SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT DINGWALL

2011 FAI 36

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Inquiry into the circumstances of the death of Daryl Malcolm Shearer

Determination

by

Sheriff Principal Sir Stephen S T Young Bt QC

Dingwall, 14 July 2011

In terms of the undernoted sub-sections of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976 the sheriff principal determines as follows:-

Section 6(1)(a)

1. The late Daryl Malcolm Shearer (date of birth 7 May 1989) died while in custody at Dingwall Police Station, Strathpeffer Road, Dingwall, Ross-shire at about 8.15 am on 27 October 2008.

Section 6(1)(b)

2. Mr Shearer died from the cumulative effects of head and neck trauma and intoxication with dihydrocodeine and diazepam.

Section 6(1)(c)

3. There were two reasonable precautions whereby Mr Shearer's death might have been avoided, namely he could have refrained from becoming involved in fights

with other young men, and he could also have refrained from abusing controlled drugs.

4. Within the framework of the current law, and so far as the evidence disclosed, there was nothing that could reasonably and properly have been done by anyone else with whom he came into contact between 23 and 27 October 2008 to avoid his death.

Note

[1] Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that at the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction –

(a) where and when the death and any accident resulting in the death took place;
(b) the cause or causes 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.

[2] Having had an opportunity to review the evidence, productions and submissions at this inquiry, I have come to the conclusion that it is unnecessary to make detailed findings in fact in this case under sub-section 6(1)(e). I say this because at the end of the day I am persuaded that the impression which I had formed at the conclusion of the inquiry itself is correct, namely that this is an essentially simple case in which the detailed events leading up to the death of Mr Shearer, which

in other cases might form a very important part of the overall story, effectively pale into insignificance in the face of what I think is the overriding point of this case. This is that Mr Shearer was the author of his own misfortune. In a nutshell, if he had not abused controlled drugs, it is probable that he would still be alive today. So, even if nothing else constructive comes of the case, I hope that it will at least have provided a salutary reminder to others of the dangers of abusing such drugs. They are potentially lethal, as they were in this case, when taken otherwise than as prescribed by a medical practitioner.

[3] Inevitably, and rightly, the care which was given to Mr Shearer while he was in police custody was the subject of detailed scrutiny during the inquiry. It will be seen that I have not found that there were any reasonable precautions that might have been taken by the police which might have avoided Mr Shearer's death. Nor has it been shown that there were any defects in the systems of working followed by the police which contributed to his death. Nonetheless, I think that there are various matters which those in authority in the police may wish to consider in reviewing the manner in which persons in custody are cared for. These are as follows:

1. This is by no means the first occasion on which I have heard evidence of an apparent misunderstanding between a doctor who has examined a prisoner in police custody and police officers as to the doctor's instructions in regard to the future care of the prisoner. There was plainly such a misunderstanding in this case between Dr Campbell, who saw Mr Shearer at the Lawson Memorial Hospital in Golspie late in the evening of 24 October 2008, and the police officers who accompanied Mr Shearer to the hospital and took him back to the police station in Dornoch afterwards. It should be emphasised that this misunderstanding did not contribute in any way to Mr Shearer's eventual death. But the point here is that it could easily have been avoided if Dr Campbell had written, or better still printed or typed, clear instructions in duplicate to the police to the effect that Mr Shearer should be taken to Raigmore Hospital the following morning to have his cheek x-rayed. One copy could then have been countersigned by the receiving police officer and retained by the doctor and the other copy could have been retained by the police and placed in a prominent position in the prisoner's custody records. In

this way there would have been no doubt afterwards both that the instruction had been given and what it had said.

2. There were times during the inquiry when it was far from clear to me that the medication prescribed by Dr Bieniecki for Mr Shearer after he had seen him in custody in the police station at Burnett Road, Inverness, had in fact been given to him exactly as the doctor had prescribed. At the end of the day I was satisfied that it probably had been. But it does seem to me that the current prisoner medication form is not as clear as it could be and that it would not be difficult to devise a form for completion as appropriate both by the prescribing doctor and by the officer administering the medication so prescribed which would vouch more clearly than does the present form precisely what medication has been prescribed and what has been given to the prisoner, and when. Perhaps the position in this case would have been clearer if I had seen the dosage box for Mr Shearer's medication as well as the prisoner medication form itself. But I should have thought that a single form incorporating all the relevant information would be preferable, if only to avoid any subsequent doubt at an inquiry such as this.

3. Various questions were asked during the inquiry about the ability of officers working in a police custody suite to replay video recordings of a prisoner's activities in his or her cell. The significance of this in the present case would have been that it might have been possible at the time to check the veracity of Mr Shearer's claims to have had a dizzy spell and to have injured his head while in custody at the police station at Burnett Road. I understand that the camera technology has been updated since the autumn of 2008, so that it may now be possible to replay video recordings in a way that was not possible then. How practicable it would in fact be to do this in the context of the workings of a busy custody suite I am not sure. But it is something that the police may wish to consider.

4. It appears doubtful whether Mr Shearer actually took the medication which had been prescribed for him by Dr Bieniecki, at least on some of the occasions that this was given to him. As I recall, the practice in the local

prison in Inverness is for the nurse who is administering the medication to check that the prisoner actually puts it in his mouth and appears to swallow it. Even this of course is no guarantee that the medication will in fact be swallowed. The point here is that, while it is clear from the video recordings that Mr Shearer consumed controlled drugs otherwise than as prescribed by a doctor while in his cell in police custody, it is not so clear how he came by these drugs. Either he had them secreted internally when he was first taken into custody on the evening of 24 October 2008, or else he hoarded the tablets that were given to him on various occasions after these had been prescribed by the doctor, or quite possibly both. Plainly he would not have been able to hoard those that were given to him while in police custody if he had consumed them as soon as they had been given to him. Plainly too there is a limit to what the police can reasonably do to check that a prisoner has taken his or her medication. But here again I think that this is a matter that the police may wish to consider.

5. In his closing speech the procurator fiscal also mentioned two other matters as worthy of further consideration. These were (a) the importance of good note taking and communication among police custody staff to ensure that any emerging problems in regard to a prisoner were identified, especially when he or she was moved from one location to another or custody officers changed at the beginning and end of shifts, and (b) the possibility that training or advice might be given to all custody staff in relation to head injuries, and specifically what should be done in the event that a prisoner has fainting or dizzy spells. I mention these matters for what they are worth. Subject to what I have already said about the administration of prescribed medication, my own impression during the inquiry was that the standard of note taking in Mr Shearer's custody records was generally satisfactory. But no doubt there will always be room for improvement here. As for the suggestion that training or advice should be given in relation to head injuries, I am not myself sure how valuable this would be. The important point here seems to me that, if the police are in any doubt about a prisoner's medical condition, they should call a doctor without delay.

[4] In conclusion I should like to add two comments. Firstly, I thank the procurator fiscal and Messrs Ramsay, Hunter and Tudhope for their assistance during the inquiry. The evidence was marshalled and presented by the procurator fiscal with admirable clarity and skill, and his submissions at the close of the evidence were very helpful. And Messrs Ramsay, Hunter and Tudhope fulfilled their respective roles with commendable care, attention to detail and, just as importantly, restraint. In some cases over which I have presided I have seen legal representatives overplay their hand, and it does their client's cause no good when this happens. I am happy to say that it did not happen in this case.

[5] Finally I extend the sympathy of the court to Mr Shearer's family and his honorary aunt (if I may so describe her) Mrs Rhona Morrison. This was indeed a sad case with a pervasive sense of waste about it. No one should underestimate the harm and distress that Mr Shearer undoubtedly caused during his short life, both to others and to himself. At the same time one should not overlook Mrs Morrison's description of him as someone of whom she was very fond and who was worth fighting on for. As she put it, he had a lovely personality and in many ways was a caring person who was determined that he should get his life sorted out and who believed that one day he would get things turned round. His father, Mr Shearer senior, gave evidence to the same effect, and it is just a pity that the potential for good in him should have been eclipsed, and then ended forever, by his abuse of controlled drugs and untimely death.