

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2026] FAI 49

GLW-B586-26

DETERMINATION

BY

SHERIFF PAUL ANTHONY REID

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

into the death of

WILLIAM DEVINE

GLASGOW, 10 September 2026

Determination

The sheriff, having considered all the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, (hereinafter referred to as “the 2016 Act”), that:

(a) In terms of section 26(2)(a) of the 2016 Act, William Devine, born 22 August 1980, then a prisoner within HM Prison Barlinnie, Lee Avenue, Glasgow, died at Glasgow Royal Infirmary, Castle Street, Glasgow on 7 April 2024 at 2105 hours.

(b) In terms of section 26(2)(c) of the 2016 Act, the cause of death was:

1(a) Multiple organ failure due to

1(b) Out of hospital cardiac arrest.

- (c) In terms of section 26(2)(b) of the 2016 Act, no accident took place and accordingly no finding requires to be made under section 26(2)(d) of the Act.
- (d) In terms of section 26(2)(e) of the 2016 Act, there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.
- (e) In terms of section 26(2)(f) of the 2016 Act, there were no defects in any system of working which contributed to the death.
- (f) In terms of section 26(2)(g) of the 2016 Act, there are no other facts which are relevant to the circumstances of the death.

Recommendations

The sheriff, having considered the information presented at the inquiry, makes no recommendations in terms of section 26(1)(b) of the 2016 Act.

NOTE:

Introduction

[1] This determination was made following the Fatal Accident Inquiry held under the 2016 Act into the circumstances of the death of William Devine, who died whilst a prisoner of HM Prison, Barlinnie, Glasgow on 7 April 2024.

Procedural history

[2] A notice of the inquiry was given by the procurator fiscal under section 15(1) of the 2016 Act on 13 April 2026. The court pronounced a first order on 14 April 2026 assigning a preliminary hearing for the inquiry to call at Glasgow Sheriff Court on 3 June 2026. On that date the matter called before me. Having heard from the procurator fiscal depute and a solicitor on behalf of the Scottish Prison Service, in particular having regard to their respective states of preparation, on joint motion, I assigned a further preliminary hearing to call on 21 July 2026 before me at Glasgow Sheriff Court. This was to allow parties to conclude their conversations with each other, to finalise instructions and to have lodged a joint minute of agreement in so far as evidence was concerned. A Fatal Accident Inquiry was assigned to call on 27 August 2026 within Glasgow Sheriff Court.

[3] A joint minute entered into between parties was lodged on 13 July 2026 which agreed the evidence for the inquiry in its entirety. This included the statements of ten witnesses.

[4] In addition, the following productions were lodged:

- (a) A post-mortem report by Dr Gillian Wilson dated 28 June 2024.
- (b) Medical records in relation to William Devine.
- (c) The Death in Prison Learning, Audit and Review dated 10 September 2024.
- (d) The death in custody folder maintained by the Scottish Prison Service.

[5] In light of the joint minute of agreement and the productions lodged, which I had reviewed, I agreed with parties that the inquiry could proceed without the requirement for witnesses to attend to give oral evidence.

[6] The inquiry took place on 27 August 2026 within Glasgow Sheriff Court. Ms Watt, procurator fiscal depute, appeared on behalf of the Crown. Mr Richmond, solicitor, appeared on behalf of the Scottish Ministers. There was no representation on behalf of the family of Mr Devine. However, the sister of the deceased Ms Jane Devine, was present in the public gallery. In discussion with her she provided helpful information. The joint minute of agreement was read to the court by the procurator fiscal depute. Written submissions were provided to the court in advance of the inquiry by all parties. I was asked by all parties to make formal findings only.

The legal framework of the inquiry

[7] The inquiry was held in terms of section 1 of the 2016 Act, and the procedure was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The inquiry was a mandatory inquiry. It was held in accordance with section 2(4)(a) of the 2016 Act. Whilst Mr Devine died in hospital, he was a prisoner of HM Prison, Barlinnie throughout that time, meaning that at the time of his death he was in legal custody.

[8] Section 1(3) of the 2016 Act sets out that the purpose of a Fatal Accident Inquiry is to establish the circumstances of the death and consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The inquiry itself is an inquisitorial process. It is not the purpose of an inquiry to establish civil or criminal

liability. The matters which should be considered in the determination are contained within section 26 of the 2016 Act and have been set out above. Section 1 also sets out the requirement of the procurator fiscal, who represents the public interest in a Fatal Accident Inquiry, who must investigate the circumstances of death and arrange for the inquiry to be held.

Summary

Circumstances of the deceased

[9] Mr Devine was born on 22 August 1980. He was 43 years of age at the time of his death. He appeared at Hamilton Sheriff Court on 2 April 2024 in relation to a charge alleging a contravention of section 49(1) of the Criminal Law (Consolidation) (Scotland) Act 1995. He was remanded in custody pending further procedure. He was placed on remand in HM Prison, Barlinnie, Lee Avenue, Glasgow.

[10] At the date of his death on 7 April 2024, Mr Devine remained a prisoner of HM Prison, Barlinnie and therefore died whilst in legal custody.

[11] Mr Devine had a history of substance misuse. His regular prescribed medications included methadone, diazepam, chlorpromazine and mirtazapine. These medications were dispensed to him under supervision of the NHS staff working in the prison.

[12] On 6 April 2024 at approximately 2148 hours prison officers responded to an emergency call from Cell 3/22. Mr Devine was resident in this cell. The call had been activated by a cellmate who advised that Mr Devine was unresponsive. The officers

attended at the cell. They found Mr Devine to be unresponsive and appeared not to be breathing. At around 2149 hours a code blue was called over the radio. Further prison officers attended. An emergency ambulance was instructed. Prison staff commenced CPR following the guidance of the defibrillator. Paramedics arrived at around 2208 hours and took over CPR. Prison officers assisted with CPR when the paramedics tired.

[13] Further advanced medical support attended at approximately 2230 and 2300 hours consisting of advanced paramedics and a doctor who continued to treat Mr Devine. Mr Devine regained circulation. He was intubated and ventilated. He remained critically unwell. Mr Devine was transferred to Glasgow Royal Infirmary at approximately 2359 hours. He received intensive care. He was placed into a neuroprotective induced coma. His condition continued to deteriorate. It was evident to the medical personnel that Mr Devine was dying. Following this, discussions were had with Mr Devine's family. A decision was made to change the focus of his care to that of comfort. Mr Devine died within Glasgow Royal Infirmary on 7 April 2024 at 2105 hours.

[14] A post-mortem examination was carried out on 16 April 2024 at the Queen Elizabeth University Hospital, Glasgow by Dr Gillian Watson. The cause of death was recorded as:

1(a) Multiple organ failure due to

1(b) Out of hospital cardiac arrest.

[15] Toxicological analysis was carried out on the hospital blood sample from Mr Devine taken on 7 April 2024. Prescription drugs were found at a therapeutic level. There were no toxicological findings to explain the cardiac arrest.

[16] A DIPLAR was conducted on 17 June in relation to the death of Mr Devine.

[17] Written submissions were lodged on behalf of all parties. All parties agreed that only formal findings should be made in this inquiry.

Discussion and conclusions

[18] In light of the evidence before the inquiry and the submissions made, I am satisfied that only formal findings should be made.

[19] I am grateful to parties for their preparation for this inquiry as a result of which all evidence was agreed and no witnesses were required to attend.

[20] I wish to conclude this determination by expressing my condolences and sympathies to the family of Mr Devine. In particular I am grateful to the contribution made to the inquiry process by Ms Jane Devine, a sister of the deceased who emphasised the family's gratitude to the prison service firstly for their efforts in trying to save the life of her brother, and then for extending his life in such a fashion that the family were able to spend time with Mr Devine prior to his death.