**SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH**

**[2026] FAI 20**

EDI-B1471-25

DETERMINATION

BY

SHERIFF GILLIAN SHARP

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

into the death of

**EDWARD CAIRNEY**

EDINBURGH 26 April 2026

The sheriff, having considered 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 ("the Act") that:

1. In terms of section 26(2)(a) of the Act, that Edward Cairney, born 9 October 1941, died within his cell at His Majesty's Prison ('HMP') Edinburgh on 15 October 2023.

2. The death did not result from an accident so no findings in terms of section 26(2)(b) need be made.

3. In terms of section 26(2)(c) of the Act, that the cause of death was 1a) complications of acute bronchopneumonia; and 2) ischaemic heart disease, hypertension, diabetes mellitus.

4. In terms of sections 26(2)(d), (e), (f) and (g), no findings fall to be made.

5. In terms of sections 26(1)(b) and 26(4), no recommendations are made.

**NOTE**

**The legal framework of the inquiry**

[1] In terms of section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths in similar circumstances. Section 26 requires the sheriff to make a determination which in terms of section 26(2) is to set out factors relevant to the circumstances of the death. These are (a) when and where the death occurred; (b) when and where any accident resulting in the death occurred; (c) the cause of the death; (d) the cause of causes of any accident resulting in the death; (e) any precautions which could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided; (f) any defect in any system of working which contributed to the death or to the accident; and (g) any other facts which are relevant to the circumstances of the death.

[2] In terms of section 26(1)(b) and 26(4), the inquiry is to make such recommendations as the sheriff considers appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances. The sheriff is not obliged to make recommendations; that is a discretionary power. The procurator fiscal depute represents the public interest. An inquiry is an inquisitorial process. The determination

must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish criminal or civil liability.

**Introduction**

[3] This inquiry was held under section 1 of the Act. It was a mandatory inquiry in terms of section 2(1) and (4) as Mr Cairney was a person who was in legal custody at the time of his death. The procurator fiscal lodged a notice of the inquiry on 16 October 2025. A preliminary hearing took place on 2 December 2025. The inquiry itself took place on 24 April 2026 at Edinburgh Sheriff Court.

[4] Three parties were represented at the inquiry. A procurator fiscal depute appeared for the Crown. Solicitors appeared for the Scottish Ministers acting through the Scottish Prison Service and for Lothian Health Board. The Crown advised that intimation of the inquiry had been made to Mr Cairney's family. The family did not attend the hearing.

[5] No oral evidence was led at the inquiry hearing. A joint minute of agreement was entered into by all parties. All parties invited me to make formal findings only in respect of sections 26(1)(a) of the Act. None of the parties invited me to make any recommendations.

[6] The following productions were lodged and referred to in the joint minute:

- Crown production 1 - Pronunciation of Life Extinct Certificate for Mr Cairney;
- Crown production 2 - Post-Mortem report, inclusive of a copy of the toxicology report, by Dr Tracy Sorkin, Consultant Forensic Pathologist;
- Crown production 3 - Medical Records of Mr Cairney;
- Crown production 4 - Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form for Mr Cairney;
- Crown production 5 - HMP Edinburgh Care Plan for Mr Cairney;
- Crown production 6 - Death in Prison Learning Audit Review (DIPLAR) report carried out at HMP Edinburgh in respect of Mr Cairney;
- Crown production 7 - Death in Custody Folder of Documentation and Records maintained by the Scottish Prison Service in relation to Mr Cairney;
- Crown production 8 - Significant Adverse Event Review (SAER) carried out at HMP Edinburgh by Lothian Health Board in respect of Mr Cairney;
- Crown production 9 - NHS Standard Operating Procedure for the management of patients receiving Multi-Compartmental Compliance Aids (MCAs) effective from October 2024;
- Crown production 10 - statement of Alexandra Oswald, Staff Nurse, dated 15 October 2023;

- Crown production 11 - statement of Kofi Benefo, Carer, dated 15 October 2023;
- Crown production 12 - statement of Donna McWhinnie, Carer, dated 15 October 2023;
- Crown production 13 - statement of Dr Kathryn Linton, consultant physician and diabetologist/endocrinologist, 17 June 2024;
- Crown production 14 - statement of Laura McConnell, Trainee Advanced Nurse Practitioner, dated 17 January 2025;
- Crown production 15 - statement of Mark Macleod, Prison Officer, dated 15 October 2023;
- Crown production 16 - statement of Ryan Sinnott, Operations Officer, dated 15 October 2023;
- Crown production 17 - statement of Kris O'Brien, Paramedic, dated 15 October 2023;
- Crown production 18 - statement of Ruth Craxford, Paramedic, dated 15 October 2023;

[7] The following narrative of the facts is derived from the joint minute of agreement and productions.

**Narrative of the facts**

***Background***

[8] On 1 November 2011, the responsibilities for the provision of healthcare to prisoners transferred from the SPS to the NHS (Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011). Since then, individual regional NHS health boards have been responsible for the delivery of health care services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

[9] Edward Cairney was born on 9 October 1941. At the time of his death he was 82 years of age and he was being held in legal custody at His Majesty's Prison ("HMP") Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN.

[10] On 14 June 2019, Mr Cairney was convicted of murder and attempting to defeat the ends of justice and remanded to HMP Barlinnie whilst awaiting sentencing.

[11] On 17 July 2019, Mr Cairney was sentenced to life imprisonment with a punishment part of 14 years.

[12] On 6 April 2020, Mr Cairney was transferred to HMP Edinburgh.

[13] Mr Cairney's death occurred between 0300 hrs and 0615 hrs on 15 October 2023 in his cell at HMP Edinburgh and his life was pronounced extinct at 0725 hrs.

***Medical history and treatment***

[14] Mr Cairney had a medical history of hypertension, Type 2 Diabetes Mellitus, cardiac issues, Angina and had a stoma, which were managed ad hoc within the prison environment.

[15] Upon admission to HMP Edinburgh, a care plan was put in place for Mr Cairney to assist him with personal hygiene and care. Equipment was obtained to help with his care requirements and reduce the risk of overnight falls, namely a wheelchair, urine bottles, zimmer frame, a monkey pole and chair. These equipment requirements were regularly reviewed through his time in HMP Edinburgh.

[16] On 28 August 2023, Mr Cairney was admitted to Edinburgh Royal Infirmary with symptoms including a fever, coughing up green sputum and shortness of breath which he reported had been ongoing for 5 days. GEOAmey staff who were escorting Mr Cairney reported that he had not been taking his usual medications for roughly 10 days. The reason for this was not known or established.

[17] Mr Cairney was found to have radiological evidence of a severe pneumonia, which was complicated by a cardiac arrythmia which was felt to be exacerbated by low serum potassium.

[18] Mr Cairney refused food, medication and personal care on multiple occasions during his admission to Edinburgh Royal Infirmary. This was consistent with Mr Cairney having previously refused food, medication and personal care whilst in HMP Edinburgh.

[19] On 29 August 2023, a Certificate of Incapacity was put in place for Mr Cairney.

[20] On 29 August 2023, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was put in place for Mr Cairney due to his frailty. This was not discussed with Mr Cairney due to his lack of capacity.

[21] The DNACPR was discussed with other healthcare professionals following its implementation. All healthcare professionals agreed that it should remain in place.

[22] On 14 September 2023, Mr Cairney's was reviewed by Psychiatry as he had been refusing his medication and had indicated that he did not want to get better. Psychiatry concluded that he did not appear to have a major depressive disorder.

[23] On 27 September 2023, Mr Cairney was deemed medically fit for discharge, but that this was delayed due to HMP Edinburgh not having the equipment to allow him to be adequately cared for. That a pressure mattress and hospital bed were ordered and delivered to HMP Edinburgh prior to Mr Cairney's release.

[24] On 06 October 2023, Mr Cairney was discharged from Edinburgh Royal Infirmary back to HMP Edinburgh. Upon his return to HMP Edinburgh, Mr Cairney was seen by an Advanced Nurse Practitioner who updated his prescription as advised by the hospital. He was taken off amitriptyline, frusemide, atorvastatin, ramipril, and diltiazem as the hospital deemed these to be affecting his heart due to the ECG changes or were no longer required. He was prescribed Aspirin 75mg, lansoprazole 30mg daily, metformin 500mg daily, GTN Spray for Angina related chest pain as required, ibuprofen gel as required, Salbutamol inhaler as required. He was also prescribed morphine at 3mg when required. This was not administered as Mr Cairney did not ever request it.

[25] Mr Cairney received day to day care from carers from the RMR care agency whilst within HMP Edinburgh. RMR care agency are an external care agency who are contracted by the SPS to manage day to day care of specific prisoners.

[26] On 9 October 2023, Mr Cairney had a follow up appointment with an Advanced Nurse Practitioner. At that appointment Mr Cairney's mobility had been found to have decreased due to lack of strength or frailty and he was found to be essentially bed bound. It was noted he had bed sores due to lying in a fixed position. Those sores were dressed and a daily change of dressing was established. An instruction was given that Mr Cairney would be on a liquid diet and that thickener would be added when he was taking fluid to prevent choking. It was decided that Mr Cairney was no longer suitable to self medicate and that his medication would be given to him on a supervised basis going forward.

[27] On 12 October 2023, an updated care plan was created for Mr Cairney to reflect the increase in the support being offered to him. This included provision of medication, turning him every two hours to prevent bed sores and assisting with feeding each meal.

**Death**

[28] At approximately 0000 hrs on 15 October 2023, Donna McWhinnie and Kofi Benefo, care assistants, entered Mr Cairney's cell to provide care. Concerns were noted regarding Mr Cairney's breathing which had become shallow and both carers noted that his condition had deteriorated. Kofi Benefo lifted up Mr Cairney's bed into a seated position so that he could breathe easier and the care assistants agreed to check on Mr Cairney every hour to provide extra care if required.

[29] Between approximately 0000 hrs and 0300 hrs on 15 October 2023, Donna McWhinnie and Kofi Benefo carried out hourly checks on Mr Cairney.

[30] At approximately 0300 hrs on 15 October 2023, Donna McWhinnie and Kofi Benefo entered Mr Cairney's cell to provide care. They considered that Mr Cairney's condition had slightly improved and that he was breathing a bit easier, however, he was still breathing intermittently. Mr Cairney took a drink of irn bru whilst they were in his cell. The care assistants agreed to go back to checking Mr Cairney every 2 hours due to his improved condition.

[31] At approximately 0615 hrs on 15 October 2023, Donna McWhinnie and Kofi Benefo entered Mr Cairney's cell and observed him to be unresponsive. They checked to see if he was breathing but found that his chest was not moving. No attempts were made to resuscitate Mr Cairney due to the DNACPR in place. They arranged for a manager to be informed that Mr Cairney was not breathing.

[32] At approximately 0630 hrs on 15 October 2023, Mark McLeod, prison officer, attended at Mr Cairney's cell and made arrangements for the emergency services to be contacted.

[33] Paramedic Kris O'Brien attended the prison and pronounced Mr Cairney's life extinct at 0725 hrs on 15 October 2023.

**Post-Mortem**

[34] On 20 October 2023 a post-mortem examination of Mr Cairney's body was conducted by Consultant Forensic Pathologist, Dr Tracy Sorkin.

[35] The cause of death was certified as 1a) Complications of acute bronchopneumonia; and 2) Ischaemic heart disease, hypertension, diabetes mellitus.

**Submissions**

[36] All parties submitted that formal findings only should be made in terms of section 26(2)(a) and 26(2)(c) and that no findings should be made in respect of the other elements of the section.

**Conclusions**

[37] On the basis of the evidence presented at the inquiry I am satisfied that I should make formal findings in terms of sections 26(2)(a) and (c) only. I have set out those findings above.

[38] On the available evidence at the inquiry I have determined that Mr Cairney died from complications of acute bronchopneumonia. A secondary cause was ischaemic heart disease, hypertension, diabetes mellitus. Mr Cairney was an elderly man who was admitted to Edinburgh Royal Infirmary with severe pneumonia on 28 August 2023, when it was discovered that he had not been taking his medication or eating and drinking for 10 days. On 3 September 2023 medical records note that he may be at the end of his life. By the time he returned to HMP Edinburgh on 7 October 2023 he was in full time bed care and a DNAR was in place due to his severe frailty.

[39] Although it does not appear that checks were carried out between 0300 hrs and 0615 hrs on the morning of his death, I have not identified any systemic defects arising or precautions that might have been taken to avoid the death. I have not identified any matter that would require a finding beyond the formal findings in terms of

section 26(2)(a) and (c) of the Act. I am satisfied that it would not be appropriate to make any recommendations in terms of section 26(1)(b) of the Act.

[40] I would like to extend condolences on behalf of all of the parties and the court to Mr Cairney's family for their loss.