SHERIFFDOM OF GLASGOW & STRATHKELVIN

[2020] FAI 11

B1713/19

DETERMINATION

BY

SHERIFF PRINCIPAL C D TURNBULL

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

into the death of

THOMAS LEIPER

Glasgow, 17 February 2020

Findings

The Sheriff Principal, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the Act") that:

F1. In terms of section 26(2)(a) of the Act Thomas Leiper (hereinafter referred to as "Mr Leiper"), born 5 July 1974, then a prisoner within HMP Barlinnie, Lee Avenue, Glasgow died there at or about 09:32 hours on 27 March 2018 within cell 21 of Delta Hall.

F2. In terms of section 26(2)(c) of the Act, the cause of the death was (1a) methadone, etizolam and amitriptyline intoxication; and (2) cardiac enlargement.

F3. In terms of section 26(2)(e) of the Act, a precaution which (i) could reasonably have been taken; and (ii) had it been taken, might realistically have resulted in the death of Mr Leiper being avoided would have been for Mr Leiper not to have ingested the methadone, etizolam and amitriptyline which caused his death.

F4. In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death.

F5. In terms of section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

Recommendations

The Sheriff Principal, having considered the information presented at the inquiry, makes no recommendations in terms of 26(1)(b) of the Act.

Note

[1] This determination is made following the fatal accident inquiry in to the death of Thomas Leiper (who I refer to as "Mr Leiper"), who died on 27 March 2018, whilst in legal custody, at HMP Barlinnie in Glasgow.

[2] Fatal accident inquiries are now governed by the terms of (a) the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the Act"); and (b) the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the Rules"). In this determination (and the appendices), unless otherwise

stated, references to sections are to sections of the Act; and references to rules are to rules within the Rules.

[3] The form of determination required by rule 6.1 (i.e. Form 6.1) stipulates the inclusion of the legal framework in terms of which the inquiry proceeds. In the majority of inquiries, that will be of limited interest. In this determination, I have set out much of the legal framework in Appendix 1. The present inquiry was a mandatory one in terms of sections 2(1)(a) and (4)(a), Mr Leiper having been in legal custody at the time of his death.

[4] The procurator fiscal represents the public interest in a fatal accident inquiry. In this inquiry, the procurator fiscal was represented by Claire Gallagher, procurator fiscal depute; Liam Smith, solicitor, appeared on behalf of the Scottish Prison Service (who I refer to as "the SPS" in this determination); Emma Toner, advocate, appeared on behalf of Serco Ltd; and Ruth Wallace, solicitor, appeared on behalf of the Scottish Prison Officer's Association. Mr Leiper's family did not participate in the inquiry. I am grateful to all those appearing and to those instructing them for their respective contributions, and for the assistance they gave to me during the course of the inquiry.

[5] A notice of an inquiry was given by the procurator fiscal under section 15(1) on 2 August 2019. I pronounced a first order on 2 August 2019, assigning a preliminary hearing and the date for the commencement of the inquiry.

[6] Preliminary hearings took place on 26 September; 24 October; and 28 November, all 2019. The participants entered into three separate joint minutes of agreement. As a consequence, it was not necessary for the participants to formally

present information to the inquiry concerning the facts and productions stated within the joint minutes, each of which was read to the inquiry.

[7] The inquiry heard evidence from eleven witnesses over three days (9; 10; and 11 December 2019). Details of the witnesses who gave evidence are set out in Appendix 2. I thereafter heard submissions from the participants on 13 December 2019.

[8] The written note lodged on behalf of the procurator fiscal in terms of rule 3.7 identified three matters she considered were likely to be in dispute at the inquiry. The remaining participants each agreed with the issues identified by the procurator fiscal. The three issues identified were as follows:

1. Why Mr Leiper was not observed four times per hour as per the Talk to Me strategy and MORS (Management of an Offender at Risk of Substances) during (the) period 06:50 (to) 08:45 hours (on 27 March 2018);
2. Whether it would have had a bearing on the outcome had Mr Leiper been observed, as per strategy, during said period; and
3. Whether appropriate measures are being taken by HMP Barlinnie and HMP Kilmarnock to prevent the flow of illegal drugs into both prisons.

[9] Mr Leiper was born on 5 July 1974. He was 43 years of age at the time of his death. On 10 November 2015, at Kilmarnock Sheriff Court, he pled guilty at a jury trial diet to a charge of assault to injury and to a contravention of section 49(1) of the Criminal law (Consolidation)(Scotland) Act 1995 (i.e. possession in a public place of an article which had a blade or was sharply pointed, without reasonable excuse or lawful authority). Sentence was deferred until 4 December 2015 for preparation of a criminal

justice social work report and a psychiatric report. Mr Leiper was remanded in custody to HMP Low Moss. On 4 December 2015 Mr Leiper was sentenced to four years imprisonment, backdated to run from 5 August 2015.

[10] Mr Leiper was initially imprisoned within HMP Low Moss. On 5 December 2016 he was transferred to HMP Kilmarnock. Mr Leiper was diagnosed with schizophrenia in 1999. He had regular routine reviews for his addictions by the addictions team whilst in prison. His medication was gabapentin, quetiapine, ranitidine, hydrocortisone and 95ml of methadone daily. He had no mental health input whilst he was within HMP Kilmarnock. His mental state was stable.

[11] The Parole Board approved Mr Leiper's release at a meeting on 27 February 2018. Mr Leiper was due to be released on 4 April 2018, little more than a week after he died.

[12] On 19 March 2018, whilst within HMP Kilmarnock, Mr Leiper was the victim of a serious assault. Due to this incident it was decided that Mr Leiper should be transferred to HMP Barlinnie. Mr Leiper was transferred from HMP Kilmarnock to HMP Barlinnie on 26 March 2018.

[13] A number of procedures were carried out prior to Mr Leiper leaving HMP Kilmarnock. These procedures are carried out when prisoners transfer to another prison in an attempt to detect and prevent illicit articles leaving the prison via prisoner transfer. Mr Leiper was required to walk through a metal / mobile phone detecting portal; he received a full strip search where all of his clothing was removed and a visual inspection of his body was carried out; and he then sat in a B.O.S.S. (Body Orifice Security Scanner) chair, a piece of security equipment which checks for any metal objects which

may be concealed within the abdominal cavities, stomach and waist areas. There were no negative indicators so Mr Leiper was handed over to the escorting staff for transfer to HMP Barlinnie. All of Mr Leiper's property was searched prior to the transfer taking place.

[14] Mr Leiper was processed through the standard admissions procedure on his arrival at HMP Barlinnie. As part of this standard process, all prisoners are assessed by a Reception Officer and a nurse under the "Talk To Me" strategy, that is the strategy used by the SPS to prevent suicides in prison. The role of the Reception Officer is to book in a prisoner and carry out an initial interview before the prisoner meets with the nursing staff. The initial interview usually lasts around 20 minutes and covers any issues the prisoner may have, for example mental health and self-harming issues. The nurse then separately assesses the prisoner to determine whether there are concerns that the prisoner may harm themselves. In both instances, account will be taken of the prisoner's history and how they are presenting at the time. If either the Reception Officer or nurse have any concerns, they can mark the prisoner as "At Risk" and an appropriate care plan is put in place (e.g. placed under observations / in an anti-ligature cell / in anti-ligature clothing).

[15] Upon his arrival at HMP Barlinnie, Mr Leiper was interviewed by Reception Officer Richard Palmer at 13:45 hours on 26 March 2018. Following his interview with Mr Leiper, Richard Palmer had no concerns. He completed the "Talk to Me" Reception Risk Assessment form and noted that Mr Leiper "communicated well / good eye contact" and had "no thoughts of suicide / self-harm". Richard Palmer thereafter

arranged for Mr Leiper to meet with a nurse, Amy Perrie. Richard Palmer sent the "Talk to Me" document on to Amy Perrie.

[16] Mr Leiper was interviewed and assessed by practitioner nurse Amy Perrie at 14:30 hours on 26 March 2018. As part of the assessment she would ask about the prisoner's mental health and psychiatric background. She asks the prisoners if they have any thoughts of suicide or self-harm or have previously had such thoughts or attempts at suicide. Based on the prisoner's response she would then explore this further. Mr Leiper strongly denied any thoughts of suicide or self-harm and gave Amy Perrie no cause for concern. Amy Perrie assessed that there was no apparent risk.

[17] Mr Leiper was placed in cell 13 within the admissions unit which is situated within Delta Hall of HMP Barlinnie,. He shared the cell with another prisoner, Francis Hughes. At approximately 21:00 hours on 26 March 2018 Mr Leiper was within cell 13 with Francis Hughes. At this time staff observed that Mr Leiper was under the influence of a substance. Mr Leiper was transferred to a safer cell, cell 21 of Delta Hall. It was decided that Mr Leiper should be placed on "Talk to Me" and MORS (Management of an Offender at Risk due to any Substances) and checked every 15 minutes. When he was relocated to cell 21, all of Mr Leiper's personal belongings were removed from his possession, including the clothing he was wearing. Mr Leiper was also placed in safer clothing. Nurse practitioner Robert Burns attended at cell 21 and carried out observations on Mr Leiper, namely, his blood pressure, pulse rate, heart rate and response levels. Mr Leiper was engaging at this time and not showing any signs of concern.

[18] Mr Leiper was thereafter checked approximately every 15 minutes by the night staff and would respond by changing his sleeping position or by waving. However, on two occasions a nurse was summoned to review Mr Leiper as he failed to respond to observations.

[19] At approximately 21:55 hours on 26 March 2018 nurse practitioner Deborah Byrne was summoned to Mr Leiper's cell. She examined Mr Leiper and found he was able to speak in full sentences but would fall asleep while talking. The possibility of calling for an ambulance was discussed, however, at that time Mr Leiper seemed to perk up and stood at his cell door asking for a cigarette. An ambulance was therefore not requested.

[20] At approximately 23:15 hours on 26 March 2018 Deborah Byrne returned to Mr Leiper's cell to review him. On entering she found Mr Leiper sitting upright sleeping. He was easily roused and stood up and talked with the nurse and the prison staff who had accompanied the nurse to his cell. Mr Leiper was talking in full sentences and asked to go back to bed. The nurse asked the prison officers to contact her if they had any further concerns about Mr Leiper.

[21] Prison Officers Stephen Morrison and Richard McNab continued to observe Mr Leiper four times an hour throughout the early hours of 27 March 2018. Mr Leiper gave the prison officers no cause for concern. At 06:25 hours on 27 March 2018 Mr Leiper was checked by Prison Officer, Stephen Morrison. Mr Leiper moved position and waved at the officer giving him no cause for concern. The night shift staff were then replaced by the early shift.

[22] At approximately 08:45 hours on 27 March 2018 Mr Leiper was found lying on his bed and was unresponsive. Nurse Brenda Bissett attended and attempted to rouse Mr Leiper. On receiving no response nurse Bissett instructed that a Code Blue be raised. Further nursing personnel attended and assisted by way of compressions, oxygen and airwave techniques until the arrival of the paramedics. Upon their arrival, the paramedics continued to work on Mr Leiper for a further 45 minutes before pronouncing life extinct at 09:32 hours on 27 March 2018. Mr Leiper was in legal custody as at the date of his death. In terms of section 26(2)(a), I have found that Mr Leiper, then a prisoner within HMP Barlinnie, Lee Avenue, Glasgow died there at or about 09:32 hours on 27 March 2018 within cell 21 of Delta Hall.

[23] At approximately 13:30 hours on 27 March 2018 officers attended at cell 13 (the cell Mr Leiper had shared with Francis Hughes). The cell was searched and, within a bin there, the officers found a Kinder Egg type plastic container and a piece of cellophane wrapping.

[24] A post mortem examination was carried out on 6 April 2018 at the Queen Elizabeth University Hospital, Glasgow by consultant forensic pathologist, Dr Marjorie Turner and by Dr Leighanne Deboys. The cause of death was recorded as: 1a. Methadone, etizolam and amitriptyline intoxication; and 2. Cardiac enlargement. I find accordingly in terms of section 26(2)(c).

[25] Forensic toxicologists, Dr Fiona Wylie and Dr Hazel Torrance analysed Mr Leiper's post mortem blood. This revealed 0.10 mg/L of amitriptyline, an anti-

depressant; 0.04 mg/L of etizolam, a benzodiazepine; 1.5 mg/L of methadone, an opioid analgesic; and 0.30 mg/L of quetiapine, an antipsychotic.

[26] The concentration of methadone detected was significantly higher than would be expected for Mr Leiper's prescribed dosage (see paragraph [10] above) and is well within the range associated with fatalities from it alone. The joint minute records that, "It would be anticipated that, given that (methadone had) been administered to Mr Leiper for at least some weeks (prior to his death, Mr Leiper) would have had some tolerance to it." Mr Leiper's medical records suggest that he was prescribed methadone as far back as July 2012 and appears to have remained on it from then until the date of his death.

[27] Etizolam is a controlled drug that is frequently seen in illicit drug use being ingested as "street valium". Both the etizolam and the amitriptyline were found at low levels but can have significant sedative and respiratory depressant effects. Whilst it cannot be excluded that the cardiac enlargement may have had a role in Mr Leiper's death, it is considered more likely, given the overall circumstances and findings, that Mr Leiper's death was the result of intoxication with methadone, etizolam and amitriptyline.

[28] Following Mr Leiper's death, Francis Hughes told David Hood, a first line manager at HMP Barlinnie, that Mr Leiper had offered him what he believed to be gabapentin tablets which he declined. Francis Hughes did not give any indication to David Hood as to how many tablets Mr Leiper had in his possession at this time but

stated that Mr Leiper produced them after he had used the toilet area within the cell. Francis Hughes did not give evidence to the inquiry.

[29] Francis Hughes was scheduled to give evidence on the second day of the inquiry (10 December 2019), however, the court was advised that morning that he had died on 8 December 2019. The evidence contained within paragraph [28] was presented by way of a joint minute of admissions.

[30] Police Scotland carried out enquiries in relation to the supplier of the drugs. The police have been unable to identify the supplier of the drugs or how Mr Leiper managed to source them.

[31] To discharge the obligations incumbent upon me in terms of section 26(2)(e) and (f), it is necessary to consider the three matters the participants considered were likely to be in dispute at the inquiry (see paragraph [8] above). It is worth noting that, ultimately, there was no real dispute amongst the participants in relation to each of these.

The first issue

[32] There is no dispute that at approximately 21:00 hours on 26 March 2018 Mr Leiper was placed on "Talk to Me" and MORS (Management of an Offender at Risk due to any Substances) and was to be checked every 15 minutes. In relation to prisoners who are suspected of being under the influence of a substance (as Mr Leiper was), MORS requires a visual observation every 15 minutes and a verbal response from the prisoner every 60 minutes. There is no dispute that Mr Leiper was not observed during the period 06:50 to 08:45 hours on 27 March 2018.

[33] The failure to carry out observations in this period is regrettable. It was not the specific responsibility of any of the residential officers on duty. It should have been. They each appear to have assumed that someone else was carrying out the observations. To that extent, the system of working was defective, albeit for the reasons outlined below I am satisfied that the defect did not contribute to Mr Leiper's death.

The second issue

[34] Reformulating the second issue somewhat, the question which falls to be answered is had Mr Leiper been observed during the period 06:50 to 08:45 hours on 27 March 2018 would he have survived? On the evidence before the inquiry, I am satisfied on a balance of probabilities that he would not. It is for this reason that I have concluded that the defect in the SPS system of working set out above at paragraph [33] did not contribute to Mr Leiper's death.

[35] I accept the evidence of Dr Stevenson that even if Mr Leiper had been observed and taken to hospital, there was virtually no chance of him surviving.

The Third Issue

[36] The inquiry heard evidence of the measures taken at HMP Barlinnie and HMP Kilmarnock to prevent the flow of illegal drugs into prisons. There was no evidence to suggest that the measures taken were in anyway inappropriate. The challenges faced by SPS (and Serco Ltd – the private operator of HMP Kilmarnock) staff in relation to drugs were eloquently spoken to in evidence. Inevitably, if more resources were made

available to SPS there are additional measures that could be taken. The extent of the evidence before the inquiry was such that I am unable to make any recommendation in relation to such measures. I was not invited to do so by any of the participants.

[37] The evidence before the inquiry is supportive of a finding that a precaution which (i) could reasonably have been taken; and (ii) had it been taken, might realistically have resulted in the death of Mr Leiper being avoided would have been for Mr Leiper not to have ingested the methadone, etizolam and amitriptyline which caused his death. I have found accordingly in terms of section 26(20(e).

[38] The court extends its sympathies to Mr Leiper's family and friends.

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Sheriff Principal C.D.Turnbull
Glasgow, 17 February 2020

APPENDIX 1

The legal framework

[A1] The purpose of a fatal accident inquiry is set out in section 1(3). It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (see section 1(4)). A fatal accident inquiry is inquisitorial, not adversarial (see rule 2.2.(1)).

[A2] Section 1(2) provides that an inquiry is to be conducted by a sheriff. In terms of section 3(5) of the Courts Reform (Scotland) 2014 Act, the sheriff principal of a sheriffdom may exercise in his or her sheriffdom the jurisdiction and powers that attach to the office of sheriff. Inquiries which raise issues of particular significance and those which may attract a significant degree of public interest are regularly presided over by sheriffs principal. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1) or, in this case, the sheriff principal.

[A3] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate. A determination under section 26 is to be in Form 6.1 (see rule 6.1)

[A4] The findings the sheriff is required to make are set out in section 26(2), namely, (a) when and where the deaths occurred; (b) when and where any accident resulting in the deaths occurred; (c) the cause or causes of the deaths; (d) the cause or causes of any

accident resulting in the deaths; (e) any precautions which (i) could reasonably have been taken; and (ii) had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided; (f) any defects in any system of working which contributed to the deaths or any accident resulting in the deaths; and (g) any other facts which are relevant to the circumstances of the deaths.

[A5] The making of recommendations is discretionary. The recommendations which the sheriff is entitled to make are set out in section 26(4). The recommendations must be directed towards (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. Recommendations may (but need not) be addressed to (i) a participant in the inquiry; or (ii) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

APPENDIX 2

Witnesses

1. Sean McFedries, SPS
2. John Patrick, SPS
3. Martin Clark, SPS
4. Patrick Bennett, SPS
5. Mark Nolan, SPS
6. Stuart Walker. SPS
7. Hugh Reid, North Ayrshire Council
8. Brian McKirdy, SPS
9. Findlay Laird, SPS
10. Pamela Swan, Serco Ltd
11. Dr Richard Stevenson