

**SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK**

[2022] FAI 15

KIL-B139-21

DETERMINATION

BY

SHERIFF ALISTAIR G WATSON

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

into the death of

**WILLIAM PRICE**

Kilmarnock, 27 August 2021

The Sheriff, having considered the information presented at an inquiry on 27 August 2021, in terms of section 1 and section 2(4)(a) of the Enquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 (“the Act”), Finds and Determines:

1. That in respect of paragraph (a) of section 26(2) of the Act, William Price, who was born on 14 October 1941, died on 6 May 2020 at 22.30 hours within University Hospital, Crosshouse, Kilmarnock.
2. That in respect of paragraph (c) of section 26(2) of the Act, the cause of death was a right lacunar infarct with left-sided weakness and associated aspiration pneumonia.

**NOTE:****Introduction**

[1] This has been a mandatory public enquiry into the death of William Price in terms of the Act. Mr Price's death occurred while he was a remand prisoner, having been remanded in custody at Hamilton Sheriff Court on 17 April 2020, and committed for further examination on a petition averring wilful fire raising and other charges. At the inquiry the interest of the Crown was represented by Mr Hill, Procurator Fiscal Depute; the interests of the Scottish Prison Service were represented by Mr Devlin, Solicitor; and the interests of SERCO were represented by Ms McDonald, Solicitor. No other party was present. Despite diligent enquiry on behalf of the Crown no next-of-kin, relative or other interested party could be found.

[2] For the purpose of the inquiry parties agreed the terms of a joint minute of agreement covering all of the necessary chapters of evidence which required to be placed before the court. In addition the court had the benefit of a number of productions including the prison custody and medical records related to the deceased. There was therefore no parole evidence presented.

**The circumstances**

[3] Following his remand by the court Mr Price was transported to Her Majesty's Prison, Kilmarnock on the same date. On arrival he was processed by staff, assessed in interview which established that he presented as being of, or at, "no apparent risk". Specifically, on his arrival at the prison, Mr Price was subject to an assessment by NHS

nurse DR who ascertained from him that he was not registered with any GP practice, was not presently prescribed any medication and in which discussion Mr Price told her that he was not suffering from any known medical condition. The nurse carried out a physical assessment of the deceased which included measurements of his height, blood pressure, pulse, saturations, temperature and respiration. All of these assessments were within the expected range and presented no cause for concern.

[4] Mr Price was housed in a single occupancy cell within the prison. No issue presented itself to staff until, at around 7.45am on 19 April 2020, prison custody officers carrying out a morning roll call attended at his cell where they found the deceased lying on the floor and in the course of an apparent seizure. The officers immediately raised an emergency alert and placed the deceased into the recovery position.

[5] Immediately thereafter, three nurses based within the prison attended at his cell and provided Mr Price with oxygen. The seizure continued for approximately 9 minutes further. Mr Price was also provided with Midazolam, but without effect. Mr Price continued to suffer a series of seizures. He was also noted to have an injury to his head. There were no signs of disturbance or of self-harm. The cell being a single occupancy room, it appears likely that the injury to the head occurred as a consequence of his fall to the floor.

[6] Paramedics arrived at about 8.38am. They also administered Midazolam, provided fluids and maintained his airway using suction. The deceased was still suffering seizures and was conveyed to Crosshouse hospital by ambulance. On arrival

at the hospital he was examined by an A&E consultant who observed a low level of consciousness, graded at 3 on the Glasgow coma scale.

[7] At hospital a CT scan was performed showing a fracture of the right side zygoma. A chest scan also confirmed aspiration pneumonia. He was transferred to the intensive care unit and placed on a ventilator. During his stay there it was observed that he was suffering from left-sided weakness and he was transferred to the stroke unit.

[8] On assessment in the stroke unit he was diagnosed by physicians as suffering a left-sided hemiparesis, a right lacunar infarct with left-sided weakness. He was admitted to Ward 3E at the stroke unit on 26 April 2020 where he presented as confused, suffering from weakness on the left side, slurred speech and an impaired swallowing reflex. He was also very agitated. He repeatedly removed a nasal gastric tube with which he had been provided.

[9] Sadly, Mr Price's condition deteriorated, and on 6 May 2020 it worsened to the extent that a decision was made to withdraw further treatment. The deceased's life was confirmed extinct on 6 May 2020 at 22.30 hours within the University Hospital, Crosshouse, Kilmarnock by Dr Arumugam Ravindrane, a locum consultant in the care of elderly medicine. The cause of death was noted as being 1 a) right lacunar infarct with left-sided weakness; 2) aspiration pneumonia.

### **Conclusions**

[10] In terms of section 26(2)(b) of the Act the death, while sudden, was not the result of any accident; and in terms of section 26(2)(e) of the Act there were no precautions

which could reasonably have been taken which might realistically have resulted in the death being avoided. Further, in terms of section 26(2)(f) of the Act there were no defects in any system of working which in any sense contributed to the death. Accordingly, there are no recommendations which can be made in light of the circumstances of Mr Price's death.

[11] At the time of his admission to HM Prison Bowhouse, Kilmarnock Mr Price was 78 years of age. Unbeknown to him, and indeed to anyone else, he was not a well man. He was appropriately processed on admission with a diligent check on his mental and physical welfare by those involved in his reception at the prison. There was nothing in the assessments made by the NHS nurse who examined him and interviewed him which would have given cause to suspect that his later seizures were imminent. He was placed in a single occupancy cell of a standard design and which presented no material risk to him as occupant.

[12] It appears that he began to suffer his seizure in the morning at the time of the morning roll call. Because of this timing he had the benefit of being immediately attended to by prison custody officers. They, and the paramedics who followed shortly thereafter, all provided appropriate first-aid measures. Everything was done for Mr Price at that point that reasonably could have been done.

[13] The deceased was transferred from prison to hospital at an early stage in the event and was given treatment which was appropriate to his condition throughout his stay there. Sadly for Mr Price, despite the significant medical interventions, his condition simply continued to deteriorate until his death. Having examined the

treatment provided to the deceased at Crosshouse Hospital I am satisfied that there is nothing more which could have been done for him there.

[14] In all the circumstances it must be concluded that there was no accident in this case. Mister Price was well cared for throughout. There is no recommendation which can be made by the court in light of the circumstances which prevailed. It would appear that Mr Price leaves no immediate family or known relatives. No doubt however his loss will be felt among his friends and I would express my condolences to them.