**SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS**

**[2026] FAI 38**

INV-B89-26

DETERMINATION

BY

SHERIFF GARY AITKEN

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

into the death of

**JOHN CALDERWOOD GALLAGHER**

INVERNESS, 15 July 2026

**Determination**

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

**In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred)**

The late John Calderwood Gallagher, born 3 November 1951, died at 1545 hours on 2 February 2024, at room 3, ward 7A, Raigmore Hospital, Old Perth Road, Inverness.

**In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in the death occurred)**

The death of said John Calderwood Gallagher was as a result of a medical condition, not an accident.

**In terms of section 26(2)(c) of the 2016 Act (the cause or causes of the death)**

The cause of the death of said John Calderwood Gallagher was metastatic squamous cell lung carcinoma.

**In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death)**

This section is not relevant in relation to the death of said John Calderwood Gallagher.

**In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)**

There are no precautions which could reasonably have been taken and had they been taken, might realistically have resulted in the death of said John Calderwood Gallagher being avoided.

**In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)**

There were no defects in any system of working which contributed to the death of said John Calderwood Gallagher.

**In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death)**

There are no other facts relevant to the circumstances of the death of said John Calderwood Gallagher.

**Recommendations**

**In terms of sections 26(1)(b) of the 2016 Act (recommendations (if any) 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances)**

There are no recommendations made.

**NOTE**

**Legal framework**

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This fatal accident inquiry was presented by the Crown as a

mandatory inquiry in terms of section 2 of the 2016 Act as John Calderwood Gallagher (hereinafter referred to as "Mr Gallagher") died while in legal custody.

[2] The purpose of this inquiry is set out in subsection 3 of section 1 of the 2016 Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding, not fault finding. It is not open to me to engage in speculation. The inquiry is an inquisitorial process. The Crown, in the form of the procurator fiscal, represents the public interest.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely where and when the death occurred, when any accident resulting in the death occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the sheriff to make recommendations in relation to matters set out in subsection 4 of section 1 of the 2016 Act.

**Introduction**

[4] This inquiry was held into the death of John Calderwood Gallagher. He was a 72 year old man who was in legal custody. He died on 2 February 2024. In late 2023 Mr Gallagher had been diagnosed with lung cancer.

[5] A preliminary hearing was held by Webex at Inverness Justice Centre on 27 April. Continued preliminary hearings were held by Webex at Inverness Justice Centre on 1 May 2026, 8 May 2026 and 10 June 2026. It was clear that the evidence was not likely to be disputed and the Crown undertook to prepare a joint minute of agreement.

[6] The inquiry proceeded by Webex at Inverness Justice Centre on 29 June 2026. Mr Tweedie, procurator fiscal depute, represented the Crown. Ms Shaw, solicitor, represented the Scottish Ministers acting through the Scottish Prison Service (hereinafter referred to as "SPS"). Ms Gormley, solicitor, represented the Highland Health Board (hereinafter referred to as "NHS Highland") and Mr Cole, solicitor, represented Mr Gallagher's next of kin. No other parties were represented. Parties lodged a substantial joint minute of agreement. I accepted the facts set out in the joint minute of agreement. The findings in fact listed at paras [9] to [40] below are derived from the joint minute of agreement.

[7] The Crown also lodged an inventory of documentary productions as follows:

1. Intimation of death
2. Medical certificate of cause of death
3. Post-mortem report
4. Death in custody folder
5. PR2 records
6. Death in prison learning audit and review
7. GP medical records

8. Hospital medical records part 1

9. Hospital medical records part 2

10. Hospital medical records part 3

11. Hospital medical records part 4

12. Hospital medical records part 5

13. Witness statement – Sylvia Gallagher

14. Witness statement – Kenneth Macleod

15. Witness statement – Diane Ross

16. Witness statement – Fiona Clark

17. Witness statement – Lee Manson

18. Witness statement – Doctor Stephen Thomas

19. Witness statement – Doctor Edward Patterson

20. Witness statement – Doctor James Fraser

21. Witness statement – Louise Patience

22. Witness statement – Laura Smith

23. Witness statement – Tracy Milton

24. Witness statement – Elizabeth McIntosh

25. Witness statement – Rosalyn Milne

26. Scottish Government DNACPR integrated adult policy document

[8] There being no dispute between parties as to the evidence the inquiry proceeded on the basis of the joint minute of agreement, which was read by Mr Tweedie.

**The facts**

***Background***

[9] At the date of his death on 2 February 2024, Mr Gallagher was aged 72, having been born on 3 November 1951.

[10] At the time of his death, Mr Gallagher was in legal custody at His Majesty's Prison Inverness, Duffy Drive, Inverness, IV2 3HH (hereinafter referred to as "HMP Inverness") under transfer to Raigmore Hospital, Old Perth Road, Inverness, IV2 3UJ.

[11] Mr Gallagher's death occurred within Raigmore Hospital, Inverness on 2 February 2024 and his life was pronounced extinct at 1545 hours by Doctor Edward Patterson.

[12] As a result of a criminal conviction in 1979 Mr Gallagher was subject to licence conditions for the rest of his life. That on 10 November 2023, the Parole Board for Scotland, in terms of a licence revocation order under section 17 of Prisoners and Criminal Proceedings (Scotland) Act 1993, determined that Mr Gallagher's licence should be revoked and recommended to the Scottish Ministers that he be recalled to custody. The decision to revoke Mr Gallagher's licence was taken having regard to information available to the Parole Board at that time. It was ordered that Mr Gallagher be returned to HMP Inverness. Accordingly, Mr Gallagher was in legal custody at the time of his death.

*Healthcare provision in Scotland prisons*

[13] On 1 November 2011, the responsibility for the provision of healthcare to prisoners transferred from the SPS to the NHS. Since then, NHS health boards have been responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care. NHS Highland is responsible for the provision of healthcare to prisoners in HMP Inverness.

*Medical history and treatment*

[14] Mr Gallagher has a past medical history which included the following conditions:

- Childhood pulmonary tuberculosis (required inpatient care for 2 years) (1962)
- Traumatic chest injury (2015)
- Chronic kidney disease stage 2
- Atrial fibrillation

[15] Mr Gallagher did not have a history of poor mental health and had not engaged with community mental health.

[16] On 15 November 2023, Mr Gallagher attended his first clinic appointment at the "urgent suspicion of cancer clinic". He was thereafter referred for a biopsy, a CT scan of his head, and PET scan of his body.

[17] On 30 November 2023, Mr Gallagher commenced MST for pain relief. The dosage was increased by the prison general practitioner due to the significant pain

experienced by Mr Gallagher. In addition, he was prescribed two additional doses of short-acting morphine at night while in prison

[18] On 1 December 2023, a meeting was held in HMP Inverness, chaired by acting governor in charge Mark Holloway and attended by Jackie McCauley, head of residential; David Ross, residential first line manager; Marion Gilles, NHS team lead; and Katie Dobson, NHS prison-based nurse. At that meeting, NHS advised that HMP Inverness were reaching the limit of the care that could be provided to Mr Gallagher as there was a deterioration event. Mr Gallagher was in a single cell so the issue of how to safely monitor him through the night given his laboured breathing and other side effects from his conditions were becoming a concern as the prison had no nurses on duty throughout the night.

[19] It was also stated that SPS staff could not hold Oramorph for the purposes of administering it to Mr Gallagher, as it is a controlled substance. Furthermore, there was a risk to Mr Gallagher should he be provided with larger quantities to administer and retain in his possession.

[20] A controlled quantity of medication was agreed upon, and Mr Gallagher was provided with a safety alarm for use during the night, together with extra blankets and bedding for comfort and warmth.

[21] On 19 December 2023, Mr Gallagher was advised of the results of his investigations. It was confirmed that he had metastatic squamous cell carcinoma of the lung, which was terminal and considered to be a life-limiting condition. As a result of

his cancer diagnosis, Mr Gallagher also experienced severe bone pain due to metastatic spread and had difficulty swallowing as a result of oesophageal compression.

[22] Mr Gallagher was admitted to Raigmore Hospital, Inverness on 19 December 2023 and remained an inpatient there until 5 January 2024. Mr Gallagher underwent insertion of an oesophageal stent due to compression caused by the tumour, which had prevented him from being able to eat or drink without vomiting. The stent successfully relieved the obstruction, and he was thereafter able to tolerate a soft diet. On 28 December 2023, Mr Gallagher underwent radiotherapy treatment to his right rib.

***Care plan***

[23] From 1 December 2023, Mr Gallagher was managed under a patient support plan. This was a multidisciplinary plan involving both SPS staff and prison healthcare staff. The plan recorded presenting issues, set out agreed goals and interventions, and provides for ongoing review. A number of case conferences were scheduled to take place during December 2023; however, these did not go ahead as Mr Gallagher was an inpatient in hospital at that time. Following his discharge on 5 January 2024, case conferences in respect of his care resumed. On 8 January 2024 and 15 January 2024, case conferences 1 and 2 took place. These case conferences involved input from both SPS and healthcare staff, and addressed matters including medication management, family contact and visits, potential transfer options, location within the establishment, assessment of risk and prognosis, dietary requirements, telephone access, and consideration of an application for compassionate release. Mr Gallagher was thereafter

admitted to hospital on 28 January 2024, following which no further case conferences took place.

[24] During Mr Gallagher's time in custody, palliative care pathways and applicable NHS clinical guidance were followed by prison healthcare staff. The SPS took appropriate steps to support and facilitate that care within the custodial setting. NHS prison healthcare staff advised that the care available within the prison was approaching the limits of what could be provided. Highland Hospice was contacted in relation to end of life care. A night-time dose of Oramorph was left within Mr Gallagher's cell for self-administration at a time when NHS staff were not available. The palliative care advice line was utilised on a frequent basis by NHS prison healthcare staff and was also included on Mr Gallagher's phone numbers. Mr Gallagher was also offered a soft food diet to assist with swallowing.

***Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR")***

[25] In May 2010, the Scottish Government published the NHS Scotland document entitled, "Do Not Attempt Cardiopulmonary Resuscitation - Integrated Adult Policy". That policy was reviewed in August 2016 and applies to all NHS Scotland staff and the care of adult patients in all care settings within the remit of NHS Scotland. Therefore, it applies to all NHS Scotland staff working within Scottish prisons. On 11 August 2023, the SPS issued a Governors and Managers Action Notice. The purpose of that notice was to provide guidance on Do Not Attempt Cardiopulmonary Resuscitation. It also

described the Do Not Attempt Resuscitation policy and the associated implications for the Scottish Prison Service.

[26] On 7 January 2024, a discussion took place at Raigmore Hospital, Inverness in relation to the DNACPR form relating to Mr Gallagher. A request was also made for a mental health assessment, and a STORM assessment was completed. On 8 January 2024, Doctor James Fraser agreed that it was appropriate for the DNACPR decision to remain in place. On 14 January 2024, Mr Gallagher expressed a wish for the DNACPR decision to be revoked. On 15 January 2024, Mr Gallagher was reviewed by Doctor James Fraser, following which the DNACPR decision remained in place. On 29 January 2024, a DNACPR decision remained in place.

***Medication***

[27] Mr Gallagher was prescribed the following regular medication:

- Aspirin tablets: 75mg, administered once daily
- Laxido sachets: 1 sachet, administered twice daily
- Metoclopramide solution: 5mg/5ml; 10mls, administered three times daily, as required
- Lansoprazole tablets: 30mg, administered once daily
- Paracetamol suspension: 250mg/5ml; 20mls, administered four times a day
- Hypromellose 0.3% eye drops: 1 drop; topical to left, administered four times a day
- Dexamethasone tablets: 6mg, administered once daily

- Morphine sulphate solution: 10mg/5ml, 50mg, administered up to every 4 hours, as required
- Morphine sulphate (MST) modified-release tablets: 150mg, administered twice daily
- Ibuprofen suspension: 400mg, administered three times daily
- Thiamine tablets: 100mg, administered three times daily
- Forceval (soluble tablets): 1 tablet, administered once daily
- Mirtazepine tablets: 15mg, administered once at night
- Sodium picosulfate: 1mg/1ml, 10mls, administered once at night
- Betnovate 0.1% ointment: administered twice daily
- Diazepam tablets: 5mg, 4 hourly for agitation; maximum four times daily

***Circumstances of death***

[28] On 21 November 2023, upon admission to HMP Inverness, a Talk To Me (TTM) Reception Risk Assessment (RRA) was completed in respect of Mr Gallagher. He was assessed as presenting no such risk and was thereafter housed within A Wing. On 1 December 2023, Mr Gallagher was moved to cell A1/05; a disabled cell located on the ground floor of HMP Inverness, due to his lung cancer diagnosis and associated care needs. At this time, he had reduced mobility and was assessed as unfit for allocation to a top bunk.

[29] On the morning of 28 January 2024, at approximately 0825 hours, Prison Officers Grant MacPherson and Daniel Fraser were on duty within in A Hall. During the course

of their routine numbers check, they attended Mr Gallagher's cell to escort him to the health centre for the administration of his medication. At that time, Mr Gallagher was observed to be experiencing difficulty breathing and stated that he required fresh air, as he was feeling extremely hot. Mr Gallagher advised prison staff that he was "struggling" and that, due to the pain he was experiencing, he would be unable to attend the health centre. Prison officers thereafter contacted healthcare staff and requested they attend at his cell. On the morning of Sunday 28 January 2024, Senior Staff Nurse Tracy Milton and Staff Nurse Elizabeth McIntosh were on duty. Both were advised by the aforementioned prison officers that Mr Gallagher was unwell, and they attended his cell without delay. On arrival, Mr Gallagher was observed to be seated on a chair by the grill gate in an effort to obtain fresh air. He appeared unwell, was noted to be weak, and was observed to be drooling from the side of his mouth. His speech was also observed to be slurred. Clinical observations were undertaken by healthcare staff in attendance. Mr Gallagher's respiratory rate was recorded at 23 breaths per minute. His oxygen saturation was initially recorded at 76% improving to 88%. During engagement with healthcare staff, his oxygen saturation increased to 96% and his respiratory rate reduced to 18 breaths per minute. Medication, including MST and Oramorph, was administered.

[30] Due to her concern regarding Mr Gallagher's presentation and his current clinical condition, Nurse McIntosh requested that an emergency ambulance be called. At 0841 hours, prison gate staff placed a call requesting that an emergency ambulance

attend the prison, and at 0846 hours a Scottish Ambulance Service (hereinafter referred to as "SAS") team arrived at the prison.

[31] Senior Staff Nurse Milton noted that, upon the arrival of the SAS team, Mr Gallagher's condition had improved and that his clinical observations had stabilised. It was also noted that Mr Gallagher stated that he was content to remain in prison, as his pain was beginning to ease. In light of that improvement and having regard to his existing care pathway and known terminal illness, the SAS team determined that transfer to hospital for accident and emergency admission was not required at that time. At 0920 hours, the SAS team departed from the prison without Mr Gallagher.

[32] Following the departure of the SAS team, Mr Gallagher continued to report breathlessness. Staff Nurse McIntosh, having ongoing concerns regarding his condition, contacted the out of hours duty doctor. It was also noted that there would be no nursing staff on duty after 1715 hours, and concern was expressed regarding the potential risk to Mr Gallagher should he remain within the prison.

[33] The out of hours duty doctor, having been advised of the circumstances, determined that Mr Gallagher required admission to hospital, and arrangements were made for a bed to be available for him within ward GA at Raigmore Hospital, Inverness. At 1041 hours, Mr Gallagher arrived at Raigmore Hospital and was admitted to ward GA. He was at that time assessed by Doctor Muir. At 1624 hours, the same day, Mr Gallagher was reviewed by Doctor Ana Paosinho, consultant. It was noted that Mr Gallagher had experienced a severe headache, followed by blurred vision. He had no scotoma and no nausea. It was further noted that he had developed right-sided facial

droop and word finding difficulties. These symptoms resolved at 0900 hours following the administration of pain relief. Doctor Paosinho recorded that Mr Gallagher thereafter exhibited no further symptoms. The senior clinical impression was either a migraine or a Transient Ischaemic Attack (TIA). A plan was discussed, and it was noted that Mr Gallagher was reluctant to return to prison, a concern which was also shared by prison staff. It was noted that Mr Gallagher was accommodated within a disabled area of the prison, with minimal staffing and no nursing staff on site over the weekend. It was agreed that he could be discharged the following morning at 0600 hours.

[34] On 29 January 2024, at 0854 hours, Mr Gallagher was reviewed by Doctor Mohammad Safadi. It was noted that on observations taken that morning that Mr Gallagher was hypoxic, with oxygen saturation recorded at 88%, (previously 99%). Mr Gallagher reported a sudden onset of pleuritic chest pain radiating across his back and into his jaw and was also noted to be short of breath. It was further noted that Mr Gallagher had a known history of dysphagia secondary to oesophageal compression from lung cancer and had reported episodes of chocking. Doctor Safadi's clinical impression was of aspiration pneumonia, having regard to unilateral changes on his chest x-ray. It was further noted that the severity of the hypoxia and radiological findings raised the possibility of a contributory element of fluid overload. Mr Gallagher was treated with intravenous antibiotics.

[35] At approximately 1017 hours, same date, Mr Gallagher was further reviewed by Doctor Stephen Thomas, consultant respiratory physician. The clinical impression was recorded as aspiration pneumonia. The management plan included that Mr Gallagher

be made nil by mouth and commenced on intravenous fluids. The clinical notes further record that Doctor Thomas discussed DNACPR with Mr Gallagher. It was additionally noted that, in the event that Mr Gallagher did not improve and his condition deteriorated, further discussions would be required regarding a palliative approach, with palliation identified as the primary objective of care.

[36] On 1 February 2024 Mr Gallagher's condition began to deteriorate. He was noted to be short of breath, to be experiencing increased pain, and to be feeling generally weaker. Doctor Patterson reviewed Mr Gallagher's condition on a daily basis. Nursing staff carried out observations at 30-minute intervals throughout each day. Throughout this period, Mr Gallagher was accompanied within his room by two prison officers at all times.

[37] On 2 February 2024, Doctor Patterson commenced his shift at 0900 hours. At approximately 1000 hours he completed a review of Mr Gallagher. At that time, Mr Gallagher advised Doctor Patterson he had slept well overnight but reported pain on the right side of his chest and continued difficulty with eating. Doctor Patterson noted that Mr Gallagher has been experiencing frequent nosebleeds, and the plan was to continue with a driver syringe. Doctor Patterson discontinued intravenous antibiotics, fluids and oxygen therapy. Mr Gallagher was thereafter left in the care of ward staff.

[38] At 1350 hours the same day Doctor Patterson was advised by nursing colleagues that Mr Gallagher had begun coughing up blood. Upon attending at his room, Doctor Patterson observed that Mr Gallagher was dying. Mr Gallagher's wife and daughter were present on the ward and remained with him in the room, together with

hospital medical staff. In light of the circumstances, the prisoner officers who were in attendance positioned themselves outside the room in order to afford privacy and dignity to Mr Gallagher and his family. Mr Gallagher's family requested that the hospital chaplain, Cate Otanes, be present at the time of his death and arrangements were made accordingly.

***Post-mortem***

[39] A post-mortem examination was carried out on 6 February 2024 by Doctor Natasha Inglis, consultant pathologist. The medical cause of death was recorded as:

1. Ia Metastatic squamous cell lung carcinoma.

[40] The conclusion section of the Doctor Inglis' post-mortem report states as follows:

> "From the reported circumstances of the case and post-mortem findings I am of the opinion that this man has died as a result of end stage metastatic squamous cell carcinoma of the lung. The history of vomiting possibly suggests that either the tumour has eroded into his oesophagus causing a catastrophic bleed or that he was actually coughing up blood, again due to a catastrophic terminal haemorrhage of the tumour."

**The evidence**

[41] Mr Tweedie intimated that all the evidence to be presented at the inquiry was contained within the joint minute of agreement, which he read out.

[42] The salient facts from the joint minute of agreement are noted above and the principal joint minute of agreement is lodged with the inquiry papers. Ms Shaw,

Mr Cole and Ms Gormley confirmed that no additional evidence was to be led by the other interested parties.

**Crown submissions**

[43] Mr Tweedie very helpfully lodged written submissions on behalf of the Crown. He made formal submissions in relation to when and where Mr Gallagher's death occurred, based on the evidence contained in the joint minute of agreement. Likewise, he made formal submissions in relation to the cause of Mr Gallagher's death, in accordance with the findings of Doctor Inglis, the pathologist, at autopsy.

[44] Mr Tweedie did not propose that any findings should be made in relation to sections 26(2)(b), (d), (e), (f) or (g) of the 2016 Act and did not propose that any recommendations be made in relation to section 26(1)(b) of the 2016 Act.

**Submissions on behalf of the SPS**

[45] Ms Shaw had also very helpfully lodged written submissions on behalf of SPS.

[46] Ms Shaw submitted that I should make formal findings in relation to sections 26(2)(a) and (c) of the 2016 Act, in line with the submissions of the other parties, and that no further findings were appropriate in the circumstances of Mr Gallagher's death.

**Submissions on behalf of Mr Gallagher's next of kin**

[47] Mr Cole had also very helpfully lodged written submissions on behalf of Mr Gallagher's next of kin.

[48] Mr Cole submitted that I should make formal findings in relation to sections 26(2)(a) and (c) of the 2016 Act, in line with the submissions of the other parties, and that no further findings were appropriate in the circumstances of Mr Gallagher's death.

**Submissions on behalf of NHS Highland**

[49] Ms Gormley had also very helpfully lodged written submissions on behalf of NHS Highland.

[50] Ms Gormley submitted that I should make formal findings in relation to sections 26(2)(a) and (c) of the 2016 Act, in line with the submissions of the other parties, and that no further findings were appropriate in the circumstances of Mr Gallagher's death.

**Discussion and conclusions**

[51] Taking into account the circumstances of Mr Gallagher's death I am satisfied that the formal findings suggested by all parties to this inquiry are appropriate and sufficient in this case. Mr Gallagher's death was due to his medical condition. His being in legal custody at the time did not contribute to that.

[52] No submissions were made to the effect that any precautions could reasonably have been taken which might realistically have resulted in Mr Gallagher's death being avoided, or that any defect in any system of working had contributed to his death.

[53] In those circumstances I make the formal findings required by the 2016 Act. I concur with the submissions made by Mr Tweedie and endorsed by Ms Shaw, Mr Cole and Ms Gormley and I adopt the submissions made by parties in relation to my findings under section 26(2)(a) and (c) of the 2016 Act, as set out above.

[54] In closing this determination, may I join with parties in expressing my condolences to the family and friends of Mr Gallagher. There can be few families in Scotland, or anywhere, who have not been adversely affected by cancer to some extent. It is a cruel disease and despite significant medical advances remains a fatal diagnosis for many people. Sadly, Mr Gallagher was one of those people. Perhaps one day cancer will, finally, be beaten. Mr Gallagher's death is no doubt still very keenly felt by his family.