2015FAI5

SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

DETERMINATION

by

Sheriff Donald S. Corke, Advocate

in an Inquiry under s.1(1)(a)(ii) under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

into the death of

WILLIAM KEVIN MUIR

Ms Poppius, PFD
Ms McDonald, solicitor, for the SPS

EDINBURGH, 21 January 2015

The Sheriff, having considered all the evidence adduced, DETERMINES in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, s.6(1):

(a) That the late William Kevin Muir, born 26 May 1969, who ordinarily resided at XXXX, while a prisoner held in legal custody and serving a sentence of imprisonment, died in his cell at West Wing, level 3, Ingliston Hall, at HMP Edinburgh, 33 Stenhouse Road, Edinburgh EH11 3LN at some point between

16:30hrs on 2 November 2013 and being pronounced life extinct at 07:55hrs on 3 November 2013.

(b) That the cause of his death was coronary atherosclerosis.

(c) That there were no reasonable precautions whereby the death might have been avoided.

(d) That there was no defect in any system of working which contributed to the death.

(e) The facts relevant to the circumstances of the death are as stated in the Note below.

Note:

[1] Oral evidence was led from: John Irvine and Stephen Banks, prison officers; Dr William Smith, GP; and DC Joyce Gunderson, reporting officer. There was also a sworn pathologist's report and toxicology report by Dr Clare Bryce (Crown pro no 1); an affidavit by Jill McMurdo, prison officer; a witness statement taken by

DC Gunderson from a prisoner friendly with the deceased (Crown pro no 5); and a joint minute.

[2] There was no problem or issue with the credibility or reliability of any of the witnesses.

[3] Productions further comprised: the extract sentence; medical records; and the intimation of death form.

[4] The evidence is quite straightforward. The deceased was being held in legal custody at Edinburgh Prison. He was the sole occupant of the single cell already specified. He was locked in his cell in accordance with routine procedure on 2 November 2013 at about 16:30hrs. The deceased was well regarded within the prison and was trusted as a pass man with cleaning and painting duties. Earlier on 2 November he had appeared well and in good spirits both to staff and a friend. He was checked when locked in his cell and there were no issues.

[5] Next morning, an officer went round on a routine check of the prisoners locked in their cells. The deceased was checked at about 07:35hrs and his cell was found to be very cold, with the windows open. He had been able to open his windows

and had preferred to keep them open. The television was on. No one else was present. The deceased seemed asleep but was stiff and cold and could not be roused. Nurses and paramedics immediately attended and life was pronounced extinct at 07:55hrs.

[6] The medical evidence showed that the deceased had various medical conditions. He had been advised to reduce weight and quit smoking but had nonetheless been assessed as not being at increased risk of cardiovascular disease in the following 10 years. Focal severe coronary atherosclerosis was found to be present at autopsy. Prisoners are not checked between 16:30hrs and 07:30hrs the next day. The deceased did however have an emergency call button and intercom, which in this case were in working order and had not been activated. It appears that deceased had suffered a sudden collapse due to his heart disease and nothing could have been done to save him. Nothing was missed that might have saved him and he had not presented with symptoms. The deceased had been allowed to keep his own medication, which was not involved in his death.

[7] As well as agreeing the joint minute, the PFD and the SPS solicitor were agreed on the need for formal findings only, as reflected above.

……21 January 2015

Sheriff D S Corke, Advocate