SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2020] FAI 19

B146-19

DETERMINATION

BY

SHERIFF PINO DI EMIDIO

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

into the death of

THOMAS CHARLES SHIELDS

PERTH, 22 April 2020

The Sheriff, having considered all the evidence presented at the Inquiry, Determines terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"):

1. Thomas Charles Shields, born 28 August 1987, died sometime before 0700 hours on 2 October 2017 within Cell 50, Bruce Wing, HM Prison Castle Huntly, Longforgan, near Dundee.
2. In terms of Section 26(2)(a) of the 2016 Act, the death occurred prior to 0700 hours on 2 October 2017 within Cell 50, Bruce Wing, HM Prison Castle Huntly, Longforgan, near Dundee.
3. In terms of Section 26(2)(b) of the 2016 Act no accident took place.

4. In terms of Section 26(2)(c) of the 2016 Act the cause of his death was the adverse effects of 5F-MDMB-PINACA.
5. In terms of section 26(2)(d) of the 2016 Act there was no accident and therefore no finding requires to be made under the subsection.
6. In terms of section 26(2)(e) of the 2016 Act there were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided.
7. In terms of section 26(2)(f) and (g) of the 2016 Act there were no defects in any system of working which contributed to the death and there are no other facts which are relevant to the circumstances of the death.

NOTE

[1] This fatal accident inquiry into the death of Thomas Charles Shields ("the deceased") was held on 16 August, 16 September and 11 November 2019. The Crown were represented by Mrs Whyte, Procurator Fiscal depute, Perth. Ms Stronach, solicitor, Perth, appeared to represent Tayside Health Board ("THB"). Mr Fairweather, solicitor, Edinburgh appeared to represent the Scottish Prison Service ("SPS").

[2] The deceased was a serving prisoner, having been sentenced on 10 March 2004 to life imprisonment at Glasgow High Court. On 1 March 2006, on appeal, the punishment part was reduced to 14 years. Accordingly at the time of his death he was in legal custody. An inquiry required to be held in terms of section 2 of the 2016 Act. The

procurator fiscal represented the public interest at the Inquiry which is an inquisitorial process. It is not the purpose of the Inquiry to establish civil or criminal liability.

Procedural history

[3] A preliminary hearing took place on 9 July 2019. At that hearing it was indicated by those who then were represented that matters were agreed and that a joint minute would in due course be extended and produced. This was said to obviate the necessity of any evidence being led at the inquiry. The deceased's family were not represented at any stage but members of the family did attend the Inquiry. The Prison Officers Association for Scotland was represented at the Preliminary Hearing but chose not to participate in the Inquiry.

[4] The role of the sheriff at an inquiry is different from that played in adversarial proceedings. Although the parties entered into a joint minute and intimated that they considered this dealt with the issues which were to be the subject matter of the inquiry, this did not constrain me from seeking certain additional information. A number of points were identified on which I required further evidence to be provided. The parties co-operated fully in pursuing these points and in the event I was satisfied that I could proceed without having to hear oral evidence.

[5] On 16 August 2019 the next of kin of the deceased were present at the hearing and condolences were expressed to them. SPS lodged (without opposition) additional production. These were the DIPLAR internal prison review report and an Affidavit of Mr Brian McKirdy, Head of Operations and Public Protection at SPS. Mr McKirdy had

been Deputy Governor at HM Prison Castle Huntly between September 2014 and September 2017. The parties lodged the Joint Minute. Both the Affidavit and the Joint Minute were read for the record. In the course of the hearing a number of points were identified that required to be followed up. Some of these related to aspects of the DIPLAR report. I also requested expansion of the information in some parts of Mr McKirdy's Affidavit. I continued the Inquiry to 16 September 2019 at 1400 hours for these inquiries to be completed and any supplementary Affidavits and Joint Minutes to be prepared.

[6] When the Inquiry resumed on 16 September 2019, the procurator fiscal depute lodged without objection an Affidavit of Dr Helen Brownlow, toxicologist and Crown Production number 11 being EMCDDA Report on Risk Assessment of the new psychoactive substance 5F-MDMB-PINACA. This material confirmed that no back calculation was possible such as would allow the court to determine when the deceased consumed the drug which caused his death. The parties also lodged a second Joint Minute of Agreement which dealt with the court's query regarding an intelligence entry and also other information about searches. Mr Fairweather lodged a further Inventory of Productions for SPS without objection which contained disciplinary paperwork relating to the deceased. He produced a draft Supplementary Affidavit of Mr Brian McKirdy. This had not been sworn as Mr McKirdy was not available to do so prior to the calling of the resumed Inquiry. Mr Fairweather also produced two further Affidavits in response to the court's inquiries. The first was an Affidavit of Paul Yarwood, Deputy Governor which dealt with the challenges which arose from

illicit drug use in the Prison and the investigation of the deceased's death. The second was a Supplementary Affidavit of Paul Durning, First Line Manager at the prison at the material time.

[7] The new material produced at the adjourned Inquiry filled in certain gaps in the timeline and clarified how the general SPS policies relating to security and illicit drugs had operated in relation to the deceased. The procurator fiscal depute read the Second Minute of Agreement and the Affidavit of Dr Helen Brownlow. Mr Fairweather read the Affidavits of Paul Yarwood and Paul Durning. I was advised that the deceased's mother remained concerned about the SPS's duty of care of prisoners after 4 February 2017 and the way drugs got into the prison. It was inevitable that I could not proceed to complete the Inquiry on this date because of Mr McKirdy's unavailability to swear his supplementary Affidavit. There would be time for members of the family to seek to make further representations to the court, if they wished.

Submissions

[8] On 11 November 2019 the Inquiry was resumed and concluded. Ms Shippen represented THB on this occasion. I was advised by the procurator fiscal depute that there had been no further contact from the mother or the deceased's sister.
Mr Fairweather read the supplementary affidavit of Mr Brian McKirdy which was now available. I then heard submissions from the parties who were represented. The Crown submitted that it was appropriate to make formal findings under section 26(2)(a) of the 2016 Act and that no recommendations were required. Ms Shippen adopted the

procurator fiscal depute's submissions. Mr Fairweather produced a helpful written submission which he adopted. He submitted that the prison authorities were involved in striking a balance in administering the Open Prison estate. The prisoners were extended a level of trust but there was in place an appropriate system of searching of prisoners and cells at Castle Huntly. That system was not defective in its application to the deceased. There was nothing in the evidence to suggest he was not a fit person at the time of his death. The deceased failed to attend at an outpatient appointment after his June 2017 seizure. There was nothing in the evidence to suggest that that incident had any effect on his death. He concurred in the submission that it was appropriate to make formal findings only in this case.

Summary of reasons for decision

Discovery of the death of Thomas Charles Shields

[9] On the evening of 1 October 2017 the deceased chatted with his near neighbour William Patterson between around 1800 and 1930 hours. He was in good spirits and said he had been playing football that day. Between around 2200 and 2300 hours the deceased made food in the kitchen area near his cell and then returned to his cell which was locked shortly thereafter. On the morning of 2 October 2017 at about 0710 hours, the deceased was found dead in Cell 50 when his cell was opened by prison staff. When he was found he had been dead for some time and there was no immediate sign of what had caused his death. At post mortem the cause of death could not be ascertained from immediate physical examination of the deceased. Samples were taken for toxicological

examination. That examination established that he had died as a result of the adverse effects of the chemical compound 5F-MDMB-PINACA.

5F-MDMB-PINACA

[10] 5F-MDMB-PINACA is a synthetic cannabinoid. It is controlled under the Misuse of Drugs Act 1971 and was so controlled at the date of death of the deceased. It is a class B drug. Synthetic cannabinoids is the term given to the range of New Psychoactive Substances ("NPS") which were introduced into the illicit drug market to mimic the appearance and effects of traditional herbal cannabis. The only significant market for this product is within the confines of the prison system. A common way of introducing it into the prison system is by dipping or spraying paper with the compound. Once a paper dipped or sprayed with the compound is introduced into the prison system it is usually subdivided into small pieces for sale. These pieces are heated so that the fumes can be inhaled. There are a significant number of known adverse effects that can arise from the use of this compound. Tests have shown that there is no uniformity to how the compound is applied to paper by dipping or spraying so that each particular small piece of paper impregnated with it may contain vastly different quantities of the compound.

HM Prison Castle Huntly - procedures for searches

[11] HM Prison Castle Huntly is an open prison surrounded by open land. It was subject to The Prisons and Young Offenders Institutions (Scotland) Rules 2011 at the time of the deceased's death. There are no walls and fences of the conventional kind.

There are established procedures for periodic searching of cells and prisoners. There is a Search Policy Statement applicable in the open estate. Compulsory and voluntary drug testing is an integral part of the local drug strategy at the prison. Routine cell searches take place on approximately a 3 month cycle. Additional intelligence based searches of cells and prisoners may also take place. Prisoners are subject to a rubdown search upon return from home leave or from being out in the community. About one in five may be subjected to a more rigorous full body search. Prisoners also work in the grounds around the prison buildings but they are not subject to rubdown searches on return unless there is cause for suspicion. They are trusted to comply with the prison rules and carry out the work assigned without minute scrutiny. Records are kept of full body searches but not of rub down searches. There are 183 cells or rooms in the prison. About 12 rooms are searches each week on a random basis. Most prisoners will have a period of home leave about 1 week each month.

HM Prison Castle Huntly records relating to the deceased

[12] The following summarises the principal entries of relevance to the Inquiry.

a. On 28 June 2016 the deceased was transferred to HM Prison Castle Huntly.

b. During his time in Castle Huntly the deceased undertook a total of 15 periods of home leave at his mother's address.

c. In the period from about 1 December 2016 to 21 August 2017, a total of 8 negative drug samples were obtained from the deceased.

d. On 4 February 2017 the deceased was placed on report after staff had difficulty rousing him at unlock at 0700 hours. He was found guilty in the orderly room of being under the influence of a prohibited substance and awarded a punishment of a caution.

e. On 24 April 2017, when the deceased was occupying Cell 14 in Wallace Wing, his cell was searched with nil result.

f. On 14 June 2017 he suffered a seizure as a result of which he fell and cut his forehead. He was taken to hospital so the cut could be sutured. He was given an outpatient appointment for a later date (8 August 2017) but he did not attend it.

g. On 28 June 2017 the deceased was subjected to a full body search with nil result.

h. On 3 August 2017 he was transferred to Cell 50 in Bruce Wing which is the cell where he was found dead. There was no recorded search of that cell in the period from his moving into it up to the date of his death.

i. On 18 September 2017 a report in relation to the deceased indicated positive response and engagement by him.

j. On about 12 and 16 October 2017 prison authorities recorded that they had received intelligence that another prisoner was suspected of having supplied the deceased with NPS prior to his death. They were unable to substantiate these reports in a way that would allow further action to be taken.

k. On 9 March 2018 an Operational and Learning Review (DIPLAR) attended by SPS and NHS staff into the death recorded two matters.

i. There had been a failure in February 2017 to complete paperwork in relation to the caution awarded to the deceased. In terms of the Management of an Offender at Risk ("MORS") Policy this should have been done at the time.

ii. There was a requirement to explore better ways to follow up non-attendance at external hospital appointments. This was a reference to the missed out patient appointment of 8 August 2017.

[13] Since the death of the deceased the SPS has begun to invest in Rapiscan machines which can aid the detection of the presence of NPS and other illicit substances in the prison system.

Conclusion

[14] It was not possible to establish on the evidence how the NPS consumed by the deceased made its way into the prison. The expert evidence was that there was no way of counting back to establish when he ingested the NPS which led to his death. He may have brought the item in himself or he may have been supplied by another prisoner within the prison. Intelligence received after his death suggested the latter. The open prison environment was not conducive to rigorous control of what drugs entered the prison. It was not even possible to establish whether the NPS was ingested within the

prison as he might have ingested it outside the prison estate in the period prior to his death.

[15] The evidence satisfied me that there was regular drug testing and searching of the deceased and of his physical environment in Castle Huntly. The deceased received a caution in February 2017 for apparent drug misuse but otherwise he appeared to be positively engaged and having regular home visits. Tragically the deceased, who had been incarcerated from a very young age, was close to release on licence at the time of his death. He was in the independent living unit and as a result in a trusted position. There was nothing to suggest that the incident where he was injured on 14 June 2017 had any connection with his death. I was satisfied that it was appropriate to make the findings stated above, having regard to the terms of the Joint Minutes and the additional evidence presented in the affidavits and other documents. I did not consider that any additional findings in my determination were required in terms of section 26(1)(a) or any recommendations in terms of section 26(1)(b) and (4) of the 2016 Act. In the circumstances, I agree with those who participated in the Inquiry that there were no reasonable precautions that could have been taken that might realistically prevent other deaths in similar circumstances.

[16] I close by offering once again my condolences to the family of the late Thomas Charles Shields.