SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2026] FAI 22

EDI-B848-25

DETERMINATION

BY

SUMMARY SHERIFF ADRIAN FRASER

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

into the death of

KEITH MUNRO

Edinburgh 21 May 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 Keith Munro, born on 22 September 1965, died on 15 November 2022 at the Marie Curie Hospice, Frogston Road West, Edinburgh. His life was formally pronounced extinct at 1920 hours by Charge Nurse Robert Prezkwaz.

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

The death of Mr Munro was not attributable to any accident.

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

The cause of death of Mr Munro was:

1a Complications of metastatic oesophageal cancer**.** This was evidenced by the presence of an oesophageal tumour which extended into the stomach, through the diaphragm, around the spleen and adrenal glands and into the omentum. There was an accumulation of a large volume of fluid within the abdominal cavity and in addition bronchopneumonia, complications of his tumour.

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

Mr Munro's cause of death did not result from an accident.

In terms of section 26(2)(e) (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 (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death 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.

In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

There are no other facts which are relevant to the circumstances of Mr Munro's death.

Recommendations

In terms of section 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

Having considered the information presented at the Inquiry, I make no recommendations in terms of Section 26(1)(b) of the Act.

NOTE

Introduction

[1] This was a mandatory Fatal Accident Inquiry in terms of section 2(4)(a) of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act").

Mr Munro's death occurred while he was in legal custody, being a prisoner in His

Majesty's Prison, Edinburgh, 33 Saughton Road, Edinburgh, under transfer to the Marie Curie Hospice, Edinburgh, at the time of his death.

Proceedings and parties

[2] Notice of the Inquiry was given by the procurator fiscal on 19 June 2025. A preliminary hearing was held at Edinburgh Sheriff Court on 06 August 2025. I assigned a procedural hearing on 19 September 2025 for further preparation by parties and to review the position in respect of participation by and possible legal representation of Mrs Mary Jayne Munro, the widow of the late Mr Keith Munro, and Dr McAvoy, the Lothian Health Board Consultant Gastroenterologist, the hospital clinician who triaged the initial referral on 11 March 2021 of Mr Munro to hospital services for a possible upper gastro-intestinal malignancy.

[3] On 19 September 2025, a procedural hearing was assigned on 11 November 2025 to allow further time for preparation and to await a report instructed by Lothian Health Board from Dr Stephen Falk, Consultant Clinical Oncologist.

[4] On 11 November 2025 I authorised the evidence of Dr Falk and Dr Jin-Yong Kang, Consultant Gastroenterologist Kang, a Crown witness, to be given by video-link. I assigned a procedural hearing on 25 November 2025 to enable Dr Falk's report to be lodged and considered.

[5] On 25 November 2025, I allowed a comprehensive joint minute of agreement of evidence, tendered at the bar, to be received. It was in the final stages of revisal and agreed all but the evidence of Dr Kang and Dr Falk. I thereafter continued the hearing

to the Inquiry previously assigned on 04 and 05 December 2025. The parties submitted that the Inquiry could proceed with only oral evidence by Dr Kang and Dr Falk, and beyond that by relying on the statements of the witnesses in lieu of parole evidence as provided for in the joint minute, and the matters referred to in the joint minute, including the contents of productions. I agreed that this was appropriate and sufficient.

[6] The Inquiry proceeded at Edinburgh Sheriff Court on 05 December, 2025, which was the only date required for the reading of the joint minute of agreement and the hearing of evidence. The Crown were represented by Simon Gregor, Procurator Fiscal Depute. The Scottish Ministers representing the Scottish Prison Service were represented by Ms Lucy Thornton, Solicitor and Lothian Health Board was represented by Sean White, Advocate.

[7] The evidence at the Inquiry, as previously agreed, was presented partly by way of the reading of the detailed and comprehensive joint minute of agreement hereinbefore referred to signed by the Crown, the Scottish Ministers for the Scottish Prison Service, Lothian Health Board, and Andrew Pollock, Solicitor for Mary Munro, the widow of the late Keith Munro.

[8] There were no witnesses called by the Scottish Ministers as representing the Scottish Prison Service but one production was lodged, an email dated 25 November 2025 from the Admin Team Lead at HMP Edinburgh. This related to a cancelled appointment, whereby Mr Munro's initial endoscopy was rescheduled from 31 January 2022 to 18 February 2022. The email reads "This appt was rearranged to 18/02/22 by the

Hospital – Mr Munro was due to attend Leith Community Treatment Centre and they rescheduled it".

[9] At the conclusion of evidence, I continued the Inquiry to a hearing on submissions on 15 January 2026 and ordered all parties to lodge written submissions on or before 13 January 2026.

[10] I closed the Inquiry on 15 January 2026 and reserved my decision.

[11] The submissions of the parties as to formal findings on all but a finding under section 26(2)(g) of the Act concurred. I accepted that in so far as the submissions concurred these were accurate and correct based on the evidence agreed and the oral evidence of Dr Kang and Dr Falk. Accordingly, these are reflected in my formal findings. On a finding under section 26(2)(g) of the Act, both the Crown and Mr Pollock representing Mrs Mary Jayne Munro, the widow of the late Mr Keith Munro contended that I should make a finding that the triaging failure to place Mr Munro on the correct treatment referral Pathway was a fact relevant to the circumstances of Mr Munro's death. Mr White for Lothian Health Board submitted that no findings under section 26(2)(g) of the Act should be made. I accepted the submissions of Mr White on this matter in which he referred to the approach taken by Sheriff Guy in the Fatal Accident Inquiry into the death of Alistair Ian Findlay [2024] FAI 28. While the triaging failure to place Mr Munro on the correct Pathway is concerning, and Lothian Health Board have acknowledged and accepted that failure, I consider that it is not appropriate to make a finding that this was a fact relevant to the circumstances of Mr Munro's death.

The Legal framework

[12] The purpose of an Inquiry such as this is set out in section 1(3) 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. In terms of section 26 of the 2016 Act the Inquiry must determine the following matters:

(a) When and where the death occurred;

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

(c) The cause or causes of the death;

(d) The cause or causes of any accident resulting in the death;

(e) Any precautions which could reasonably have been taken which had they been taken might realistically have resulted in the death or any accident resulting in the death being avoided;

(f) Any defects in any system of working which contributed to the death; and

(g) Any other facts which are relevant to the circumstances of the death.

It is open to the sheriff to make recommendations in relation to the matters set out in subsection 4 of section 26 the 2016 Act.

[13] The Inquiry is not intended to establish civil or criminal liability. It is an exercise in fact finding, not fault finding. It is an inquisitorial process. It is not open to me to engage in speculation.

[14] The Procurator Fiscal represents the public interest. The Sheriff's determination must be based on the evidence presented at the Inquiry. The Sheriff's determination is

not admissible in evidence and may not be founded upon in any judicial proceedings of any nature.

The circumstances of the deceased and his death.

[15] Mr Munro, was born on 22 September 1965. At the time of his death he was 57 years of age.

[16] At the time of his death he was being held in legal custody at His Majesty's Prison Edinburgh, Saughton Road, Edinburgh, EH13 3LN under transfer to Marie Curie Hospice, Frogston Road West, Edinburgh, EH10 7DR.

[17] On 29 April 2010, at Edinburgh High Court, Mr Munro was sentenced to an Order for Lifelong Restriction, backdated to 24 August 2009, with a punishment part of 11 months.

[18] Mr Munro has previously been known by the name Keith Martin, or Keith Jordan. Reference to these names within the Crown productions are references to Mr Munro.

Provision of healthcare in Scottish Prisons

[19] On 1 November 2011, the responsibility 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 healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

Medical

[20] In February 2021, Mr Munro was a 55-year-old male. His previous medical history included *inter alia* angina; coronary artery disease; an angioplasty for his right coronary artery; bilateral inguinal hernia repair; and bilateral iliac angioplasty due to claudication. He had also been a smoker for a number of years.

Chronology of cancer diagnosis

[21] On 22 February 2021 Mr Munro attended Edinburgh Royal Infirmary complaining of chest pain. He reported a two-week period of difficulty swallowing (dysphagia) and was noted as having been anaemic. Mr Munro self-discharged from hospital against medical advice and was advised to contact the prison General Practitioner (hereinafter referred to as "the prison GP").

[22] On 01 March 2021, Mr Munro attended at the Western General Hospital for a chest x-ray, which confirmed that his lungs were essentially clear with no pleural effusion.

[23] On 02 March 2021 Mr Munro attended an appointment with the prison GP, on this occasion Dr William Smith, complaining of pain in his ribs from a fall. He reported a one-month history of food sticking in his mid-chest and he was noted to have iron deficiency. Dr Smith thereafter prescribed co-codamol, omeprazole, and ferrous fumarate, and referred Mr Munro to the Gastroenterology department at Edinburgh Royal Infirmary (Crown Production 15, Re-sorted Hospital Records Combining Crown

Production 4 and Crown Production 14 (hereinafter referred to as "Crown Production 15"); page 111 is the referral form). The letter included the words "urgent" and "? upper GI, meaning "gastro-intestinal", ("gastro-intestinal" being hereinafter referred to as "GI") malignancy".

[24] On 11 March 2021, Mr Munro's referral was triaged at hospital by Dr McAvoy, Consultant Gastroenterologist. Dr McAvoy placed him on the "urgent" referral pathway and he was placed on the waiting list for an upper endoscopy (gastroscopy). This was done in error. Mr Munro should, instead, have been placed on the "urgent suspicion of cancer" pathway. This is an error which was made by, and is accepted by, Lothian Health Board. It was made through human error.

[25] The "urgent" referral pathway is one of four different triage outcomes, being: "routine"; "urgent"; "urgent suspicion of cancer"; and "emergency", in ascending order of urgency. A routine referral in this context would generally indicate a low risk of cancer or significant benign pathology; an urgent referral would generally indicate a <1% positive predictive value for cancer based on symptoms; an urgent suspicion of cancer referral would generally indicate a >3% positive predictive value for cancer based on symptoms; and an emergency upper GI endoscopy referral would generally only be required for upper GI bleeding, food bolus obstruction and foreign body removal.

[26] Waiting list timeframes for gastroscopies in 2021, on the "urgent" and "urgent suspicion" of cancer pathways, were approximately 9-10 months and 21 days, respectively. These timeframes were longer than pre-pandemic (8-12 weeks and 2 weeks, respectively). That was due, in part, to delays and backlogs in treatment

during the Covid-19 pandemic (detailed in Louise Hanlon's witness statement, Lothian Health Board Production 3). Emergency referrals would typically be seen within 24 hours, and routine referrals would have much longer waiting times.

[27] On 19 April 2021, Mr Munro attended prison healthcare for a GP consultation complaining of swallowing difficulties, by which point a response was still awaited from the Gastroenterology referral made on 2 March 2021 (detailed in Crown Production 3, Prison Medical Records, page 17).

[28] On 11 May 2021, Mr Munro attended prison healthcare for a consultation with the prison GP, complaining of food sticking in his throat and low mood. Prison administrative staff checked the status of Mr Munro's referral with Edinburgh Royal Infirmary and were advised he was on the "urgent" waiting list for endoscopy (detailed in Crown Production 3, Prison Medical Records, page 17).

[29] On 19 June 2021, Mr Munro was reviewed by a prison nurse complaining of chest pain. An ambulance was called to take Mr Munro to hospital for assessment but he refused to go to hospital (detailed in Crown Production 3, Prison Medical Records, page 17).

[30] On 29 June 2021, Mr Munro was treated at the Accident & Emergency Department at St John's Hospital, Livingston, following an assault within the prison. He reported having been attacked with a kettle containing boiling water and sugar. He sustained burns to the face and chest, facial fractures resulting in nasal deviation and broken teeth. He was admitted.

[31] He was reviewed by the Cardiology Department following complaints of chest pain. The reviewing cardiologist noted some features in keeping with angina and recommended increasing anti-anginal therapy. He also noted that Mr Munro had ongoing GI symptoms and that he was awaiting GI investigations (detailed in Crown Production 3, Prison Medical Records, page 124). Mr Munro remained an inpatient until he was discharged on 01 July 2021.

[32] On 19 August 2021, Mr Munro attended hospital complaining of chest pain and difficulty swallowing. Hospital staff noted that Mr Munro had been experiencing gastric issues but felt that what he was experiencing was different. Hospital staff ascertained the status of the outstanding endoscopy referral and confirmed that he was on the waiting list (detailed in Crown Production 3, Prison Medical Records, pages 117 to 119).

[33] On 3 September 2021, Mr Munro was treated at hospital, at the Accident & Emergency Department for a broken ankle.

[34] On 14 September 2021, Mr Munro received corrective treatment as an out-patient for his broken ankle.

[35] On 5 October 2021, Mr Munro was seen by a prison nurse. A note was made of 12 kilograms of weight loss since May 2021 (86kg from 98kg). He was listed to see the prison GP and they arranged to obtain blood samples for routine testing the following day (detailed in Crown Production 3, Prison Medical Records, page 16).

[36] On 12 October 2021, Mr Munro attended a consultation with the prison GP, complaining of ongoing difficulties with food sticking in his throat. He was advised to

continue on a liquid diet. Contact was subsequently made with the prison kitchen manager to facilitate this (detailed in Crown Production 3, Prison Medical Records, page 15). Thereafter, on 27 October 2021, Mr Munro failed to attend hospital for an orthopaedic review appointment (detailed in Crown Production 3, Prison Medical Records, page 15).

[37] On 8 December 2021, Mr Munro attended a consultation with a prison nurse complaining of worsening symptoms of being unable to swallow medication and liquidised food without vomiting. The nurse noted the outstanding endoscopy appointment and undertook to discuss his presentation with the prison GP (detailed in Crown Production 3, Prison Medical Records, page 15).

[38] On 11 January 2022, Mr Munro attended a consultation with the prison GP, following reports of having vomited all night on 2 January 2022. The prison GP noted the outstanding endoscopy referral since March 2021 and agreed to chase the hospital for the appointment (detailed in Crown Production 3, Prison Medical Records, page 15).

[39] On 11 January 2022, an appointment was made for Mr Munro to receive an endoscopy on 31 January 2022. This was cancelled and transferred to a different date. The exact circumstances of the cancellation, and who was responsible for this, are unclear. The appointment was transferred to 18 February 2022 at East Lothian Community Hospital (detailed in Crown Production 3, Prison Medical Notes, page 15; Lothian Health Board Production 6, Extracts from TRAK regarding cancelled appointment on 31 January 2022 and the subject of the email referred to at para [8] above).

[40] On 18 February 2022, Mr Munro attended East Lothian Community Hospital for his first attempted endoscopy. A large amount of food was found in his proximal oesophagus and the process was abandoned with consideration to be given to a plan to repeat this with a period of fasting beforehand (detailed in Crown Production 15, page 315).

[41] On 4 March 2022, Mr Munro was taken to hospital due to a rectal bleed and admitted overnight. A CT scan showed a thickening of his oesophagus and doctors planned to keep Mr Munro admitted and repeat the endoscopy after a period of fasting. However, Mr Munro self-discharged against medical advice prior to any further investigation. He did so having received advice that the purpose of the repeat endoscopy was to find the underlying cause of his symptoms which may include malignancy (detailed in Crown Production 3, Prison Medical Records, page 14, and Crown Production 15, page 704).

[42] On 8 March 2022, Doctor Clare Elizabeth Nwobi discussed Mr Munro's case with the on-call Gastroenterology Registrar. They agreed a plan to admit Mr Munro to hospital the night before an endoscopy to control his fast and submitted a request for an endoscopy under the "urgent suspicion of cancer" referral pathway (detailed in Crown Production 15, page 344).

[43] On 8 April 2022, Mr Munro attended the Western General Hospital, Edinburgh, for a second attempted endoscopy. The procedure took place under local anaesthetic due to Mr Munro's low heart rate. Once intubated, a large volume of fluid was found in his oesophagus. Mr Munro withdrew his consent during the procedure and the

endoscopy could not be completed. Doctors planned to maintain Mr Munro's admission, control his fast and re-attempt the procedure. Mr Munro declined and self-discharged against medical advice. He did so having been advised of the risks in delaying investigation and treatment. He removed his own cannula and refused further observations prior to discharge (detailed in Crown Production 15, pages 82, 368 and 369).

[44] On 25 April 2022, Mr Munro was admitted to hospital complaining of nausea, vomiting and epigastric (upper middle abdomen) pain. He reported being unable to manage solid foods or liquids. He was hypotensive (having low blood pressure) on admission, bradycardic (having a slow heart rate) with a severe acute kidney injury ("AKI"). He was treated for aspiration pneumonia and was admitted (detailed in Crown Production 15, pages 60 to 80; Crown Production 3, Prison Medical Records, pages 13 and 81).

[45] On 29 April 2022, while still an inpatient, Mr Munro's third attempted endoscopy was successful. The results showed a gastric carcinoma which required staging and referral to the Upper GI Cancer Multidisciplinary Team (hereinafter referred to as the "MDT"). A gastric feeding tube was inserted into his oesophagus to allow soft food to be consumed (detailed in Crown Production 3 Prison Medical Records, pages 12 and 80). Mr Munro suffered a chest infection after the procedure.

[46] On 2 May 2022 a Computed Tomography scan (hereinafter referred to as "a CT scan") was performed which demonstrated: a "bulky oesophageal gastric tumour"; ongoing aspiration risk despite NG (nasogastric) tube insertion, being the insertion of a

thin, flexible, temporary tube passed through the nostril, down the throat, and into the stomach; and growth of lymph nodes raising concerns of metastasis (cancer spread) (detailed in Crown Production 3, Prison Medical Records, pages 3 and 12).

[47] On 3 May 2022, whilst still in hospital, Mr Munro opted to have the gastric tube removed and self-discharged against medical advice. He did so having been advised of the likelihood of cancer, the risks of discharge, including insufficient nutrition and death within a timeframe of days to weeks and that by discharging himself he may jeopardise any opportunity for possible treatment.

[48] Prior to discharge, Mr Munro explained that he had had enough of being in hospital and of being "poked and prodded" and did not see the point in staying in hospital as he was "getting life anyway" (detailed in Crown Production 15, pages 55 and 430; Crown Production 3, Prison Medical Records, pages 11, 12 and 81).

[49] On 6 May 2022, Mr Munro was discussed at a meeting of the Upper GI Cancer Mult-Disciplinary Team (hereinafter referred to as "MDT"). They noted a history of dysphagia and significant weight loss from 120kg to 62kg. It was further noted that the endoscopy results showed a distal oesophageal stricture with biopsies reporting poorly differentiated adenocarcinoma. There was also an incidental finding of a lesion on his right lung, which was indeterminate. Staging of the carcinoma was noted as "T3N2Mx" meaning that the tumour had grown into the outer lining of the stomach (T3), cancer cells were present in 3 to 6 nearby lymph nodes (N2) but that metastases could not be assessed at the time (Mx). It was further noted by the MDT that Mr Munro had

significant comorbidities (detailed in Crown Production 15, page 436; Crown Production 3, Prison Medical Records, page 11).

[50] The recommendation of the MDT was for an oesophageal stent to be placed to palliate the dysphasia and treatment would be palliative only.

Treatment

[51] On 17 May 2022, Mr Munro attended at hospital complaining of worsening dysphagia. He was admitted for a palliative oesophageal stent to be inserted to enable better feeding (detailed in Crown Production 15, pages 506 to 512).

[52] On 18/19 May 2022 (both dates are referred to in medical records as the relevant date), Mr Munro had the oesophageal stent inserted endoscopically (detailed in Crown Production 15, pages 513 to 519).

[53] On 19 May 2022, Mr Munro self-discharged from hospital, against medical advice. Hospital staff had wished to recheck Mr Munro's refeeding bloods for 48 hours post-procedure. He did so having been advised of the risks arising from self-discharge, including the risk of re-feeding syndrome (detailed in Crown Production 3, Prison Medical Records, page 9; Crown Production 15, pages 43 to 45, and 513 to 519).

[54] On 3 July 2022, Mr Munro attended hospital with reported chest pain and vomiting. Healthcare staff suspected he had an Upper GI bleed with significant haemoglobin loss. Mr Munro required a blood transfusion (detailed in Crown Production 3, Prison Medical Records, page 7; Crown Production 15, pages 556 to 560).

[55] On 4 July 2022, Mr Munro self-discharged from hospital without further treatment, against medical advice. He did so having been advised of the risks of self-discharging from hospital. It was explained to him by medical staff that he was dying, and early discharge without treatment may hasten his death. He indicated that "he doesn't care" when advised of the importance of fasting. He indicated that he was frustrated by the hospital monitors and felt like a "pin cushion". He explained that he felt like he was going to die anyway and so did not consider there was any point to staying in hospital. It was noted that a Do Not Attempt Cardio-Pulmonary Resuscitation ("DNACPR") was in place and a referral was made to the palliative care team. Mr Munro was not prepared to await the palliative care review prior to discharge (detailed in Crown Production 3, Prison Medical Records, pages 6 and 7; Crown Production 15, pages 561 to 573).

[56] On 13 August 2022, Mr Munro attended hospital to receive a further blood transfusion. He received one unit of blood. He thereafter self-discharged from hospital against medical advice. He was noted to be slightly hypotensive during admission. He declined to stay overnight to receive a further unit of blood (detailed in Crown Production 3, Prison Medical Records, page 4; Crown Production 15, pages 590 to 593).

[57] On 16 September 2022, Mr Munro was an emergency admission to hospital with symptomatic anaemia (detailed in Crown Production 3, Prison Medical Records, pages 2, 3 and 62).

[58] After admission, Mr Munro received three units of blood. His DNACPR was discussed with him and remained in place. Mr Munro subsequently self-discharged

against medical advice (detailed in Crown Production 15, pages 609 to 614, and page 625).

[59] On 22 September 2022, Mr Munro again attended at hospital as an emergency, reporting 2 episodes of fresh blood vomit and pain in his upper abdomen (detailed in Crown Production 3, Prison Medical Records, page 2; Crown Production 15, pages 633 and 634).

[60] On 28 October 2022, Mr Munro was admitted to hospital complaining of lower abdominal pain, vomiting, and fever. He required further blood transfusion. He was thereafter placed on a syringe driver to administer analgesia as he was approaching the end of his life. He did not return to HMP Edinburgh (detailed in Crown Production 15, pages 2 to 9; Crown Production 3, Prison Medical Records, pages 45 to 49).

End of life

[61] On 2 November 2022, Mr Munro was transferred to Marie Curie Hospice, Edinburgh under escort by Geo-Amey. There he continued to receive palliative care. He was prescribed morphine both orally and via syringe and fentanyl patches for pain management. He was prescribed laxatives as well as Midazolam to manage anxiety/distress and Levomepromazine to manage nausea/vomiting and, latterly, delirium.

[62] From 8 November 2022, morphine was substituted for Oxycodone as Mr Munro's principal form of opioid pain relief.

[63] From 11 November 2022, Mr Munro was prescribed diamorphine.

[64] On 15 November 2022, Hospice staff recognised Mr Munro was approaching the end of life and his wife, Mrs Munro, was contacted to attend. She arrived at around 1900 hours.

[65] At 1920 hours on 15 November 2022, hospice staff were of the opinion that Mr Munro had died. Robert Przekwaz, Charge Nurse, performed signs of life tests and verified Mr Munro's death at 1945 hours.

[66] While more careful triaging by Dr McAvoy may be considered a precaution which could and should have been taken, any such precaution would not have prevented Mr Munro's death.

[67] The advanced stage of Mr Munro's cancer in March 2021, together with his significant comorbidities, meant that he would not have been a candidate for curative treatment with earlier diagnosis. Although he would have received significantly more palliative care, and thus a better quality of life, his life would not have been prolonged due to the continued progress of the disease and the predominantly gastric nature of Mr Munro's cancer.

[68] Once diagnosed and discussed at the multi-disciplinary cancer team meeting on 6 May 2022, treatment options were limited to palliative care only. Due to the presence of significant co-morbidities, in particular poorly controlled angina, which predated Mr Munro's cancer symptoms, he would never have been a candidate for potentially curative treatment options. Regardless of the time of the diagnosis following Mr Munro's reported symptoms, treatment options would have been palliative only.

[69] Had palliative care been provided earlier (i.e. if cancer had been diagnosed around May 2021) this would not have extended Mr Munro's life past 15 November 2022. Although he would have had an improved nutritional state, he would not have replaced any weight lost and would nonetheless still had difficulty processing food due the tumour extending into his stomach.

Post-Mortem Examination

[70] A post-mortem examination of the body of Mr Munro was undertaken on 25 November 2022 by Doctor Kerryanne Shearer, Forensic Pathologist.

[71] Doctor Shearer certified Mr Munro's cause of death as: 1a) Complications of metastatic oesophageal cancer.

[72] Dr Shearer observed the presence of an oesophageal tumour which had spread into the stomach, through the diaphragm, around the spleen and adrenal glands and into the omentum. She also noted a large accumulation of liquid in the abdominal cavity and bronchopneumonia; both complications associated with the tumour.

[73] Significant ischaemic heart disease was also noted, but it was indicated that this was unlikely to have been the most significant factor in Mr Munro's death.

Death in Prison Learning, Audit and Review (hereinafter referred to as "DIPLAR")

[74] Following a death in custody, the Scottish Prison Service and NHS Health Board must review the incident in full and identify any learning opportunities to improve services.

[75] The DIPLAR is the joint SPS and NHS process for reviewing all deaths in custody.

[76] The DIPLAR provides a system for recording learning and any identified actions.

[77] The DIPLAR process aims to ensure transparency of practice and opinion and focuses on establishment self-improvement.

[78] The DIPLAR process aims to allow the SPS and NHS to develop an evidence base through a reporting and learning system that analyses all deaths and contributes to improving not only its strategy but other suicide prevention strategies throughout Scotland. Crown Production 9 is a copy of the Review report.

[79] Section 5 of the Review report records

> "Mr Munro was located in the Marie Curie Hospice in Edinburgh where he was receiving end of life care for oesophagus cancer. Mr Munro was transferred to the hospice on the 28 October and passed away in the hospice on the 15 November 2022. Mr Munro was escorted by Geo-Amey staff whilst he was in the hospice, and he was uncuffed on the days leading up to and on the day of his death."

[80] Section 7 of the Review report records:

> "Marie Curie staff contacted the family of Mr Munro to make them aware of his passing. Staff from Marie Curie provided appropriate support to Mr Munro's wife and family. The family were upset by the passing of Mr Munro and again were supported through this by Marie Curie staff. The Governor, Deputy Governor and Chaplain all spoke with the family to offer their condolences and offer support to the family. The death did not affect the SPS staff, and one friend of Keith's was offered support from the chaplaincy team however this was not required. No memorial was requested therefore no memorial service was held."

[81] Section 8 of the Review report records:

"Identified as good practice:

- Mr Munro had an early diagnosis of his condition and planned intervention that was required to ensure he was comfortable.
- The smooth admission of Mr Munro into the hospice.
- The professional working relationships between SPS, Geo-Amey, Marie Curie and NHS to ensure Mr Munro received the care and dignity by all parties.
- Ongoing support for Geo-Amey staff by the management and employee assistance programme.
- An early risk assessment from Geo-Amey on how to best manage Mr Munro whilst in the hospice and a risk assessment of cuffing.
- Information provided to Geo-Amey staff from their management team with regards to how to manage Mr Munro – Standard Operating Procedure.
- Pre-planning for end-of-life care."

The reference to early diagnosis and planned intervention has, of course, to be considered against the background of when Mr Munro reported symptoms, and the triaging error which occurred.

[82] Section 9 of the Review report identifies as learning points:

- Clarification of the roll that the RMA (Risk Management Authority for prisoners on lifelong restriction) plays in compassionate release decisions as they advised that Mr Munro would not get compassionate release and it was therefore not applied for. This clarification was identified as an action point for Scottish Prison Service Headquarters to be carried out by April 2023.
- A site visit to be arranged to the hospice for Scottish Prison Service and Geo-Amey staff to familiarise themselves with the process. Familiarisation visits were identified as an action point along with familiarisation visits by

Marie Curie staff to the SPS establishment. This action point was the responsibility of Scottish Prison Service and Geo-Amey to be carried out by June 2023.

- A single point of contact for Scottish Prison Service, NHS and Marie Curie to be identified for communications.

[83] Barbara Mundweil is a GP at HMP Edinburgh. She has worked as a GP since the year 2000. She has worked at HMP Edinburgh since September 2022. She is employed by Lothian Health Board.

[84] Dr Mundweil reviewed the referral letter completed by Dr William Smith on 2 March 2021 referring Mr Munro to Gastroenterology due to a 4 week history of dysphagia. This was written on the standard headed notepaper that was used for hospital referrals made by the prison GP in March 2021. The referral was sent by post. This was usual practice at the time. The letterhead and form did not have specific sections, for example, for the GP to note the priority level of the referral. The entire letter was free-worded although Dr Smith marked it as urgent and noted in the letter the possibility of upper GI malignancy.

[85] Around one year ago, the process for GP referrals from the prison changed. The referral is now completed on an electronic form and sent electronically via a system called 'Sci Gateway'. The new electronic referral form requires the GP to select from a pre-populated list whether the referral is "routine", "urgent", or "urgent-suspected cancer". The referral cannot be submitted to the hospital unless one of these options is selected.

[86] In terms of any process in place for the GP following up referrals, there is no specific system, written instructions or guidance in place; it is at the discretion of the GP. If a prisoner re-presents to the GP with the same and especially worse symptoms, this may prompt the prison GP to arrange for a hospital appointment to be chased. If an appointment is to be chased, it is usual practice for the prison GP to ask the administration team to phone the hospital. This was done in Mr Munro's case.

Local case review

[87] A Local Case Review is an internal review which is undertaken by Health Boards in connection with deaths of patients who were under the care of mental health services. They look at the care given to the patient by the service in the time leading up to the patient's death. This helps to identify any improvements. Depending on the outcome, it may be escalated to a Level 1 review or an expanded independent case review where the circumstances merit further internal learning.

[88] A Local Case Review was conducted by F Delaney, on behalf of Lothian Health Board (specifically Royal Edinburgh Hospital and Associated Services (hereinafter referred to as "REAS") into the healthcare provided to Mr Munro from January 2021. The findings of the Review are documented in Crown Production 10. From a REAS perspective care was identified as appropriate, issues of delay sitting with GI services.

NHS Lothian Structured Mortality Review

[89] A Structured Mortality Review (hereinafter referred to as "SMRT") is a structured review tool used by Health Boards in the event of unexpected deaths of inpatients. It looks at different areas of patient care (eg arrival at hospital; ongoing clinical care; care during procedures; deterioration; etc.). It is completed by both a clinical and nursing reviewer and is used to determine whether there has been an adverse event. The Health Board will use the information to commission a level 1 review if the findings are that there has been an adverse event or that there were care delivery problems which have or may have led to the death.

[90] A Structured Mortality Review was conducted by Neil Boyle, Deputy Associate Nurse Director and Dr Colin Noble, Consultant Gastroenterologist, on behalf of NHS Lothian. The findings of the SMRT are documented in Crown Production 11.

[91] Crown Production 11 states: "The delay in diagnostics would not have changed the final outcome, but may have given opportunities for earlier oesophageal stenting, allowing better nutrition and better quality end of life care."

[92] Under Key Learning Points/ Care delivery problems it states "Endoscopy waiting times, referred for urgent OGD, triaged to urgent OGD waiting list (wait 20 wks), should have been triaged to cancer pathway given EDS score on index referral." Under Recommendations, it states "Share outcome via MDT and circulate referral guidelines for pathway." Under Further action, it is stated: Review of triage with advice to calculate EDS on all dysphagia patients and triage appropriately. GI Clinical Director working with primary care Lead GPs to review GI Ref Help guidelines for patients

referred with dysphasia and a suspicion of cancer. Pages will be updated to reflect that referrers should include an EDS score on the referral." This is included in an Improvement Plan Summary Document attached to the main document.

Agreement of productions and witness statements

[93] Generally, it was agreed that documentary evidence may be admitted into evidence without the need for it to be spoken to by its author; and that Productions are what they bear to be.

Crown productions

[94] Crown Production 1 is a true and accurate copy of Mr Munro's Medical Certificate of Cause of Death (Form 11), under Section 24(1) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, dated 25 November 2022, certified by Dr Kerryanne Shearer, Forensic Pathologist.

[95] Crown Production 2 is a true and accurate copy of the final post-mortem report dated 18 January 2023, authored by Dr Kerryanne Shearer, Forensic Pathologist, following post-mortem examination of the body of Mr Munro which took place on 25 November 2022.

[96] Crown Production 3 is a true and accurate copy of Mr Munro's Prison Healthcare medical records, the contents of which are agreed to be accurate.

[97] Crown Productions 4 and 14 are true and accurate copies of Mr Munro's hospital records from his time in custody, the contents of which are agreed to be accurate.

[98] Crown Production 5 is a true and accurate copy of Mr Munro's Marie Curie Hospice records from his time in custody, the contents of which are agreed to be accurate.

[99] Crown Production 6 is a true and accurate copy of the Death in Custody Folder of documentation and records maintained by the Scottish Prison Service in relation to Mr Munro, the contents of which are agreed to be accurate.

[100] Crown Production 7 is a true and accurate copy of Mr Munros' Prisoner Escort Record maintained by Geo-Amey during his escort outside of HMP Edinburgh from 28 October 2022 until 15 November 2022, the contents of which are agreed to be accurate.

[101] Crown Production 8 is a true and accurate copy of an investigation report conducted by Jim Munro, Geo-Amey Security and Investigation Lead (Scotland) into Mr Munro's death, dated 24 November 2022.

[102] Crown Production 9 is a true and accurate copy of the Death in Prison Learning Audit and Review (DIPLAR) report carried out at HMP Edinburgh following Mr Munro's death.

[103] Crown Production 10 is a true and accurate copy of the Local Case Review for a potential Significant Adverse Event Review ("SAER") carried out by Lothian Health Board following Mr Munro's death.

[104] Crown Production 11 is a true and accurate copy of the NHS Lothian Structured Mortality Review Tool 2023 completed by Lothian Health Board following Mr Munro's death.

[105] Crown Production 12 is a true and accurate copy of written responses to a series of medical questions prepared by Drs Ian Penman and Norma McAvoy, dated 4 March 2024.

[106] Crown Production 13 is a true and accurate copy of a report authored by Dr Jin-Yong Kang, Consultant Gastroenterologist, dated 6 January 2025.

[107] Crown Production 15 is a collated and sorted amalgamation of the Hospital records comprising Crown Productions 4 and 14, the contents of which are agreed to be accurate.

Lothian Health Board productions

[108] Production 1 for Lothian Health Board is a true and accurate copy of a report authored by Dr Stephen Falk, Consultant Clinical Oncologist, dated 8 November 2025.

[109] Production 2 for Lothian Health Board is a true and accurate copy of emails sent by Dr Alan Christie and Dr Sorcha Campbell, both Consultant Oncologists, dated 17 September 2025.

[110] Appendix 1 to Dr Noble's second statement (Lothian Health Board Production 4) is a true and accurate copy of the British Society of Gastroenterology (BSG) NICE Guidelines which were in place in 2021.

[111] Appendix 2 to Dr Noble's second statement (Lothian Health Board Production 4) is a true and accurate copy of the Scottish Referral Guidelines for Suspected Cancer which were in place in 2021.

[112] Appendix 4 to Dr Noble's second statement (Lothian Health Board Production 4) is a true and accurate copy of current RefHelp referral guidelines relating to dysphagia.

[113] Production 5 for Lothian Health Board (which is repeated at Appendix 3 to Dr Noble's second statement (Lothian Health Board Production 4)) is a true and accurate copy of guidance for the correct use of the Edinburgh Dysphagia Score.

[114] Production 6 for Lothian Health Board contains true and accurate screenshots from Trakcare showing details regarding Mr Munro's cancelled hospital appointment on 31 January 2022.

[115] Appendix 1 to Dr Mundweil's statement (Lothian Health Board Production 7) is a true and accurate screenshot of the current referral form available to prison GPs.

Witnesses

[116] It was agreed that the following witnesses have provided statements, which have been lodged with the court:

a. Dr Colin Noble, Clinical Director of Gastroenterology

b. Dr Iain Page, Consultant in Infectious Disease and Acute Medicine

c. Elaine McAdam, Advanced Nurse Practitioner

d. Arlene Garthley, Residential Prison Officer

e. Robert Przekwas, Charge Nurse

f. Claire Dougal, Staff Nurse

g. Sean McGerr, Prison Custody Officer

h. Samuel Foster, Prison Custody Officer

i. Louise Hanlon, Clinical Services manager of Endoscopy

j. Barbara Mundweil, General Practitioner

[117] It was agreed that all statements produced within the Crown and Lothian Health Board Productions are to be afforded the status of a "witness statement" as defined in Rule 4.13 of Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[118] It was agreed that all typed statements within the Crown and Lothian Health Board Productions are to be afforded the status of signed manuscripts.

Conclusions

[119] On the basis of the evidence presented at the enquiry I am satisfied that I should make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act only. I have set out those formal findings above.

[120] In respect of section 26(2)(e) of the Act (reasonable precautions which may realistically have prevented the death) any precaution must be a reasonable precaution which, if taken, might realistically have prevented the death occurring. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have done so (the 2016 Act Explanatory Notes). This is therefore a two-stage test.

[121] In the determination into the death of Zach Banner [2020] FAI 18, the sheriff stated at paragraph 53 (page 68):

> "In my view the task of this inquiry is to consider, with the wisdom of hindsight, whether there were any precautions which could reasonably have been taken which might realistically have resulted in death, or any accident resulting in

> death, being avoided. I consider that a precaution might realistically have resulted in the death, or any accident resulting in death, being avoided, if there was a real or lively possibility that it might have done so"

[122] Based on the evidence the Inquiry heard, there is only one reasonable precaution that ought to be considered.

[123] A reasonable precaution would have been for Dr McAvoy to correctly triage Mr Munro's referral on 11 March 2021 and place him on the urgent suspicion of cancer pathway. Lothian Health Board correctly accept that there was an error in the triaging of Mr Munro's referral. Having regard to the information contained in the referral form, Mr Munro should have been identified as a patient suited to the "urgent suspicion of cancer" pathway and ought to have been triaged accordingly. This appears to have arisen due to human error.

[124] In relation to the first stage of the test, this is an inherently reasonable precaution as it should have been the correct outcome of the referral process. There was no dispute by any of the parties about this.

[125] In relation to the second stage of the test, I required to consider whether there was a real or likely possibility that Mr Munro's death would have been prevented on 15 November 2022 had this precaution been taken. Based on the expert evidence before the Inquiry, it cannot be said that Mr Munro's death would have been prevented by this course of action. The advanced stage of Mr Munro's cancer in March 2021, together with his significant comorbidities, meant he would not have been a candidate for curative treatment with earlier diagnosis. Although he would have received significantly more palliative care, and thus a better quality of life, Dr Falk was of the opinion his life would

not have been prolonged due to the continued progress of the disease and the predominantly gastric nature of Mr Munro's cancer. While Dr Kang, Consultant Gastroenterologist, in his opinion (Crown Production 13) at pages 10 and 12 raised the possibility of life prolonging treatment, he expressly deferred to oncology on this question (page 10) and indicated during oral evidence that, on reflection, the availability of treatment would have been limited to that which might have improved Mr Munro's quality of life.

[126] Consequently, the second stage of the test is not met.

[127] There are no other reasonable precautions identified by the Crown which might have realistically prevented Mr Munro's death.

[128] With regard to section 26(2)(f) of the Act (defects in any system of working which contributed to the death) in deciding whether to make any determination as to defects in any system of working which contributed to the death, as a precondition to making such a recommendation, I must be satisfied that the defect in question did in fact cause or contribute to the death (Zach Banner, at paragraph 66).

[129] I have not identified any systemic defects in any systems of working which contributed to Mr Munro's death.

[130] Turning to any other facts which are relevant to the circumstances of the death in terms of section 26(2)(g) of the Act, although the incorrectly triaged referral form did not cause or contribute to Mr Munro's death, nor would it have prevented his death if it had been triaged correctly, as I indicated earlier it is nonetheless concerning that Mr Munro suffered around 10 additional months of symptoms which ought to have been identified

and diagnosed significantly earlier. Even taking into account the occasions on which Mr Munro self-discharged against medical advice, an earlier diagnosis would have resulted in considerably more palliative care and alleviation of symptoms and an improved quality of life in his final months.

[131] In the Fatal Accident Inquiry into the death of Alistair Ian Findlay [2024] FAI 28, Sheriff Guy sets out the relevant law at para [55] to [61] as follows:

> "[55] In McMillan v T Leith Developments Ltd 2017 SC 642 a full bench of the Inner House considered the principles that the court requires to apply when interpreting a statutory provision. At paragraph 54 of the judgement, Lord President Carloway states:
>
> > 'The task of the court was, and is, to seek the meaning of the words used; often described as ascertaining the intention of Parliament expressed in the statutory language in light of the particular context (R v Secretary of State for the Environment, Transport and the Regions, ex p Spath Holme Ltd, Lord Nicholls, pp 396, 397; citing Black Clawson International Ltd v 30 Papierwerke Waldhof-Aschaffenburg AG, Lord Reid, p 613). Although the courts may employ certain accepted canons of interpretation, 'an appropriate starting point is that language is to be taken to bear its ordinary meaning in the general context of the statute.' (Ibid Lord Nicholls, p 397.) As the defenders submitted, if the terms were legal ones, they will be given their legal meaning. Where there is an apparent ambiguity in the wording, however, reference can be had to certain internal or external aids, many of which were alluded to, and some founded upon, in the submissions to this court.'
>
> [56] Approaching the interpretation of section 26(2)(g) with regard to these principles, the starting point is to consider the ordinary meaning of the words used in the section. A finding can only be made if the fact identified is 'relevant to the circumstances of the death'. This term is not defined within the Act. The word 'relevant' is defined in Cambridge English Dictionary as 'connected with what is happening or being discussed'. The word 'circumstance' is defined as 'a fact or event that makes a situation the way it is'. Therefore, applying the ordinary meaning of these words, I accept counsel for the Health Board's submission that that it is necessary for a fact to be connected to the death in some way if it is to be the subject of a finding under the section.

> [57] I do not accept the procurator fiscal depute's submission that a finding can only be made if it might prevent other deaths in similar circumstances. The words used in the section do not make this a necessary prerequisite to a finding and this does not emerge from a wider consideration of the Act.
>
> [58] The purpose of the inquiry in section 1(3) of the Act is two-fold: to (a) establish the circumstances of the death and (b) what steps (if any) might be taken to prevent other deaths in similar circumstances. These purposes are reflected in the matters that the sheriff requires to determine under section 26 of the Act. While these purposes are connected, it is apparent from the wording in sections 1(3) and 26 that they are distinct and reflect the different stages of the inquiry process.
>
> [59] In my opinion, once it has been established that a fact is relevant to the circumstances of the death, it is open to a sheriff to make a finding under section 26(2)(g). As to when this might be appropriate, I consider that the section provides the sheriff with wide scope to address any matter that comes to light during the inquiry that they deem to be in the public interest.
>
> [60] This construction is consistent with Carmichael's proposed interpretation of the identically worded paragraph 6(1)(e) of The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the statutory predecessor to the Act) in his textbook Sudden Deaths and Fatal Accident Inquiries (3rd ed). At paragraph 5-77 of this textbook the learned author states:
>
> > [61]'The wording of this paragraph, though it gives the sheriff wide scope, none the less provides the facts which the sheriff finds established under this head must be relevant to the circumstances of the death. It means, it is submitted, the circumstances of the death as they may affect the public interest. There is a distinction between findings under s6(1)(c) and (d) where there is required to be a causal connection, and under s6(1)(e) where no such connection is required.'"

[132] It is apparent from evidence before the Inquiry that there were various delays to Mr Munro undergoing investigation and treatment for symptoms related to the underlying malignancy arising partly due to the triaging error, and partly for other reasons, including practical difficulties in performing an endoscopy and Mr Munro's refusal or reluctance to engage with interventions.

[133] I accept the submissions by Counsel for Lothian Health Board that

> "The totality of the expert evidence available to the Inquiry, in any event, suggests that: but for the aforementioned delays in Mr Munro undergoing investigation and treatment, Mr Munro would likely have had earlier access to palliative treatment, such as stenting; that had Mr Munro engaged with such treatment then this would have provided Mr Munro with an opportunity to have ameliorated certain symptoms sooner than was the case, resulting in improved quality of his life. This is all relative to symptomatic control prior to palliative care becoming available to Mr Munro rather than to the circumstances surrounding Mr Munro's later death."

[134] In terms of section 26(4) of the Act, in the event of findings under section 26(2)(e), (f), or (g), I have the power to crystallise those findings into recommendations under section 26(4)(a) – (d). However, in the event of no findings being made under sections 26(2)(e), (f), or (g) that does not preclude the making of recommendations regarding the matters referred to in section 26(4)(a) – (d) if they might realistically prevent other deaths in similar circumstances.

[135] The matters referred to in section 26(4)(a) – (d) are:

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.

[136] Louise Hanlon, Clinical Services Manager, detailed relevant changes made to healthcare processes in response to this death, particularly in relation to the emphasis placed on Edinburgh Dysphagia Score calculations and updates to referral guidance. Dr Mundweil also highlighted, that the process for GP referrals from the prison has changed. The referral is now completed on an electronic form and sent electronically via

a system called "Sci Gateway". The new electronic referral form requires the GP to select from a pre-populated list whether the referral is "routine", "urgent", or "urgent-suspected cancer". The referral cannot be submitted to the hospital unless one of these options is selected.

[137] These improvements aim to prevent future deaths in similar circumstances. Lothian Health Board acknowledged that an error was made in the triaging of Mr Munro's referral to gastroenterology in March 2021. The Board apologised to Mr Munro's family for the error. The Board acknowledged that the improvements subsequently made to the referral processes have come too late for Mr Munro but hoped that some comfort might be derived from the fact that these improvements should minimise the risk of similar errors occurring in the future.

[138] In light of the foregoing, having regard to improvements made, I have not identified any recommendations which would realistically prevent future similar deaths.

[139] I wish to conclude by expressing my condolences to the loved ones of Mr Munro for their sad loss.