SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2019] FAI 4

B1476/18

DETERMINATION

BY

SHERIFF JOHANNA JOHNSTON QC

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

into the death of

DAVID ROACHE

Glasgow, 10 January 2019. The Sheriff having considered the information presented at the inquiry determines in terms of section 26 of The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 Act FINDS AND DETERMINES that:-

(1) In terms of section 26(2)(a) of the 2016 Act, David Roache, born 13 February 1973, and residing latterly at Her Majesty's Prison, Low Moss died at Her Majesty's Prison, Low Moss on 9 July 2016, life having been pronounced extinct at 10.55 hours on that date.

(2) In terms of section 26(2)(c) of the 2016 Act the death was caused by:

1(a) Incised wound to the neck

(3) In terms of section 26(2)(e) of the 2016 Act there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided had they been taken.

(4) In terms of section 26(2)(f) of the 2016 Act there are no defects in any system of working which contributed to the death or the accident resulting in the death.

(5) In terms of section 26(2)(g) of the 2016 Act there are no other facts which are relevant to the circumstances of the death.

Recommendations

In terms of section 26(1)(b) of the 2016 Act there are no recommendations to be made.

NOTE

Introduction

[1] An inquiry into the death of David Roache, born 13 February 1973 was required by virtue of the terms of section 2(4)(a) of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act") in respect that it occurred whilst he was in legal custody.

[2] On 9 January 2019 an inquiry was held. Ms L McRobert, Procurator Fiscal Depute at Glasgow presented the information following upon the investigation by the Procurator Fiscal into the circumstances of the death of Mr Roache. Mr A Phillips, Solicitor, represented the Prison Officers' Association (Scotland), Ms G Hogwood, Solicitor represented Greater Glasgow Health Board and Ms A Chalmers, Solicitor, represented the Scottish Prison Service. The family of Mr Roache were not represented. Ms McRobert advised the Inquiry that she had met with the mother of the deceased and

having advised her of the results of the investigation and having taken legal advice, his mother had decided that she did not wish to be represented at the Inquiry.

[3] A Joint Minute was produced by the procurator fiscal depute, signed by Mr Phillips, Ms Hogwood and Ms Chalmers agreeing facts which could be admitted into evidence without the necessity of witnesses being led. None of the participating parties identified any issues in dispute or matters which the sheriff might be invited to address in the determination.

The legal framework

[4] A Fatal Accident Inquiry was held under section 1 of the aforesaid 2016 Act.

[5] The Inquiry is governed by the Fatal Accident Inquiry Rules 2017.

[6] In terms of section 1(3) of the 2016 Act: the purpose of an Inquiry 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.

[7] The matters to be covered in the determination under section 26 are when and where the death occurred and the cause or causes of the death.

[8] The Crown in the public interest is represented by the procurator fiscal depute. A Fatal Accident Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

[9] On 25 July 2002 at Forfar High Court, David Roache was found guilty of murder. He was sentenced to life imprisonment with the requirement to serve a minimum period of 15 years' imprisonment. He was subsequently sentenced to periods of 30 months' imprisonment, 9 months' imprisonment and 14 months' imprisonment each to commence upon expiry of all previous sentences. On 9 July 2016, Mr Roache was serving his sentence at her Majesty's Prison, Low Moss having been transferred from Her Majesty's Prison, Shotts on 4 July 2016.

[10] At 5.51 pm on 8 July 2016 Mr Roache entered his cell and at 8.32 pm the cell was checked and locked for the night. Examination of CCTV footage showed that no one entered or exited his cell until it was unlocked on the morning of 9 July 2016.

[11] At approximately 8.10 am on 9 July 2016 the cell was unlocked by Sean Mulholland, a Prison Management Officer. Mr Mulholland opened the door and observed Mr Roache sitting on a chair with his head tilted back. He assumed that he had fallen asleep so he closed the door and carried on unlocking cells within the block.

[12] At approximately 8.50 am, prisoner George McEoch went to waken Mr Roache. He opened the cell door and observed him to be sitting in his chair. He entered the cell, placed milk on the desk and observed that Mr Roache had a deep laceration to his neck. Mr McEoch immediately left the cell to seek assistance. Prison Management Officers Emma Wells, Scott Davis and Craig McArthur attended and found Mr Roache surrounded by a pool of blood on the floor. He was seated on a chair and there was a plastic spoon handle or similar implement with a razor blade attached to it sitting on the

table next to him. Medical staff attended at the cell and life was pronounced extinct at 10.55 am on 9 July 2016 by Dr Senthill.

[13] A post mortem was conducted of the late David Roache on 19 July 2016, by Dr Christopher Johnson, Forensic Pathologist, of the University of Glasgow. The cause of death was certified as:

1(a) Incised wound to the neck

Discussion and Conclusions

[14] Mr Roache had received medical treatment for mental health problems in the course of his imprisonment**.** In June 2015 Mr Roache was transferred to HMP Shotts. During his admission assessment, it was noted that he had no active thoughts of self-harm and was no apparent risk of suicide. He was reviewed by Mental Health Nursing Staff in July 2015 and he described no current problems and was referred to a therapy group for support.

[15] In November 2015, Mr Roache described feelings of paranoia during a mental health review. On 20 November 2015, he was assessed by a psychiatrist and prescribed medication. He continued to be monitored by the Mental Health Team within the prison over the following months. In February 2016, the deceased refused medication for several weeks, however, did not appear to suffer any deterioration in his mental health.

[16] In June 2016, Mr Roache had a consultation with a general practitioner. Mr Roache stated that he had been depressed for 18-24 months and stated he was in "a dark place." He stated that he had had suicidal ideation all his life. It was noted by the doctor

that Mr Roache said that he felt able to ask for help if his symptoms deteriorated. The doctor decided that Mr Roache required psychiatric input. Mr Roache was, thereafter, placed within the Segregation Unit at the prison and had mental health reviews by nursing staff during the period up until his transfer in July 2016.

[17] On 4 July 2016, Mr Roache was transferred from Her Majesty's Prison, Shotts to Her Majesty's Prison, Low Moss. On his arrival at Low Moss, he received a Reception Risk Assessment and gave no cause for concern and denied feeling suicidal. He was then subject to a Health Care Risk Assessment by a nurse and a general practitioner and assessed as being at no apparent risk and in the course of the assessment he denied feeling suicidal.

[18] The procurator fiscal depute instructed a report from Philip Wheatley to consider the prison records and medical records of Mr Roache and comment on any precautions which could reasonably been taken that would have realistically resulted in the death being avoided and any defects in any system of working which may have contributed to the death. Mr Wheatley has 45 years of prison management experience and has provided operational advice and support on prison matters in many jurisdictions including the UK, South Africa and New Zealand. Mr Wheatley concluded that:

> "from a prison operational perspective I do not believe there was anything practicable that could have been done on the night of his death to deny him access to effective means of killing himself, without imposing such draconian restrictions on him that would have increased his feelings of despair. There is nothing in the papers provided to me that would have justified prison staff at Low Moss imposing such restrictions."

[19] The procurator fiscal depute instructed a psychiatric report from Dr Duncan Alcock, Consultant Forensic Psychiatrist based at the State Hospital, Carstairs. He has held the position of the Associate Medical Director for the State Hospital for seven years. He is the Consultant Psychiatrist to Her Majesty's Young Offenders Institution, Polmont involved in the care of the female prison population.

[20] Dr Alcock considered the prison records and medical records of Mr Roache and was instructed to consider and comment on any precautions which could reasonably been taken that would have realistically resulted in the death being avoided and any defects in any system of working which contributed to the death. In addition, he was asked to comment on the care and treatment of Mr Roache whilst in custody.

[21] Dr Alcock concluded that there was no reason to suspect that Mr Roache would take his own life. Mr Roache had had repeated contact with mental health practitioners in the weeks leading up to his death and on specific questioning on each occasion he described no active thoughts, intent or plans to take his own life. Dr Alcock concluded that it would be difficult for those staff who had contact with him to have predicted his death and therefore have prevented it.

[22] I did not require to be addressed at length by parties. There were no issues in dispute and there was unanimity amongst the parties that it was not necessary for me to make any findings beyond the formal findings required by section 26(2)(a) and (c) of the 2016 Act. I was satisfied that the circumstances of the death of Mr Roache had been fully investigated. There are no further recommendations that I wish to make and my

conclusions are reflected in my formal findings under section 26(2)(a) and (c) of the 2016 Act.