SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2020] FAI 42

KIL-B169-20

DETERMINATION

BY

SHERIFF GEORGE JAMIESON

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

into the death of

FRANCIS (known as FRANK) ANDREW HART

Kilmarnock, 2 October 2020

DETERMINATION

The sheriff having considered the information presented at the inquiry, Determines in terms of section 26 of the Act that:-

Francis (known as Frank) Andrew Hart, born 31 December 1992, ordinarily resident in Cumnock, died at University Hospital Crosshouse, Kilmarnock on 17 December 2018 at 17:28 while in legal custody at that time.

In terms of section 26(2)(a), the death occurred on 17 December 2018 at 17:28 at University Hospital Crosshouse, Kilmarnock.

In terms of section 26(2)(b), no accident occurred which resulted in the death.

In terms of section 26(2)(c), the cause of the death was Basilar artery dissection.

In terms of section 26(2)(d), there were no cause or causes of any accident resulting in the death, there being no accident that occurred which resulted in the death.

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

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

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

RECOMMENDATIONS

No recommendations are made.

NOTE

Introduction

[1] On 24 September 2020 at Kilmarnock Sheriff Court a public inquiry was held under the 2016 Act into the death of the deceased Francis (known as Frank) Andrew Hart, born 31 December 1992 at Crosshouse Hospital, Kilmarnock on 17 December 2018 at 17:28.

[2] The death was reported to COPFS on 8 January 2019.

[3] Preliminary hearings were held at Kilmarnock Sheriff Court by teleconference on 8 July 2020, 24 July 2020, 31 August 2020 and 17 September 2020.

[4] STUART FAURÉ, Procurator Fiscal Depute represented the Crown at the inquiry.

[5] LIAM SMITH, Solicitor represented the Scottish Prison Service at the inquiry.

[6] JULIA McDONALD, Solicitor represented Serco Limited at the inquiry.

[7] GORDON LAURIE, Prison Custody Officer and PE Instructor, HMP, Kilmarnock, gave evidence at the inquiry.

[8] Crown label number 1 being CCTV footage of the gym area within HMP Kilmarnock recorded on 18 December 2018 was played in court during the course of GORDON LAURIE'S evidence. This footage recorded the deceased collapsing while using the gym at HMP, Kilmarnock on 17 December 2018.

[9] JOHN FLEMING, Security Manager, HMP, Kilmarnock gave evidence at the inquiry.

The legal framework

[10] An inquiry was held under section 1 of the 2016 Act.

[11] The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[12] In terms of sections 1(3) and (4) of the 2016 Act, the purpose of the inquiry was to (a) establish the circumstances of the death, and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the inquiry was not to establish civil or criminal liability.

[13] In terms of sections 26(1), (2) and (4) of the 2016 Act, the sheriff must as soon as possible after the conclusion of the evidence and submissions in the inquiry, make a determination setting out:

(1) In terms of subsections (1)(a) and (2), in relation to the death to which the inquiry relates, the sheriff's findings as to (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, and (g) any other facts which are relevant to the circumstances of the death.

(2) In terms of subsections (1)(b) and (4), 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 other steps, which might realistically prevent other deaths in similar circumstances.

[14] The procurator fiscal depute represented the public interest at the inquiry.

[15] The inquiry was an inquisitorial process.

Summary

Agreed facts

[16] Parties entered into a joint minute agreeing the following facts:

1. On 25 June 2018, FRANCIS (known as FRANK) ANDREW HART, date of birth 12 August 1992 ("the deceased") appeared at Ayr Sheriff Court in respect of case bearing PF reference number AY18002322 and was granted bail.
2. On 25 July 2018, the deceased appeared at Ayr Sheriff Court in respect of case bearing PF reference number AY18002963 and was granted bail.
3. On 22 August 2018, the deceased appeared at Ayr Sheriff Court in respect of both above-noted cases and pleaded guilty to a charge in contravention of the Criminal Procedure (Scotland) Act 1995, section 27(1)(b), and to

two charges of contravening section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010.

4. On 13 September 2018, the deceased appeared at Ayr Sheriff Court in respect of case bearing PF reference number AY18003759 and was remanded in custody within HMP Kilmarnock.

5. On 12 October 2018, the deceased appeared at Ayr Sheriff Court in respect of the above case and pleaded guilty to a charge of contravening the Criminal Procedure (Scotland) Act 1995 section 27(1)(b) and a charge in contravention of section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010.

6. On 8 November 2018, again at Ayr Sheriff Court, the deceased was sentenced to 240 days imprisonment (backdated to 13 September 2018), 96 days imprisonment and 96 days imprisonment for the aforementioned cases. These sentences were to be served consecutively.

7. The deceased was returned to HMP Kilmarnock ("the prison") to serve his sentence. He was accordingly in legal custody at the time of his death.

8. The deceased was processed upon his initial arrival at the prison following remand on 13 September 2018. On 9 October 2018, the deceased underwent a medical assessment within the prison health centre. Within the medical history section of the assessment form, it was noted that the deceased had no history of Hypertension, IHD/Angina,

Asthma, COPD, Epilepsy, Diabetes or Cardiovascular Disease. The deceased's height and weight were noted and his blood pressure on that date is noted as 14/61 mmHg. Within the assessment it is also noted that the deceased stated that he suffered from Bi-Polar disorder and that he had used cocaine. It is further noted that the deceased stated that he exercised on a daily basis.

9. The deceased was a regular user of the prison gym. Within the prison all prisoners are allowed to use the prison gym except those prisoners who are "on punishment". At any one time up to 40 prisoners can be using the prison gym facilities.

10. On 12 December 2018, the deceased was within the prison gym and was lifting weights. At approximately 18.15 the deceased was seen to collapse. Witness Gordon Laurie, one of the prison PT instructors was alerted by other prisoners and he radioed a medical response, known as a "code blue" response immediately. Ann Walker, one of the prison nurses, went to the prison gymnasium along with other staff members. On arrival several other prison offices were in attendance. The deceased was lying on the gymnasium floor in the recovery position.

Nurse Anne Walker attended to the deceased and noted that he was unresponsive to voice and pain. His body was noted to be stiff with bi- lateral extensive posturing. Nurse Walker completed a set of observations, namely blood pressure, heart rate, respiratory rate and

saturations as well as temperature and blood glucose levels. These were all within normal limits. Nurse Walker gave the deceased supplementary oxygen via a guedal, a tube which was inserted into the airway to ensure that the airway remained open and potent. The deceased remained stable. The guedal was removed when the deceased vomited. Nurse Walker remained with the deceased until the paramedics arrived. 10 mg of Diazepam was administered as an anticonvulsant.

11. At 18.53 on 12 December 2018, paramedic, John Welsh, received a call to attend at HM Prison Kilmarnock. He arrived at the prison at 18.58. He was led to the prison gym by prison staff. On arrival at the gym he observed the deceased lying on his left side with three nurses present as well as members of prison staff. He described the deceased as "actively convulsing". Prison nursing staff confirmed to John Welsh that the oxygen saturation of the deceased was 100 per cent and that his heart rate was fast. The deceased was noted to be rigid and then showed some signs of decerebrate posturing - the full extension of the arms with an outward rotation of the hands which is a significant finding with a cerebral event. No injury of note was observed.

12. A second ambulance crew attended and the care of the deceased was handed over to them. The deceased was subsequently transferred by ambulance to Crosshouse Hospital in Kilmarnock.

13. On arrival at Crosshouse Hospital, the deceased was noted to have cardiac arrhythmia with hypoxia and the possibility of drug ingestion was raised. He was intubated and a CT scan was carried out. This was inconclusive. The deceased was commenced on anticonvulsant medication and was treated for a possible central nervous system infection. During the evening following admission on 12 December 2018 he was administered 4mg of lorazepam. There was information that the deceased had been complaining of dental pain and was noted to have taken an excess of paracetamol – 24 tablets and ibuprofen – 24 tablets on 24 November 2018. He had been seen by a dentist at hospital on 24 November 2018 and was found to have gross dental caries. On 24 November 2018 the deceased had his fillings dressed and he was prescribed pain relief. A lumbar puncture was carried out on 13 December 2018 and the results were negative. A further CT scan was carried out on 14 December 2018. This reported extensive infraction of cerebellum occipital lobes on both thalaemi. Early cerebral tonsil herniation and mild hydrocephalus, a total succal effacement of supratentorial brain was noted. This means a massive stroke to the rear of the brain. It was subsequently determined by Dr Athanasios Grivas, Consultant Neurosurgeon, that there was no neurosurgical intervention possible and that it was a devastating and unsurvivable stroke. On 17 December 2018, the decision to withdraw treatment was made by

Dr Geoffrey Warnock. At 17.15 the deceased was extubated, his inotropes were discontinued and his vasopressors were stopped. The deceased was given morphine and Midazolam and he passed away at 17.28. Life was pronounced extinct by Dr Maximilliane Kellner and this was certified at 18.05 on 17 December 2020.

14. On 18 December 2018, at 10.00 hours Prison Custody Officer Graham Millar assisted police officers to search the prison cell of the deceased, cell number B13. This search was carried out with the assistance of a dog trained to detect the presence of drugs, but the dog gave no positive indication for the presence of drugs. Shortly afterwards a systemic search of the deceased's cell was carried out by Detective Constable Robert Blackley and another officer. Amongst items seized were (i) a pink tablet later identified as the anti-depressant molipaxin, (ii) crushed white powder which was later identified as tramadol and (iii) various small pieces of paper which were found to have traces of the synthetic cannabinoid, Spice" on them.

15. A post mortem examination was carried out by Dr Marjorie Turner, Consultant Pathologist and Dr Julie McAdam, Consultant Pathologist on 27 December 2018 at the Queen Elizabeth University Hospital in Glasgow. The cause of death was certified as 1a: Basilar artery dissection.

16. In the conclusion to the post mortem report the pathologists have commented that:

> "there was no evidence of any pathological risk factors in the development of arterial dissection - such as any connective tissue disorder, vessel wall abnormality or anatomical abnormality - and no apparent history of hypertension. However, dissection of intracranial and extracranial blood vessels has been described in association with weight lifting. Apart from Bronchopneumonia which would have developed as a consequence of a period of unconsciousness prior to death, there was no other evidence of natural disease."

17. There was no significant injury to the body. Analysis of blood samples taken after admission to hospital revealed low levels of diazepam and lorazepam (benzodiazepines). Also detected was a breakdown product of a synthetic cannabinoid receptor agonist.

18. The pathologists have noted that synthetic cannabinoid receptor agonists can cause hypertension and the presence of this drug could potentially have been a factor in the development of basilar artery dissection. The pathologists noted the history of cocaine use, but there was no evidence of recent cocaine use or other stimulants.

I make the following findings in fact based on the evidence of Gordon Laurie at the inquiry:

1. In 2018, prisoners wishing to use the gym at HMP, Kilmarnock were required to undergo an induction with a PE instructor on a one to one basis.

2. The induction consisted of the PE instructor explaining to the prisoner how to operate the gym equipment and included a questionnaire in which the prisoner confirmed that the use of the gym equipment had been explained to the prisoner and the prisoner's understanding of the induction.

3. Prisoners were also required to disclose their medical history in the questionnaire.

4. Prisoners were not allowed to use the gym if any medical issues were highlighted until the nurse and/or doctor had approved the prisoner using the gym.

5. The information from the questionnaire was required to be typed into the prison's CMS system and remain on the prisoner's file. This did not happen in the deceased's case. An audit conducted after the deceased's death found no evidence on the CMS system that the deceased - and some other prisoners - had been inducted into the gym.

6. The PTI manager at the time when the deceased was using the gym informed Mr Laurie that he thought the deceased had been inducted into the gym but was not sure.

7. The deceased is likely to have been inducted into the gym, given his frequent use of the gym and the prison's policy of not allowing prisoners to use the gym without an induction.

8. The induction process would have made no material contribution to the deceased's death as the deceased's post mortem found that:

> "there was no evidence of any pathological risk factors in the development of arterial dissection - such as any connective tissue disorder, vessel wall abnormality or anatomical abnormality - and no apparent history of hypertension".

9. HMP Kilmarnock has now tightened up its process of allowing prisoners' use of the gym. No prisoner is now allowed entry to the gym without the prison staff checking on the CMS that they have been inducted for gym use.

10. On 17 December 2018, the deceased had ran to the gym from his cell to secure the use of weights before other prisoners. Prisoners running to the gym for this purpose was common practice within the prison.

I make the following findings in fact based on the evidence of John Fleming at the inquiry:

1. Mr Fleming was security manager at HMP, Kilmarnock in 2018.

2. The Security and Operations Group that he manages within the prison is distinct from the Intelligence Unit, though the two units work together when required.

3. One of the roles of the Security and Operations Group within HMP Kilmarnock in 2018 was to take security measures to both prevent

illicit drugs from entering the prison, and discovering the presence of such drugs if they do find their way into the prison.

4. Despite the best efforts of the Security and Operations Group, they were in 2018, and continue to be, unable to prevent all illicit drugs finding their way into the prison due to the ingenuity of prisoners in circumventing security measures.

5. Intelligence files from within HMP Kilmarnock dated 12 December 2018 reveal that the deceased had been taking "Spice" prior to attending the gym.

6. They also reveal that prior to attending the gym for the 18:00 session, the deceased had been using psychoactive substances in his workshop during the morning session.

7. Prisoners using the gym would be denied access to the gym if the intelligence unit highlighted any issues.

8. The intelligence dated 12 December 2018 is not likely to have been passed on to the Security and Operations Group. Had this information been passed to the Security and Operations Unit, Mr Fleming or one of his managers would have acted on the intelligence and instructed a search of the deceased's cell.

9. Any such search would not necessarily have prevented the deceased from continuing in any practice to use illicit drugs prior to exercise on any future occasion, including the date of his death.

Submissions

[17] Parties were agreed that I should make findings in terms of sections 26(1)(a) and (2)(a) and (c) of the 2016 Act relating to the date, place and cause of death.

[18] They were agreed that no findings were required in terms of sections 26(1)(a) and (2)(b), (d), (e) and (f) of the 2016 Act, and that I should not make any recommendations in terms of sections 26(1)(b) and (4) of the Act.

[19] They further agreed that there was insufficient evidence upon which I could conclude that any recent illicit drug use on the part of the deceased while in HMP Kilmarnock materially contributed to his death.

[20] The procurator fiscal depute suggested however that I should make a finding in terms of sections 26(1)(a) and (2)(g) of the 2016 Act restricted to the record keeping issue.

[21] He submitted that the prison's failure to record any health questionnaire completed by the deceased prior to his gym induction on the prison's CMS system was relevant to the circumstances of the death, albeit not causally linked to any defective system of working.

[22] Mr Smith and Ms McDonald did not think this factor was relevant to the circumstances of the deceased's death as there were no reasonable precautions the prison could reasonably have taken which might realistically have resulted in avoiding the deceased's death. The record keeping issue was therefore not, in their submission, relevant to the circumstances of the death.

Discussion

Cause of death

[23] Although the pathologists noted in their report that dissection of intracranial and extracranial blood vessels has been described in association with weight lifting, and synthetic cannabinoid receptor agonists can cause hypertension and the presence of this drug could potentially have been a factor in the development of basilar artery dissection, I agree with parties that there is insufficient evidence to allow me to conclude that any drug use by the deceased materially contributed to his death.

Record keeping

[24] In my opinion, the record keeping issue is not a circumstance "relevant" to the deceased's death within the meaning of section 26(2)(g) of the Act as I have found that the deceased was likely to have been inducted into the gym, and in any event the prison's failure to record the induction on its CMS had no causal relationship to the deceased's death.

[25] I therefore agree with the submissions made by Mr Smith and Ms McDonald that the record keeping issue was not relevant to the circumstances of the deceased's death.

Recommendations

[26] I agree with parties that no recommendations are necessary as the prison has since the deceased's death tightened up the procedures for prisoners using the prison gym.

Conclusion

[27] I agree with Mr Smith when he said that the deceased's death was tragic and unavoidable.

[28] I thank the parties for their assistance in conducting this inquiry. I wish to particularly commend them for the efficient and sensitive manner in which they prepared for and conducted the inquiry.

[29] Mr Hart's family conducted themselves with dignity at the inquiry.

[30] I extend my condolences to them for the tragic loss of their son and brother.