artery, it was helpful that the post-mortem report indicated that:

> "Individuals with severe atherosclerosis of the coronary arteries supplying oxygenated blood to the heart and an enlarged heart are at risk of sudden death at any time due to a fatal cardiac arrhythmia or an ischaemic event such as a heart attack. Hypertension and coronary artery atherosclerosis are directly linked to the development of cardiac enlargement and interstitial fibrosis."

[14] The submissions on behalf of all participating parties were very brief. In summary, all parties were content that I should find the facts established as set out in the Joint Minute of Agreement and to find the time, place, cause and circumstances of Mr Millar's death are in accordance with the conclusions of the Joint Minute and the post-mortem report.

Discussion and conclusions

[15] From the terms of the post-mortem examination report, it is clear that the condition of Mr Millar's heart and one of his coronary arteries that he was "at risk of sudden death at any time". His hypertension had previously been recognised and he was taking prescribed medication for that. The toxicology report indicated no substances other than his prescribed medication. There had been no movement at Mr Millar's cell on 2 March 2017 between him entering at 1329 hours and Mr Thomson carrying out his routine checks at 1740 hours. Following his recent home visit, he had not complained of any additional health concerns and there is no evidence from which any error or failure on the part of anyone or any organisation having responsibility for his care can be identified. On the contrary, once Mr Millar was found in an unresponsive state at or about 1740 hours on the evening of Thursday 2 March 2017, all appropriate efforts seem to have been made to sustain his life over a period of just under 40 minutes before he was pronounced "life extinct". I am satisfied that he died due to hypertensive and ischaemic heart disease and that there is no requirement to make any recommendations in the circumstances.