SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2023] FAI 27

B1409-22

DETERMINATION

BY

SHERIFF DAVID TAYLOR

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

into the death of

PAUL DOWDS

GLASGOW, 22 May 2023

The Sheriff, having considered all of 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 (hereinafter referred to as "the Act") that:

(1) In terms of section 26(2)(a) of the Act, Paul Dowds, born on 3 August 1974, then a prisoner within HM Prison Low Moss, 190 Crosshill Road, Glasgow, died at 5.15pm on 11 July 2020 within Glasgow Royal Infirmary, Castle Street, Glasgow.

(2) In terms of section 26(2)(c) of the Act, the cause of death was:

1a bilateral watershed infarcts.

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

(4) In terms of section 26(2)(f) of the Act, there were no defects in any systems of working which contributed to the death.

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

Recommendations

The Sheriff having considered the information presented at the Inquiry, Makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE:

Introduction

[1] This Determination is made following the Fatal Accident Inquiry held under the Act into the circumstances of the death of Paul Dowds, born 3 August 1974, who died while a prisoner in HM Prison Low Moss, 190 Crosshill Road, Glasgow on 11 July 2020.

[2] Two parties were represented at the Inquiry: Mr Gregor, Procurator Fiscal Depute, appeared for the Crown and Mr Considine, solicitor, appeared on behalf of the Scottish Ministers for the Scottish Prison Service. Intimation of the Inquiry was made to the deceased's son [name redacted] who elected not to participate.

[3] For the purposes of the Inquiry parties tendered a Joint Minute of Agreement which covered all of the necessary chapters of evidence which required to be placed before the court. Therefore, no parole evidence was presented. All parties invited me to make only formal findings in terms of section 26(2)(a) and (c) of the Act.

Legal Framework

[4] This Inquiry was held in terms of section 1 of the Act. It was a mandatory Inquiry in terms of section 2(4)(a) of the Act as Mr Dowds was in legal custody at the time of his death. Although Mr Dowds died whilst in hospital, he remained a prisoner of HM Prison Low Moss throughout that time, meaning that at the time of his death, he was in legal custody.

[5] In terms of section 1(3) of the Act, the purpose of an Inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent any other deaths occurring in similar circumstances. Section 26 requires the sheriff to make a Determination which in terms of section 26(2), is to set out the factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These are:

(a) when and where the death occurred;

(b) when and where any accident resulting in the death occurred;

(c) the cause or causes of death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided;

(f) any defect in any system of working which contributed to the death or to the accident; and

(g) any other facts which are relevant to the circumstances of the death.

[6] In terms of sections 26(1)(b) and 26(4) of the Act, the Inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working; and

(d) the taking of any steps which might realistically prevent other deaths in similar circumstances.

The Procurator Fiscal represents the public interest. An Inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Determination must be based on the evidence presented at the Inquiry. It is not the purpose of an Inquiry to establish criminal or civil liability (section 1(4) of the Act).

Findings

(i) Paul Dowds was born on 3 August 1974.

(ii) Mr Dowds was remanded in custody in HM Prison Low Moss on 21 November 2019 in respect of charges of assault to severe injury and assault and robbery.

(iii) As at the date of his death on 11 July 2020 Mr Dowds was a prisoner in HM Prison, Low Moss and was accordingly in legal custody at the time of his death.

(iv) On his arrival at HM Prison Low Moss on 21 November 2019 Mr Dowds was subject to an assessment by the health care staff as part of his prison admission process. It was noted that Mr Dowds had a history of psychiatric disorder and drug use and that he was under the care of a psychiatrist and a community psychiatric nurse. He was also the subject of a "Talk to Me" risk assessment as part of the Scottish Prison Service's suicide prevention strategy. The "Talk to Me" risk assessment did not assess Mr Dowds as being at risk of committing suicide nor of having any thoughts of deliberate self-harm.

(v) Mr Dowds was reassessed and placed on the "Talk to Me" programme on 30 November 2019 as he reported hearing his deceased former partner speak to him. He remained on the "Talk to Me" programme until 9 January 2020 during which time he was reviewed on a daily basis by Scottish Prison Service staff and NHS nursing staff, was placed under 60 minute cell observation and received regular mental health assessments.

(vi) On 9 January 2020 Mr Dowds was removed from the "Talk to Me" programme as his mental health was assessed as having improved.

(vii) On 3 February 2020 Mr Dowds was assaulted. He sustained injuries to his head, right hand and back for which he received hospital treatment.

(viii) On 8 May 2020 it was noted that Mr Dowds had attempted to conceal an espranor tablet being addiction medication which he had been prescribed. At a subsequent addiction review Mr Dowds' addiction medication was changed and he was commenced on a low dose of methadone.

(ix) On 9 June 2020 Mr Dowds made a self-referral to the prison's medical staff reporting a deterioration in his mental state. The referral was discussed by the staff and on the same date a referral was made to schedule an appointment. Mr Dowds died before this appointment could occur.

(x) On 18 June 2020 Mr Dowds was observed to be fit and well during the evening lock up check. No concerns were raised in relation to his state of health at that time. He was not on any form of official observations under the Management of Offenders at Risk of Substance (MORS) policy nor under the "Talk to Me" programme.

(xi) At around 8.05am on 19 June 2020 prison officers [name redacted] and [name redacted] were carrying out a morning check of the prisoners on Kelvin Hall, HM Prison, Low Moss. In the course of the morning check prison officer [name redacted] checked Mr Dowds' cell; cell 2 D.09, Kelvin Hall.

(xii) Prison Officer [name redacted] found Mr Dowds to be in an unresponsive state, lying on his back on the floor. Mr Dowds had vomit around his mouth and was making a rasping noise as he tried to breath.

(xiii) Prison officer [name redacted] immediately transmitted a code blue message on the prison's radio system. A code blue message is a message indicating that a prisoner is unresponsive and is having difficulty breathing.

(xiv) In response to the code blue message prison officer [name redacted] and First Line Manager [name redacted] attended Mr Dowds' cell. Prison officers [names redacted], [name redacted] and [name redacted], and First Line Manager [name redacted] placed Mr Dowds in the recovery position while they awaited the arrival of nursing staff.

(xv) Acting charge nurses [name redacted] and [name redacted] attended Mr Dowds' cell at about 8.12am. Staff Nurse [name redacted] attended Mr Dowds' cell at about 8.14am.

(xvi) An emergency ambulance was called at about 8.15am.

(xvii) While waiting for the ambulance to arrive the acting charge nurses carried out observations on Mr Dowds and made attempts to clear his airway. Staff Nurse [name redacted] commenced oxygen therapy. Mr Dowds' temperature was measured at 40 degrees Celsius at about 8.20am and his blood oxygen saturation level (SPO2) level was recorded at 35%. One 40ml dose of naxolone was administered to Mr Dowds by acting charge nurse [name redacted] at about 8.25am due to suspected drug intoxication.

(xviii) An ambulance arrived at HM Prison Low Moss at about 8.25am and paramedics arrived at Mr Dowds' cell at about 8.30am.

(xix) At or about 9.00am Mr Dowds was conveyed to Glasgow Royal Infirmary in an ambulance.

(xx) On admission to hospital, Mr Dowds was unconscious and making no verbal communication. He was admitted to the Intensive Care Unit (ICU). Head CT and X-ray scans identified a possible hypoxic brain injury. Mr Dowds was intubated. He had renal impairment and liver impairment. He had a metabolic acidosis and raised creatine kinase levels due to muscle fibre breakdown. There was no evidence of a central nervous system infection. Dr Chalmers, Consultant Intensivist, assessed Mr Dowds' consciousness by stopping sedation. While sedation was stopped he did not regain consciousness.

(xxi) Dr Chalmers reviewed Mr Dowds on 22 June 2020, 25 June 2020, 4 July 2020 and 5 July 2020. On 3 July 2020 at a multidisciplinary meeting of medical staff, it was agreed that further investigations had not identified a firm diagnosis but there was no evidence of further seizure activity. Mr Dowds' condition remained poor and he remained unresponsive. A decision was taken to allow for a further period of time to allow for some improvement but if he remained comatose then he would be moved to end-of-life care.

(xxii) Mr Dowds' condition did not improve and he did not regain consciousness. On 8 July 2020 he was removed from the ventilator due to him breathing for himself. Neurological assessments were carried out and he was found to have no brain activity. On 9 July 2020 Mr Dowds was transferred to Ward 21 for end-of-life care and made as comfortable as possible.

(xxiii) Mr Dowds' life was pronounced extinct at 5.15pm on 11 July 2020.

(xxiv) Responsibility for the provision of health care to prisoners transferred from the Scottish Prison Service to the NHS on 1 November 2011. Since then, individual regional NHS health boards have been responsible for the delivery of health care services within prisons in Scotland which fall within the geographical ambit for the provision of medical care.

(xxv) A post-mortem examination was carried out by Dr Julie McAdam, Forensic Pathologist on 5 August 2020. Crown production number 1 is a report of the post-mortem examination. The cause of the death of Mr Dowds was reported as:

1a Bilateral watershed infarcts.

The conclusion section of the report included the following passages:

> "Clinically he was thought to have hypoxic brain injury and sepsis, the latter associated with a sore on his back, which was thought to be associated with a 'long lie' on the floor of his cell prior to being found.

> As to why he should have had a period of prolonged low blood pressure, microscopic examination of the heart revealed an area of established fibrosis (scarring) which is longstanding, but which could have caused a cardiac event with an associated period of hypotension.
>
> There was a history of a previous seizure and it is possible that this man could have had a period of hypotension related to seizure activity. The history of drug use is also noted and although drug intoxication can also cause low blood pressure, given the period of time between admission to hospital and death, meaningful toxicological analysis of the blood was not possible.
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> In summary, the major finding at post mortem was of bilateral watershed infarcts in the brain ('strokes') and there were no features to suggest sepsis, albeit there was terminal patchy bronchopneumonia. Bilateral watershed infarcts would have been the result of a period of lack of blood flow to the brain, likely due to low blood pressure. Potential causes of low blood pressure would include a cardiac event due to underlying ischaemic damage in the heart, an episode of drug use or a seizure. Given that it is not possible to be certain of the underlying precipitating factor, the cause of death is best regarded as bilateral watershed infarcts."

(xxvi) Neuropathological examination of sections from Mr Dowds' brain was carried out by Professor Colin Smith, Consultant Neuropathologist on 17 August 2020. Neuropathological examination confirmed that there was established bilateral watershed infarction and also a suggestion of a mild degree of global ischaemic brain injury.

Conclusions

[7] Paul Dowds was a 45 year old man who had a history of drug use and mental health problems. He had also suffered from a previous seizure in 2014. He was given appropriate medical treatment during his time in custody at HM Prison, Low Moss. On the morning of 19 June 2020 Mr Dowds was found lying on his back on the floor of his

cell in an unresponsive condition. The appropriate code blue message was transmitted immediately and prison officers and nursing staff attended promptly in response to the code blue message. Mr Dowds received appropriate treatment including oxygen therapy and a 40ml dose of naxolone whilst an ambulance was called. On admission to hospital sadly Mr Dowds' condition did not improve despite receiving appropriate medical treatment and he died on 11 July 2020. Having considered the treatment provided to Mr Dowds at HM Prison Low Moss and at Glasgow Royal Infirmary, I am satisfied that he was well cared for throughout and that there is nothing more that could have been done for him. Given these circumstances of his death 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.

[8] I am grateful to parties for their preparation for this Inquiry as a result of which all of the evidence was agreed and no witnesses were required to attend.

[9] I wish to conclude this Determination by expressing my sympathies and condolences, along with the parties who appeared at the Inquiry, to the family and friends of Mr Dowds and to his next of kin.