SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

FATAL ACCIDENT INQUIRY

INTO THE DEATH OF

CHRISTOPHER WILLIAM STEPHEN WHITE

SHERIFF'S DETERMINATION

GREENOCK **28th April 2009**

The Sheriff, having on 22, 23 and 24 April 2009, held an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, into the circumstances of the death of Christopher William Stephen White, and having considered all the evidence adduced and submissions thereon at the Inquiry, DETERMINES as follows:

1 In terms of Section 6(1)(a) of the Act, that the death of Christopher William Stephen White, whose date of birth was 14 July 1984, and who, at the time of his death was an inmate at Her Majesty's Prison Gateside, Greenock, took place within Cell 19, Ailsa Hall, at Her Majesty's Prison Gateside, Greenock, at 05:45 hours on 25 March 2007.

2 In terms of Section 6(1)(b) of the Act, the cause of death was

A Heroin, dihydrocodeine and diazepam intoxication

I declined to make any further findings.

NOTE

The Fatal Accident Inquiry was held under Section 1(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

The Crown evidence was led by Mr McGeehan, the Procurator Fiscal Depute. The deceased's family was represented by Mr Cairns, Solicitor, Dumbarton, and the Scottish Prison Service by Mrs Martin-Brown, Solicitor.

I head evidence in the Inquiry on 22 and 23 April 2009 and I heard submissions on 24 April 2009.

Evidence was led by the Procurator Fiscal Depute from Martin Lindsay, Prison Officer; David Hyslop, Prison Officer; Andrew Wilson, Prison Officer; John Kerr, Prison Officer; Gordon Davies, Prison Officer; Malcolm Smith, Operations Manager, HMP Gateside; Samuel McIntosh, Prison Officer; Michael McKelvie, Prison Officer; and Detective Sergeant Greig Wilkie, the officer appointed to investigate the death. I also heard from Dr Kohlhagen, Police Casualty Surgeon, and Dr Ainsworth, one of the Consultant Forensic Pathologists who carried out the *post-mortem*.

Several productions were also lodged by the Procurator Fiscal. No witness were called by either Mrs Martin-Brown or Mr Cairns.

SUBMISSIONS

Mr McGeehan asked me to make formal findings in respect of Section 6(1)(a) and (b) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976. From the evidence, Mr White had died of a drugs overdose. His death was caused by heroin, dihydrocodeine and diazepam intoxication and occurred at Her Majesty's Prison Gateside, Greenock, in Ailsa Hall in Cell 9 on 25 March 2007 at 05.45 hours.

In respect of Sections 6(1)(c), (d) and (e), he asked me to make no findings. He asked to reserve any further submissions after Mr Cairns, who wished me to make findings in

terms of 6(1)(e). Thereafter, Mrs Martin-Brown also asked to delay her submissions until I had heard from Mr Cairns.

Mr Cairns, in his submissions, asked me to make findings as suggested by Mr McGeehan in terms of 6(1)(a) and (b), but additionally asked me to make a finding in terms of 6(1)(e). He considered there were matters worth commenting on - in relation to the search of the cell, the conduct of the strip search, the question of delay, and the delay from the date of death to the actual date of the Inquiry. With regard to the search of the cell, he asked me to consider that it had been inappropriate that the cell-mate, Mr Parker, was allowed to remain in the cell after the prison officers had found drugs in the cell. It remained a matter of speculation as to where the heroin, which was taken by Mr White, had come from and therefore it was not appropriate to allow them to remain together in the cell. Additionally the police were to be involved in an investigation and that should have given them cause for thought with regard to allowing Mr Parker and Mr White to remain in the cell. It certainly did not appear to be the wisest course, or best practice. With regard to the strip search, it was clear that this had been limited in its scope. The police often did internal searches, as it was known that drug users will use their rectum to hide of drugs. It was arguable that, prison officers likewise, should consider strip searches to include the internal areas. With regard to the question of delay, he suggested, with respect to all the officers, that they perhaps ought to have considered going into the cell immediately on discovery that there was a difficulty with an inmate and they should perhaps not have been restricted by the rules, procedures and protocols mentioned by them. Although the prison officers said they undertook a risk assessment, one of them specifically stated that he considered there was no real risk of threat or harm, it was surprising, if not questionable, why they had not entered the cell prior to Mr Smith's arrival. There was a resultant delay in entering the cell and while there is no evidence to suggest that this would have made a difference, it is still worthy of comment. Furthermore, there was some evidence to suggest that one of the officers had heard snoring twenty-five minutes before the incident occurred and while he could not say that it came from Mr White, there had been evidence from Dr Ainsworth that it was a common feature or symptom of deaths from heroin intoxication. It could not be said to be a fact that the snoring had come from Mr White, but there was a possibility, and that may have indicated that he had been alive at that time. He suggested that prison officers, although he did not criticise those that had appeared before the Inquiry, ought to be

thinking "outside the box" and not to feel hidebound by the culture of prison service procedures, policy and protocol. He asked me to consider that from the evidence in this case, it would appear that there had been an over-reliance on bureaucratic procedures and that perhaps there had been an exclusion of common sense. His final point was that he had some concerns that, as was clear from the evidence given, some of the prison officers could not recollect their evidence clearly and additionally, Dr Kohlhagen was unable to recollect about *rigor mortis* at the time of examining the body. It was unfortunate that it had taken two years for this Inquiry to be heard, as the evidence which may have been provided, in particular by Dr Kohlhagen, may have assisted the Inquiry.

I was then addressed by Mr McGeehan, who considered that the submissions made by Mr Cairns were broadly fair, but did not agree that I should make any findings in terms of Section 6(1)(e). In respect of the matters raised by him, they may be worthy of comment, but they were not "relevant" to the death, as is required in terms of Section 6(1)(e). He suggested that in respect of all the matters raised - the search of the cell, the strip search, the delay in entering the cell, the snoring, the adhering to policy and procedure, and the delay of the Inquiry - were matters which I may choose to comment upon in any note attached to the determination. He submitted they were not matters which should be in the determination in terms of Section6(1)(e) as they were not actually relevant to Mr White's death as is required by the Act.

I then heard from Mrs Martin-Brown and she endorsed the submissions made by Mr McGeehan that the matters being referred to by Mr Cairns were not relevant to the circumstances of the death, as required by Section 6(1)(e). She asked me to note that while it was suggested that Mr Parker and Mr White ought to have been separated, it was Mr Parker who sounded the alarm and the fact that they were together was not relevant with regard to the question of Mr White's death. The officers had made it clear that they would not separate the inmates unless there was an indication it was appropriate to do so and that would include factors such as violence or blame between them after the drugs incident. It did not apply in this case. With regard to the adequacy of the strip search, the officers had followed the guidelines and that there was no real evidence of what police do, or the circumstances in which police would do such a search. There was no evidence to support that it was either appropriate or legal to do an internal search. The officers had done what was required of them and that was to follow training and guidance. With

regard to the question of whether or not there had been any delay in entering the cell, the alarm occurred at 3.10 am and entry into the cell occurred between 3.12 and 3.17 am, which was only a matter of minutes. The prison officers, having made their risk assessment, which included the fact that there were 2 inmates within cell 19, did not consider it was appropriate to enter until the other officers arrived. Mrs Martin-Brown also asked me to note that Prison Officer McKelvie had felt no pulse or breath and despite giving CPR, there was no sign of pulse or breath. Furthermore, Mr McIntosh had said in his evidence that a few moments into CPR, he considered that Mr White had died. With regard to the snoring, Mr Parker, in his statement, said the snoring had ceased fifteen minutes before the alarm and with the evidence from Dr Ainsworth, that would suggest that the likelihood of recovery was limited. She also wished to take issue with Mr Cairns' suggestion about the officers not thinking "outside the box" when it came to entering the cell. It would not be appropriate for prison officers to ignore policy and procedure and there was no suggestion in their conduct, that day, that they had not taken into account a risk assessment in arriving at their decision. In the circumstances, she asked me not to consider making any findings in terms of 6(1)(e).

Mr Cairns asked me if I were not minded to make any findings in terms of 6(1)(e), that I consider, as had been suggested by Mr McGeehan, that I mention the matters raised by him in any notes that I may issue.

CIRCUMSTANCES OF DEATH

On the evidence presented to the Inquiry, the circumstances of the death, which I have set out in detail in support of my determination, were as follows:-

The deceased, Christopher William Stephen White, was a 22-year-old man who, on 22 March 2007, was sentenced at Dumbarton Sheriff Court to three months' imprisonment. He was admitted into HMP Gateside on that date at about 17.40 hours. He underwent the formal induction procedure on arrival and thereafter was placed in Cell 19 in Ailsa Hall on his own. The following day another inmate, Brian Parker, whom he knew, was allowed to share that cell with him. During the morning of 24 March 2007, prison officers noted that there appeared to be a number of other prisoners visiting that cell with

unusual frequency. They were concerned, as the "visitors" were bringing items such as coffee, shampoo, etc. Following a discussion, the prison officers decided that they would do a cell search. This was done after lunch when they commenced with a strip search of both individuals, done separately, followed by a thorough cell search. While nothing illegal was found on either Mr Parker or Mr White, during the cell search, various wraps of a brown substance in clingfilm were found at the bottom of a bottle of Head and Shoulders shampoo. As a result of this, there was a report to the Governor and both inmates were confined to their cell. The item that had been found was subsequently confirmed as heroin. At 4.30 pm, both were given medication which included diazepam. They were thereafter kept in their cell and food for their evening meal was given to them in the cell. They were checked later in the evening at the usual rounds and everything appeared to be in order. Prison Officer Gordon Davies was the first to be alerted in relation to a difficulty in the cell. At approximately 3.10 am, a cell alarm bell was heard by him. It was from Cell 19. When he went to the cell, the inmate, Parker, said that his inmate needed help. Prison Officer Davies cancelled the alarm and put on the light. Having sought assistance from fellow-officer McKelvie, a sealed pack containing the key for access to the cell was obtained. It was not used until their supervisor, Mr Malcolm Smith, arrived on the scene. From the evidence, it appears that it took between two to six minutes for all four officers to be at the cell and for it to be opened with the sealed pack key. On entry, attempts at resuscitation were made, but were ultimately unsuccessful. The evidence from the fellow-inmate, Byron Parker, was by way of a statement which was lodged, as he failed to attend the Inquiry. In his statement he said that he had seen his cell-mate, Christopher White, sitting on a chair inhaling heroin, using the lid of a Pot Noodle carton which he was heating with a lighter. Mr Parker thereafter returned to his bed and fell asleep. In his statement, Mr Parker said that he had fallen asleep at about seven o'clock, lying on the top bunk, and Christopher had been on the bottom bunk watching the television. He woke up at about ten o'clock, while the television was still on, which was when he saw Christopher having the heroin. He described Mr White as snoring very heavily after falling asleep on the bottom bunk. When he heard the snoring stop, he thought nothing of it, other than Christopher was still sleeping. His recollection was, that about fifteen minutes after the snoring stopped, he got up to change the television channel and looked over at Chris and thought, he was not breathing. He went over to him, put his face to his nose and, not being able to feel any breath, put his ear to his chest and could not hear a heartbeat. He also felt his wrist, but could not feel a pulse.

He then turned him on to his side and put him into the recovery position and upon doing so fluid came out of his nose and his mouth. He put his hand inside Christopher's mouth to make sure he didn't swallow his tongue and to get his false teeth out. It was after that that he pressed the buzzer to call for assistance.

While all the timings mentioned in Mr Parker's statement does not accord with the prison officers, I have no reason to doubt that his description of what occurred in relation to Mr White actually happened. The prison officers, once they had gained entry to the cell, attempted resuscitation and when the paramedics arrived at 3.24 am, further attempts at resuscitation were made, but were unsuccessful. He was formally declared dead by Dr Kohlhagen later that morning at 5:45a.m.

It is always a tragedy when a young person dies and, for the family and friends, there is always the sorrow of what might have been for their future. I have sympathy with Mr White's mother as she had a son who has died too young. This was a young man whose life was blighted by the effects of drugs. His medical records show that he was a drug user and clearly, on 25 March, the heroin that he used was to cause his death. There is no evidence before the Inquiry as to where the heroin came from. Mr Cairns, while he made criticisms of Mr White and Mr Parker being allowed to continue to share their cell after the discovery of drugs, there is nothing to suggest that the drugs came from Mr Parker. We simply do not, and will not know, how he obtained these drugs. What we do know, however, is that the dose that he took on the late evening of 24 March caused him to die of heroin, dihydrocodeine and diazepam intoxication. I am satisfied that the steps taken to revive him were appropriate, but ultimately these attempts failed. There is no evidence before the Inquiry that would allow me to make a finding that his death might have been prevented, had the officers entered the cell any earlier, or Mr Parker had not been allowed to remain in the cell with Mr White.

Section 6(1)(e), states:

"(e) any other facts which are relevant to the circumstances of the death."

Mr Cairns, in his primary submissions asked me to make findings in respect of the above section on various matters of concern. I decline to do so but as a matter of courtesy to him and to Mr White's family I consider it appropriate to comment on them in this note.

Cell Sharing

There was no evidence to suggest that the sharing of a cell in any way contributed to the death of Mr White. Mr Cairns did suggest that if there was going to be a police investigation, it was not appropriate to have had both Mr Parker and Mr White, who both denied ownership of the drugs, to be allowed to remain together. That may well be the case, but the criteria used by the prison officers was whether or not there was any danger to either of the inmates in relation to continuing to occupy the cell. Clearly, their assessment was, since neither was fighting nor blaming each other, there was no need to separate them and they were allowed to continue using Cell 19. I see no merit in this submission in respect of separation of the two men. Indeed, I take the view that had it not been for Mr Parker being in that cell, there is every possibility that the prison officers would not have been alerted to his death as early as they were, despite the fact that they were not able to revive him.

Strip Search

With regard to the question of a strip search and whether or not there should have been an internal search, there was no evidence presented to the Inquiry giving reasons why prison officers do not do internal examinations. It may be to do with the individual's human rights, but I do not know. The procedures that are followed by the Scottish Prison Service with regard to that, for the purposes of this Inquiry, is a matter for them as, in my view, there is nothing to suggest that it was relevant to the death of Christopher White. There were packages found in his rectum, but there is no suggestion it is through ingestion of those packages that his death was caused.

Delay

Prison Officers Davies having heard the alarm went to Cell 19. He had not been far away and was there very quickly. He looked into the spy hole and could see Mr Parker was extremely distressed. He was told that there was something wrong with Mr White and he needed help. Mr McKelvie who had been on an upper level of Ailsa Hall had also heard the alarm and had come down to assist. Mr Davies had called the Operations Manager Mr

Smith. Mr Davies and Mr McKelvie knew there were two inmates in Cell 19 and decided that although they had the sealed pack they would wait for Mr Smith. A sealed pack holds a key which is sealed and to be used in the event of an emergency if prison officers require to get into a cell. The key opens all the cells on the block and is kept sealed for security reasons. While outside the cell, they did look in and knew that Mr Parker was upset and agitated, as well as emotional, and they could see Mr White lying on his bed in the lower bunk. They, however, decided to wait until their supervisor, Mr Malcolm Smith, had arrived. He had to come from another part of the prison, and was with another prison officer. The evidence from the 4 officers varies as to how long it actually took them to arrive. Only Mr Smith thought it had taken as long as 5 or 6 minutes with the others thinking it was about 2 or 3 minutes. Mr Cairns suggested that the officers should not have been so concerned about procedures and protocol and should have entered immediately. The officers were concerned about entering the cell, as there were two prisoners within it. While neither, in their evidence, appeared to have any real concerns about it being a "set up", they erred on the side of caution and did not enter the cell. I believe that both prison officers were experienced and having made a risk assessment, were perfectly right to await the other officers arriving. I see no criticism in the fact that they waited. They have, on a daily basis, to consider the safety and security of themselves, their fellow officers, the prisoners and all those who work within the prison and it would have been inappropriate, despite their own personal views about real risk, to enter that cell without further support. I cannot agree with Mr Cairns that they should have applied common sense. The dangers of doing that is that the carefully considered Rules and Procedures put in place by the Scottish Prison Service for the protection, safety and security of all those within the prison and indeed those out with, would be seriously undermined. One person's common sense may be another person's bad judgment. Clearly the saving of a life is important but only within the rules and procedures which mean it can be done safely without danger to others. There is no evidence to suggest that even had they entered that cell that the outcome for Mr White would have been any different. While Mr Cairns felt able to criticise them for following protocol and procedures, I am satisfied that they made a risk assessment within rules and procedures which allowed them the flexibility of making the decision themselves not to enter the cell until others arrived. Mr Cairns also said that it was not clear why they had taken the decision not to enter the cell, but for my own part, I can very well understand

that there were good reasons. In these circumstances, I do not consider that I can make any finding in terms of 6(1)(e) in respect of the delay suggested by Mr Cairns.

Snoring

There was no definitive evidence that it was Mr White who was heard snoring. According to Mr Parker, Mr White had stopped snoring some fifteen minutes before he found him, although assessing time is notoriously difficult and I accept that limited reliance can be placed on the timings. Dr Ainsworth, said that it was a common feature and symptom from deaths from heroin intoxication but none of the evidence in respect of this takes us further forward. No facts can be established about Mr White and his snoring in relation to delay and timing.

Prison Policy and Protocol

Mr Cairns raised his concerns that the evidence from the prison officers, suggested a culture of following procedure, policy and protocol too rigidly. He suggested that there was an over-reliance on bureaucratic elements, to the exclusion of common sense. I have mentioned my view about common sense in an earlier paragraph. I do not agree with Mr Cairns. The prison officers themselves said that had there been an individual person in that cell, their reactions may have been different. They had taken into account a distressed inmate in a cell with another inmate and having been presented with this made a risk assessment in relation the safety and security issues. They were aware of the protocols and procedures in respect of safety and took these into account quite appropriately. In the circumstances, as presented to them, with two inmates, they decided that it was inappropriate to enter the cell. I do not think they have been too rigid in their assessment.

Mr Cairns also mentioned the delay in the date for this Inquiry being set. It is some 2 years after Christopher White's death. Undoubtedly that really is too long a time. The Procurator Fiscal Depute accepted there was a delay and indicated that there were operational reasons for that. For all concerned it is always better to have an inquiry as soon as possible and it is very unfortunate that it took as long as it did to get to this stage but I trust that the Procurator Fiscal's department will be mindful for the need for speed in such Inquiries and endeavor to ensure that operational reasons delays are always kept to a minimum.

Having considered all of the evidence and all the submissions made, I am limited in the findings I can make. We do not know where the heroin came from that was taken by Mr White. We do know that he was a young man who had a drug addiction and that drug addiction was current. It is a risk taken by all drug users that the addiction that they have may well be the instrument of their death. It is a tragedy that Mr White's mother has lost her son. I am sure that in her heart of hearts his addiction was a source of distress for her and that that distress has now turned to a deep sense of loss. It is not easy for a mother to face the death of her child, but for it to have happened while he was in prison must be even more difficult for her. I am satisfied, however, without reservation that on 25 March 2007, there was nothing that might have been done to prevent his death. Mr Parker, on observing his friend, Mr White, inhaling heroin, was not to know that that particular occasion would be the last occasion that Mr White would inhale heroin, because it ultimately caused his death. I do not believe that any of the matters raised by Mr Cairns were relevant to the circumstances of Mr White's death. The reality is that Mr White was a drug addict who has died at a young age because of that addiction, although that does not make it any less tragic for him and his family and friends.

Having considered all of the evidence, submissions made and for the reasons stated, I decline to make any findings in respect of Section 6(1)(c), (d) or (e

Sheriff Rajni Swanney
Sheriff of North Strathclyde at Greenock 28th April 2008