SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2018] FAI 6

GLW-B1454-18

DETERMINATION

BY

SHERIFF JOHN NEIL McCORMICK

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

into the death of

GARY CHARLES BLACK

GLASGOW, 31 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, that:

(1) Gary Charles Black, born 19 June 1987, (hereinafter referred to as either Mr Black or "the deceased") residing latterly at HM Prison, Low Moss, died at 13:54 hours on 15 January 2017 at HM Prison, Low Moss, Crosshill Road, Bishopbriggs.

(2) In terms of section 26(2)(a) the death occurred at HM Prison, Low Moss when the deceased was in legal custody.

(3) In terms of section 26(2)(c) the cause of death was morphine and delorazepam intoxication.

(4) No findings were sought or are made in respect of section 26(2)(b), (d), (e), (f) and (g).

NOTE:

Introduction

[1] This Fatal Accident Inquiry was convened in terms of section 2(4)(a) of the 2016 Act as Mr Black was in legal custody at the time of his death.

[2] The deceased's death was reported to the Crown Office and Procurator Fiscal Service which presented a Petition for an Inquiry into the death of Mr Black. The case first called on 24 July 2018. Thereafter, preliminary hearings took place on 17 September and 10 December 2018 at which a Fatal Accident Inquiry was assigned for 7 January 2019 at 10.00 am.

[3] At the Inquiry the representatives of the participants were Ms C Gallagher, Procurator Fiscal Depute for the Crown, Mr W Henderson, Solicitor, on behalf of NHS Greater Glasgow and Clyde Health Board, Mr A Phillips, Solicitor, on behalf of the Prison Officers' Association (Scotland) and Ms A Chalmers, Solicitor, on behalf of the Scottish Prison Service. A substantial joint minute of agreement was entered into, narrating the facts relating to the circumstances of the death. This was agreed and signed by all parties to the Inquiry. In addition, the following four Crown witnesses were led, Detective Sergeant Scott McNulty, Detective Constable Steven Gault, Dr Joseph Daly and Alan Easton, Unit Manager at HM Prison, Low Moss. With the exception of Mr Alan Easton, none of the witnesses were cross-examined. Mr Easton was cross-examined merely to clarify one or two points of examination-in-chief. I found all the witnesses credible and reliable.

Legal framework

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

[5] The Inquiry is governed by the Act of Sederunt (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 governed in this Determination under section 26 are when and where the death occurred and the cause or causes of death.

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

Summary of facts

[9] The following facts summarise the evidence before the Inquiry some of which are drawn from the terms of the Joint Minute and others from the oral evidence led at the Inquiry.

[10] On 16 April 2015 at Airdrie Sheriff Court, Gary Charles Black, date of birth 19 June 1987, was convicted by a jury after trial of two charges of attempt to pervert the course of justice. Sentence was deferred until 1 May 2015 for preparation of a Criminal Justice Social Work report. Mr Black was remanded in custody to HM Prison, Addiewell. On 1 May 2015, at Airdrie Sheriff Court, Mr Black was sentenced to five years' imprisonment (Crown Production Number 5, page 775). Mr Black was sent to HM Prison, Shotts to serve his sentence.

[11] On 12 July 2016 at Hamilton Sheriff Court, Mr Black pled guilty to an amended charge of assault. He was sentenced to four months' imprisonment. Mr Black was returned to HM Prison, Shotts.

[12] On 16 September 2016, Mr Black was transferred from HM Prison, Shotts to HM Prison, Low Moss. Mr Black was transferred so that he could take part in the Self Change Programme. This is a high intensity programme for individuals with a vast history of violence.

[13] From 16 September 2016 until the date of death on 15 January 2017, Mr Black was incarcerated in HM Prison, Low Moss (hereinafter referred to as "Low Moss" or "the prison"). He was in legal custody as at the date of his death.

[14] Mr Black was residing within Clyde Hall, Level 2, Section 2, Cell B/04. He was the sole occupant of this cell.

[15] On 16 September 2016, Mr Black was processed on his arrival at Low Moss following his transfer from HM Prison, Shotts. Upon his arrival, Mr Black was interviewed by Reception Officer, Gregg Reid, at 13:30 hours. The role of the Reception Officer is to book in a prisoner and carry out an initial interview before the prisoner meets with the nursing staff. The initial interview usually lasts around 20 minutes and covers any issues the prisoner may have, for example, mental health issues and/or self-harming issues which may require to be put on "ACT to Care". "ACT to Care" was the strategy used by the Scottish Prison Service to prevent suicides in prison. The strategy has since changed and has been renamed "Talk to Me".

[16] Following his interview with Mr Black , Gregg Reid had no concerns. He completed the Reception Risk Assessment Form (pages 655-657 of Crown production 5) and noted "no apparent issues or concerns". Gregg Reid asked Mr Black if he was suicidal and he replied

"no" (page 657 of Crown Production 5). Gregg Reid, thereafter, arranged for Mr Black to meet with nurse Mara Fraser. Gregg Reid sent the "ACT to Care" document on to Mara Fraser.

[17] Mr Black was interviewed and assessed by practitioner nurse Mara Fraser. Her findings are recorded in the Reception Risk Assessment Form (page 658, Crown Production 5). As part of the assessment she would ask about the prisoner's mental health and psychiatric background. She asks prisoners if they have any thoughts of suicide or self-harm or prior thoughts of or attempts at suicide. Based on their response she would then explore this further. She assesses their body language, eye contact, fidgeting and agitation and would again probe further if there are any indicators. Mara Fraser noted that Mr Black was "no risk". She assessed that there was no apparent risk.

[18] On 17 September 2016 Mr Black was assessed by Dr Suchitra Senthil. The doctor asked Mr Black the questions which are listed on the "ACT to Care" document. He asked Mr Black questions about his mental health, suicidal thoughts, his medication and allergies. Dr Suchitra Senthil noted "consultation, transfer from Shots, sentenced to five years. PMH (past medical history) backache, depression, seizures, meds as per Kardex, allergies nil of drug origin, no suicidal ideation ACT complete" (page 258 Crown Production 4). The doctor assessed that Mr Black had no cause for concern regarding his mental health and that he had no thoughts of self-harm or suicide. Mr Black had presented well throughout this consultation and gave good eye contact.

[19] The Self Change Programme is available within Low Moss. Mr Black commenced the programme on 20 September 2016. He was participating within the Core Phase, which is group therapy.

[20] Mr Black was a willing participant in the Core Phase but he was inconsistent at times regarding his level of participation. His presentation at sessions led the staff running the sessions to form the opinion that he may have been using illicit substances. Staff within Mr Black's residential unit had made similar observations of hyperactivity. Staff requested that Mr Black undergo a mandatory drug test. He passed this test. Prison staff requested that Mr Black be monitored as an individual who was suspected of substance abuse. NHS nurses within the hospital did not think that this was appropriate. On 5 December 2016 Mr Black attended a supported learning session and his inconsistent presentation was discussed. Mr Black denied misusing substances. He attributed his hyperactivity to a traumatic brain injury. The Health Care Department was contacted and advised that this behaviour could have been as a result of brain injury.

[21] Mr Black suffered a drugs overdose on 21 December 2016 and was restored to the Core Phase on 29 December 2016. Staff discussed the overdose with Mr Black who stated that he was not a regular user of substances and that this was a one off. He stated it was a seizure and not an overdose (something which he subsequently admitted on 11 January 2017). On 4 January 2017 Mr Black attended a supported learning session and he stated again to staff that he was not misusing substances. Mr Black attended four more Core Phase sessions before his death. The events of 21 December were as follows.

[22] At approximately 17:00 hours on 21 December 2016 Mr Black was found within his cell unresponsive. A Code Blue emergency call was made and Nurse Fiona Reynolds attended at Mr Black's cell. On arrival at the cell, Mr Black was unresponsive. Mr Black's breathing was laboured and he was starting to turn blue. He was put on oxygen and his oxygen levels started

to pick up. Nurse Reynolds opened his airways and he started to respond. Mr Black was given 2 milligrams of Naloxone (Narcan) which reverses the effects of opiates. By the time paramedics arrived he was conscious, alert and orientated. Mr Black was transferred to Glasgow Royal Infirmary A & E Department.

[23] At approximately 18:16 hours on 21 December 2016 Dr Rachel Harris examined Mr Black at Glasgow Royal Infirmary. He denied taking illicit drugs and complained of a headache, neck and chest pain. Mr Black was fully alert and conscious. Dr Harris performed an ECG trace which was normal and ordered a CT scan which was normal. No other medication was prescribed as she formed the impression that Mr Black had taken some sort of drugs within the prison given the fact that he responded to Naloxone. He was discharged with no follow up plan.

[24] Following Mr Black's return to Low Moss he was placed on "medical observation" by the nursing staff. Mr Black should have been risk assessed on his return to prison. Due to an oversight, he was not. However, Prison Officers checked on Mr Black's physical condition approximately every 15 minutes and Dr Daly consulted with Mr Black on the morning of 22 December 2016 and kept a detailed note of his findings. I am satisfied that the failure to complete the risk assessment on Mr Black's return to prison did not contribute to his demise in January 2017. I note that prison staff have been retrained on the importance of risk assessment in circumstances such as this.

[25] On the morning of 22 December 2016, nursing staff entered Mr Black's cell and found multiple prescribed medications. The medications found in his cell included painkillers and anti-depressants in significant quantities.

[26] Dr Neitu Jeyasingh examined Mr Black on 12 January 2017. Mr Black complained about lower back pain and nothing about his presentation caused the doctor any concern.

Events of 14 - 15 January 2017

[27] At approximately 17:25 hours on Saturday 14 January 2017, Prison Officer Gary Robertson locked Mr Black within his cell. All was in order at this time. At about 08:11 hours on Sunday 15 January 2017, Prison Officer Gary Robertson opened Mr Black's cell and got no response from him. Mr Black had no pulse and was not breathing. Other staff members came to assist. Nurses checked for a pulse but there was none. Emergency services were contacted and uniformed police officers attended. Dr Mohammed Moughal attended and life was pronounced extinct at 13:54 hours on Sunday 15 January.

[28] Detective Constable Paul Doherty and Detective Sergeant Douglas Robertson attended the prison along with Scenes of Crime Officer, Karen Maginnis.

[29] The deceased was lying face down on his bed. He was dressed in a pair of white socks, white boxer shorts and a blue jumper with a Blue Chelsea FC shirt below that. Detective Constable Paul Doherty and Detective Sergeant Douglas Robertson searched the cell and recovered a small mobile phone (Crown Label Number 1), a plastic wrap from the bin and a burnt piece of foil from under the shelf under the television.

[30] There is CCTV footage (Crown Label Number 3) taken from within the prison which shows Mr Black entering his cell at 17:27 hours on 14 January 2017, his cell being locked and thereafter no one enters his cell until 08:11 hours on 15 January 2017 when Gary Robertson, prison officer, is seen entering his cell.

Post Mortem

[31] A post mortem examination was carried out on 25 January 2017 at the Queen Elizabeth University Hospital, Glasgow by Consultant Forensic Pathologist, Dr Marjorie Turner and the cause of death was recorded as:

1a. Morphine and delorazepam intoxication.

Submissions and conclusions

[32] The procurator fiscal depute invited the court to make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act in respect of Mr Black's death. This submission was adopted by Mr Henderson, Solicitor, for NHS Greater Glasgow and Clyde; by Mr Phillips, Solicitor, for the Scottish Prison Officers' Association and by Ms Chalmers, Solicitor, for the Scottish Prison Service. Having considered the terms of the Joint Minute, the oral evidence and the productions in this case, I am satisfied that a formal Determination is appropriate in the circumstances of Mr Black's demise. No submissions were made in terms of section 26(2)(e) (any precautions which could reasonably have been taken and which might realistically have resulted in the death being avoided); section 26(2)(f) (any defects in any system of working which contributed to the death) or section 26(2)(g) (any other facts relevant to the circumstances of the death). I was satisfied that there was no basis on which to make any findings in terms of these provisions.

[33] Although Mr Black had previously managed to stockpile a considerable quantity of prescribed medication; that medication had been removed from his cell on 22 December 2016.

Thereafter, medication prescribed to Mr Black was dispensed under supervision. That was appropriate. There is no evidence to suggest that between 22 December 2016 (when multiple prescribed medication was removed from Mr Black's cell) and the date when Mr Black was found unresponsive in his cell, 15 January 2017; that Mr Black had acquired a further cache of prescribed medication. Significantly, standing the cause of death (morphine and delorazepam intoxication), the evidence of Dr Daly was that the medication prescribed (and dispensed to Mr Black under supervision) would not have contributed to that cause of death.

[34] In short, by the evening of 14 January 2017 Mr Black had managed to acquire illicit drugs which he then consumed in his cell overnight and which led to his demise. There is no evidence to suggest that he had intended to take his own life.

[35] It is agreed in terms of the Joint Minute that Mr Black had suffered a drugs overdose on 22 December 2016. It is recorded in the medical records for 11 January 2017 that Mr Black had then "admitted to taking legal high" on 20 December 2016 and he "reports got a real fright and states has learned his lesson". It would appear that, despite having suffered a recent overdose and having advised medical staff that he had learned his lesson, Mr Black consumed illicit drugs during the night of 14 to 15 January 2017. Drug paraphernalia was found in Mr Black's cell after his death.

[36] Whilst the Prison Authorities endeavour to prevent illicit drugs being taken into the prison, it is regrettable that, despite those endeavours, quantities of illicit drugs manage to be acquired and consumed by prisoners such as Mr Black.

[37] For the sake of completeness, after both investigation and forensic analysis, neither the police nor the prison authorities were able to establish how Mr Black had acquired the drugs which led to his death.

[38] Finally, I wish to thank Ms Gallagher, Procurator Fiscal Depute for the Crown, Mr Henderson, Solicitor, for NHS Greater Glasgow and Clyde, Mr Phillips, Solicitor, for the Scottish Prison Officers' Association and Ms Chalmers, Solicitor, for the Scottish Prison Service for their helpful and professional contribution to the Inquiry and for agreeing the terms of the Joint Minute which considerably shortened the duration of the hearing and limited the oral evidence required.

[39] Before closing I wish to convey my condolences to Mr Black's partner, Eileen Guy, and to his mother, Ann Black.