SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT PETERHEAD

[2019] FAI 22

PHD-B80-18

DETERMINATION

BY

SHERIFF CHRISTINE P McCROSSAN

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

into the death of

JOHN THOMAS HILDRETH GORDON

Peterhead, 31 May 2019

The Sheriff, having considered the information presented at an inquiry under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 finds and determines:

(1) In terms of section 26(2)(a) that John Thomas Hildreth Gordon born on 6 June 1960 died in HMP Grampian, South Road, Peterhead on 29 March 2015, life being formally pronounced extinct at 08:38 hours on that date;

(2) In terms of section 26(2)(c) that the death was by natural causes, that being coronary artery disease.

Note

Legal Framework

[1] This Inquiry was held under section 1 of the 2016 Act. This was a mandatory inquiry in terms of section 2(1) and (4) of the 2016 Act as Mr Gordon was in legal custody at the time of his death. The purpose of the Inquiry was to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[2] The Procurator Fiscal issued notice of the inquiry on 15 May 2018. A preliminary hearing took place at Peterhead Sheriff Court on 29 June 2018. Mr Hanton, Procurator Fiscal Depute appeared for the Crown. Representatives were in attendance for the Scottish Prison Service, the Prison Officers' Association (Scotland) and NHS Grampian. The family of Mr Gordon were not represented. The matter was initially continued until 6 August. This date was subsequently discharged and the matter called on Monday 20 August 2018. On that date the case was continued to allow the family to obtain legal advice. On 2 November 2018 the procurator fiscal advised the court that Mr Gordon's family had retained a legal advisor and a Joint Minute was under consideration. A Joint Minute dated 23 November 2018 was agreed.

[3] The Inquiry commenced on 27 November 2018. Mr Hanton again represented the Crown. Mr Hanton produced the Joint Minute agreed between the Crown, the Scottish Prison Service, NHS Grampian; and the solicitor for the Gordon family. Mr Hanton read out the terms of the Joint Minute. He invited the court to make formal findings in terms of Section 26(2)(a) and (c) of the 2016 Act. This was a position adopted

by all represented parties. Mr Hanton concluded by expressing condolences to the family of Mr Gordon.

Circumstances

[4] The following narrative is taken from the terms of the agreed Joint Minute.

[5] Mr Gordon returned to HMP Grampian on 16 March 2015 and was allocated cell 2B01 within Ellon wing at HMP Grampian, South Road, Peterhead

[6] Mr Gordon was assessed by medical staff on 28 March 2015 in the said prison in relation to his concern that he had suffered a stroke. He advised the medical staff that he felt generally unwell but was not suffering any pain. He also stated that he had fallen out of bed on occasion.

[7] Given the concerns raised regarding Mr Gordon falling from his bed, the medical staff within the said prison completed a "Health Care Marker – Basic Care Plan." Said care plan related to hourly observations of Mr Gordon, while he was in his cell. Said observations were to ensure that he had not fallen from his bed.

[8] At about 17:00 hours, same day, Mr Gordon was locked in his cell overnight.

[9] Mr Gordon was next observed in his cell at 08:10 hours

[10] Upon being checked at 08:10 hours on 29 March 2015 Mr Gordon was found to be lying, obviously deceased, on the floor of his cell.

[11] Life was pronounced extinct at 08:38 hours, same day, by paramedics employed by the Scottish ambulance service.

[12] The death of Mr Gordon was reported to the procurator fiscal at Aberdeen on 30 March 2015.

[13] The body of Mr Gordon was subject to a post mortem examination by Drs Matthew Stewart Lyle and Paul Anthony James Brown on 31 March 2015 at Aberdeen mortuary and it was their considered opinion that he had died as a consequence of a natural cause, that being coronary artery disease. The post-mortem report is Crown production number 2.

Conclusion

[14] No submissions were made by any party that any precautions could reasonably have been taken which might realistically have resulted in Mr Gordon's death being avoided (section 26(2)(e)); or that any defect in any system of working had contributed to his death (section 26(2)(f)). Nor were any submissions made to indicate that any other facts relevant to the circumstances of Mr Gordon's death fell to be included in my determination (section 26(2)(g)).

[15] I am satisfied that in all the circumstances formal findings should be made in this case. I have set out those formal findings at the outset of this determination.

[16] In conclusion I wish to express my condolences to the bereaved family of Mr Gordon and my regret that it has taken a considerable number of months to issue this determination.