

SHERIFFDOM OF LoTHIAN AND BORDERS AT EDINBURGH

[2017] FAI 11

2B212/17

DETERMINATION

BY

SHERIFF NORMAN MCFADYEN

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES
(SCOTLAND) ACT 1976

into the death of

ADAM ORLINSKI

EDINBURGH, 5 June 2017

The Sheriff, having considered all the evidence, FINDS and DETERMINES

(i) in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the 1976 Act) that Adam Orlinski, born 6 December 1957, who was lawfully detained in custody at HMP Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN, having been remanded in custody by the sheriff at Edinburgh under section 8 of the Extradition Act 2003, died at 1657 on 8 July 2015 in the Royal Infirmary of Edinburgh

(ii) in terms of section 6(1)(b) of the 1976 Act the cause of his death was:

1a Ischaemic and hypertensive heart disease.

(iii) in terms of section 6(1)(c), there were no reasonable precautions whereby the death might have been avoided;

(iv) in terms of section 6(1)(d) there were no defects in any system of working which contributed to the death;

(v) in terms of section 6(1)(e) there were no other facts which were relevant to the circumstances of the death.

Note

Introduction

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Adam Orlinski who died at the Royal Infirmary of Edinburgh on 8 July 2015. Mr Orlinski was at the time of his death in legal custody and an inquiry was thus mandatory under section 1(1)(a)(ii) of the 1976 Act.

[2] Ms R Cook, Procurator Fiscal Depute, represented the public interest and Ms Thornton, Solicitor, represented the Scottish Prison Service. The National Health Service and the Prison Officers Association had intimated that they did not intend to participate in the inquiry. The family of Mr Orlinski were not represented and I was informed at a preliminary hearing and again at the inquiry that it had not been possible to trace them for intimation. The holding of the inquiry had been properly advertised in the usual way.

[3] A Joint Minute of Agreement was entered into by parties and received by the Inquiry. No other evidence was led.

[4] Section 6(1) of the 1976 Act requires the presiding sheriff to make determinations in the following matters (a) where and when the death took place; (b) the cause of such death; (c) the reasonable precautions, if any, whereby the death might have been avoided; (d) the defects, if any, in any system of working which contributed to the death; and (e) any other facts which are relevant to the circumstances of the death.

[5] I was invited by the Procurator Fiscal Depute and the solicitor for the Scottish Prison Service to make a formal determination and not find it appropriate or necessary to make any determination in respect of section 6(1)(c) (d) or (e).

[6] This was an inquiry which proceeded wholly on the basis of a joint minute of agreement which incorporated by reference extensive documentation relating to the medical condition of Mr Orlinski and his treatment when he took ill at the prison and in hospital and full statements from those responsible for responding to his illness and as to the circumstances leading up to his death. While the existing legislation and rules do not provide in terms for evidence to be considered in this manner and for facts to be treated as proved by joint minute, it is a practice which had developed, particularly in mandatory inquiries where the sheriff considers that the findings which can be made are not controversial. I note that, for the future, in inquiries under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, the relevant rules provide that

“It is not necessary for the participants to present information to the inquiry concerning—

(a) a fact agreed by all participants;

(b) a production, the terms and application of which are agreed by all participants”

(Act of Sederunt (Fatal Accident Inquiry Rules) 2017, rule 4.10(1)).

[7] While the court should be cautious about proceeding without hearing oral evidence in a case where the family of the deceased are not represented and particularly so in the case of a person who has died while in the custody of the state, I am satisfied from consideration of the documents to which I have referred that the circumstances of Mr Orlinski’s death were thoroughly and appropriately investigated, that he received appropriate medical care in prison and in particular

appropriate emergency medical care there and at the Royal Infirmary of Edinburgh and nothing could reasonably have been done to save his life. In these circumstances I was satisfied that nothing would have been achieved by requiring the attendance and examination of witnesses and I was prepared to proceed on the basis of the joint minute and documents, including statements, referred to therein.

[8] After considering the Joint Minute of Agreement and documents and statements referred to therein and hearing submissions, I made the following findings:

Findings

(1) At the date and time of his death, Mr Orlinski, who was a Polish national, was lawfully detained in custody at HMP Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN, having been remanded under section 8 of the Extradition Act 2003. He appeared at Edinburgh Sheriff Court on 4 June 2015 pursuant to a European Arrest Warrant issued by the regional Court in Warsaw, Poland for his return in order to serve a prison sentence for offences of which he had been convicted in Poland in 2012. Bail was refused, and a preliminary hearing was set for 15 June 2015 with a full extradition hearing on 18 June 2015. On 15 June 2015, a defence motion to adjourn was granted and a fresh preliminary hearing was set for 22 June with a full extradition hearing on 9 July 2015. On 22 June 2015, a further defence motion to adjourn was granted and a fresh preliminary hearing was set for 2 July 2015. On 2 July 2015, the matter was continued for the full extradition hearing on 9 July 2015, but Mr Orlinski died on 8 July 2015. He remained in custody at HMP Edinburgh from the date of his initial appearance on 4 June 2015 until his death.

(2) Mr Orlinski was placed in cell 3, Glenesk Hall within Level 2 at HMP Edinburgh on 4 June 2015. On 5 June 2015 he was moved to cell 33 in Glenesk Hall Level 2. On 9 June 2015, he moved to cell 16 in Glenesk Hall level 3 until the date of his death. Mr Orlinski shared cell 16 with another Polish inmate, Marius Gozdal.

(3) At around 1400 hours on 8 July 2015, Mr Gozdal was within cell 16 along with Mr Orlinski, who complained that he was not feeling well. Accordingly, Mr Gozdal and Mr Orlinski approached prison officers Alastair Kennedy and Dale Black at the staff desk to inform them. Mr Orlinski presented as pale, sweaty and clutching his chest. The nurse was telephoned straight away by Mr Black and Mr Orlinski returned to his cell to sit down and await the nurse. Mr Kennedy checked on Mr Orlinski in his cell and noted that he was sitting uncomfortably. Mr Kennedy told Mr Gozdal to tell Mr Orlinski that a nurse was on her way (being aware that Mr Orlinski was Polish and was unsure whether he spoke English well). Mr Kennedy then returned to the desk to await the nurse. Mr Orlinski then collapsed and Mr Gozdal alerted staff. Mr Kennedy attended at the cell and saw Mr Orlinski lying on the floor of the cell making a gurgling noise. Mr Kennedy shouted "CODE BLUE" (indicating a prisoner was not breathing) three times and began cardiopulmonary resuscitation (CPR) on Mr Orlinski. About a minute later, nurse Jean Wallace attended and took over CPR from Mr Kennedy. Mr Kennedy telephoned the control room and requested an ambulance. During this time, a number of nursing staff attended at Mr Orlinski's cell. The Scottish Ambulance Service arrived at approximately 1435 and treatment continued in Glenesk Hall for approximately an hour before Mr Orlinski was taken to Edinburgh Royal Infirmary. During this time, Mr Orlinski intermittently flipped into ventricular fibrillation (VF) arrest and

required multiple shocks by the paramedics. He was occasionally irritable and was fighting to pull equipment and his drip out of himself.

(4) Mr Orlinski arrived at the Royal Infirmary of Edinburgh at 1549.

Resuscitation was continued and advanced life support performed but his life was pronounced extinct by Dr Nicola DiRollo at 1657.

(5) A post mortem examination was conducted on the body of Mr Orlinski on 14 July 2015 by consultant forensic pathologist Dr Kerryanne Shearer at the City of Edinburgh mortuary. The cause of death was certified as

1a Ischaemic and hypertensive heart disease.

Dr Shearer concluded that such heart disease could have caused sudden death at any time from the onset of a fatal cardiac arrhythmia.

(6) A new patient questionnaire completed for Dr Meggs and Partners surgery where Mr Orlinski was registered as a patient on or around 19 November 2012 simply notes "Epilepsy" under the heading "Medical History". In the patient registration form dated 11 February 2013 for Wellhall Medical Centre, where Mr Orlinski was subsequently registered as a patient, under the section "Family History" there is recorded "NO" next to the question "Family History of Ischaemic Heart Disease" and it is recorded that he answered "NO" to "Heart Complaint" under the question "DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?".

(7) Dr R K McLay of the Wellhall Medical Centre reviewed Mr Orlinski's medical records on 22 June 2015 and noted that he suffered from epilepsy, elevated blood pressure, kidney stones and primary hyperparathyroidism. Dr McLay stated at that time that "At present, his conditions are stable and I would not anticipate there being any issues with him being held prison (sic)".

(8) Although Mr Orlinski's cell mate believed that he had filled out a form at the prison advising that he had problems with his heart, that does not accord with the statement of Dr Craig Revell, the prison doctor, who saw him the day after his admission, treated him later and attended him when he took ill, nor with the prison records, or indeed any of his medical records, which do not record any diagnosis of heart disease or problems and it is likely that the cell-mate was mistaken or that Mr Orlinski himself was confused. There do appear to have been significant communication difficulties given Mr Orlinski's lack of competence in English, although these did not contribute to the circumstances leading to his death. Mr Orlinski was obese and suffered high blood pressure (hypertension) and raised cholesterol levels and it is not surprising that he had heart disease, but there is no record of any diagnosis of heart disease and the only relevant reference in his medical records is to an attendance at Hairmyres Hospital on 8 January 2015 which was recorded, in the discharge summary, as "ref from cardiology (ecg in tray)" but no investigations were carried out and it is noted "pt attended A&E in error". Given Mr Orlinski's poor communication skills and that no examination was carried out, this attendance is of no significance.

(9) Given that there was no history of heart disease known to the medical or prison authorities, there was no obvious step which the Scottish Prison Service could have taken to treat the specific condition from which he died. His treatment when he took ill was appropriate and timely.

Postscript

I extend my condolences to the family of Mr Orlinski and my gratitude to Ms Cook, the procurator fiscal depute and Ms Thornton, the solicitor for the Scottish Prison Service for their thorough and careful presentation of the evidence and submissions.