

B3619/14

DETERMINATION

BY SHERIFF LINDSAY WOOD

following an inquiry held at Glasgow on the fifth to seventh May, third to fifth June, twenty eighth to thirty first July, twenty fourth to twenty sixth August and third September all two thousand and fifteen

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

into the death of

GERARD TIERNEY

(born 4 December 1969 who died at Glasgow Victoria Infirmary on
30 January 2013)

GLASGOW, December 2015.

PART I

Introduction and legal framework

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Gerard Tierney who died at Glasgow Victoria Infirmary on 30 January 2013. Mrs M Dunipace, procurator fiscal depute, represented the public interest, Mr S Gilbride, Advocate, represented Mr Tierney's family, Mr M O'Reilly, Solicitor, represented Greater Glasgow Health Board, Mr D Hamilton, Advocate, represented the Scottish Ambulance Service, Mr A Gillies, Solicitor Advocate, represented Sergeant Graeme Jamieson, Ms R Stannage, Solicitor, represented

the Chief Constable of Police Scotland, and Ms Laura Connor, Solicitor, represented Mr David Keltie, Police Custody and Support Officer.

[2] The Inquiry heard evidence and submissions over the course of 13 days in May, June, July and August 2015. There was a hearing on submissions on 3 September 2015. The Crown led evidence from 28 witnesses as follows:

- 1 Police Constable James Allison
- 2 Dr Michelle Boyle
- 3 David O'Hara, Paramedic
- 4 Police Constable Derrick Lunan
- 5 Daveed Malik
- 6 Police Sergeant Helen Downie
- 7 Police Constable Elizabeth Fallon
- 8 Police Constable Lynn Caldwell
- 9 Police Constable John McMahon
- 10 Police Constable Stuart Forrest
- 11 Police Constable Kelly Miller
- 12 Police Constable Fiona McDermid
- 13 PCSO Elaine McGreavey
- 14 Police Sergeant Graeme Jamieson
- 15 PCSO David Keltie
- 16 PCSO Stuart Paton
- 17 PCSO Duncan Donaldson
- 18 PCSO Martin Keenan
- 19 PCSO Paul Devlin
- 20 Police Sergeant John Hendry
- 21 Julie Granger, Paramedic
- 22 Ronald McGuinness, Paramedic

- 23 Police Inspector Kevin Struthers
- 24 Police Inspector David Simpkins
- 25 Dr Fiona Hunter
- 26 Dr John Clark
- 27 Dr Michael Johnstone
- 28 Professor David Bateman

The family of Mr Tierney led evidence from:

- 1 Sergeant Derek Carmichael
- 2 Mr Tierney's brother, Paul

A Joint Minute of Agreement on certain uncontroversial evidence was entered into by parties and received by the Inquiry.

No other evidence was led.

Legal Framework

[3] Section 6 of the said 1976 Act requires the presiding sheriff to make determinations in the following matters (a) where and when the death and any accident resulting in the death took place; (b) the cause of such death and any accident resulting in the death; (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided; (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and (e) any other facts which are relevant to the circumstances of the death.

[4] The court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the Sheriff's powers do not go beyond making a determination in relation to the circumstances established to his

satisfaction by evidence following upon investigation by the procurator fiscal and any other party if so advised.

PART II

Determination as to the circumstances of the death

[5] The sheriff, having considered all the evidence, FINDS and DETERMINES that in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

- (i) in terms of section 6(1)(a) that Gerard Tierney, born 4 December 1969 died of a paracetamol overdose within the Intensive Care Unit of Glasgow Victoria Infirmary on 30 January 2013. Life was pronounced extinct at 0212 hours.
- (ii) in terms of section 6(1)(b) that the cause of his death was multi-organ failure and oesophageal perforation due to acute hepatic necrosis with a potential contributing cause of a head injury; all said causes being due to paracetamol intoxication arising from Mr Tierney's voluntary ingestion of a significant amount of paracetamol on or around 26 January 2013.
- (iii) in terms of section 6(1)(c), there were no reasonable precautions, if any, whereby the death and the accident resulting in the death might have been avoided.
- (iv) in terms of section 6(1)(d), there were no defects in any system of working which contributed to the death or any accident resulting in the death.
- (v) in terms of section 6(1)(e), there were no other facts which were relevant to the circumstances of the death.

PART III

[6] After hearing and considering all of the evidence and submissions, I make the following findings:

- (1) At approximately 1600 hours on 28 January 2013, Mr Tierney was struck by a car at Aikenhead Road, Glasgow. He had deliberately walked out in front of the car and a collision could not be avoided by the driver. Police and Emergency services were called and Mr Tierney was taken to Glasgow Victoria Infirmary by ambulance. Mr Tierney waited at the A & E Department at the Victoria Infirmary and lay on a spinal board on top of a trolley. He had to wait over an hour before he was seen. He gave accounts to witnesses at the accident locus, to paramedics and to police that he had stepped out deliberately. He was reluctant to engage with police officers at the hospital and he did not say to them that he had taken paracetamol. When the police initially checked out Mr Tierney's PNC (Police National Computer records), there was nothing to suggest that he was prone to self-harm. Mr Tierney had told a paramedic, David O'Hara, who treated him after the collision that he had taken a paracetamol overdose two days before. Mr Tierney did not present to Mr O'Hara with symptoms of overdose. There were also no signs of serious injuries. When Mr Tierney was handed over by Mr O'Hara at the hospital to the triage nurse, he advised her of the overdose assertion and of Mr Tierney stepping out in front of the car. This was all included in the patient report form (E Pacer) which was handed to the triage nurse. Unfortunately, the triage nurse who is believed to be a Morag Calder, now lives in Canada and cannot be traced. The overdose information from the paramedic was not passed on by the triage nurse to Dr Michelle Boyle, the A & E Consultant at the Victoria Infirmary who saw Mr Tierney on her own that evening. Dr Boyle was not given the E Pacer either. That has been mislaid. Dr Boyle was told by the triage nurse that Mr Tierney had

jumped in front of a car and was struck. She put that to Mr Tierney who said that he had taken alcohol and stumbled as a result. He was insistent on that position. He said that he had not jumped in front of the car. She found him slightly intoxicated but consistent and he wasn't of low mood. He did not seem suicidal to her. There was no sign of overdose. There was nothing to suggest that his mental health needed to be investigated. Dr Boyle noted that Mr Tierney was alert and orientated. He was not evasive and nor had he suffered from a loss of consciousness. Dr Boyle had been trained in mental health issues and she considered that Mr Tierney had legal capacity. From her assessment, he did not meet the criteria for treatment as an adult with incapacity. He had no apparent mental health disorder requiring treatment. Even if Dr Boyle had been made aware of the overdose allegation, she would not have altered the way she dealt with matters given her assessment of Mr Tierney and the whole circumstances. In the event, Mr Tierney was not found to have any serious injury, such as a fracture, which required treatment but he was advised to stay in hospital overnight for observation. He chose not to and discharged himself.

- (2) PC Derek Lunan answered a call from the Victoria Infirmary around midnight on 28 January 2013, saying a man was loitering outside Ward 12. PC Lunan went there and found Mr Tierney. He had some old bloodstaining on his clothing and had the appearance of a drug user. He was not drunk and did not seem in any particular difficulties. He didn't say why he was there. A PNC check was carried out but it did not flag up the earlier road traffic collision. PC Lunan spoke to the A & E Department at the hospital who advised that Mr Tierney had been in

earlier and discharged himself. PC Lunan then went back to Mr Tierney who said he was homeless. There was nothing in particular about his demeanour to suggest he needed hospital treatment.

PC Lunan offered to take Mr Tierney to the Hamish Allen Centre which is a homeless hostel but he refused and was allowed to go. PC Lunan did not have any particular concerns about Mr Tierney.

- (3) In the early hours of 29 January 2013, at Caledonia Road, Glasgow, Mr Tierney jumped in front of a van driven by Mr Daveed Malik. Mr Malik just missed him. This incident was witnessed by two police officers, WPC Caldwell and WPC Fallon. They spoke to Mr Tierney who was quiet and wouldn't respond. He gave his name, did not smell of alcohol and was described as a "a bit of a poor wee soul". There were concerns about his safety as the previous road traffic collision was flagged up to the officers by another police officer. Mr Tierney told WPC Caldwell that he was not hurt but was going to be. He said he didn't want to go to the hospital. For his safety, the police officers decided to arrest him for a breach of the peace at 0105 hours and took him to Aikenhead Road Police Station. He didn't complain about that. There were no behavioural indications of drug overdose. At the charge bar at Aikenhead Road Police Station when he was waiting to be processed, Mr Tierney complained of stomach pain. He was being asked questions and it was clear he understood them. He was quiet and lacked eye contact. His head was down. There was no sign of real illness or that he needed urgent medical attention. He was coherent, coordinated and walking. PC Lunan rang WPC Fallon when Mr Tierney was waiting in the queue at the charge bar and advised that he had seen Mr Tierney outside Ward 12 at the Victoria Infirmary. The

Custody Sergeant, Sergeant Graeme Jamieson, was advised of both traffic incidents and of Mr Tierney being outside Ward 12.

- (4) Present at the charge bar when Mr Tierney was “booked in” were the two female police officers, Sergeant Jamieson and a number of Police Custody and Support Officers. One of them, Elaine McGreavey who has 11½ years’ experience had some concerns about how Mr Tierney was handled. Her remit is to look after the care and welfare of those who are brought into custody. She observed that Mr Tierney did not appear to be in pain initially although he later said he had a sore stomach. She had concern about the road traffic matters. She thought Mr Tierney should be put on constant observations when placed in a cell. Sergeant Jamieson decided against that and Elaine McGreavey did not challenge his decision as she had done that once before and Sergeant Jamieson had not put the then prisoner under constant observation. Ms McGreavey said 20 minutes later, she found that prisoner in the cell with a ligature around her neck and she managed to get it off in time. Her view of Mr Tierney was that he looked like someone who didn’t look after himself and she conceded that many prisoners are like that and often say they have sore stomachs and other ailments. What Mr Tierney said was nothing out of the ordinary. She heard him allege that he had taken 120 (later changed to 150) paracetamol tablets two days before but she didn’t believe that. She did not think Mr Tierney was in particular discomfort. She did have concerns about self-harming given the previous traffic incidents. She said he was coherent and although he had alcohol in him, he was not drunk. She said he was grey and a bit unkempt. He was like many of the prisoners she deals with. There was nothing extraordinary and

many tell lies and talk “nonsense” at the charge bar. When Sergeant Jamieson processed Mr Tierney as a prisoner being taken into custody, Ms McGreavey typed in the details and Sergeant Jamieson also made a written record in his own Duty Sergeant notes. Ms McGreavey put the video on in Mr Tierney’s cell (No. 12) as she assumed that there would be constant observation. WPC Caldwell had asked Sergeant Jamieson if Mr Tierney was to be taken to the Victoria Infirmary as she had concerns about his condition and he had asked for painkillers. He was not taken to hospital but instead admitted into custody.

PCSO David Keltie had 11½ years’ experience and had been working at Aikenhead Road for three years. He remembered Mr Tierney complaining of having a sore stomach, asking for painkillers and saying to Sergeant Jamieson and others that he had taken 150 paracetamol tablets. He was clenching a bit but did not look that ill. There was a smell of alcohol. Mr Keltie doubted whether Mr Tierney was in real pain. He checked on Mr Tierney in his cell during the night and overall had no concerns about his condition.

- (5) Graeme Jamieson was the Duty Custody Sergeant at Aikenhead Road Police Station on the night of 28/29 January 2013. He has over 22 years’ police experience and is now a temporary inspector with responsibility for all custody issues throughout Scotland. He was taken off his responsibilities at Aikenhead Road following the death of Mr Tierney and moved elsewhere. He had worked at Aikenhead Road from 4 December 2012. On the night in question, he had worked from 2200 hours on 28 January to 0700 hours on 29 January. The night was quiet, prisoner wise. There were only 8 or 9 prisoners and the cells can take up to 56. Sergeant Jamieson was on duty with Police Custody and

Support Officers. When Mr Tierney arrived at the charge bar, WPC Caldwell told Sergeant Jamieson that she had arrested Mr Tierney for a breach of the peace as he had walked in front of a van. He was also told that Mr Tierney had been at the Victoria Infirmary for treatment earlier as he had been involved in a road traffic accident. Sergeant Jamieson decided to take Mr Tierney into police custody at 0125 hours and not send him to hospital. He did not think a police surgeon or medical intervention was needed. Mr Tierney was able to converse. Sergeant Jamieson spoke to him and PCSO Elaine McGreavey filled in the normal custody forms. Mr Tierney was not drunk although he had taken drink. Mr Tierney complained of a sore knee and a sore stomach. He told Sergeant Jamieson he had taken a bottle of vodka and 150 paracetamol tablets two days before. That was recorded in Sergeant Jamieson's duty notes. Sergeant Jamieson was very sceptical about the claim and the number of paracetamol tablets claimed to have been taken. From his demeanour, it was not apparent that Mr Tierney had taken such a large quantity of drugs. He had been at hospital earlier and Sergeant Jamieson presumed Mr Tierney had been fully checked there. There did not appear to be any mental health issues. He decided to have Mr Tierney put in a cell with routine observations (visited every hour) and not under constant watch. Sergeant Jamieson thought any stomach pain was down to the first road traffic incident and that there was perhaps a continuing level of discomfort. None of the support officers or police officers questioned Sergeant Jamieson's decision. Sergeant Jamieson said if he was ever asked about constant observations, he would ask why and would be prepared to change his

mind if need be. He could not recall a previous incident with a female prisoner and Ms McGreavey involving a ligature. Sergeant Jamieson visited all of the cells at 0300 hours. Mr Tierney asked for water and was given it. There were no concerns then or for the rest of his shift. Towards the end of his shift, between 0600 and 0630 hours, Sergeant Jamieson gave a prisoner briefing handover to Sergeant John Henry. He did not mention self-harm or suicide re Mr Tierney as he did not think there were such risks. The sergeants had a discussion and went round each cell. Mr Tierney was lying down. They spoke to him and he seemed fine. Sergeant Jamieson did not mention the paracetamol claim to Sergeant Henry as he was very sceptical about the amount said to have been taken and didn't believe it. He did not think the second van incident was an attempt by Mr Tierney on his own life. He did not recall WPC Caldwell saying that Mr Tierney said to her that he would hurt himself. WPC Caldwell did not raise self-harm concerns with him. Sergeant Jamieson did not make a connection between the paracetamol and the stomach pain. He did not think Mr Tierney was in obvious pain. He thought any pain was possibly down to the first road traffic incident. He did not believe Mr Tierney had taken 150 paracetamol tablets as he did not present as if he had. If he had believed him, he would have sent him to hospital. He did not remember Mr Tierney being yellow. He did not think that Mr Tierney was at risk of self-harm or suicide whilst in his custody or that he was seriously ill. If Sergeant Jamieson was presented with the same scenario again, he conceded he would send a prisoner to hospital as he had obviously judged it wrong in this case and police procedures have changed as a result.

- (6) Police Scotland Standard Operating Procedures say that a police surgeon should be called if there is the slightest indication of drug overdose. Sergeant Jamieson did not believe Mr Tierney had taken 150 paracetamol tablets and so there was not “the slightest reason”. Sergeant Jamieson said that if he had been concerned about self-harm, he would put the prisoner on constant observation with CCTV assistance. He confirmed if such circumstances occurred again and because of this experience, he would send a prisoner to hospital but he did not believe he had reason to do so with Mr Tierney.
- (7) Sergeant Jamieson is the “decision maker” when a prisoner is presented at the charge bar. He has to consider whether there are lawful grounds to detain and also the care and welfare of the prisoner. He relies on what he sees, his training and his experience. He also gets information from the arresting officers. He then assimilates and decides what to do. Sergeant Jamieson said that if he had believed 150 paracetamol had been taken, he would have sent Mr Tierney straight to hospital. All others present were also sceptical about the allegation. Sergeant Jamieson did not think anyone who had taken 150 paracetamol tablets would be walking and talking in front of him. On 1 April 2013, as a consequence of Mr Tierney’s death, a memo was issued by Police Scotland stating that if there is any suggestion that a quantity of paracetamol has been consumed, the prisoner should be taken to hospital. Sergeant Jamieson confirmed that he had been told and knew that Mr Tierney had walked out deliberately in front of the first vehicle but couldn’t say why that is not recorded in his duty sergeant notes.
- (8) At the end of Sergeant Jamieson’s shift and his handover to Sergeant Henry, there was also a handover between the respective Police

Custody and Support Officers. There were no concerns regarding Mr Tierney and none of the incoming PCSOs had been advised of the alleged paracetamol overdose as Sergeant Jamieson had not passed that on to Sergeant Henry. At 0650 hours, Mr Tierney buzzed to have his toilet flushed and was attended to by a PCSO. The Inquiry was shown CCTV evidence of Mr Tierney getting up from his bed around 0736 hours, standing uneasily and then falling back with his head hitting the cell floor. Following that, and unknown to him at the time, PCSO Duncan Donaldson with seven years' experience and working under Sergeant Henry went to Mr Tierney's cell with the intention of preparing him for court. He put his jacket through the hatch but he didn't take it and when he looked again, he saw Mr Tierney lying on his back. He spoke to him and there was a mumbled response. He and another officer went into the cell at 0747 hours and picked up Mr Tierney who was limp and they put him on his mattress in the recovery position. Sergeant Henry was advised and an ambulance was called. Paramedics arrived within a short period and were shown to the cell and began to treat Mr Tierney. After being advised of the fall, Sergeant Henry advised his Inspector, Kevin Struthers who was on duty and who asked to be kept briefed. Sergeant Henry went to the cell when the paramedics arrived. He did not tell the paramedics about the paracetamol allegation as he was not then aware of it. The paramedics did all they could to treat and assist Mr Tierney. His blood pressure and blood sugar were low. He was pale and a little jaundiced. They applied glycogen into his muscle. They also gave him oxygen. They quickly realised he was seriously unwell and needed to be taken to hospital immediately. They noticed a significant bump on Mr Tierney's

head and during their examination and treatment of him at the cells, they were told of the paracetamol allegation. They took him by trolley to the ambulance and when outside, they could see he was extremely jaundiced. That was clearly indicative of liver problems. The ambulance reached Victoria Infirmary in a matter of minutes. There was a handover to hospital A & E staff and having been advised in advance, Dr Fiona Hunter was there to receive Mr Tierney.

- (9) Sergeant Henry confirmed in his evidence that he had read Sergeant Jamieson's notes after Sergeant Jamieson went off duty and it recorded the paracetamol allegation. He had not been told that verbally by Sergeant Jamieson. Sergeant Henry confirmed that when admitting a prisoner and there is a medical issue, he makes a judgment call which might be different from the arresting officers or indeed from another custody sergeant. His position is that if there is the slightest reason for medical intervention, he calls for the police surgeon or sends the prisoner to hospital. He accepted that if the duty sergeant does not believe certain assertions, then he does not need to tell the incoming sergeant at handover. Sergeant Henry confirmed that he was later told of Mr Tierney's death. Inspector Struthers, aged 46 with 23 years' experience was told that Mr Tierney deteriorated in hospital and died. He was told that there had been a bump to Mr Tierney's head and as a result he reviewed the cell's CCTV which showed Mr Tierney falling back and hitting the floor at 0736 on 29 January.
- (10) The Inquiry was told there are now NHS nurses on site 24/7 at Aikenhead Road Police Station. A casualty surgeon can still be called or the prisoner taken to hospital if need be. Sergeant Henry felt that the introduction of nurses provided better care and safety for prisoners.

More prisoners are referred to hospital now than previously. The Glasgow and Inverclyde Police Stations are covered by three nurses. One is based permanently at Aikenhead Road and the other two travel between police stations and attend wherever they are required. Triage is exercised and the nurses also cover mental health issues.

- (11) Whilst taking Mr Tierney to the Victoria Infirmary on 29 January 2013, the paramedics advised the A & E Department that they were en route and on arrival, Mr Tierney was seen by Dr Fiona Hunter who was then a Specialist Registrar in Emergency Medicine at the Victoria Infirmary and is now a Consultant in Emergency Medicine at Monklands Hospital in Lanarkshire. Dr Hunter confirmed that she was given an ambulance report form by the paramedics with background information and there was also a verbal handover. Dr Hunter confirmed that Mr Tierney's skin was an abnormal yellow colour. He had low blood sugar. He was cold, his speech was incomprehensible and he had no leg movement on pain stimulation. Mr Tierney had a Glasgow coma scale score of 3/15. Dr Hunter explained she would be worried about any GCS score below 9/15. Dr Hunter had been advised that Mr Tierney may have taken a large paracetamol overdose two days previously. As a result, Dr Hunter administered the paracetamol antidote but went on to explain that Mr Tierney was already in organ failure and it was highly unlikely that the antidote would be effective. She noted Mr Tierney had unequal pupils and blood oozing from his head. She considered these symptoms to be indicative of an intracranial bleed. She explained she spoke with a neurosurgeon who confirmed that surgery could not be done due to Mr Tierney's abnormal clotting and liver failure. Dr Hunter explained that she

contacted the Liver Unit in Edinburgh regarding a liver transplant but she was advised that Mr Tierney would not be a suitable candidate due to his history of alcohol abuse amongst other factors. Dr Hunter also considered him not to be physically capable of a transfer to Edinburgh. Accordingly, Dr Hunter transferred Mr Tierney to the Intensive Care Unit within Victoria Infirmary and he subsequently died there at 0212 hours on 30 January 2013. It had not been possible to save his life.

- (12) Dr Michael Johnston, Consultant in Accident & Emergency at Ninewells Hospital gave expert evidence to the Inquiry about the correct system of handovers from paramedics to medical staff. He accepted in relation to the paramedic aspect of the handover on 28 January 2013 that it followed best practice and was indeed exemplary. Similarly, he fully supported what was done by the paramedics on 29 January when they delivered Mr Tierney to Dr Hunter and her staff. Dr Johnston also gave opinion on Dr Boyle's assessment of Mr Tierney and confirmed there is very little that can be done with a patient who has legal capacity and there is no evidence of psychotic behaviour. He confirmed that Dr Boyle could not have prevented Mr Tierney from leaving the hospital and that the care provided to him was in keeping with the expected standard of treatment delivered at any A & E Department throughout the country.
- (13) The Crown also led expert evidence from Professor Nicholas Bateman, Consultant Clinical Toxicologist. By way of background, Professor Bateman explained the he is the Director of the Poisons Unit in Edinburgh. He explained that Edinburgh treats around 2,000 drug overdoses each year, approximately 900 of which involve paracetamol. Professor Bateman explained that there are approximately 200 deaths

each year throughout the United Kingdom as a result of paracetamol overdose. It was Professor Bateman's opinion that liver damage begins around 15 hours after the ingestion of a substantial quantity of paracetamol. He explained that only around 10% of patients who receive treatment after this point in time will survive. He explained that a patient would not initially feel unwell after ingesting paracetamol. He explained that the patient usually only develops pain in the abdomen around 36 to 48 hours after ingestion. In the present circumstances, Professor Bateman explained that Mr Tierney could have survived an overdose of 150 paracetamol tablets if he had sought treatment within 10 hours of ingestion. However, treatment after 48 hours would only have a very marginal effect if at all. He explained he could not precisely state the point in time that Mr Tierney ingested the paracetamol. However, based on the degree of liver damage caused, it was his opinion that the overdose had been taken approximately 60 hours before Mr Tierney's final admission to the Victoria Infirmary which would take it back to the evening of 26 January 2013. Professor Bateman explained that Mr Tierney had suffered from severe renal injury by the time of his death. He explained that Mr Tierney's liver was necrotic at the post-mortem and it would have been necrotic prior to his death. Professor Bateman explained that Mr Tierney was the most unwell person that he had ever studied and that his chances of survival from his paracetamol overdose were as "slim as you could get". It was Professor Bateman's opinion that "the die was cast" for Mr Tierney from around 24 hours after the ingestion of paracetamol and he would not have survived if treatment had been administered any time after this. Professor Bateman was specifically asked whether

intervention at the earlier stage of 5.00 pm on 28 January (just after the car collision) would have made a difference to the survival of Mr Tierney. His answer was that the severity of the injuries to his organs were such that he could say with certainty that such injuries had not developed between 5.00 pm on 28 January and the following day. Accordingly, it was very unlikely that intervention at 5.00 pm would have made any difference. He said that the chances of mortality had there been earlier intervention on 28 January would have fallen from 95% to 90%. Professor Bateman also dealt with the effect of the head injury which Mr Tierney sustained in his cell. He provided unchallengeable evidence that the fall would have been as a result of Mr Tierney's low blood sugar and low blood pressure both of which were caused by the liver damage due to the paracetamol overdose.

(14) Dr John Clark, an experienced consultant forensic pathologist also gave evidence. He carried out a post mortem on Mr Tierney with a colleague on 31 January 2013 at the Southern General Hospital Glasgow. With regard to the head injury, he confirmed it had been a contributing factor to Mr Tierney's death as it accelerated the process but it was not the cause of death. The fall had fractured Mr Tierney's skull which caused bleeding in the brain and the bleeding was made worse by the paracetamol intoxication. Dr Clark confirmed that Mr Tierney would have died no matter the unfortunate fall as the liver damage was irrecoverable. He stated that an overdose of paracetamol can be extremely dangerous as it can overwhelm the liver. That is what happened here.

(15) Professor Bateman's opinion was shared by Dr Hunter who specifically said that the antidote response to the paracetamol would have had

good prospects ordinarily if given within eight hours but if presenting after two days, the prognosis was very poor and that Mr Tierney was unlikely to survive. With there being multiple organ failure, the antidote was highly unlikely to work and on Mr Tierney's first contact with the paramedics just after 4.00 pm on 28 January, his death was almost certain.

- (16) Two witnesses were led in evidence on behalf of the family. Sergeant Derek Carmichael could recall dealings with Mr Tierney on 5 November 2012 when he was the duty sergeant at Aikenhead Road. He was brought in by two police officers on a charge of drunk and incapable. He told Sergeant Carmichael that he was suffering from depression, was taking medication, had considered self-harm and that he now wanted to die. Sergeant Carmichael admitted him into custody and given what he had said, he put him on constant observations as he was a potential suicide risk. He was "red lined" in the custody records as a result of what he had said. Mr Tierney's brother, Paul Tierney, aged 52, gave some insightful family background. Mr Tierney was the youngest of five siblings and was brought up in the Gorbals. There was no problem with him as a child. However, as he got older, he changed. At age 17, he attempted suicide and was detained under the Mental Health Act. He was released and thereafter, he became very quiet, shy and almost reclusive. He suffered from depression throughout his life and attempted suicide on more than one occasion. He suffered from hallucinations and paranoid ideation. On one occasion in 2003, he jumped out of a car and was injured. He once tried to break his neck with a bell bar and on another occasion, he slashed both of his wrists. On an occasion at Dykebar Hospital, he slashed an inpatient. That was

not like him as he was not in the least violent. Paul Tierney was forever concerned about his brother's psychiatric problems and he just hoped that he would get help and take it. For periods he was very ill and housebound. He had issues with alcohol and drugs to a lesser extent. He tried to address his alcohol issues but mainly failed. He was homeless from time to time. He was supposed to go to the mental health clinic at Florence Street but didn't go often enough and the staff told Paul Tierney more than once that his brother had to help himself. Paul Tierney last saw his brother on 30 December 2012 when he was once again in low mood. His mental health issues continued until he died. Paul Tierney always felt his brother really needed to be hospitalised and treated therein and this caused great frustration to him and his family.

Submissions

[17] The agents representing the parties to the Inquiry were more or less agreed as to where and when Mr Tierney's death took place and the cause of such. None of the parties submitted that there were any reasonable precautions which might have prevented Mr Tierney's death and no one suggested that there were any defects in any system of working which contributed to Mr Tierney's death. I was in agreement with the thrust of these submissions and these are all laid out in my findings under subsections 6(1)(a), 6(1)(b), 6(1)(c) and 6(1)(d) of the Act. Those representing the Crown, the Chief Constable and the family of Mr Tierney made varying suggestions of findings I might make under subsection 6(1)(e) being any other facts which are relevant to the circumstances of the death. As will be seen, I did not make any such findings under section 6(1)(e) and I cover that under the section headed "Conclusions".

Conclusions

[18] To begin with, I wish to deal with the evidence led relating to inserting markers etc. on various computer systems which thereafter could possibly have been checked both by medical professionals and police officers to assist in the assessment of Mr Tierney. What was clear from the Inquiry was that it was not straightforward to do that and indeed, there seemed to be access limitations. I was pleased to hear that Police Scotland will be introducing a National Custody System very soon which will allow custody officers access to the custody records of prisoners throughout Scotland. That is to be welcomed. However, in my view, there were no such glaring omissions which contributed to Mr Tierney's death and I am not persuaded to make any findings under subsection 6(1)(e) of the Act as these matters were far from straightforward and have to be balanced against the live assessment of the patient/prisoner by the appropriate medical/police professionals.

[19] Much of the Inquiry was taken up by a fairly rigorous examination of the actings and opinions of those working for Police Scotland, for Greater Glasgow Health Board and for the Scottish Ambulance Service. Working backwards, I can clearly state without, I am sure, contradiction that the service provided by paramedics in twice treating Mr Tierney, taking him to the Victoria Infirmary and handing him over to medical staff was of a high standard and could not be faulted.

[20] I now turn to the three employees of Greater Glasgow Health Board being the triage nurse, Dr Boyle and Dr Hunter. It does not sit easy to cast aspersions on what the triage nurse did or did not do on 28 January 2013 when she has not been traced as a witness and is not able to defend herself. However, there is compelling evidence from the paramedic, David O'Hara and other sources that relevant information about Mr Tierney was given to the

nurse and the E Pacer form handed to her. Regrettably, that information and the said form did not reach Dr Boyle, the A & E Consultant who saw Mr Tierney. That said, I can conclude from my assessment of Dr Boyle that she was able to satisfy herself about the condition of Mr Tierney, both physically and mentally, and she did not feel the need to detain him in any way, instruct further tests, have other treatment carried out or involve other medical professionals. I would go further and say that even if Dr Boyle had known of the paracetamol overdose allegation or she accepted that walking in front of the car was a deliberate attempt on Mr Tierney's life, her views would not have changed from her actual examination and assessment of Mr Tierney and as a result, he was entitled to discharge himself from the hospital and which he duly did. I accept it does seem odd that Dr Boyle was not fully briefed by the triage nurse or handed the E Pacer form which has been mislaid. The latter seems to be the result of human error. However, I am prepared to accept Dr Boyle's evidence in that regard. I say all this in the context of a very busy Glasgow A & E Department when decisions have to be taken without unnecessary delay and actioned appropriately and realistically, there can't always be a counsel of perfection. Busy A & E Departments would not operate effectively if matters became unnecessarily protracted. In this case, Dr Boyle who is a consultant with appropriate experience and knowledge, was not sufficiently concerned to do any more than she did and in my view, that was quite understandable. In the overall context, she should not be faulted for not insisting on being given more information.

[21] The actions of Dr Hunter when Mr Tierney was received the following day at the Victoria Infirmary were exemplary. She assessed Mr Tierney fully, treated him appropriately and as best she could but realised that there was

nothing she could do to save his life and he died in the early hours of the following morning.

[22] As far as the employees of Police Scotland are concerned, this court can have no criticism whatsoever of the various police constables and police custody and support officers who came in contact with Mr Tierney in his last days. In effect, they all cared for his best interests from the time he was struck by a motor vehicle at approximately 1600 hours on 28 January 2013 in Aikenhead Road until he was found lying in his cell at 0736 hours on 29 January 2013. The evidence of Sergeants Downie and Carmichael assisted the Inquiry as did the evidence of Inspectors Struthers and Simpkins. The evidence of Sergeant Henry was very helpful and relevant. He had his opinions and recollections but his dealings with Mr Tierney were relatively limited and he could not be faulted.

[23] Sergeant Graeme Jamieson was the most scrutinised witness in this Inquiry. He was criticised for a number of matters but principally because he did not send Mr Tierney to hospital instead of admitting him into custody. His position was that he did not believe Mr Tierney was seriously overdosed or that he was seriously unwell. He was made aware of the two road traffic incidents but he was not persuaded that Mr Tierney was trying to take his own life. He was influenced by the fact that Mr Tierney had recently been in hospital and examined and his own assessment of Mr Tierney at the charge bar did not prompt him to have Mr Tierney checked again in hospital. He thought Mr Tierney looked like a lot of prisoners in Glasgow who over abuse alcohol and/or drugs for many years. He believed Mr Tierney fitted into that category and ironically, his claim of having taken a 150 paracetamol tablets was not taken seriously as Mr Tierney did not present in that fashion not only to Sergeant Jamieson but to all of the officers who dealt with him at that time.

As duty custody officer, Sergeant Jamieson requires to make judgment calls and unfortunately on this occasion, he got it wrong. He also chose not to put Mr Tierney under constant observation as he did not feel Mr Tierney was going to do anything to harm himself. As it turned out, Mr Tierney had an uneventful if restless overnight sleep with no apparent indication to those checking on him that his condition was deteriorating. There were no suicide attempts. It was some six hours plus later that the impact of the paracetamol overdose manifested itself when Mr Tierney stood up in his cell but was so unwell that he immediately collapsed to the floor.

Despite the different views expressed by the various officers from the time Mr Tierney was picked up in Caledonia Road to the time he was taken to his cell at Aikenhead Road Police Station, none of them properly challenged Sergeant Jamieson's decision to take him into custody. In following Police Scotland's Standard Operating Procedures, Sergeant Jamieson did not think Mr Tierney had taken a drug overdose and so there was no need for medical intervention. Thankfully police stations in the Glasgow and Inverclyde area can now call upon NHS nurses to assist and assess where there may be medical issues with prisoners and there cannot be any doubt that they are much better equipped and trained to make such decisions than any police officer could do.

[24] I therefore came to the view that Sergeant Jamieson's decision not to send Mr Tierney to hospital etc. was understandable in all the circumstances but no matter, this court cannot ignore the fact that at the time Mr Tierney was taken into police custody, his death was by then inevitable. The persuasive and compelling evidence of Professor Bateman, Dr Hunter and Dr Clark make that quite clear. Mr Tierney was going to die and unfortunately, he was also going to die at the time he was struck by a car at Aikenhead Road and taken to the Victoria Infirmary for the first time. Put shortly, Mr Tierney had chosen to

end his life sometime before then and that ties in with the evidence we heard from his brother, Paul. Mr Tierney was a man who had not enjoyed the best of health as a result of his poor mental health and lifestyle. By taking such a large amount of paracetamol tablets, he was intent on poisoning himself and ending his life. It would seem that to accelerate the process in a quite different way, he twice walked out in front of motor vehicles and only missed being struck on the second occasion due to the vigilant driving of Mr Malik. The second occasion was witnessed by police officers and for Mr Tierney's own safety, they arrested him and took him to Aikenhead Road Police Station where he was assessed and put into police cells. If he had been taken to hospital at that time, he would still have died as his liver was so severely damaged by then.

[25] Accordingly, given the way that Mr Tierney took his own life and the surrounding circumstances, I do not believe it is appropriate to determine facts under subsection 6(1)(e) of the Act which were relevant to the circumstances of the death as that might seem to apportion some responsibility for the death on others and by that I mean Dr Boyle and Sergeant Jamieson who, in this court's view, acted professionally and appropriately and I believe should not be subject to criticism.

[26] Finally, I wish to thank all of the witnesses for their assistance with this Inquiry and all Counsel and Solicitors for their valuable and professional contributions. I conclude by recording my condolences to the family of Mr Tierney and in particular to his siblings who sat in court throughout the Inquiry and conducted themselves with the upmost dignity and respect.

SHERIFF L WOOD

Sheriff of Glasgow and Strathkelvin
GLASGOW, December 2015