# INQUIRY UNDER THE FATAL ACCIDENTS AND SUDDEN DEATH (SCOTLAND) ACT INTO THE SUDDEN DEATH OF WILLIAM BOYLE

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SHERIFFDOM of TAYSIDE CENTRAL & FIFE

**DETERMINATION**

**by**

**ROBERT ALASTAIR DUNLOP, QUEEN'S COUNSEL, Sheriff Principal of the Sheriffdom of Tayside Central and Fife following an INQUIRY held at Forfar on 19th and 20th October 2006 into the death of**

## WILLIAM McCARTNEY BOYLE

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FORFAR, 20th October 2006. The Sheriff Principal, having considered all the evidence adduced, Determines:-

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that William McCartney Boyle, born 6 March 1970, died in room B23 of B Wing, HM Prison, Noranside, Fern, by Forfar, Angus between midnight 25 October 2005 and 0740 hours on 26 October 2005.

2. In terms of Section 6(1)(b) of the said Act that William McCartney Boyle's death was caused by the adverse effects of heroin.

**NOTE:**

[1] In this Inquiry evidence was presented on behalf of the Crown by Mrs Brown. The Scottish Prison Service was represented by Mr Stewart, Solicitor, Dundas & Wilson, Edinburgh. No other party was represented. Mr Boyle's father and brother were present throughout the proceedings but took no active part in them.

[2] The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that a public inquiry should be held into the death of any person held in legal custody. The reasons for making such Inquiry compulsory are obvious. It is clearly appropriate that, where somebody has been deprived of his or her freedom by legal process and then dies while in custody, a court should investigate the circumstances of the death in public.

[3] The purpose of the Inquiry is defined in Section 6(1) of the Act, which is in the following terms:-

"At the conclusion of the evidence and any submissions thereon ... the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction -

a) where and when the death and any accident resulting in the death took place;

b) the cause or causes of such death and any accident resulting in the death;

c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and

e) any other facts which are relevant to the circumstances of the death."

[4] In terms of the Act the procurator fiscal has the responsibility in the public interest of investigating the circumstances of the death and placing before the court evidence bearing upon those circumstances.

[5] The evidence led at the Inquiry gave rise to little controversy. The key facts which I have found established are as follows. William Boyle was a prisoner in HM Prison, Noranside, having been transferred there on 18 October 2005. HMP Noranside is part of the open estate of the Scottish Prison Service. As at 25 October 2005 he occupied room B23 in B Wing, which he shared with another prisoner, Paul Simon McIntosh.

[6] During the evening of 25 October 2005, after B Wing had been secured at about 9.15pm, William Boyle and Paul McIntosh smoked a quantity of heroin. This was done by placing a quantity of heroin on a piece of foil, applying a lit flame below the foil and then inhaling the smoke produced from the heroin as it burned. The heroin had been procured by William Boyle and was contained in two bags, known within the prison as £10 bags. As a result of inhaling the smoke from the heroin Mr Boyle showed a number of signs that he had been affected by the heroin. At one point he vomited. Paul McIntosh saw nothing unusual in Mr Boyle's condition.

[7] Paul McIntosh went to bed at about midnight at which time William Boyle was sitting in a chair watching the television. Shortly after 0715 hours on 26 October 2005 a prison officer opened up B wing and came into room B23. William Boyle was in his bed but when the prison officer spoke to him he got no response. On checking him the prison officer saw what he mistakenly thought was blood at the side of his mouth. He then summoned other staff to attend.

[8] One of the members of staff who attended was the prison nurse, who examined William Boyle at about 0740 hours and found no sign of life. There were traces of vomit down the side of his head. There was no pulse or heart sound and his pupils were fixed and dilated. There was staining of the body which indicated that death had occurred some time before.

[9] A post mortem examination of William Boyle was carried out by Dr Sadler and Professor Pounder on 28 October 2005. The examination revealed no significant natural disease or trauma to account for death. The lungs were found to be heavy and congested, which is a common but non-specific finding in many drug related deaths. In view of the history, circumstances and negative autopsy findings, and pending toxicological analysis, death was then presumed to be drug related. The findings of post mortem examination are contained within Crown production 4.

[10] Blood and urine samples taken from William Boyle were analysed for the presence of various substances and the result of such analysis is set out in a forensic toxicology report which is Crown production 6. There was a finding of 0.02 milligrams of morphine per litre of femoral blood and opiates tested positive in the urine sample. In a supplementary report on their post mortem examination, which reflected the toxicological findings, Dr Sadler and Professor Pounder concluded that death was attributable to the adverse effects of heroin. The supplementary report is Crown Production 5.

[11] I am satisfied that the conclusion of Dr Sadler and Professor Pounder is well founded. It is not possible to identify the precise time of death but it clearly occurred between midnight on the night of 25 October and 0740 hours on 26 October 2005 when the prison nurse examined William Boyle and found no signs of life. I have framed my determination in terms of sections 6(1)(a) and (b) accordingly.

[12] I was not invited to make any determination under the remaining paragraphs of sub section 1 and in my view none are appropriate on the basis of the evidence led. It was clear that there are chronic difficulties in keeping drugs out of prison and there are several opportunities for their introduction into the open estate in particular. The Scottish Prison Service has an Addictions Policy which seeks to address the problems of drugs in prison but there was no attempt in the Inquiry to undertake a comprehensive examination of that policy and I do not consider that there is any proper basis upon which I could make any findings about it. There is a regime of drug testing at Noranside which is primarily led by intelligence gathering and evidence of suspected use of drugs but also related to activities in which a risk assessment is thought appropriate. The effectiveness of the Policy is kept under review.

[13] So far as Mr Boyle was concerned he did not present as a person who was at risk. His prison records show that he had taken advantage of a number of programmes made available in prison, including one related to the awareness of drug problems. Viewing the evidence of his time in prison positively, it appeared that he was a person who was genuinely trying to sort himself out.

[14] In the final analysis the evidence does not disclose any way in which this death might have been avoided apart from the obvious one, namely abstinence from abuse of drugs. The reasons why people abuse drugs are no doubt varied but the circumstances of this case highlight yet again the folly of that sort of behaviour. It is an activity which is fraught with danger and the tragic circumstances of this case merely serve to reinforce that point of view.