SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT STIRLING

[2026] FAI 15

STI-B218-25

DETERMINATION

BY

SHERIFF EUAN GOSNEY

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

into the death of

WILLIAM MACDOWELL

STIRLING, 30 March 2026

Determination

The Sheriff, having considered the evidence presented at an inquiry on 12 March 2026 and oral submissions thereon, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereafter referred to as "the Act") that:

Findings:

(a) In terms of section 26(2)(a) of the Act, when and where the death occurred:

William MacDowell died at 1047 hours on 15 February 2023 at Forth Valley Royal Hospital, Larbert.

(b) In terms of section 26(2)(b) of the Act; when and where any accident resulting in the death occurred:

His death was not the result of an accident

(c) In terms of section 26(2)(c) of the Act; the cause or causes of the death:

The cause of William MacDowell's death was:

(i) Clinically diagnosed decompensated cardiac failure in association with hypertension, alcoholic liver cirrhosis and lymphoplasmacytic lymphoma

(d) In terms of section 26(2)(d) of the Act; the cause or causes of any accident resulting in the death:

His death was not an accident

(e) In terms of section 26(2)(e) of the Act; any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided:

There were no precautions which could reasonably have been taken whereby his death might realistically have been avoided.

(f) In terms of section 26(2)(f) of the Act; any defects in any system of working which contributed to the death or any accident resulting in death:

There were no defects in any system of working which contributed to his death.

Recommendations

In terms of section 26(1)(b) of the Act, there are, on the available evidence, no recommendations to be made.

NOTE

Introduction

[1] This is an inquiry into the death of William MacDowell. At the time of his death Mr MacDowell was a serving prisoner at HMP Glenochil. This is, accordingly, a mandatory inquiry held under section 2(4) of the Act.

[2] The Procurator Fiscal issued a notice of inquiry on 31 October 2025. A Preliminary Hearing was held on 7 January 2026 by Webex. The inquiry was held at Stirling Sheriff Court on 12 March 2026.

[3] Ms Townsend, Procurator Fiscal Depute, represented the Crown. Mr Halley, solicitor, represented the Scottish Ministers acting through the Scottish Prison Service ("SPS"). Ms Souter, solicitor, represented the Forth Valley Health Board. The next of kin of Mr MacDowell, having been intimated upon, elected not to observe the inquiry.

The legal framework

[4] This inquiry was held under section 1 of the Act. The relevant procedural rules are found in the Act of Sederunt (Fatal Accident Inquiry Rules 2017) ("the 2017 rules"). The purpose of the inquiry as defined by section 1(3) of the Act is to:

(a) establish the circumstances of the death and:

(b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances

It is not the purpose of the inquiry to establish civil or criminal liability.

[5] Section 26 of the of the Act requires the sheriff to make a determination which, in terms of section 26(2), is to set out the facts relevant to the circumstances of the death, in so far as they have been established, to his satisfaction. These are:

(a) when and where the death occurred;

(b) when and where any accident resulting in the death occurred;

(c) the cause or causes of death;

(d) the cause or 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 factors which are relevant to the circumstances of the death.

[6] In terms of section 26(1)(b) and 26(4) of the Act, the inquiry is to make such recommendations (if any) 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 steps which might realistically prevent other deaths in similar circumstances.

Facts and circumstances

[7] All the facts were agreed between the parties and were contained in an extensive joint minute. Productions were agreed in the joint minute and subsequently lodged in process.

Responsibility for healthcare services

[8] Since 1 November 2011, each individual regional NHS health board has been responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision so medical care.

Background

[9] Mr MacDowell was born on 3 October 1941 and died on 15 February 2023. At the time of his death, he was 81 years of age and was in legal custody at Forth Valley Royal Hospital under GEOAmey escort on transfer from HMP Glenochil.

[10] On 29 September 2022, Mr MacDowell was sentenced to a life sentence with a punishment part of 30 years having been convicted of murder and attempts to defeat the ends of justice.

Underlying health conditions

[11] Mr MacDowell had a medical history of lymphoplasmacytic lymphoma, heart failure, alcohol related liver cirrhosis, oesophageal varices, chronic hyponatraemia, gout, atrial fibrillation and hypertension. At the time of his death, he was prescribed a number of medications, including omeprazole, oxycodone, midazolam, bisoprolol and pregabalin.

[12] Prior to entering prison Mr MacDowell was known to the palliative care service in Carlise for his lymphoma.

[13] That on 17 August 2022, prior to Mr MacDowell entering prison, a Do Not Attempt Cardiopulmonary Resuscitation form was put in place for him.

[14] Following consultation with Dr Roxburgh on 30 September 2022, Mr MacDowell was assessed to be stable but at risk of sudden decline.

[15] On 23 November 2022 William MacDowell was transferred from HMP Grampian to HMP Glenochil in order that his care needs could be more appropriately managed. He was then under the care of Dr Jack Kildare. When Mr MacDowell arrived at HMP Glenochil he was already on palliative care and was wheelchair bound. His prognosis was assessed to be very poor and his life expectancy was deemed to be weeks to a couple of months

[16] Mr MacDowell resided within a single cell within Abercrombie 3 at HMP Glenochil. In the months preceding his death, Mr MacDowell was under regular care He was seen routinely by Dr Kildare or members of his team. The purpose of

Mr MacDowell's care was primarily to make the end of his life as comfortable as possible and manage any pain.

[17] In the months preceding Mr MacDowell's admission to hospital, his health steadily declined.

Circumstances of death

[18] On 6 February 2023, carers noticed that Mr MacDowell's right hand was swollen. Medical staff were asked to review him. Mr MacDowell was seen by Staff Nurse Nicola Marshall who discussed Mr MacDowell's medication with Advanced Nuse Practitioner Louise Kane. Ms Kane confirmed that Mr MacDowell was already on maximum diuretics without interfering with his kidney function and that as long as his capillary refill was fine and a radial pulse could be felt, the swelling should be monitored for worsening. Mr MacDowell was listed for a further review the following morning.

[19] On 7 February 2023 Mr MacDowell was reviewed by Advanced Nurse Practitioner Jackie McKeich and Advanced Nuse Practitioner Louise Kane. Mr MacDowell reported feeling unwell and had difficulty maintaining sentences. Increased shortness of breath was evident, as was pitting oedema to his legs, saddle area, back abdomen and right arm. Dr Kildare was contacted and it was decided that Mr MacDowell should be admitted to hospital. Mr MacDowell was conveyed by ambulance to Forth Valley Royal Hospital and admitted to the Acute Assessment Unit.

[20] On 7 February 2023 Mr MacDowell was admitted to Forth Valley Royal Hospital with exacerbation of his cardiac failure and fluid overload. He was provided palliative, end of life, care.

[21] Mr MacDowell was reviewed regularly by medical staff throughout his admission to Forth Valley Royal Hospital. He was on 24-hour guard by prison custodial officers. At 2200 hours on 7 February 2023 GEOAmey officers arrived and transferred responsibility from SPS officers. Following a Handcuffing Risk Assessment being carried out, it was deemed that no mechanical restraints would be necessary and Mr MacDowell remained uncuffed throughout his period of hospitalisation.

[22] On 13 February 2023, Mr MacDowell's next of kin were contacted by Forth Valley Royal Hospital staff and informed that Mr MacDowell's condition had declined and that he was dying. Mr MacDowell's family visited him on 14 February 2023 at 1430 hours and stayed with him until 1810 hours that evening.

[23] On 15 February 2023 at 0740 hours, GEOAmey officers alerted nursing staff that Mr MacDowell's breathing had changed and become laboured. Nursing staff entered Mr MacDowell's room to put in another IV line. Mr MacDowell's family were contacted by nursing staff in order to inform them that his condition had continued to deteriorate. Medical staff continued to provide additional medication to help with Mr MacDowell's breathing difficulties and to make him more comfortable. Mr MacDowell's oxygen mask was changed to an oxygen nasal cannula.

[24] At around 1000 hours on 15 February 2023, GEOAmey officers alerted NHS staff that Mr MacDowell appeared to not be breathing. Nurses entered Mr MacDowell's

room, confirmed that he had stopped breathing and arranged for a doctor to attend to confirm his death.

[25] At 1047 hours on 15 February 2023, Dr Anna Coogan pronounced Mr MacDowell's life extinct.

Post-mortem

[26] That on 9 March 2023 a postmortem examination of Mr MacDowell's body was conducted by Consultant Forensic Pathologist Dr Ralph BouHaider.

[27] A toxicology analysis was carried out on Mr MacDowell's hospital blood samples. Dr BouHaider concluded that there were no findings on toxicology to explain his death.

[28] The cause of death was certified as 1a. Clinically diagnosed decompensated cardiac failure in association with hypertension, alcoholic liver cirrhosis and lymphoplasmacytic lymphoma.

Death in Prison Learning, Audit and Review

[29] A Death in Prison Learning, Audit and Review ("DIPLAR") is completed after the death of any person in prison custody in Scotland and provides a system for SPS and the applicable NHS Board to record and learning and identify actions following a death.

[30] On 7 April 2023, a DIPLAR was carried out by SPS and NHS Forth Valley. No learning points have been identified.

Submissions

[31] All the parties submitted that only mandatory findings under sections 26(2)(a) and 26(2)(c) should be made. No findings in terms of section 26(2)(b), (d), (e), (f) or (g) were sought, nor any recommendations.

Analysis and conclusions

[32] Having considered all the evidence in this inquiry, my findings are in line with the conclusions of the DIPLAR. Mr MacDowell had an extensive history of physical health problems. There was good information sharing between SPS and Forth Valley. Mr MacDowell received compassionate care as well as a good level of care planning around his daily care needs, consistent reviews and palliative considerations in order to manage his symptoms. There was no evidence to suggest any precautions which could reasonably have been taken whereby his death might realistically have been avoided; nor any defects in any system of working which contributed to his death.