

SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

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

FATAL ACCIDENT INQUIRY
INTO THE DEATH OF

PAUL HARPER

SHERIFF'S DETERMINATION

GREENOCK

28th October 2011

The Sheriff, having on 27th , 28th and 29th September 2011, held an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, into the circumstances of the death of Paul Harper, 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 Paul Harper, whose date of birth was 22 May 1978, and who, at the time of his death was an inmate at Her Majesty's Prison Gateside, Greenock, took place within Cell 15, Ailsa Hall, at Her Majesty's Prison Gateside, Greenock, at 15:40 hours on 18th November 2010.
- 2 In terms of Section 6(1) (b) of the Act, the cause of death was
 - 1 a) Hanging

I decline 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 McDonald, the Procurator Fiscal Depute and the Scottish Prison Service was represented by Mrs Hammond, Solicitor. The family were unrepresented.

I heard evidence in the Inquiry on 27, 28 and 29 September 2011.

Evidence was led by the Procurator Fiscal Depute from Charles McMahon, Consultant Psychiatrist; Dr Andrew Kirk, Scottish Prison Service, Robert Rice, Prison Officer; John Thomas, Prison Officer; Jillian Paton, Nurse at HMP Gateside Prison; Rodger Robson, Andrew McTaggart, Addiction Worker at HMP Gateside; Michael Hagan, Prison Officer; Raymond Anderson, Hall Manager; Andrew Davidson, Unit Manager; Charles Hoggitt, Nurse at HMP Gateside; and Doris Williamson, Clinical Manager at HMP Gateside.

I also had the benefit of two Joint Minutes of Agreement which assisted in limiting the evidence that required to be led at the inquiry.

Several productions were also lodged by the Procurator Fiscal and which were referred to by the various witnesses. No witness were called by Mrs Hammond

SUBMISSIONS

Mr McDonald 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 and to determine that Mr Paul Harper died in Ailsa Hall, Cell 15, Her Majesty's Prison Gateside, Old Inverkip Road, Greenock, on 18th November 2010 at 15.40 hours and that the primary cause of death was by hanging.

In respect of Sections 6(1) (c) and (d), he asked me to make no findings. He did, however ask me to make findings in respect of (e).

Mr McDonald suggested that there were two issues that had been flagged up by the Fatal Accident Inquiry evidence. He suggested that there was no access to medical records and that although this was now about to happen, at the time of Mr Harper's death, there was no access. He considered that it is possible that it may have made a difference. He also accepted, however, that Dr Kirk was aware of the previous self-harm episode in respect of Mr Harper. Mr Harper, however, had not told the induction officer about this episode. It was his view that had such evidence been available to the induction officer, and access to medical records available, it may have made a difference. There had also been evidence about the new drugs protocol which, although it was slightly confused, suggested that when drugs were found, and anyone appeared intoxicated, the protocol now in place would result in a mandatory referral to the medical practitioners. At the time of Mr Harper's death no such protocol was in place and he submitted that had such a protocol been in place it might have made a difference and was therefore relevant to the circumstances of his death

I then heard from Mrs Hammond and she endorsed the submissions made by Mr McDonald in respect of Sections 6(1) (a) and (b) but asked me to decline to make any further findings. Mrs Hammond suggested that there had been no evidence before the Inquiry that either of the matters referred to by Mr McDonald would have made any difference to the outcome. There was no evidence that the lack of records was relevant to his death. The only basis on which I could make a finding in terms of 6(1) (e) was if there had been evidence at the Inquiry to suggest the same. It was clear that there had been no medical evidence in relation to the records being available or not being available, being relevant to his death. With regard to the question of mandatory referral to health records, no evidence was led before the Inquiry that suggested they would or would not have made a difference. Furthermore Dr. Kirk was in fact aware of Mr Harper's previous suicide attempt. In these circumstances, she asked me to decline to make any further findings, other than those in terms of 6(1) (a) and (b). The prison staff had followed the appropriate induction and there was no suggestion that that they had not taken into all the appropriate risk assessments in considering that Mr Harper was not at risk. In the circumstances, she asked me not to consider making any findings in terms of 6(1) (e).

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, Paul Harper was a 31-year-old man, who was sentenced to 90 days imprisonment at Greenock Sheriff Court on 17th November 2010. He arrived at prison about 12:30pm and underwent the formal induction procedure on arrival and thereafter was placed in Cell 15 in Ailsa Hall, along with another prisoner, Rodger Robson. The prison authorities were aware that this was the first custodial sentence that the deceased had served and went through the formal procedures which included a suicide risk assessment called ACT. This is a process used by induction offices to attempt to identify if there are any concerns about possible suicide, by questioning and interaction with the inmates. If any concerns are highlighted, then the prisoner would be monitored more closely, with regular checks on the prisoner, which could be 15, 30 or 60 minute intervals. It is used to minimise the risk of prisoner suicide. Following Mr Harper's induction and ACT assessment, no concerns were raised, and he was returned to his cell.

Later on the evening of 17th November, the prison authorities became concerned that a number of prisoners appeared to be under the influence of drugs and, after observations, a decision was made to conduct a search of Mr Harper's cell. I heard evidence from Mr Robson, a cell mate, that Mr Harper had taken drugs into prison by secreting them in his rectum, a practice commonly known as "banking". Mr Harper then, against advice from Mr Robson, brought the drugs out into open view in the cell. Mr Harper apparently took some of the Diazepam that he had. He also gave some to Mr Robson. Mr Robson repeated his advice to Mr Harper on a number of occasions to keep the drugs out of sight. Mr Harper did not take that advice. The result was that when the search was conducted, the prison officers had no difficulty in finding the various drugs, as he had only managed to place them in his boxer shorts. As this was a breach of prison rules, Mr Harper was put on report. Mr Harper was advised about the consequences and procedures for his breach of the prison rules. At his hearing the following day, he admitted possession of the drugs and indicated that they were for his own personal use. He was advised that the police had

been involved and would be attending to make their own investigations. After his report hearing, he was returned to his cell on his own. Mr Robson had been moved to the upper hall, as his 24-hour period of induction and observation had been completed without incident. A number of witnesses described Mr Harper as being relaxed and seemingly unperturbed throughout his interaction with the various prison officers and medical staff. He seemed to show no outward concern as to being in prison, or in respect of the inquiries in relation to the drugs find. It was also clear from the evidence that if any of the staff, no matter a prison officer, medical staff or supervisor, believed Mr Harper required ACT procedures because of their assessment at any time, they would have been instigated. All staff at every level is trained in ACT procedures and have annual refresher courses. After being returned to his cell on his own, Mr Harper took his own life by using a shoe lace to hang himself from the window of his cell. When he was discovered, attempts were made to revive him, but to no avail and he was pronounced dead.

FINDINGS

I was asked to make formal findings which I have done but I was also asked by Mr McDonald to consider making findings in terms of Section 6(1) (e), which states:

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

I can only do that on the basis of evidence presented to the Inquiry. No medical evidence was presented to the Inquiry with regard to the medical notes being available making any difference. I accept that there will be a change in practice shortly, but I did not hear any evidence to suggest that its' availability for Mr Harper may have altered the outcome. Mr Harper was seen by Dr. Kirk on the morning of his death and was aware that there had been a previous attempt to take his own life but that did not affect his view about the manner and demeanor of Mr Harper. His presentation did not fit the criteria that would alert him to Mr Harper being a suicide risk. With regard to the new drugs protocol, there was no evidence presented to the inquiry that it would have made a difference. From my understanding, although it would now be mandatory to refer an individual who was caught with or taking drugs, to the medical team, it would not mean that there would be ACT procedures put in place – it would be an assessment, just as it is now. The reality is that Mr Harper did not present as a suicide risk either on the day before or on the day of

his death. I am satisfied that the prison authorities have in place the appropriate procedure to manage and deal with the risk of suicide but that will never prevent such deaths occurring amongst the prisoners in their care. It is a deeply sad fact of life that the drug addiction that Mr Harper had made him feel that it was better to take his own life than to keep living with his addiction. Having considered all of the evidence I do not consider that there is evidence before the Inquiry that would allow me to make any findings in respect of section 6(1) (e).

CONCLUSION

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 and Mrs Harper as they have to live in the knowledge that their son has taken his own life and 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, who was unable to beat his addiction. Such was his addiction that he came to court knowing that he would receive a prison sentence and therefore came prepared, by “banking” the drugs. He seemed to be accepting of his situation and appeared to give no outward sign of his intention. All the witnesses noticed his calm and self-assured demeanor. There appeared to be no signs that he was unable to cope, or was contemplating taking his own life – even his cell mate said that he did not think that was his intention. The ACT assessment did not suggest that there were any concerns. The reality was however that he did take his own life despite the outward appearance.

Having considered all of the evidence and all the submissions made I am satisfied that only the formal findings in respect of the place, time and cause of death should be made. The assessments and procedures are, in my view, a useful tool but they cannot ever be regarded as being infallible. I am satisfied that the training that is given to all SPS employees is an indicator that they are very much alive to the possibility of suicide of prisoners in their care. To ensure the safety of the prisoners in their care, they have developed practices and procedures to ensure that they can minimise any suicide risk. It is a risk assessment and in reality is unable to prevent a death when an individual, such as Mr Harper, has decided to mask his thoughts to ensure his appearance and manner do not give rise to suspicions. We do not know when Mr Harper decided that he would take his

own life, but he had decided about it sufficiently to write an explanation to his parents and to take care of details for his funeral. He had decided he was going to commit suicide and, in my view, it would not have been possible to gauge that risk in terms of his presentation to those who were tasked with his care. We do know that he was a young man who had a drug addiction and that drug addiction was current. He was aware of the pain caused to his family by his addiction and behaviour. It is a tragedy that Mr and Mrs Harper have lost their son. I can imagine that his addiction was a source of distress to them and Mr Harper was aware of that as well and it has resulted in his choice to take his life without thinking through, that their distress would change to a deep sense of loss. It is not easy for a parent to face the death of a child, but for it to have happened while he was in prison must be even more difficult for them. My sympathies are with them.

Having heard all of the evidence, I am satisfied that there was nothing that might have been done to prevent his death. Mr Harper was a drug addict who died at a young age because of his 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

27thOctober 2011