2010 FAI 44

DETERMINATION

by

SHERIFF A W NOBLE
Sheriff of Lothian and Borders at Edinburgh
following a Fatal Accident Inquiry
into the death of
BERNARD GRAHAM

Edinburgh, 11 October 2010. The Sheriff, having considered the evidence adduced and submissions thereon at the Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter "the Act"), Determines:

(a) in terms of section 6(1)(a) of the Act that Bernard Graham (hereinafter "the deceased"), born on 4 May 1958, died between about 11 p.m. on 9 November 2009 and 8.25 a.m. on 10 November 2009 within Cell 8, Glenesk Hall, Her Majesty's Prison Saughton, Edinburgh;

(b) in terms of section 6(1)(b) of the Act that the cause of death was coronary artery thrombosis due to coronary artery atherosclerosis;

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

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

(e) in terms of section 6(1)(e) of the Act that there are no other facts which are relevant to the circumstances of the deceased's death.

NOTE

1. Introduction and Parties represented at the Inquiry

This fatal accident inquiry was held in terms of section (1)(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter "the Act"). It was a mandatory

inquiry because the deceased died in legal custody. Two parties appeared. The Procurator Fiscal was represented by a procurator fiscal depute, Ms McGarvey. Mr Rolfe, solicitor, appeared for the Scottish Ministers on behalf of the Scottish Prison Service.

2. Legal Framework

The duties of the court at a fatal accident inquiry are set out 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."

3. Evidence and Submissions

No oral evidence was led at the inquiry. Instead I had affidavits from Dr Ralph BouHaidar, the consultant forensic pathologist who carried out the post-mortem on the deceased, and Sunella Brahma, a forensic scientist who examined blood and urine samples from the deceased. I also had witness statements from the following witnesses:

1. Steven Beveridge, the prisoner who shared the deceased's cell.
2. Alastair Kennedy, a prison officer at HMP Saughton.
3. Gillian Peden, a practitioner nurse at HMP Saughton.
4. Neil Proven, a clinical lead and trained paramedic within the Scottish Ambulance Service.
5. Alistair Hutchens, a detective sergeant in Lothian and Borders Police based at Craigmillar Police Station, Edinburgh.
6. Dr Webster Madira, consultant chemical pathologist and principal medical supervisor for forensic toxicology, University Hospitals of Leicester NHS Trust.

It was agreed by joint minute that the written statements were true and accurate records of what the witnesses said and were to be taken to be the equivalent of oral evidence. The joint minute also agreed the terms and accuracy of Crown Productions 1 and 3, Dr Bou-Haidar's draft and final post-mortem reports; Crown Production 2, a toxicology report prepared by two forensic scientists, Sarah Ann Murphy and Karen Marie Lifsey, in relation to certain items found within the cell occupied by the deceased; Crown Production 4, Dr Madira's statement/report; Crown Production 5, Ms Brahma's toxicology report; Crown Production 6, the deceased's prescription sheet and recording sheet; and Crown Production 7, the Declaration of the Fact of Death relative to the deceased.

As is evident from the previous paragraph, extensive enquiries were carried out into the deceased's death. It is clear from these enquiries that the deceased's death was from natural causes, the right coronary artery, which was affected by severe atherosclerosis, being completely occluded by a haemorrhagic thrombus. There was no trace whatsoever of any illicit drugs in the deceased's system, and the diazepam which the deceased was prescribed produced a reading which was a tiny fraction of the toxic level, let alone the fatal level.

Against that background, both Ms McGarvey and Mr Rolfe submitted that only findings in terms of section 6(1)(a) and 6(1)(b) of the Act were warranted. I accept that submission. As regards section 6(1)(a), I have stated the time of death as between about 11 p.m. on 9 November 2009 and 8.25 a.m. on 10 November 2009. According to Steven Beveridge, the deceased's cellmate, the deceased was still moving about in his bed when he (Mr Beveridge) fell asleep at about 11 p.m. on 9 November. Eight twenty five a.m. on 10 November is the time when Mr Proven declared that the deceased was dead, although it would appear likely that he had died some time before that. (Mr Beveridge had raised the alarm when he discovered the deceased cold and unresponsive in his bed at about 8 a.m. In spite of the signs, nurses employed at the prison carried out intensive CPR measures until life was declared extinct by the attending paramedics.)

Ms McGarvey intimated that the deceased's daughter, Lisa Graham, had no concerns about the circumstances of her father's death. Ms McGarvey also stated that she would like to express her sympathies to the family of the deceased. Mr Rolfe associated himself with that. I would also like to extend my own condolences to the deceased's family.