SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN PERTH

[2021] FAI 34

PER-B267-19

DETERMINATION

BY

SHERIFF PRINCIPAL MARYSIA W LEWIS

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

into the death of

GARY WILLIAMSON

Perth, 2 September 2020

The Sheriff Principal, having considered the information presented at the inquiry determines that:

(1) In terms of section 26(2)(a) of the Fatal Accidents and sudden Deaths Etc (Scotland) Act 2016 ("the Act") Gary Williamson, born on 12 December 1995, died at 18.25 hours on 14 June 2018 within the intensive care unit at Perth Royal Infirmary, Taymount Terrace, Perth.

(2) In terms of section 26(2)(b) and (d) of the Act there was no accident resulting in the death, and there are no recommendations which might realistically prevent other deaths in similar circumstances.

(3) In terms of section 26(2)(c) of the Act the cause of the death was due to the combined acute and chronic adverse effects from which he suffered as a result of his taking lethal quantities of Buprenorphine and Etizolam.

(4) In terms of section 26(2)(e) of the Act there were no precautions which could reasonably have been taken whereby the death might have been avoided.

(5) In terms of section 6(2)(f) and (g) of the Act there were no defects in any system of working which contributed to the death and there were no other facts relevant to the circumstances of the death.

NOTE

Introduction

[1] The inquiry was held in to the death of Mr Williamson under section 1 of the Act. Mrs Whyte, Procurator Fiscal Depute, represented the Crown; Mr Smith represented the Scottish Prison Service; Ms Wallace represented that the Prison Officers Association Scotland; and Ms Gormley represented Tayside Health Board. Mr Williamson's family did not participate.

[2] Mr Williamson was a serving prisoner having been sentenced to 6 months imprisonment at Dundee sheriff court. This was a mandatory inquiry in terms of sections 2(1) and 2(4) as Mr Williamson was, at the time of his death, in legal custody. It is not the purpose of the inquiry to establish criminal or civil liability – it is to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

Procedure

[3] On 18 June 2018 the death of Mr Williamson was reported to the Procurator Fiscal. On 15 October 2019 a preliminary hearing took place at which there was much discussion about the presentation of evidence, the preparation of affidavits and witness statements, the lodging of productions including policy documents and standard operating procedures, protocols and the completion of an extensive joint minute. The Crown indicated that due to the extent of the matters agreed there would be no requirement to hear any oral testimony and that at the conclusion of the proceedings all parties would be inviting me to make formal findings only. I indicated that I required sight of the protocols and policies in place at the time of the death of the deceased in relation to the prevention of the introduction of drugs into the prison estate and the measures which ought to have been taken to search prisoners and their cells for banned substances and items.

[4] Since this inquiry took place I have become aware that a number of sheriffs in Perth have expressed concern about critical omissions in joint minutes regarding policies and protocols in relation to the prevention of the introduction of drugs into the prison estate and also the measures which ought to have been taken to search prisoners and their cells for banned substances and items. They have also provided robust comment on what appear to be repeated failures to lead evidence that even if the policies were fit for purpose, the policies were followed in relation to the deceased. I endorse their views.

[5] The issues which I explored with the parties were addressed by the time the inquiry took place. The parties cooperated fully in pursuing these matters and I was satisfied that I could proceed without the need to hear oral evidence.

[6] Parties had entered into an extensive joint minute of agreement in terms of Rule 4.10 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules"). The relevant terms of the joint minute are reflected in this determination and in particular cover the incarceration of Mr Williamson, a description of the CCTV footage, the conduct of the post-mortem, the results of the post-mortem, the toxicology report and the recovery of drugs from the cell in which Mr Williamson's body was discovered. It also contains agreement relating to large quantities of productions, photographs and witness statements. The joint minute was read for the record during the course of which minor typographical errors were noted and appropriate amendments were made.

[7] The Crown presented 38 witness statements. Most of these related to the taking of photographs, the collating of all relevant paperwork from HMP Perth, the medical intervention, the search of the cell and subsequent police investigation. In addition the Crown relied upon affidavits provided by the following: JF (an operations officer at HMP Perth), JM (a prison officer at HMP Perth), RY (a prison officer at HMP Perth), and AC (a state enrolled nurse, registered mental health nurse and substance misuse team worker based at HMP Perth). JD, an operations officer at HMP Perth, is on long term sick leave and was unable to provide an affidavit. The participants at the inquiry undertook to accept his witness statement as being true and accurate – and this is reflected in the joint minute.

[8] Mr Smith read the police statement of JD and the affidavit of JF. Ms Wallace read the affidavits of RY, JM and AC. During the reading of the affidavits it became clear that they were not appropriately cross referenced to the documentary productions and this resulted in numerous questions from me. I therefore encourage those who present material to an inquiry of this type to ensure that the affidavits contain appropriate cross references to the relevant material.

[9] The Crown had lodged the following productions:

1) Intimation of death;
2) Post-mortem examination report;
3) Toxicology report;
4) Book of photographs;
5) Prison medical records;
6) Death in custody folder;
7) Medical records.

I also had sight of the protocols and the standard operating procedures referred to in the joint minute. These were produced by the Scottish Prison Service.

Summary of facts

[10] The following paragraphs summarise the principle events relative to this inquiry and provide primarily a timeline of those events on 13 and 14 June 2018.

Admission to HMP Perth

[11] Gary Williamson ("the deceased") was born on 12 December 1995. He was the adoptive son of Mr PC and Mrs MC.

[12] The deceased was in a relationship with CMcN. At 09.00 hours on 13 June 2018 the deceased told CMcN that he had taken five Valium tablets. She did not consider that his walking and talking were affected.

[13] Later that morning at Dundee Sheriff Court the deceased was sentenced to 6 months imprisonment for repeated breaches of a restriction of liberty order. He was conveyed to HMP Perth to begin serving his sentence. (Crown production 6 page 87 is the copy warrant relating to the sentence.)

[14] At 11.50 hours on arrival at HMP Perth the deceased was taken to holding cell 1 pending undergoing the standard admissions assessment. (Crown production 6 page 91 is a record of the arrival time at HMP Perth.)

[15] As part of the HMP Perth Standard Operating Procedure OPS-001 "Reception-Admission Procedures" (SPS production 1) all prisoners are assessed. The admission procedure principally comprises of five main activities: checking court orders and the prisoner's identity; searching and other security procedures; information gathering - a reception interview, entries in to the Prisoner Supervision System, a Talk to Me interview and entering the details in to the PR2; conducting initial health and welfare screening; and providing information on the establishment, local procedures and specific entitlements.

[16] The role of the reception officer is to book in a prisoner and to carry out an initial interview prior to the prisoner meeting with the nursing staff. The initial interview usually lasts around 10 minutes and covers any issues the prisoner may have, for example, mental health issues and self-harming issues.

[17] Prison Officer JD was working at the prisoner reception desk along with Prison Officers RY, JF and DB. At 12.10 hours Officer JD interviewed the deceased and carried out the assessment under the Talk to Me strategy. He recorded on the Reception Risk Assessment Form (Crown production 6 pages 92 and 93) that the deceased "presented well throughout", "communicated well" and assessed him as "no apparent risk". He also recorded that the deceased suffered from anxiety, PTSD, depression, agoraphobia, that although there had been a previous attempt at self-harm he had no thoughts of suicide or self-harm, and that he was valium dependant. The statement of Officer JD was agreed to be a true account of the assessment carried out as part of the admission to HMP Perth procedures.

[18] Officer JF was assisting with the processing of prisoners by carrying out searches on all prisoners entering or leaving the reception area. As soon as the risk assessment was completed, Officer JF took the deceased to a cubicle for the purposes of a search. The deceased walked through a cell sense scanner. The scanner did not detect any metal objects.

[19] Officer JF followed the standard rotating visual inspection in accordance with the HMP Perth Standard Operating Procedure OPS – 302 – "Searching Prisoners" (SPS production 2). This Procedure complies with the Prison and Young Offenders

Institutions (Scotland) Rules 2011 and guidance contained within GMA 80A/03 Strip Searching of Prisoners (SPS productions 3 and 4), and the purpose of it is to ensure the safety and wellbeing of all prisoners and staff by preventing the introduction of unauthorised or prohibited items or those considered to be a threat to security, good order and discipline. The contents of those productions were agreed to be true and accurate.

[20] Officer JF asked the deceased if he was concealing any items, which the deceased denied. Officer JF asked the deceased if he had previously had a body search and the deceased confirmed that he had. The inspection was conducted by Officer JF in the presence of Officer JD, each of whom is the same gender as the deceased. Officer JF instructed the deceased to remove his upper clothing and to raise his hands and turn, which he did. His upper clothing was inspected by Officer JF who then returned it to the deceased. Officer JF instructed the deceased to remove his lower clothing and turn, which he did. Each garment and shoes were checked and returned to the deceased. The deceased stood with his legs apart during the search and raised the soles of his feet when requested to do so. Nothing was found during the search. Officer JF considered that the deceased was a bit nervous but did not appear to be under the influence of any substance and gave no cause for concern. No injuries were seen by either Officer. The search was completed by 12.50 hours.

[21] SPS production 3 provides that examination of the anus, genital or perineum should not be a routine part of a body search and should only be done where there are grounds for suspicion that a prisoner is concealing a forbidden article in those areas.

Officer JF did not ask the deceased to squat because he did not have reasonable grounds to suspect that the deceased was internally concealing illegal items.

[22] The deceased returned to the reception desk. He was placed in holding cell 4 awaiting further assessment. At 13.30 hours he was assessed by Nurse AC at the nurses' station. Nurse AC has been a nurse at HMP Perth for 22 years. She is substance misuse nurse and assesses prisoners for treatment and supports them during treatment. In June 2018 the Substance Misuse Team undertook the health care admission process whereas now the Primary Care Team has that responsibility.

[23] Nurse AC asked the deceased a number of questions about his physical and mental health, recorded his answers in to the Vision computer programme and completed the Healthcare Risk Assessment (Crown production 6 page 94). The deceased reported to her that he occasionally misused valium and heroin and that he had last taken Valium on 12 June 2018. He advised her that he had a history of anxiety, depression and PTSD. Despite being affected by a number of deaths in the family over a 10 year period he had no thoughts of self-harm or suicide.

[24] As part of the assessment Nurse AC looked for signs of intoxication or impairment such as slurred speech, unsteadiness on the feet, inability to communicate and the size of pupils. She noted that he initially appeared a little nervous but was soon laughing and joking: he made good eye contact; was not having difficulty in speaking or walking; and gave no indication which might raise concern that he was under the influence of any substance.

[25] Every person admitted to HMP Perth is asked to provide a sample of urine which is dip tested by nursing staff. This test will detect methadone, opiates, benzos, buprenorphine and cocaine. Nurse AC emphasised the need to obtain a clean sample at the time of admission rather than later in the day when the opportunity to obtain illicit substances may have been taken by a prisoner. She required the deceased to provide a sample of urine during his healthcare risk assessment. He was unable to do so. Nurse AC gave the deceased some water and then waited a further 20-30 minutes. He was still unable to produce a sample. She informed the deceased that he would be seen by a doctor the following day as part of the routine admission. This assessment was completed at 13.24 hours.

Allocation of cell

[26] After the standard admissions process had been carried out, the deceased was placed in holding cell 4. Several prisoners entered and exited the cell.

[27] At 14.19 hours Prison Officer PMcL escorted the deceased from cell 4 to Hall C. Prison Officer RY was working in C hall that day. Officer PMcL passed the paperwork in respect of the deceased to Officer RY and left the deceased in the care of Officer RY. The deceased was taken by Officer RY to an interview room for induction. During the induction, Officer RY facilitated a phone call between Mr Williamson and his cousin. During the call the deceased advised his cousin of his imprisonment and asked that his girlfriend be informed. There was no mention of drugs or drug related activities.

[28] The deceased collected bedding. Officer RY then escorted the deceased to cell 2/66 which is a shared cell. The prisoner who was already in cell 2/66 refused to take a cellmate. That prisoner was volatile, hostile and argumentative.

[29] Officer RY placed the deceased temporarily in cell C2/72 pending identifying an available cell in B hall. The deceased remained in that cell for upwards of 30 minutes. During that period Officer RY observed several prisoners (these were subsequently identified as JP, RB, GF and CG) standing around the entrance to cell C2/72. Other prisoners were walking along the galleries attending to daily chores. He did not see anything untoward in their actions.

[30] On being advised of the availability of an alternative cell, Officer RY collected the deceased from cell C2/72. The deceased was alone and gave no cause for concern. Officer RY conveyed the deceased to B hall where an available cell had been identified. On his arrival at B hall the deceased was handed over to Prison Officer JM. At no point during the interaction between Officer RY and Mr Williamson did the deceased appear to be under the influence of any substance.

[31] Officer JM allocated the deceased cell 4/31. On discovering that the MD, who is related to the deceased, was also resident in B hall in cell 4/29, Officer JM took the deceased to meet MD in cell 4/29. MD had a cell mate – GO. A single cell was available elsewhere in C hall. Officer JM suggested that GO move to the single cell, permitting the deceased and MD to share. All three agreed to that proposal. GO vacated the cell at 16.06 hours.

[32] During his transition from the admission holding cell to his eventual destination in B hall, the deceased did come in to contact with a number of prisoners.

Subsequent movements

[33] Shortly after 16.48 hours Officer JM locked the whole hall as part of the preparation for the start of the evening meal. A short time later Officer JM unlocked the cell to permit the deceased and Mr MD to collect their meals. They did so and returned to the cell, which Officer JM locked.

[34] At 19.00 hours the cells were opened to permit the prisoners to participate in recreational activities. Officer JM did not see the deceased in the recreational area. He did not see the deceased enter the cells of others nor did he notice other prisoners entering the cell occupied by the deceased and Mr MD. He observed him after night time locked down in his cell.

[35] The movements of the deceased are captured on the CCTV footage: he did come into contact with prisoners (AA, RB, RC, MW during the recreation period; he played pool with Mr MD; and was involved with a series of telephone calls made by Mr MD from the communal phone. The cells were locked down at 20.19 hours.

[36] Officer JM noted that throughout his contact with the deceased, he had no concerns over the deceased's presentation whom he considered had presented as confident.

[37] None of the Officers who had any contact with the deceased during his admission process had any reason to believe that he was under the influence of illicit substances or was "packing drugs" or "banking drugs".

Telephone calls

[38] Prisoners are allocated a prisoner number and a personal PIN number both of which are unique to them. Each prisoner can make phone calls from within the prison using their PIN numbers. To access the phone system the prisoner must input their prisoner number followed by their unique four digit PIN number. All calls are recorded and the prisoners are made aware of this.

[39] Mr MD made a series of telephone calls on the afternoon and in the early evening of 14 June. A recording of all calls made by Mr MD from 11 June through to 21 June 2018 were downloaded from a computer programme linked to the Scottish Prisoner Network, used by the SPS and located within the Intelligence Management Unit at HMP Perth. The download was placed on a disc. The disc was not played during the inquiry. The subsequent intelligence reports indicate that the discussions did not involve criminality.

CCTV Footage

[40] The CCTV footage from HMP Perth was viewed by investigating police officers including DC EB. A detailed narration of the content of that footage is set out in the joint minute based on the witness statement of DC EB and reveals a multitude of

movements from the point of admission of the deceased through to the allocation of his cell in B hall and into the evening until lockdown. No criminality was seen by those viewing the CCTV nor did DC EB consider that the deceased was acting as if under the influence of any substance.

[41] Officer RY was asked to view a segment of the CCTV footage covering the period 15.11 to 15.29 hours on 13 June and he identified the following prisoners who each had contact with the deceased – JP, CG, RB, GF and WR.

Death of Mr Williamson

[42] In the early hours of 14 June MD awoke. He discovered the deceased lying on his bed in a pool of vomit. At 01.45 hours Mr MD summoned assistance though use of the cell intercom and spoke with prison officer KM. A full emergency response followed. Officer KM arrived at the cell and observed the deceased lying on his bed unresponsive. She called for immediate assistance. BH (operations officer), ML (operations officer) and BS (front line manager) arrived swiftly. They began CPR and continued to apply CPR in rotation until paramedics arrived.

[43] LP, ambulance technician, received a telephone call at 01.50 hours advising of a cardiac arrest at HMP Perth. She and her colleague SS arrived by ambulance at HMP Perth at 01.58 hours. They were taken immediately to a cell in B Hall. She saw a male lying on the floor in a pool of black vomit.

[44] The paramedics removed the deceased from his cell and continued to provide CPR. They placed the deceased on a stretcher and conveyed him by ambulance to the

Accident and Emergency department at Perth Royal Infirmary. The deceased was transferred to the intensive care unit where he was given multi-system support.

[45] Extensive assessment was carried out and treatment continued throughout the night into the early hours of the following morning. At 05.30 hours a thorough neurological assessment was carried out. There was no evidence of brain stem activity detected at that time. The family was informed. At 06.15 hours ventilation was disconnected. Life was pronounced extinct at 06.25 hours.

[46] At 07.00 hours Detective Constables A and P inspected the body of the decease and observed no obvious injuries or marks.

Forensic examination of items found in cell

[47] At 20.30 hours on 15 June 2018 CD, a Scene Examination Shift Supervisor of the SPA attended at HMP Perth and took scene photographs of the cell area (Crown production 4). A search of Mr Williamson's cell by PC F, PC D and PC K supervised by PC McD took place on 15 June 2018 at 21.00 hours. They found the following - on the bedframe, a plastic wrap containing crystal substance; behind the safe a wrap containing Buprenorphine, within a loaf of bread on a shelf a kinder egg containing quantities of tablets (63 tablets containing oxymetholone) and within a roll a snap bag containing four pieces of brown resinous substance (6.9 grams of cannabis resin). The search did not reveal how those substances came into the deceased's possession.

Post-mortem

[48] On 19 June 2018 at Ninewells Hospital in Dundee a post-mortem examination was carried out by Dr TMcN and Dr DS, both consultant forensic pathologists at the University of Dundee. They determined that the cause of death was the combined acute and chronic adverse effects of Buprenorphine and Etizolam. Crown production 2 is the post mortem examination report.

[49] Post-mortem samples of blood, urine and vitreous humour were analysed (Crown production 3) revealed the presence of Buprenorphine and Etizolam.

[50] Buprenorphine is a powerful opioid painkilling drug that is used in opiate replacement therapy. It acts as a partial agonist and works by blocking the opiate receptors. It is a potent and long lasting drug. As with all opiates it has a number of side effects. Among these is its ability to cause respiratory depression. Severe respiratory depression can induce coma and death. It has a high currency value in prisons. The circulation of drugs within prisons is clearly an ongoing problem that is difficult to eradicate and is a challenge within the prison setting.

Observations of inmates

[51] During the course of the police investigation fellow inmates GO and MD reported the following.

[52] GO did not know the deceased. His first impression was that the deceased was under the influence of drugs - his eyes were glazed but his speech was not slurred. He overheard the deceased tell Mr MD that he had taken 40 valium. He did not see the

deceased take any substances; did not see him in possession of any substances; did not hear the deceased speak to other prisoners about drugs being taken and he did not overhear any of the phone calls. He encountered the deceased in the passing in the early evening and did not notice any change in the presentation of the deceased.

[53] MD is the partner of Ms MC – she is the cousin of the deceased. He was aware that the deceased smoked cannabis leaf and cannabis resin as well as taking valium. His first impression on encountering the deceased was that the deceased was under the influence of drugs: his voice was slurred. He challenged the deceased about his presentation and the deceased advised Mr MD that he had taken 40 valium prior to going to court and that he had been given a line of subutex in C hall. He showed Mr MD the residue of the subutex which was in a cigarette paper. Mr MD advised the deceased to put it in the safe.

[54] Although he saw the deceased interact with other prisoners during the day and in the evening during the recreational period, he did not see the deceased take any drugs. During the early part of the evening the deceased produced a kinder egg from which he took green tablets. He also produced dope wrapped in cling film. Mr MD assumed that the deceased had been banking these items because they were produced after a visit to the toilet. He did not see the deceased consume any of the items. The deceased placed the dope in a clear medicine bag and then put it inside a bread roll. He placed the kinder egg in a loaf.

[55] Mr MD did not see the deceased sell any of the drugs to fellow prisoners.

[56] After lockdown, Mr MD saw the deceased smoke a small amount of cannabis and later a small amount of dope.

[57] Neither Mr GO or Mr MD reported their immediate suspicions to any of the prison officers. Mr MD did not report his observations of drug concealing and drug taking to the staff. I cannot say with any certainty that had they done so, the death of Mr Williamson could have been avoided.

Submissions

[58] The Crown submitted that the Court should make formal findings under section 26(2)(a) of the 2016 Act and that no recommendations were required. Mr Smith for the Scottish Prison Service invited me to make formal findings as did Ms Wallace for the Prison Officers Association Scotland. There was nothing in the presentation of the deceased from the point of admission onwards to indicate risk or to indicate issues with the use of illicit drugs. All staff who encountered the deceased spoke of his pleasant demeanour, that he had engaged well and gave no cause for concern. There was no intelligence to suggest that the deceased was using or banking drugs. There was no requirement for an internal body search and any further measures would not have been reasonable. I was also invited on behalf of Tayside Health Board to make formal findings only. It was submitted that there was no evidence to support the conclusion that there were defects in the system attributable to the Health Service and in particular to the acting of Nurse AC. The deceased's interactions with Nurse AC did not suggest

that that he was under the influence of drugs and she did not report any concerns. He was not considered to be at risk.

Conclusion

[59] The prison service and the health service require to take reasonable precautions to prevent deaths in prison. On the evidence placed before me, the supervision and care of the deceased by the prison staff and medical staff cannot be criticised. I am satisfied that the Operating Procedures aimed at detecting and preventing the importation of illicit drugs into the prison are reasonable and were followed in this case.

[60] Those working within the prison service are well aware that attempts will be made to circumvent the systems which are put in place. There was no intelligence or suspicion expressed to the staff by any serving prisoner which would have resulted in the deceased or his cell being searched. The nursing staff did not record any observation about the presentation of the deceased which would indicate that he had taken or was banking illicit substances. If Mr Williamson was suspected as being under the influence of illegal substances during the admissions process or at any other point, any member of staff who was in contact with him could have placed him on the SPS Management of an Offender at Risk due to any Substance (MORS) policy. The healthcare staff would then have put an appropriate care plan in place.

[61] It was not possible to establish from the evidence how the drugs consumed by the deceased made their way into the prison. He may have brought the items in himself as Mr MD suspected or he may have been supplied by another prisoner within the

prison. If prisoners are determined to obtain illicit drugs then they will find innovative and imaginative ways of doing so.

[62] I am satisfied that it is appropriate to make the findings stated above, having regard to the terms of the Joint Minute and the additional evidence presented in the affidavits and other documents. I do not consider that any additional findings in my determination are required in terms of section 26(1)(a) or any recommendations in terms of section 26(1)(b) and (4) of the 2016 Act. On the evidence available to me, there were no reasonable precautions that could have been taken that might realistically prevent other deaths in similar circumstances.

[63] I offer my condolences to the family of the late Gary Williamson for their loss and for their patience in awaiting the outcome of the inquiry.