SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2023] FAI 4

GLW-B501-23

DETERMINATION

BY

SHERIFF PATRICK HUGHES

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

into the death of

DARRYL GOODWIN

GLASGOW, 12 December 2023

Determination

The Sheriff, having considered the information presented at the Inquiry, determines:

(1) in terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"), that Darryl Goodwin died at 15:50 hours on 26 June 2021 within the resuscitation area of the Accident & Emergency Unit at the Queen Elizabeth University Hospital, Glasgow;

(2) in terms of Section 26(2)(c) of the Act, that the cause of death was amitriptyline, tramadol, etizolam, chlorpromazine and mirtazapine intoxication;

(3) in terms of section 26(2)(e) of the Act, that 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, that there were no defects in any system of working which contributed to the death;

(5) in terms of 26(2)(g) of the Act, that there are no other facts relevant to the circumstances of the death,

and thereafter makes no further determination in terms of Sections 26(2) (b) or (d) of the Act, on the basis that the death did not result from an accident.

RECOMMENDATIONS

In terms of 26(1)(b) of the Act, no recommendations are made.

NOTE

Introduction

[1] This Determination is made following the Fatal Accident Inquiry held under the Act into the death of Darryl Goodwin on 26 June 2021. Notice of the inquiry was given by the procurator fiscal under section 15(1) of the Act on 5 April 2023. Preliminary hearings took place on 5 June 2023 and 26 July 2023. The inquiry itself took place on 4 September 2023, when the court made avizandum.

[2] The Crown was represented by Ms Doran, Procurator Fiscal Depute. Ms Whyte, solicitor appeared for Police Scotland. Mr McKittrick, solicitor appeared for Police

Constables Niall Murphy and Emma Andrews. Ms Grant, solicitor appeared for Mr Goodwin's family. I am grateful to all parties for the assistance they have offered throughout the inquiry.

[3] No oral evidence was led at the inquiry. Instead, a comprehensive and detailed joint minute of agreed evidence was entered into by all parties. That joint minute forms the whole of the evidence before the inquiry and is the basis for the findings set out above. This Determination does not reproduce the entirety of the joint minute, but its content is summarised below from paragraph 7 onwards. All parties invited the court to make only formal findings in terms of paragraphs (a) and (c) of section 26(2) of the Act.

The Legal Framework

[4] The law governing this inquiry is set out in section 1 of the Act and in the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The purpose of this inquiry is to establish the circumstances of Darryl Goodwin's death, and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. A fatal accident inquiry is not an exercise in establishing criminal or civil liability. Its purpose is not to apportion blame or find fault. It is an inquisitorial process, the purpose of which is to establish facts. The public interest is represented by the Crown. In terms of section 26(1)(a) and section 26(2) of the Act, the sheriff's determination must set out findings made on:

(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, and

(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.

[5] In terms of section 26(1)(b) and section 26(4) of the Act the sheriff must make such recommendations, if any, as are considered appropriate regarding any of the following matters which might realistically prevent other deaths in similar circumstances;

(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 other steps.

[6] As a result of section 2(4)(a) of the Act, the holding of this inquiry was mandatory, because Mr Goodwin died whilst in legal custody.

Summary

[7] Darryl Goodwin was born on 8 June 1990. He is survived by his parents, by his younger sister, and by his daughter, now aged 14, who has lived with her paternal

grandparents since she was a baby. Mr Goodwin had for some years suffered from a number of mental and physical health issues. He also had issues arising from drug misuse which had required hospitalisation on more than one occasion in the five years prior to his death. In particular he was dependent on opiates, and had a 16mg daily prescription for Espranor, an opiate substitute which he took under supervision in a pharmacy. In addition, he was prescribed 45mg daily of the antidepressant mirtazapine and 100 mg twice-daily of the antipsychotic chlorpromazine.

[8] At 13.32 hours on 26 June 2021 the police received a call from a member of the public who had heard banging from inside Mr Goodwin's flat going on for around three hours, and was concerned that someone might be trapped inside. The police called Mr Goodwin's telephone number twice within the next ten minutes but these calls went straight to voicemail. Consequently, Police Constables Emma Andrews and Niall Murphy were detailed to attend at the property. They arrived there at 14.15.15 hours, but received no response from within Mr Goodwin's property. They proceeded to make door-to-door enquiries with the other properties in the building.

[9] Meanwhile at 14.21.52 hours Mr Goodwin ran onto Howat Street from Govan Road. This area is covered by public space CCTV, and footage captured by camera G36 between 14.00 and 14.55 hours was lodged as a production. Shortly after first appearing on CCTV, Mr Goodwin fell to the pavement three times, at 14.21.54, 14.22.01, and 14.22.18 hours. The last fall was particularly dramatic, with Mr Goodwin landing face first on the pavement. He then attended at the entrance to the close adjacent to his own close, becoming increasingly unsteady on his feet and holding on to the railings for

support. At 14.25.09 hours Mr Goodwin moved on to the entrance to his own close, where he encountered Constables Murphy and Andrews. They observed him to have "substantial" injuries to his face, close to his eyes, which resembled "carpet burn" that was starting to "scab over"[1]. He was unsteady on his feet and his speech was slurred, which led the officers to conclude that he was under the influence of alcohol or drugs.

[10] The officers helped Mr Goodwin back into his flat, where they noted that the inside door handle was missing; he advised them that he had been locked in earlier that day, and also that he had taken heroin and diazepam, in greater quantities than usual.

[11] PC Murphy suggested that Mr Goodwin be taken to hospital to be seen by a healthcare professional, to which Mr Goodwin agreed. PC Murphy ordered an ambulance at 14.35.32 hours using his Airwave radio terminal but then cancelled this almost immediately, since the two officers had concluded that it would be quicker for them to take Mr Goodwin to hospital in their own vehicle. This decision was made following a radio consultation with a more senior officer, Police Sergeant Gary Aitken. The Queen Elizabeth University Hospital is a 1.2 mile drive away from 13 Howat Street, and the officers considered it would take them only a few minutes to drive there. The emergency call they had made for an ambulance was classified by the ambulance service as "yellow"[2], which would have a median response target of less than 22 minutes;

[1] Crown Production No.14, statement of PC Murphy dated 29 June 2021, p.472

[2] A yellow call is classed as an emergency patient with no life-threatening symptoms. Emergency calls are classed by the Scottish Ambulance service using four colours, with yellow as the lowest priority and purple as the highest priority with a median response target of less than 6 minutes 20 seconds.

however in June 2021 pressures on the ambulance service meant that that target was not achieved, and yellow calls at that time had an average response time of 50 minutes.

[12] As Mr Goodwin was still unsteady on his feet, Constables Murphy and Andrews helped him walk down stairs from his flat to the front entrance of his close. Each officer had a hold of one arm to steady and support him; he was not handcuffed. The group arrived back outside on Howat Street, again being recorded on CCTV. Mr Goodwin was compliant, and they stopped at railings while PC Murphy used point-to-point communication to liaise with Sergeant Aitken. Suddenly Mr Goodwin lashed out at PC Murphy, twisting his upper body in his direction, lunging towards him and shouting; however he did not make contact with PC Murphy.

[13] As a result of this behaviour, Constables Andrews and Murphy took Mr Goodwin to the ground in a recognised escort takedown technique, with both officers being careful to support his weight with their bodies, in accordance with their training. Mr Goodwin was initially placed prone on the ground, facing down. He continued to kick out, wriggle around and evade the application of handcuffs, despite PC Murphy advising him that they were trying to take him to hospital. Handcuffs were then applied to Mr Goodwin, stacked to the rear in accordance with the officers' training, Police Scotland guidance, and standard operating procedures ("SOPs"). The officers then rolled Mr Goodwin on to his right-hand side because they were concerned about the risk of positional asphyxia if he remained lying face down.

[14] PC Murphy then advised Mr Goodwin that he was under arrest for a contravention of Section 38 of the Criminal Justice and Licensing (Scotland) Act 2010.

This was recorded in the Police Scotland System for Tasking Operational Resource ("STORM") at 14.36.32 hours, as was PC Murphy's request for a cell van to transport Mr Goodwin to hospital. The use of such a vehicle is in accordance with Police Scotland's SOP on the Care and Welfare of Persons in Custody. These provide that in certain circumstances a prisoner must be taken directly to hospital instead of to a custody centre[3], and that there are occasions when the prisoner should be transported to hospital by police vehicle rather than by ambulance, particularly when the circumstances warrant immediate attention and there are concerns about ambulance delay.

[15] Mr Goodwin continued to kick out with his legs. PC Andrews restrained his legs and Mr Goodwin calmed down a little. PC Murphy was at Mr Goodwin's head and shoulders, supporting his head.

[16] Two plain-clothes officers, Police Constables Fiona Crum and James Dickson, saw this incident as they were driving past and stopped to help. PC Crum asked Mr Goodwin "if he could breathe ok"[4] and Mr Goodwin nodded. On PC Dickson's suggestion, Mr Goodwin was moved into a sitting position, leaning against a metal bollard. Although initially compliant with this change in position, he then threw his head back in an attempt to strike his head off the bollard. PC Andrews placed her (gloved) hand between Mr Goodwin's head and the bollard to prevent injury; on

[3] Crown Production No.34, Police Scotland Standard Operating Procedure on Care and Welfare of Persons in Police Custody, Version 15.00, published 20/02/2020, Sections 10, 11 and 18.
[4] PC Crum's statement makes clear that he had no concerns about Mr Goodwin's ability to breathe, "this is just something I always ask" (Crown Production No.18 p.497).

checking her glove she did not observe any blood. Mr Goodwin continued to kick out and in doing so kicked his shoes off; PC Crum retrieved these and helped put them back on Mr Goodwin's feet.

[17] At around 14.44 hours Police Sergeant Andrew Roy arrived at Howat Street with a marked police cell van. Constables Andrews, Murphy and Crum walked Mr Goodwin approximately twenty yards to the rear of the van; he was unsteady on his feet, and made jolting movements backwards, kicking and shouting incoherently, resisting going into the van. He entered the van after being told that he was going to hospital, although he continued to shout and swear, kicking the side of the van and hitting his head off the cell wall. Sergeant Roy asked him if he was OK, to which Mr Goodwin replied "fuck off". The van then left Howat Street, with PC Murphy driving and PC Andrews sitting in a rear-facing passenger seat where she could see into the cell where Mr Goodwin was situated. Constables Crum and Dickson had no further involvement with the incident. Sergeant Roy's subsequent involvement is set out at paragraph 23 below.

[18] PC Andrews maintained observation of Mr Goodwin throughout the journey. As the van travelled towards the Queen Elizabeth University Hospital, Mr Goodwin kicked out and repeatedly struck the left and rear sides of his head off the inside of the cell. PC Andrews reported this to the control room at 14.47.44 hours. Mr Goodwin then tensed, looking "rigid"[5], before sliding on to the floor of the cell van, lying on his left-hand side, and seemed to be shaking. PC Andrews said to PC Murphy that she believed

[5] Crown Production No.12, statement of PC Andrews dated 29 June 2021

Mr Goodwin was having a seizure. By this stage they were approximately two to three minutes from the hospital entrance. PC Andrews continued to speak to Mr Goodwin for around 20 seconds, but obtained no response. She entered the cell, noted that his breathing was laboured, and intimated her concern to PC Murphy. He pulled into a layby on Govan Road next to Ronald McDonald House, around 300 yards from the hospital's main entrance, got out and opened the rear cell.

[19] At around 14.51 hours PC Andrews contacted the control room and requested an ambulance, stating that Mr Goodwin was having a suspected seizure and that his breathing had become irregular. This latter call for an ambulance was categorised as "purple", with a median response target of less than 6 minutes and 20 seconds; two ambulances were tasked to respond at 14.54 and 14.55 hours respectively.

[20] PC Murphy removed the handcuffs from Mr Goodwin. Both officers then removed him from the rear of the van and placed him on to the ground, in the recovery position. Blood was visible around his lips, and he now had symptoms of agonal breathing. Because of these factors, mouth-to-mouth resuscitation was not attempted. This was in accordance with Scottish Police Emergency Life Support training, and also recommended best practice for officers during the Covid-19 pandemic.

[21] PC Murphy rolled Mr Goodwin onto his back and commenced cardio-pulmonary resuscitation (CPR) at around 14.53 hours. PC Andrews tilted Mr Goodwin's head back and saw that there was no sign of his airway being blocked.

[22] PC Andrews stopped a passing motorist and asked him to go to the Accident & Emergency department of the hospital to request a defibrillator. She also went to

Ronald McDonald House to see if one was available there, and a request was made via the Airwave communications network as to whether any nearby firearms stations possessed a defibrillator.

[23] Police Sergeant Andrew Roy, having heard the call about a male having laboured breathing, attended the scene within two minutes and took over chest compressions from PC Murphy.

[24] At 14.57.31 hours PC Andrews flagged down a passing ambulance, crewed by William Jackson, paramedic, and Paul Foster, ambulance technician. Having turned into the layby to help, they disconnected their defibrillator from the patient who was on board their ambulance and applied the defibrillator pads to Mr Goodwin's chest. William Jackson concluded that Mr Goodwin had pulseless electrical activity, which is deemed not to be a shockable rhythm. He assessed Mr Goodwin's airway and observed dried blood. He inserted a size 4 i-gel (a supraglottic airway device used in airway management) and ventilated Mr Goodwin with oxygen and a bag valve mask.

[25] Paul Foster took over chest compressions and William Jackson focused on airway management. He used a suction device to remove fluid from Mr Goodwin's airway, noticing a small amount of blood, then replaced the i-gel referred to above with a larger size 5 version, which was a more secure fit.

[26] The dispatched ambulances arrived at 15.00 and 15.01 hours respectively. Another paramedic, Paul Watson, assisted William Jackson and Paul Foster. Mr Goodwin was given advanced life support, and adrenaline was administered

through IV access using an intraosseous needle. Naloxone, a drug used to reverse the effects of narcotic drugs, was also administered.

[27] Meanwhile, police officers who attended at Mr Goodwin's home on Howat Street to secure the property noted several boxes of medication there that were prescribed to a different person.

[28] At approximately 15.20 hours Mr Goodwin was taken by ambulance to the hospital, a journey of around 60 seconds during which life support was continuous throughout. He arrived in the hospital's resuscitation room at 15.27 hours, where he was received by Dr Susan Daisley MBChB BSc FRCP FFICM FRCEM DIPMIC.
Dr Daisley obtained a history from police and paramedics; she confirmed cardiac arrest, intubated Mr Goodwin, placed him on a cardiac compression device, and continued to administer adrenaline and other cardiac arrest drugs.

[29] At 15.50 hours CPR was abandoned and life was pronounced extinct. Dr Daisley concluded, in the absence of any other explanation, that cardiac arrest was due to drug toxicity. After death was pronounced she examined the back of Mr Goodwin's head and noticed a 5cm partial thickness laceration there.

[30] On 7 July 2021 a post-mortem examination was conducted by Dr Julia Bell MB ChB FRCPath DipFMS DMJ (Path) and Dr Gemma Kemp MBBS FRCPath, whose report is dated 10 September 2021. This found that there were no conjunctival petechial haemorrhages, and no obvious injuries within the mouth. In addition to the intraosseous needle in the left upper outer arm, there were needle puncture marks in the right elbow crease and in the right side of the groin. The abrasions previously noted by

Constables Andrews and Murphy were recorded as being on the right upper cheek, lateral to the outer corner of the right eye, measuring 4 x 1.5cm, and below the outer aspect of the left eye, measuring 3.5 x 1.5cm. There was also a vertical laceration measuring 4cm in the upper occipital region of the scalp, with no abrasion or bruising of surrounding skin. There were a number of superficial abrasions and bruises on the arms and hands, an abrasion to the right knee measuring 3.5 x 2cm, two areas of bruising on the scalp measuring 10 x 11cm and 8 x 5cm and also fractures to the ribs and sternum consistent with resuscitation attempts. The trachea and major bronchi contained a small amount of brown fluid. The lungs were very oedematous (i.e. swollen with excess fluid) and were congested. Subsequent neuropathological examination by Professor Colin Smith BSc MBChB MD FRCPath showed no significant abnormality in the brain.

[31] Samples of blood and urine were taken for analysis. On 2 August 2021 a toxicology report was prepared by forensic toxicologists Dr Peter Maskell BSc PhD FRSC CChem CSci MCSFS and Dr Fiona Wylie BSc PhD MRSC. Their analysis identified the presence of the following substances to be present: alcohol; the anti-depressants amitriptyline and mirtazapine; the benzodiazepine etizolam (metabolite); the antipsychotic chlorpromazine, and the opioid analgesic tramadol.

[32] The post mortem report concluded that the circumstances surrounding Mr Goodwin's death were suggestive of the death having been drug-related. The levels of amitriptyline and tramadol were high, well above their recommended therapeutic ranges. The mirtazapine level was slightly higher than the recommended therapeutic range. The chlorpromazine level was therapeutic. A moderate level of

alpha-hydroxyetizolam (the metabolite of etizolam) was also present; this is considered a particularly potent benzodiazepine. The combination of drugs at these levels would have put Mr Goodwin at significant risk of fatal intoxication. These drugs act on the central nervous system and would have had an additive effect which could lead to a variety of toxic effects, including slowing of breathing, unconsciousness, and cardiorespiratory arrest. Amitriptyline, at high levels, can cause cardiac arrhythmias and seizures.

[33] Mr Goodwin had no significant natural disease. There was a laceration and some bruising at the back of his head. There were bruises and abrasions on the face and limbs, including linear bruising around the wrists which could have been related to the use of handcuffs. The other injuries referred to were non-specific and some, including the scalp laceration, could have occurred at the time of terminal collapse. There were no injuries that would account for the death. The cause of Mr Goodwin's death was consistent with it having been drug-related. It was not possible to be certain as to the exact contribution each drug had, or the potential interactions that could occur from the combination of drugs. All of those drugs were included in the primary cause of death, which was given as 1a: amitriptyline, tramadol, etizolam, chlorpromazine and mirtazapine intoxication.

Conclusions

[34] Having considered the evidence before the inquiry, I agree with parties that only formal findings in terms of Section 26(2)(a) and Section 26(2)(c) of the Act are justified.

The medical evidence makes clear that Mr Goodwin's death was caused by drug intoxication. The drugs which caused the intoxication were ingested prior to his entry into police custody. Constables Murphy and Andrews' decision-making and interactions with Mr Goodwin complied with the Police Scotland SOP for Care and Welfare of Persons in Police Custody. Their use of force was later reviewed by Police Constable David MacKay, an experienced Operation Safety Trainer based at the Scottish Police College in Inverness. His opinion - based on consideration of CCTV footage, STORM reports and officers' training records - was that the force used by Constables Murphy and Andrews was reasonable, in that it was proportionate, accountable and necessary. The technique used to take Mr Goodwin to the ground was a recognised one, and whilst Mr Goodwin was on the ground, no undue pressure was applied to his back neck or chest. The shoulder pin technique used whilst he was on the ground is again a recognised one, where pressure is applied to the scapula rather than the back. PC MacKay's conclusion was that the interactions of Constables Murphy and Andrews conformed to their training, police guidance and established processes. I accept this assessment. I am satisfied that there was no precaution which could have been taken which might have averted the death, nor any defect in any system of working which contributed to the death.

[35] I conclude by joining with all parties in offering my condolences to Mr Goodwin's family.