SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

2010 FAI17

DETERMINATION

of

Sheriff Grahame Ritchie Fleming Esq QC

in the inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

into the circumstances of the death

of

Gary Andrew Traynor who was born on 8 November 1964

Livingston 19 April 2010

The Sheriff having resumed consideration of the cause-

1. Determines in terms of section 6(1)(a) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 that the late Mr Gary Andrew Traynor , born 8 November 1964 died in cell No.48 of Tay B wing at Her Majesty's Prison, Station Road, Addiewell on 15 March 2009 sometime between about 17.20 and about 19.04.
2. Determines in terms of section 6(1)(b) of said Act that the deceased died of ischaemic heart disease due to coronary artery thrombosis and atherosclerosis.

3. Determines in terms of section 6(1)(c) of said Act that there were no reasonable precautions whereby his death might have been avoided.
4. Makes no determination in terms of Section 6(1)(d) of said Act.

5. Makes no determination in respect of Section 6(1)(e) of said Act.

Grahame Ritchie Fleming, Esq., Q.C.

Sheriff of the Lothian and Borders at Livingston

NOTE

In this fatal accident inquiry into the death of Gary Andrew Traynor, born 8 November 1964, (hereinafter "the deceased") the Crown were represented by Mr Jonathan Barclay, Procurator Fiscal Depute. Mrs Gail Whealing, solicitor, appeared on behalf of Kalyx Services (hereinafter "Kalyx") the company who have responsibility for the running of HMP Addiewell by virtue of a contract with the Scottish Prison Service. Mr Craig Watt, solicitor, appeared on behalf of the Scottish Ministers.

I heard evidence on 19, 22 and 29 March 2010 and submissions on that latter date.

A joint minute of agreement was lodged on behalf of the parties.

The Crown led the following witnesses-

Steven Archibald Downs Park (aged 32), formerly a prisoner at HMP Addiewell and presently residing at 10 Queensdale Road, Larkhall, Donald Dougall (aged 38) prisoner at HMP Addiewell, Niall Gordon Drysdale (aged 29) and Gary Thomas Cullion (aged 39) both Prison Officers at HMP Addiewell, Claire Louise Donlon (aged 31) Registered Mental Health Nurse formerly employed at HMP Addiewell, Karen Iris Margaret Scott,(aged 42) Paramedic with the Scottish Ambulance Service, DC Phillip Richards, (aged 41) Lothian and Borders Police, Livingston CID, PC Ross Meldrum,(aged 32) Lothian and Borders Police, Anthony Richard Simpson,(aged 40) Deputy Director HMP Addiewell and Mr James George Thomson,(aged 37) Technical Services Manager at HMP Addiewell (hereinafter "the Prison").

Neither Mrs Whealing nor Mr Watt led any evidence.

I considered all the witnesses were endeavouring to assist the Court and were credible and in the main reliable. Mr Simpson, however, did not have any detailed knowledge of certain aspects of the functioning of various systems at the Prison since he is more involved in strategic planning for and is responsible for the commercial interests of Kalyx. As a result he was often unable to provide the inquiry with information on matters of detail or was forced to make assumptions or speculate and for that reason, but through no fault of his own, his evidence was not as helpful as it might have been.

Steven Archibald Downs Park

He gave evidence that in the afternoon of the 15 March 2009 he had been in his cell (no.52) of Tay B wing of the Prison watching a football match with Donald Dougall, the deceased and another prisoner.

At about 5.15pm the prisoners were locked up to allow the officers a meal break. At 6.00pm the cells were unlocked so that the prisoners could collect and eat their dinner. Because he had not seen the deceased collect his dinner, at about 6.20 – 6.30pm he went to the deceased's cell and found the door ajar. He looked into but did not completely enter the cell and saw the deceased lying fully clothed on his bed which was located at the left wall as viewed from the cell door. The deceased's head was at the end of the bed remote from the cell door. He was white in colour and looked as if he was sleeping. Park had shouted at him but got no response. There was no one else in the cell at that time. Park told Dougall that the deceased did not look well and was white and Dougall then went into the cell ,came out and shouted on prison officer Gary Cullion.

Donald Dougall

On 15/3/09 he was a prisoner at the Prison occupying cell No.45.

He confirmed that *inter alios* he and the deceased had watched television in Park's cell until about 5.15pm when the prisoners were locked up. He had seen the deceased walk on his own back to his cell for lock up. Dougall stated that following the unlocking of the cells he was on his way back from returning his plates to the kitchen, having had his dinner, when he was informed by Park that there was something wrong with the deceased. He went into the deceased's cell. The deceased was lying on his back on his bed with his clothes on and with his head at the end of the bed remote from the cell door. He looked as if he was sleeping. Dougall shook the deceased's foot twice but got no response. He tested for the deceased's pulse on his wrist but found none. Dougall stated he had then run to the hall and spoken to Prison Officer Cullion, who was downstairs in

the wing, telling him something was the matter with the deceased and that he should come and see him. Cullion came right away and both went into the cell. This was about 6.30 – 6.40pm. Park went back to his own cell. Cullion immediately radioed for help. Nurses arrived within a matter of seconds and he and the other prisoners were put back in their cells.

Niall Gordon Drysdale

He stated that when the wing was locked down on 15/3/09 he had conducted the head count of prisoners on the top floor of Tay B wing where the deceased's cell (number 48) was located. He had opened the deceased's cell door about 5.25pm and saw the deceased within the cell. He had a vague recollection that the deceased was lying on his bed. He had not spoken to the deceased and the deceased had not acknowledged his presence in any way. This was not unusual. Drysdale had then carried on with the head count of the wing. If it had appeared that something was wrong with the deceased he stated he would have summoned assistance.

At 6.00pm the cells were unlocked but he could not recall whether it was he who had unlocked the deceased's cell or Prison Officer Cullion. The first thing that he knew that something was amiss was at about 7pm when he heard Cullion calling a "code blue" on his radio which indicated a prisoner was unconscious. He had gone to the upper floor of the wing to search for Cullion because he had not stated in which cell in Tay B he was located. He found Cullion in the deceased's cell about a minute later. Donald Dougall was there also.

He saw the deceased lying on his bed on top of the covers with his head and shoulders propped against the far wall. He had his clothes on and there were no signs of injury on him. His pallor was very grey and he looked very unwell. Drysdale did not think the deceased was alive. A couple of minutes later two nurses, Claire Louise Donlon and a nurse he knew only as "Jamie" arrived. The crash bag, which was stored in the satellite hub of the wing, was brought by another officer to the cell and he saw the nurses starting CPR. An ambulance was called and arrived about 15 to 20 minutes later. There was a delay of about 5 minutes in opening the doors at the back of the wing while keys were obtained for it from the gate house to allow the paramedics in.

He identified label two as showing the upper floor of Tay B wing of the Prison which had stairs at either end of it.

Drysdale spoke to there being a button located in the cell about 5 feet off the floor. If a prisoner pressed it he could communicate with the operational support officer (OSO) who was on duty in the satellite hub. Pressing the button caused a phone to ring in the hub and a monitor screen there advises the OSO in which cell the button has been pressed. When the OSO picks up the phone he and the prisoner can speak to one another as there is a microphone and speaker located beside the button in the cell.

The hub is manned even when the prison officers are on their break.

Drysdale had no recollection of the button in the deceased's cell having been activated on the day in question.

Gary Douglas Cullion

He stated he had seen the deceased in Park's cell number 52 sitting on the bed watching a football match with other prisoners and that he had observed nothing which had given him cause for concern or anything unusual about the deceased. The deceased was someone who kept himself to himself. He had not been the officer who had locked the deceased up at about 5.00pm.

At about 6.30pm while he was on the lower floor of Tay B wing the prisoner Dougall had waved to him and shouted on him requesting he come up to the upper level. He immediately did so and found Dougall outside the deceased's cell (no.48). Dougall had asked him to look inside the cell which he did. He saw the deceased slouched on the bed with the small of his back against the far wall. He was grey in colour, looked very unwell and did not appear alive. Dougall asked him what he thought of this and walked up to the deceased and lifted his eyelids.

Cullion immediately radioed a code blue and partly closed the cell door to prevent other prisoners who were congregating to enter the cell.

He said that nurse Claire Louise Donlon then came running and he signalled to her from the upper floor to come upstairs. When she came into the cell she lowered the deceased's body flat on the bed from the slouched position, undid his top and asked for the crash bag. Her colleague, whom he only knew as "Jamie", arrived and both started to tend to the accused. A minute of two later Officer David Duff came with the crash bag and the two nurses started CPR with mouth to mouth resuscitation and chest compression. They continued with this until the paramedics arrived which he thought was about 15 to 20

minutes later but felt a lot longer. He was not aware of any delay in their arrival. They immediately set to work on the deceased and did so for at least 30 minutes.

At some point the deputy director Tony Simpson turned up from his home when the nurses and Drysdale were present and before the deceased's body was removed.
In relation to the cell alarm he said that when the button for this in the cell was pressed LED lights flashed inside and outside the cell which could be reset by pressing a button outside the cell.
When he had gone into the deceased's cell the light was not flashing.
He stated that the deceased was a heavy smoker and there was no restriction on smoking in the cells (a fact confirmed by Mr. Anthony Simpson, the deputy director)

Claire Louise Donlon

She is a Registered Mental Health Nurse and holds a diploma in Mental Health Nursing. Between November 2008 and the beginning of March 2010 she was employed at the Prison. During that period she estimated that Kalyx employed 5 Registered General Nurses , 8 Mental Health Nurses and 1 Registered Learning Disability Nurse. All nurses were given basic training by Kalyx to enable them, whatever their discipline, to be able to respond to any situation at the prison requiring nursing care. She stated that nurses of whatever discipline when training to become nurses are taught basic blood pressure nursing skills and interpretation of results and only a cardiac nurse in a cardiac ward would be given greater training in detecting problems from blood pressure measurements.

On the evening of Sunday 15 March 2009 she was one of four nurses on duty at the Prison. At some point during the evening, the precise time of which she could not remember while with her colleague Jamie McDonald, another Mental Health Nurse, she had received a radio message informing her of a code blue. The duty manager, Sharon Ainsley, who was also with her at that time informed her of the location of the call. She went to the deceased's cell which took her between 30 and 60 seconds. The cell door was open and she saw the deceased on his bed, partially upright, with his back pressed against the wall in a slouched position, both legs on the bed and his body at a forty five degree angle. She entered the cell.

He didn't respond to voice. His cardiac output, breathing and carotid pulse in his neck were checked but there was no sign of life. One of the prison officers moved the deceased so he was lying on the bed on his back. CPR was begun immediately and lasted five to ten minutes until the crash bag arrived. The crash bag contained *inter alia* an ambi bag, a defibrillator and a sats machine (for detecting oxygen saturation in the body). The two continued CPR using the ambi bag and chest compressions. Miss Donlon placed the pads of the defibrillator on to the deceased's chest , connected them to and switched on the defibrillator but at no point was the machine able to detect any heart rhythm. She also placed the sats equipment on the deceased's finger and this detected very low oxygen saturation at this point. CPR was continued by the nurses until the paramedics arrived. The paramedics were briefed by her and they removed the nurses' equipment and attached their own defibrillator. It was they who turned the deceased's body around so that his head was closer to the cell door for better access.

The paramedics' defibrillator had displayed the same flat line response as had been shown on their one. The paramedics inserted a venflon into the deceased's left arm and injected him with adrenalin by means of this. Miss Donlon indicated that the site of the pad in photograph three and four of label one was a common one for such a venflon to be situated. The paramedics worked on the deceased for about forty minutes but there was no response and they pronounced him dead.

Miss Donlon recalled that some time prior to his death she had seen the deceased at the mental health clinic and had made the entry for 15 February 2009 of production number eight (but not the following entry). She had not been unduly concerned about his mental health. Because he had complained of tiredness she wished to have his liver and thyroid function tested and a full blood count which would disclose if he was anaemic but he had not otherwise complained of being physically unwell.

She confirmed making the entry for 15 March 2009 in production number six which were his Scottish Prison Service Healthcare Records and disclosed that the deceased had a history of drug and alcohol abuse. The first page of production number seven was the Kalyx nursing assessment form and was completed (though not signed) by her on 9 January 2009 the date the deceased was transferred to the Prison from Barlinnie Prison. His blood pressure was recorded as 139/88 which was not particularly high or abnormal in her view. That sort of blood pressure was not uncommon in someone who used illicit drugs and it reflected his lifestyle. She would be concerned if the systolic was over 150 and the diastolic between 90-105 and would have flagged this up for the GP. Page two of

production seven was Kalyx Healthcare Admissions form completed by a doctor who would have been given sight of her assessment form in accordance with normal procedure. Under the heading "Past Medical" it recorded that the deceased did not have high blood pressure or a cardiac problem.

Karen Iris Margaret Scott

She has been employed by the Scottish Ambulance Service for fifteen years, for seven of these as a technician and for the last eight as a paramedic.

About 18.55 on 15 March 2009 a call was received by her control room for an ambulance to attend the Prison. She was told that there had been a male found hanging at the prison and a possible cardiac arrest. She and a colleague, Paul Coyle, were mobilised at 18.56 and had driven directly to the Prison, activating their sirens and emergency lights. The arrived at 19.04.They were unable to gain immediate access to the Prison because they had to wait for the gates to be opened but were only delayed by a couple of minutes. On arriving at the deceased's cell she found two people performing CPR on him which she confirmed was being carried out correctly. She and her colleague attached pads to the deceased's chest and connected their own defibrillator to him. She stated that the defibrillator assessed the patient's heart rhythm and determined whether there is a shockable rhythm. She explained that a shockable rhythm is where the heart is in ventricular fibrillation ie is quivering, because there is abnormal electrical activity passing through it. The machine did not detect any electrical activity at all in the deceased's heart i.e. there was no heart beat, which contra- indicated an electrical shock

being administered. She had felt the deceased's neck and found no palpable pulse. CPR was recommenced and she had a vague recollection that the deceased was turned around so his head was closest to the cell doors as shown in photograph one of label one. They endeavoured to intubate the deceased but were unable to do so. There was no sign of life. They injected him with epinephrine (adrenalin) and atropine via a venflon inserted into the deceased in an endeavour to stimulate his heart. This was not successful. CPR was recommenced. She confirmed that the pad shown on the deceased's right wrist in photographs two and three of label one was situated on one of the two sites commonly used on a patient to insert a venflon. She could not absolutely confirm that the syringe shown in photographs eleven and twelve of label one had been used to inject the drugs but was clear that the deceased had not been injected to the neck.
Resuscitation began at 19.09 and ceased at 19.33 when life was pronounced extinct. Because the deceased had appeared warm when she had touched him she inferred that he had not been dead for any great length of time, though she indicated that she was not an expert in such matters.

She stated that although their defibrillator was more sophisticated than what she described as the "shock box" that the nurses had and which was already in the cell, it would have made no difference to the outcome had the prison staff had a machine such as theirs.

PC Ross Meldrum

He has eight years police service.

At about 19.00 hours while on mobile patrol with PC Marjoribanks in West Calder he received a call instructing him to attend the Prison because a prisoner had been found hanging in his cell. They arrived there shortly before 19.10 hours.

He had looked into the deceased's cell and saw two paramedics there with the deceased although he could not recall where the deceased's body was. At no time did he go into the cell.

He had noted the details of various witnesses. He contacted his control room to advise that the CID should be informed and he was there when these officers arrived. He also contacted an undertaker who arrived at 20.35 and removed the deceased to St John's Hospital Mortuary. PC Meldrum accompanied the body to St John's Hospital and had there removed the deceased's clothing. He had seen no marks of violence on the deceased's body.

DC Phillip Richards

He has 15 years police service.

On the evening of Sunday 15 March 2009 he had received a call instructing him to attend the Prison where it was believed a prisoner had committed suicide by hanging. He arrived there at about 20.05 hours having had to travel from Edinburgh. The deceased's cell had been sealed off by the duty manager following the departure of the paramedics. He awaited the arrival of the senior identification officer and then entered the cell.

The deceased was lying on his bed with his head nearest the cell door as in photographs one and two of label one and it was explained to him that the body had been turned round from the original position to facilitate CPR. He confirmed that label one was a book of the photographs taken by the identification officer and spoke to their content. He indicated that photographs 11 and 12 show a syringe but which did not have a needle on it and it had been later explained to him that this had been used to administer treatment to the deceased.

Once the deceased's body had been removed from the cell by the undertakers he instructed the duty manager to seal the cell off again. He noted a statement from Donald Dougall.

While in the Prison he had viewed the relevant CCTV footage of the area where the deceased's cell was and which was stored on the hard drive of the Prison's computer. His notes disclose that at 17.20 Drysdale can be seen performing a head count. At 18.16 Cullion was seen opening the cells though he did not go into any of them and prisoners were seen coming out of their cells to go for their meal. At 18.45 Dougall was seen to enter the deceased's cell come out, look downstairs, return to the cell and then come out straight away. On each of these occasions Dougall was in the cell for only a very short time. At 18.48 Dougall is seen closing the cell door and going down the stairs as if he was about to summon assistance. At 18.50 Gary Cullion is seen coming up the stairs and entering the deceased's cell. Other people are then seen arriving at the area. He had not observed anyone else entering the deceased's cell before Dougall had.

Richards explained that he had been unable to obtain a copy of the footage on DVD from the computer's hard drive because he was told by a manager of the Prison that there was no one available then who had the necessary technical expertise to burn such a disc. Subsequently another officer went to obtain a copy of the footage on a DVD. This was subsequently handed to him but when he came to review it later he found that the footage stopped at 18.30 hours. DC Richards stated he had tried to see if the original footage was still available on the hard drive but it had been over written after, he believed, thirty days. DC Richards accepted that he had not instructed the prison authorities not to over write the footage and agreed that it would be most useful if a system were instituted at the Prison whereby if there was a death in custody the relevant CCTV footage was not over written until the Prison was given permission to do so by the police.

Anthony Richard Simpson

He is an employee of Kalyx. He spoke to his considerable experience in the Scottish Prison Service at various prisons throughout Scotland and at Greenock prison and Glen Ochil YOI. He took up his post at the Prison on 31 March 2008.

Under reference to production three he confirmed that the deceased had been sentenced to four and a half years imprisonment to date from 28 April 2008.

He stated that the first he was aware of the incident was when during the evening of 15 March 2009 he was called at home about a possible death in the Prison and he arrived there sometime between 18.45 – 19.15. He made sure the emergency services were on

site and that the police were contacted and that Kalyx Senior Management in London and the Scottish Prison Service, on whose behalf Kalyx run the Prison, were informed. He also made sure the Prison would continue to function as normally as it could in the circumstances. He did not go to the deceased's cell.

In respect of the deceased's transfer from HMP Barlinnie on 9 January 2009 he confirmed, under reference to production number five, that the deceased had undergone a medical assessment at Barlinnie to ensure that he was fit to travel. That document accompanied the deceased to the Prison as had production six. Under a reference to production seven, he confirmed that the deceased had been assessed by a nurse. In general this would be a registered general nurse or a registered mental health nurse. There would also be an assessment of self harm risk by the nurse and production number nine related to such assessment of the deceased (though the date of the deceased's birth stated therein was incorrect). The next stage was for a prisoner to be seen by a doctor. Prison rules dictated that this must take place within twenty four hours of transfer.

He indicated that routine medical examination took place once a year for high health risk prisoners the elderly or when health records required this but the deceased had not been long enough in the prison for any checkups. Prisoners had access to a nurse and/or doctor practically on request.

Mr Simpson stated that if a prisoner was unwell he could press a button located at chest height on the wall of the cell which activated an alarm in the permanently manned satellite hub in the wing and which enabled the prisoner to communicate with the staff

member on duty there. A light was also illuminated outside the cell from which the alarm had been activated. The light had to be re-set ie switched off by an officer attending at the cell. He said the hub was still staffed during meal and tea breaks and if the person in the hub needed for example to use the lavatory another member of staff would be re-deployed to cover him.

If the prison authorities were aware of a particular health difficulty with a prisoner the Prison had "disabled cells" where such a prisoner could raise the alarm from his bed.

He did not think the deceased had activated the alarm that night but couldn't say why he thought that. He stated that there was a log kept on the computer of when an alarm was activated but he had not examined the log for the 15 March 2009. He was not aware whether it would have been automatically over written at some point since that date.

In respect of CCTV footage his understanding was that it was over written after fourteen days. He said that it was standard practice to copy immediately onto a DVD appropriate CCTV footage in cases of criminal assaults and the like for evidential purposes.

He agreed that it would be a good idea where there was a death in custody to instruct that any relevant footage stored on the hard drive should not be over written until permission was obtained to do so from the police.

Mr Simpson also spoke to the monitoring of the performance by Kalyx of their contract with the Scottish Prison Service and that he was not aware of any concerns that had been expressed by that Service arising from the circumstances of the deceased's death.

At the conclusion of Mr Simpson's evidence the depute fiscal indicated that he would try and ascertain whether there was still a log of any activation of the alarm from the deceased's cell on 15 March 2009. Mrs Whealing helpfully cooperated in obtaining the necessary information from the Prison.

I was subsequently advised by the Procurator Fiscal Depute that the alarm for the deceased's cell had indeed been activated on the evening in question and a copy of the computer log thereof was lodged as production twelve. I was further informed that the Prison security manager, Russell Gordon, was on his way to help parties in an understanding of the log and the accuracy of the timings therein stated.

In the meantime on the unopposed motion of the Procurator Fiscal Depute, Mr Simpson was recalled to give further evidence.

Mr Simpson reiterated that when a button in the cell was pushed by a prisoner inter alia a red light was illuminated outside the cell, located to the side of the cell door. That light did not flash but stayed illuminated. He believed it would be visible to anyone at either end of the floor on which the cell in question was located but not from elsewhere in the wing.

The light was not intended to function as an alarm but really as a guide to the officer on duty on the floor to identify the cell from which a prisoner had pressed a button.
He was also “fairly sure” a light came on in the cell to confirm to the pursuer that the button had been activated. In addition when the button was pressed a schematic on a screen in the satellite hub showed the area and cell where the button had been pressed and the staff member in the hub was able to initiate communication with the prisoner in that cell and ask him what the problem was. He stated that at the left side of the cell door shown in photographs three and four of label one could be seen two metallic squares. One contained the light switch the other contained the cell microphone through which communication could take place with the hub and the button to which he had been referring.
Mr Simpson had not seen production twelve and had little detailed knowledge of its content.

Following this further evidence the Procurator Fiscal depute indicated he had met with the Prison’s head of operational security and obtained further detail about the alarm system. In light of his investigations he indicated that he wished the police to make further enquiries at the Prison including investigation as to who had made the call from the deceased’s cell and the timing thereof as he felt it was important for the Court to have all relevant information placed before it. Accordingly he sought to adjourn the inquiry to a later date and this motion was not opposed. When the inquiry reconvened in

the afternoon of the 29 March 2010 Mr Barclay sought to recall DC Richards and this was not opposed by Mrs Whealing or Mr Watt.

DC Richards stated that in response to Mr. Barclay's instructions he had attended at the Prison on 24 March 2010 and spoken to Jim Thomson IT Manager, who had been responsible for producing production twelve and who had explained to him how the emergency button system operated.

The button in the cell was recessed into the wall thereof at about chest height and there was also a microphone and speaker located there. When the button was pressed it activated a flashing light outside the cell and the phone system in the control hub in the appropriate wing of the prison. If no one answered the phone in the hub within sixty seconds the system defaulted to the emergency control room which is the main control room for the Prison.

In respect of production twelve and the entries therein relating to Tay B 48 (the deceased's cell) the call had been answered by the hub in the wing. Mr Thomson had advised him that the call made then had been recorded on the computer system and he, Richards had listened to it and noted its contents.

The call was as follows:-

Female voice – "Hello"

Male voice – "Claire very important I need this door opened upstairs we've got a guy here he's away we need it open get a prisoner open eh ah a PC up here now please round about fifty round about fifty"

Female voice – “Is it upstairs”

Male voice – “It’s ok we’ve got it open thanks”

Female voice – “Nae bother”.

Thomson had confirmed the times contained in the log were accurate and that he and one of his colleagues had recognised the male voice as that of Gary Cullion. Cullion had been interviewed and with prompting had remembered pressing the button.

DC Richards confirmed once more that he and his colleague DC Langton had viewed the CCTV footage directly from the Prison’s computer system and not from a disc and that he had been told that there was no one available to copy the footage by burning it onto a disc at that time. He had asked that the disc be burned once the appropriate person came on duty and made arrangements for it to be uplifted the following day. He said that because he had gone off duty after the incident he had left a request that another officer recover the appropriate CCTV footage on a disc. Initially he stated he had not specified the passage in the footage which should be copied though had indicated the times he was interested in because he was conscious that there might be relevant footage beyond that he had seen on the evening of 15 March. He also stated it was for the police officer allocated to obtaining the copy, whom he believed had been a PC Chan, to view the footage and indicate to the person on the Prison staff who was to do the copying, the part he wanted copied onto the DVD. However, subsequently DC Richards stated he <u>had</u> asked for footage from the lockdown of the cells (at 17.20) until Cullion was seen entering the deceased’s cell at (18.50) and nothing more.

[I observe, however, that my impression from his answers and demeanour is that DC Richards did not really remember what instructions he left as to what was to be copied]

He could provide no explanation as to why all the relevant footage was not on the disc which the police had obtained from the Prison. The police officer who obtained it from the Prison had believed it did. He assumed that one of the Prison staff had burnt the disc and would have downloaded the section requested by the police. This would have happened on 16 March 2009 and he Richards would have received the disc two or three days later. Some months afterwards he had viewed the disc but only part of it and it was the office of the Procurator Fiscal who had notified him in about February 2010 that some of the footage was missing. He stated that with hindsight he should have viewed the whole disc himself. He said he now views all footage recovered on disc though there were time constraints placed on him.

He accepted that either the police or the person in the Prison who had burnt the disc or both had been at fault in failing to ensure that the disc contained all the relevant footage.

Gary Cullion was then recalled by the Procurator Fiscal Depute, again without objection. He confirmed that it was indeed he who had activated the emergency button in the deceased's cell and at about the time shown in production twelve. He had done so because he had had difficulty in opening the door to the cell while inside and thought it had been locked behind him probably by himself. At this point in time only he, Donald Dougall and the deceased were in the cell and he had panicked a bit. He had spoken to

Claire McDonald and told her he needed someone to come and open the door because it had been locked. He had already radioed the code blue by this time. He had said that he had not mentioned all of this when he first gave evidence because he had forgotten about it.

His understanding was that the light outside the cell would flash until the officer in the hub answered when it would stop flashing but remain on.

James George Thomson

He stated that he had worked at the Prison for just over two years. He said that the system in the cells was a communication tool to the hub in the wing of the prison. When a prisoner pressed the button in the cell an audible alarm sounded in the hub and a monitor screen flashed up there to indicate the cell from which the call originated. The member of staff in the hub then would pick up a handset and was able to speak to the prisoner and vice versa.

Pressing the button also activated a flashing light located outside the cell. When the handset was subsequently put down the call was disconnected. The light outside the cell had to be switched off by a member of staff pressing a reset button.

He said the hub was always manned and if the call was not answered within sixty seconds it was diverted to the emergency control room and a light flashed in both the hub and the control room until the call was answered.

A log of all calls made via this system and the content thereof were stored on a hard drive which had such capacity that there would be no need for it to be overwritten. He confirmed production twelve was part of the computerised log covering 15 March 2009 and which he had created on 22March 2010 and which showed activation of the button in the deceased's cell. He said that the timings give were accurate because IT staff checked the computer Mondays to Fridays though, (somewhat bizarrely to my mind) only by an IT staff member looking at his watch!!

He confirmed that CCTV footage for 15 March 2009 would no longer be available as the computer's hard drive was overwritten after fourteen days unless a back up copy was made. The head of operations would be the person who would determine whether a backup copy was necessary. He was unable to say whether there was a system in place for making backup copies relevant to a death in custody. The IT unit had no such procedure because this was a security not an IT matter. The burning onto a DVD disc of material from the hard drive was not part of the responsibilities of the IT staff but of the security staff.

Submissions by the Crown –

The Fiscal referred to the joint minute and the post mortem report where the cause of death was given as ischaemic heart disease, coronary artery thrombosis and coronary artery atherosclerosis. That report disclosed no marks of violence on the deceased's body and toxicology was negative for drugs and alcohol.

Under reference to production eleven, he observed there were no entries relating to cardio –vascular or blood pressure problems or problems with the deceased's heart or arteries and submitted there had been nothing to alert the Prison authorities to any potential problem with any of these.

The date of death was not an issue and in respect of the time thereof he invited me to find that the deceased had died of natural causes within the Prison sometime between 18.15 and 18.45 when he was discovered by prisoners and the Prison nurses worked on the deceased.

In respect of section 6(1)(d) of the 1976 Act the Crown's position was that the immediate response by the Prison to the situation was adequate, a prison officer had attended the cell and called for assistance, the response from the medical staff in the Prison was in keeping with the emergency and nurses had arrived and given CPR, the crash bag had been made available to them and an ambulance called immediately. The paramedics had done everything they could to revive the deceased but were unsuccessful.

Although Niall Drysdale had said that there had been a delay at the Prison gates on exploring this with the other prison officer, Claire Louise Donlon and the paramedics any such delay was insignificant.

The police had responded immediately, the locus was secured, statements noted and photographs taken. The CCTV footage had been viewed and the matter reported to the Procurator Fiscal.

Some criticism might be made, he said, of the failure of Donlon to sign production seven and of the fact that the relevant fields in production five had not been completed.

The Fiscal indicated that there perhaps might be some scope to find that a better system should be put in place for retaining CCTV footage. He also indicated that perhaps for long term prisoners there should be yearly medical checks because a prisoner was unlikely to refer himself. The Court might also have been surprised by the evidence there was no restriction on smoking in cells.

Submissions on behalf of Kalyx-

Mrs Whealing submitted that my findings in terms of section 6(1)(a) of the 1976 Act should reflect articles one, two and three of the joint minute. While 19.33 was the time that life was declared extinct by the paramedics she suggested that on the evidence, death occurred sometime between 17.20 when Drysdale locked the prisoners up and spoke to seeing the deceased in his cell and 18.55 when Coyle and Scott got the call to attend at the Prison. Mrs Whealing also made reference to Miss Donlon's evidence that though she was not clear as to timing, when she had entered the cell there were no signs Mr. Traynor was alive. He was non responsive to voice and when she had checked his cardiac output and breathing and his neck pulse was checked there were no signs of life.

In respect of section 6(1)(b) she adopted the depute Fiscal's position as to cause of death conform to articles seven, eight and nine of the joint minute.

She submitted that the Court should make no other findings and there should be a formal determination only.

She adopted the submission by the depute fiscal under reference to section 6(1)(d) of the Act as to the adequacy of the way that the deceased was dealt with. Any delay at the Prison gates for the paramedics was not significant. Miss Scott had stated she received a call at 18.55, she and her partner had arrived at the Prison at 19.04 and at 19.09 resuscitation commenced.

Any criticism which might be made of the completion or otherwise of forms five and seven of process was irrelevant to the circumstances of the deceased's death. The main point to note from these documents was there was no previous indication of cardiac difficulty or disease.

As far as CCTV footage was concerned it was a matter for the Court as to whether any comment should be made but asserted that those working for Kalyx running the Prison in the circumstances of this case had done all that they had been required or requested to do by the police.

Submissions on behalf of the Scottish Ministers-

Mr Watt adopted the submissions by Mrs Whealing on the time of death.

It was open to the Court he said, to select the time the deceased was formally pronounced dead by the paramedics or hold that the deceased had died between the period between

the lock-up at 17.20 and ending either when he was seen by a fellow prisoner at 18.45, when the Mental Health Nurses attended or when the paramedics attended, but he submitted that death had probably occurred before it was formally called by the paramedics. He suggested death took place between the time the deceased was locked up and when he was discovered by the prisoner who took his pulse and found none.

In respect of section 6(1)(b) he adopted the submissions of the Procurator Fiscal Depute and Mrs Whealing.

So far as section 6(1)(c),(d) and(e) of the Act were concerned none of the issues highlighted by the Procurator Fiscal were in his submission contributory factors or relevant to the deceased's death.

The fact that the medical transfer form from HMP Barlinnie had not been properly filled in had no bearing whatsoever on or made any contribution to this. Any criticism of that form or of the form number seven of process might be contained as a comment in my note but should not appear in the determination. Equally any criticism of any failures to keep CCTV footage or the Prison's policy on smoking was not relevant to anything I had to determine.

He invited me to make a formal determination only.

Decision.

<u>Place and Time of death</u>

There is no doubt and it was not disputed that the deceased died in HMP Addiewell on 15 March 2009.

So far as the time of death is concerned I have concluded that the deceased was dead before the paramedics arrived and by the time the nurses tried to resuscitate him. They were the first *medically trained* persons to establish that there were no signs of life and for that reason I prefer to determine this as the end point when *they* saw him rather than when the prisoner Dougall took his pulse and found none.

It is difficult to be certain precisely when this end point was but it must have been after Cullion's call to the hub which was at 18:51:56 and before the paramedics arrived at the prison which they logged at 1904.

The last time the deceased was seen alive was at about 1720 when Dougall saw him go back to his cell at a time when the prisoners were being locked up.

Accordingly I shall determine the time of death as sometime between about 1720 and about 1904.

<u>The cause of death</u>

There was a considerable body of evidence which satisfies me that the deceased died of natural causes.

(Why messages were passed to various persons that a hanging was involved was never explored in the evidence and accordingly must remain a mystery).

Neither Park, Drysdale nor Cullion noted anything amiss in the deceased's cell to suggest that there might have been a disturbance there. Their evidence was echoed by PC

Meldrum who noted nothing to suggest anything untoward and he observed that the only sign of disturbance in the cell was from the items discarded by the paramedics. He had seen nothing suspicious nor any marks of violence on the deceased's body when he saw it at the mortuary. DC Richards also saw no signs of violence on the deceased and in particular no marks or blood which might have given him cause for concern and expressed a view that in such a small area if there had been a disturbance he would have expected the cell to have been in disarray. Likewise the post mortem report does not reveal any indication that the deceased had been subjected to violence or injury.
I am satisfied on the basis of the post mortem and toxicology reports lodged (productions one and two respectively) that the cause of death was ischaemic heart disease due to coronary artery sclerosis and atherosclerosis.

Reasonable precautions whereby the death might have been avoided-

I am satisfied that Kalyx had no reason to suspect that the deceased had heart, artery or blood pressure problems. The deceased's medical notes, production eleven, contain no entries in respect of these. The doctor who completed the admission form, production seven seems to have asked the deceased if he had any cardiac problems and recorded that the deceased had said "no" and likewise that he had not suffered from any past high blood pressure. Equally there was no evidence that the blood pressure measurement taken by Claire Louise Donlon should have alerted anyone to the possibility of cardiac problems and indeed she indicated that his blood pressure was within the normal limits of

somebody of his lifestyle. Furthermore he had not complained of any physical problems when she saw him on the 15 February 2009.

Both Park and Dougall indicated that the deceased had not complained of feeling unwell on the day he died or indeed previously.

Park said when watching the football the deceased had looked the same as always and Dougall also indicated that he appeared fine when he had observed him then.

Both Drysdale and Cullion confirmed that the deceased had never complained to them of being unwell and Cullion indicated that he had never seen the deceased looking unwell or anything that had given him cause for concern about the deceased's health.

I am satisfied in these circumstances that there were no reasonable precautions which could have been taken and which might have avoided the deceased's death.

Defects in any system of working which contributed to the death.

There was nothing in the evidence to suggest that the prison staff should have discovered the deceased was in difficulties before they did.

On the basis of Cullion's own evidence and that of DC Richards (who indicated that Thomson and a colleague of Thomson's had recognised Cullion's voice on the recording) I am satisfied that the call from the deceased's cell which is logged in production twelve was made by Cullion and not by the deceased.

I also am satisfied on the evidence of Claire Louise Donlon that the response when his body was discovered was entirely satisfactory. On the evidence given by the paramedic, Ms Scott no criticism can in my view be made of the procedures adopted by the nurses to

resuscitate him nor of the equipment available to them. Equally I am satisfied that the paramedics' attempts to revive him were satisfactory and that the delay to their entry at the gate to the prison was minimal and of no significance.

It was suggested at one point to Miss Donlon that it might be helpful if a specific question was to be included in the nursing assessment form, of which the first page of production seven is an example, along the lines of "Do you have a cardiac problem?" That was something apparently which is included in the form a general practitioner completes when taking on a new NHS patient. However a prisoner would need to know that he had a heart problem and she conceded that other questions in the form, for example about taking medication, would alert a nurse to this anyway. In any event I observe that such a question *is* included in the form which the prison doctor completes and in the circumstances of this case failure to ask such a question in the nursing assessment is of no relevance.

There was no evidence from anyone with the requisite medical expertise about the adequacy of the Prison's system of medical checkups for prisoners and accordingly I make no determination thereanent.

I do not therefore make any determination or recommendation in respect of section 6(1)(d) of the Act.

<u>Other facts which are relevant to the circumstances of the death.</u>

There are none in my opinion.

Miscellaneous matters

During the course of the evidence it was disclosed that in essence there was and is no restriction on the amount of tobacco prisoners can smoke in their cells in the Prison. But that in my view was not demonstrated to have any relevance to this inquiry and I do not propose to say anything further about it beyond observing that it may well be that there is a proper reason for this policy, for example, in terms of maintaining good order in the prison where withdrawal of nicotine from prisoners who smoke might cause difficulties. It was also noted during the inquiry that the nursing assessment part of production seven had not been signed and that the prison transfer form, production five, had not been completed properly.

These defects had no bearing on the circumstances of the deceased's death but indicate a degree of carelessness particularly by personnel at HMP Barlinnie.

Production five I conceive to be a form of importance as it seems to be the first document which would highlight to the receiving prison any material medical problems relating to the prisoner being transferred. Due care should therefore be taken to see that it is properly completed.

I would also wish to mention, although again it is of no real significance in the circumstances of this case, the retention of CCTV footage in the Prison. I am not able on the evidence presented to me to decide who was at fault for the fact that label two does not contain the footage it should. Absent any defect in the disc itself either the police or the person burning the copy or both are the likely culprits but I cannot say which.

It seems to me to be desirable, however, that where there is a death in custody and footage is in existence stored on a hard drive which might be relevant to that death, that this should **not** be over written, even if a copy is made by burning it onto a DVD or separately stored in some other way, until permission to do so is given by the Procurator Fiscal or the police.

One can envisage that it is not merely in the instant case that problems may arise with any copy made from the hard drive of a computer either because sufficient care has not been taken to secure that the appropriate footage is copied or because of some error in copying or even I suppose, because of a defect in the disc.

Certainly my experience of the copying of CCTV footage in criminal cases indicates that not uncommonly the copy is found to be defective in one way or another.

Fortunately in the instant matter DC Richards had taken a note of what he had seen.

In the result however my determinations in this inquiry are formal.