SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2019] FAI 47

HAM-B488-19

DETERMINATION

BY

SUMMARY SHERIFF ALLAN MCKAY

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

into the death of

GARY ANTHONY KANE

Hamilton, 1 November 2019

DETERMINATION

The sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:-

a) In terms of section 26(2)(a) Gary Anthony Kane, date of birth 23 August 1971, died at HMP Shotts, Newmiln and Canthill Road, Shotts between 9pm on 10 September 2018 and 7.35 am on 11 September 2018.

b) In terms of section 26(2)(b) Mr Kane's death was not the result of an accident.

c) In terms of section 26(2)(c) the cause of Mr Kane's death was a spontaneous subarachnoid haemorrhage due to a ruptured aneurysm of the right middle cerebral artery.

d) As there was no accident section 26(2)(d) does not apply.

e) In terms of section 26(2)(e) there were no reasonable precautions by which the death might have been avoided

f) In terms of section 26(2)(f) there were no defects in any system of working which contributed to his death.

g) In terms of section 26(2)(g) there are other facts which are relevant to the circumstances of his death which are dealt with in the note appended hereto.

RECOMMENDATION

In terms of section 26(1)(b) there are no recommendations which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] This inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") into the death of Gary Anthony Kane. Preliminary hearings of the inquiry were held on 21 August and 11 September, both 2019 before my colleague who was unable to conduct the inquiry. The inquiry considered evidence, written and oral submissions on 1 November 2019. No witnesses were led. Evidence was agreed by joint minute.

Representation at the inquiry:

For the Crown, Mr Faure, Procurator Fiscal Depute

For the family of Gary Anthony Kane, Gary McAteer, Solicitor

For Scottish Prison Service, Liam Smith, Solicitor

For Scottish Prison Officers Association, Ruth Wallace, Solicitor

For NHS Lanarkshire, Linsey Miller, Solicitor

The Legal Framework

[2] This was an inquiry held under section 1 of the Act, in accordance with section 2(4)(a), on the grounds that the person who died was, at the time of his death, in legal custody. The inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[3] The purpose of the inquiry held in terms of the Act is for the Sheriff to establish the circumstances of the death, and to consider which steps (if any) might be taken to prevent other deaths in similar circumstances. The Sheriff is required in terms of section 26 of the Act to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction;

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 –

i. Could reasonably have been taken

ii. 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 or any accident resulting in the death

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

[4] The Sheriff must also make such recommendations as to the taking of reasonable precautions, the making of improvements to any system of working, the introduction of any system of working and the taking of any other steps which might realistically prevent other deaths in similar circumstances (sections 26(1)(b) and 26(4)).

[5] The court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry, and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act sets out that the determination of the Sheriff shall not be admissible as evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death. It also reflects the position that a Fatal Accident Inquiry is not a forum designed to establish legal fault. The procurator fiscal for the Crown represents the public interest. The inquiry is an inquisitorial process.

Summary

[6] Gary Anthony Kane was born on 23 August 1971. He was convicted of murder on 29 November 2012 at The High Court sitting at Dumbarton and was subsequently sentenced on the 11 January 2013 to life imprisonment, the punishment part of the sentence being set at seventeen years. His earliest date of release was 5 February 2029.

[7] At the time of his death he was a serving prisoner, detained within HMP Shotts, Newmill & Canthill Road, Shotts, North Lanarkshire, ML7 4LE. His prison number was 68424, and he was housed within Allanton Hall, Level 01, Cell 54.

[8] On the 10 September 2018 at approximately 9pm the deceased was seen within his cell by Prison Officers Kirsty Murray and Jordan Cringles. Nothing of concern was noted.

[9] On the 11 September 2018 at approximately 7.35am Gary was found within his cell. He was naked, lying on the cell floor and had a fresh laceration to his forehead. He was unresponsive. Prison Officer Natalie Walker rendered first aid. She could not find a pulse and called for assistance using her radio. Prison Officer McAllister assisted her in providing first aid to the deceased.

[10] Practitioner Nurses Rachel Fisher and Amy O'Brien, both employed by NHS Lanarkshire to work inside the prison responded to the call for assistance. They brought medical equipment with them to the cell. They used a defibrillator and commenced Cardiopulmonary Resuscitation (CPR). Oxygen, from a portable oxygen machine was administered and a suction machine was also used. They were unable to feel a pulse despite numerous cycles of CPR.

[11] Paramedics Janet Cuthbertson and Stewart McCulloch arrived in the cell shortly before 8am. Nurse Fisher confirmed CPR had been ongoing for twenty minutes without sign of life. Paramedic McCulloch pronounced life extinct at or about 8.00am.

[12] Detective Constables Iain Hughes and Craig Wait, both based at Wishaw Police Station attended the prison on 11 September and investigated the circumstances surrounding Gary's death. CCTV footage was reviewed by them. They focused their attention on the period between lockdown at 9pm on the 10 September 2018 and 7.34am on the 11 September 2018. The footage showed the cell door had remained closed throughout the intervening period. No person had entered or left the cell in that time.

[13] DCs Hughes and Wait searched Gary's cell. Both were present when the cell was photographed by Scenes of Crime Officer Law. DC Hughes took possession of Gary's prison medical notes.

[14] Gary's body was taken to the Queen Elizabeth II University Hospital in Glasgow.

[15] On the 13 September 2018 a post mortem examination was carried out at the said hospital by Dr Julie McAdam, a Forensic Pathologist. She recorded the cause of death as:

1a Spontaneous subarachnoid haemorrhage

1b Ruptured right middle cerebral artery aneurysm

[16] On the 20 September 2018 a histological examination was conducted by Professor Colin Smith, a Consultant Neuropathologist at the University of Edinburgh who confirmed the cause of death in similar terms to that originally recorded by Dr McAdam.

[17] A toxicology report prepared by Lauren O'Connor, a Forensic Toxicologist dated the 7 November 2018 confirmed the presence of buprenorphine and metabolite norbuprenorphine in Gary's blood and urine. He had been prescribed buprenorphine. This did not cause or contribute to Gary's death.

[18] Gary had sustained a wound on the left side of his forehead. The pathologist determined that Gary died as a result of a spontaneous subarachnoid haemorrhage due to a ruptured aneurism of the right middle cerebral artery (a main artery at the base of the brain). This aneurysm would have caused sudden collapse and rapid death. The laceration on the left side of the forehead was consistent with Gary's head impacting on a hard surface, such as the stone bedframe, as a result of this terminal collapse.

[19] This was a non-survivable event. Early intervention would not have improved Gary's chances of survival.

Discussion and Conclusion

[20] The inquiry was inquisitorial. It progressed expeditiously and efficiently. All participants were able to participate effectively in furthering the purpose of the inquiry.

[21] The evidence agreed in relation to the circumstances was clear and unequivocal.

[22] I made a determination setting out my findings as to the circumstances referred to in section 26(2)(a) to (f) in agreement with all participants. I made a determination that no recommendations were deemed appropriate in terms of section 26(1)(b) in agreement with all participants.

[23] In determining there were other facts relevant to the circumstances of the death in terms of section 26(2)(g) I have set these out in the summary.

[24] I wish to commend the Procurator Fiscal Depute and those representing the other parties for their helpful and professional contributions. They assisted in agreeing a joint minute which considerably shortened the length of the inquiry hearing and avoided witnesses having to attend to give evidence.

[25] I join with those representatives and genuinely express my condolences to the mother of Gary Anthony Kane. She contributed fully to the purpose of the inquiry.