SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

2020 FAI 30

GRE-B82-20

DETERMINATION

BY

SHERIFF JOSEPH C HUGHES

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

into the death of

JOHN GARNER

Greenock, 11 August 2020

Determination

The Sheriff having considered the information presented at the Inquiry under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") determines as follows:

1. In terms of section 26(2)(a) of the Act that John Garner (hereinafter referred to as "Mr Garner"), born 22 November 1956, latterly a convicted prisoner at HMP Greenock, died within the said prison sometime before approximately 0750 hours on 4 March 2019. Mr Garner was formally pronounced dead on 4 March 2019 at 0924 hours;
2. In terms of section 26(2)(c) of the Act that the cause of Mr Garner's death was:

   I(a) Myocardial Infarction,

I(b) Ischaemic Heart Disease and

II Hepatocellular cancer with spread related to Hepatitis C.

3. In terms of section 26(2) (b), (d), (e), (f) and (g) no other findings are warranted on the evidence before the Inquiry.

Recommendations

The death of Mr Garner was due to natural causes as appears from the findings of Dr Kathryn Clark who attended and examined Mr Garner and pronounced life extinct at 0924 hours. There was no post mortem examination. In terms of section 26(1) (b) of the Act no recommendations are appropriate on the evidence before the Inquiry.

NOTE

Introduction

[1] This Inquiry was held under the Act into the death of Mr John Garner who died on 4 March 2019.

[2] Two parties were represented at the Inquiry. The appearances were Mr Stuart Faure, Procurator Fiscal Depute, for the Crown, and Mr Liam Smith, Solicitor for the Scottish Prison Service ("SPS"). The family were not directly involved and no members of the public took part in this virtual hearing. Mr Garner's next of kin has been kept informed of this Inquiry by the Procurator Fiscal's office and will be advised of this Determination.

[3] There was a preliminary hearing on 18 June 2020 and a hearing on 30 July 2020. A Joint Minute of Agreement was signed on behalf of all participating parties in which all material facts were agreed obviating the need for evidence to be led. Both parties invited me to make only formal findings in terms of section 26(2) (a) and (c) of the Act.

The legal framework

[4] The Inquiry was held under section 1 of the Act and governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[5] The purpose of an Inquiry under section 1(3) of the Act is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[6] It was a mandatory Inquiry in terms of section 2(1) and (4)(a) of the Act as the deceased was in legal custody at the time of his death.

[7] In terms of section 26 of the Act, the Determination requires to set out the findings of the sheriff and any appropriate recommendations.

[8] At the Inquiry, the Procurator Fiscal Depute represents the public interest. The Inquiry is an inquisitorial process and (under section 1(4) of the Act) it is not its purpose to establish civil or criminal liability. It is not a forum to establish legal fault. This Determination shall not be admissible as evidence or be founded upon in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of Mr Garner's death.

Summary

[9] The material facts at this Inquiry were undisputed and uncontroversial.

[10] The Inquiry was held into the death of John Garner, who was born on 22 November 1956. The deceased, Mr Garner, was lawfully detained in custody at HMP Greenock having been convicted of murder on 17 March 2006. He was sentenced to life imprisonment with the minimum term set at fifteen years. His minimum term was due to expire on 24 April 2020. Initially he was imprisoned in England before being moved to HMP Shotts and thereafter being moved to HMP Greenock in November 2018.

[11] Mr Garner had only one visit at HMP Greenock and this was with his solicitor on 14 February 2019. Mr Garner had three compassionate visits to see his mother on 28 December 2018, 22 January 2019 and finally on 15 February 2019. Mr Garner participated in Special Escorted Leaves facilitated by SPS staff from Arran House for these visits, allowing for a more holistic visit to take place.

[12] Mr Garner received confirmation of a diagnosis of liver cancer, which had spread to his other major organs, by Professor Jeff Evans of the Beatson West of Scotland Cancer Centre, Gartnavel Hospital, Glasgow, on 21 November 2018. This is recorded within Crown Production Six. Mr Garner was therefore unwell for some time.

[13] Mr Garner chose not to have any proactive treatment post diagnosis. Instead he chose a palliative pathway which was agreed to by Professor Evans and Dr Kathryn Clark, Medical Officer at HMP Greenock. This was managed on a daily basis by the healthcare team within the prison. Post diagnosis, on 26 November 2018, Mr Garner was moved from the main prison block into alternative accommodation, still within the

prison campus, where the prison regime was more relaxed and prisoners were given a higher level of trust and freedom. Mr Garner was provided with his own private room within the alternative accommodation called Arran House, the Community Integration Unit. Mr Garner was attended to on a daily basis by nursing staff within the unit. He received high dosage of pain killers throughout each day. I was provided with a number of documentary productions including Mr Garner's Medical Notes contained within Crown Production Three. The SPS took all steps possible to ensure Mr Garner remained comfortable and was appropriately cared for, especially in the months leading up to his death.

[14] On the morning of 4th March 2019 Mr Garner was discovered in his bed within his room by a residential officer, Mr Stephen Rodgers at approximately 0750 hours. Mr Garner was cold, not breathing and rigor mortis was present. Mr Rodgers found no suspicious circumstances.

[15] Staff Nurse David McCue attended Mr Garner's room and examined Mr Garner. He also confirmed rigor mortis was present. Mr McCue found no suspicious circumstances.

[16] The aforesaid Dr Clark examined Mr Garner within his own room and pronounced life extinct at 0924 hours on 4 March 2019. Dr Clark found no suspicious circumstances. There was no post mortem examination. Dr Clark issued a death certificate on 6 March 2019 recording the cause of death as: I(a) Myocardial Infarction, I(b) Ischaemic Heart Disease and II Hepatocellular Cancer with spread related to

Hepatitis C. The death has been recorded as such with the Registrar of Births, Deaths and Marriages and verified in Crown Production One.

[17] The death certificate issued by Dr Clark was unsigned. She later confirmed it was the first time she had used the electronic death certificate reporting process and inadvertently missed the signature section. Having had sight of death certificate (Crown Production One), Dr Clark confirmed that this was the death certificate she issued in respect of the death of Mr Garner on 6 March 2019. The death of Mr Garner was intimated to the Procurator Fiscal at Glasgow on 7 March 2019 as verified within Crown Production Two.

[18] Talk to Me ("TTM") is the SPS' Suicide Prevention Strategy in place to safeguard the well-being of the inmates. TTM is a national policy across all SPS establishments, including HMP Greenock. All staff that come into contact with prisoners is trained on TTM. Throughout their entire time in custody, prisoners are continually assessed under TTM, including at admission and following court visits. TTM also includes a "concern form" process. If, at any point, any member of staff has a concern about a prisoner they can fill out a "concern form". The prisoner then meets with, and is assessed by, a group of trained individuals who decide whether the prisoner is "At Risk" or "No Apparent Risk". If deemed as "At Risk", an appropriate care plan will be put in place, such as the prisoner being placed on observation. If deemed as "No Apparent Risk" no further action is taken.

[19] Dr Clark and Nurse Alison Glass filled out a concern form in respect of Mr Garner on 27 February 2019 at 1430 hours. This followed upon comments expressed

by Mr Garner suggesting low mood and suicidal intent. Shortly thereafter, namely within one hour, a case conference took place with Mr Garner on the same day at 1515 hours within Arran House during which these comments were discussed in context. A multi-disciplinary group of professionals assessed Mr Garner as "No Apparent Risk". Accordingly, no further action was taken. This assessment referral is recorded within SPS Production Two which was signed by Mr Garner, Nurse Alison Glass, Nurse Suzanne Taylor and First Line Manager Kat Logan. The form is SPS Production One. It is a true and accurate form.

[20] Mr Garner's death was subject to a review by the SPS as verified within the Death in Prison Learning, Audit and Review ("DIPLAR") Report dated the 29 March 2019 and signed by Mr Gerry Watt SPS Chair and Mr Gordon Hannah NHS Chair. The Report is SPS Production Two. It is a true and accurate Report. The Report highlighted a significant list of examples of good practice, with no learning points resulting in no action plan being required.

[21] There is no evidence before the Inquiry that Mr Garner's death was anything other than an anticipated natural death whilst he was in legal custody. The death has been investigated by the police and was also the subject of an internal review by the SPS in accordance with the protocols in place relating to such a death. Neither investigation identified any issues. The Inquiry is satisfied that this was a natural death with no unanticipated contributing factors.

[22] The medical cause of death was certified as:

I(a) Myocardial Infarction,

I(b) Ischaemic Heart Disease and

II Hepatocellular cancer with spread related to Hepatitis C.

[23] Life was pronounced extinct at 0924 hours on 4 March 2019.

[24] There is no criticism directed to the care of Mr Garner whilst in prison.

Submissions

[25] Those parties who participated in the Inquiry lodged written submissions and were content that I proceed to make my Determination without the need for a hearing on the submissions. I thank both parties for the full submissions that were lodged.

Discussion and conclusions

[26] Given the circumstances of the death of Mr Garner, I am satisfied, as submitted by all parties, that only findings in terms of paragraphs (a) and (c) of section 26(2) of the Act should be made in this case. The death was solely due to natural causes, accurately described in the death certificate. I am satisfied that the death of Mr Garner was a foreseeable event and that those who engaged with him within Arran House engaged appropriately with him in a professional and sympathetic manner. I accordingly have made formal findings in terms of section 26(2) (a) and(c) of the Act. No other finding appeared appropriate on the evidence presented to the Inquiry.

[27] All parties expressed their sincere condolences to Mr Garner's family and friends bereaved by his loss, and to these I add my own condolences.