SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2022] FAI 5

GLW-B826-21

DETERMINATION

BY

SHERIFF A M CUBIE

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

into the death of

GARY ROE

Glasgow, 21 January 2022

Determination

The Sheriff, having considered the information presented at the Inquiry, determines, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") the following:

1. In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred) that Gary Roe, born 27 December 1968, died at Glasgow Royal Infirmary, Glasgow, on 16 November 2019 at 6.00pm.

2. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death), that the cause of death was hanging.

3. In terms of section 26(2)(e) of the 2016 Act that there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

4. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death) that there are no other facts which are relevant to the circumstances of the death.

5. In terms of section 26(1)(b) of the 2016 Act, that there are no recommendations which might realistically prevent other deaths in similar circumstances arising from the information provided.

NOTE

Introduction

[1] This inquiry into the death of Mr Roe was held on 2 December 2021 by way of a WebEx hearing. Miss Brown, Procurator Fiscal Depute, represented the Crown. Mr Considine, Solicitor, represented the Scottish Prison Service (SPS), Miss Wallace, solicitor, represented the Scottish Prison Officers Association (SPOA) and Miss Paton solicitor, of the NHS Central Legal Office represented the interests of the relevant Health Board. The family were not represented.

[2] No oral evidence was presented to the inquiry. The parties entered into a detailed and comprehensive Joint Minute of Admissions in advance of the hearing. I am grateful for the care and attention given to the agreement reached.

Purpose of this Inquiry

[3] The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules") govern fatal accident inquiries. A fatal accident inquiry is held under section 1 of the 2016 Act and its purpose in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the inquiry is not to establish civil or criminal liability. The process is inquisitorial in character. The procurator fiscal represents the public interest at the inquiry. The present inquiry was mandatory in terms of sections 2(1) and (4) of the 2016 Act as Mr Roe was in legal custody at the time of his death.

[4] As regards the circumstances, the sheriff must make findings regarding: (a) when and where the death occurred; (b) when and where any accident resulting in the death occurred; (c) the cause or causes of the death; (d) the cause or causes of any accident resulting in the death; (e) any precautions which— (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided; (f) any defects in any system of working which contributed to the death or any accident resulting in the death; and (g) any other facts which are relevant to the circumstances of the death.

[5] In terms of section 26(4) the sheriff is entitled to make recommendations regarding (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

Factual circumstances

Events leading to Mr Roe's reception into HMP Low Moss

[6] On 20 January 2018 Gary Roe had appeared on petition at Greenock Sheriff Court and was remanded in custody. On 6 February 2018 he was fully committed for trial and again remanded in custody. After sundry procedure on 15 August 2018 he appeared at the High Court in Glasgow and pled guilty to a charge of assault to severe injury and permanent disfigurement and danger to life. The victim was his son. After preparation of reports and investigation of a previous conviction the deceased appeared on 9 October 2018 at the High Court in Glasgow query was sentenced a period of six years and four months in prison to run from 29 January 2018. Mr Roe qualified for parole on 29 March 2021.

[7] Mr Roe was first imprisoned within HM Prison Greenock before being transferred to HM Prison Shotts and latterly HM Prison Low Moss, where he was at the time of his death.

[8] On 4 June 2019 Mr Roe took 30 co-codamol pills, which he disclosed on 11 June 2019. As a result of a concern expressed by a family member that this was a suicide bid, referral was made to the multi-disciplinary mental health team. The review did not take place as he was transferred to HMP Low Moss on 1 July 2019.

HMP Low Moss

[9] On his arrival the deceased was a subject to a reception risk assessment in accordance with the SPS suicide prevention strategy "Talk to Me". The conclusion of the

assessing member of staff was that Mr Roe was at no apparent risk. Mr Roe was thereafter assessed by a healthcare professional who noted that he denied any thoughts of self-harm or suicide, and concurred with the assessment that Mr Roe was at no apparent risk. Mr Roe was further assessed under the Talk to Me strategy on 25 September, 1 October, 3 October, and 12 November 2019; no issues arose either from the deceased or for assessing members of staff on these occasions. He continued to be assessed as at no apparent risk.

[10] Mr Roe appeared settled during his time in HMP Low Moss, working in the kitchen then in the timber assembly workshop. The week prior to his death he had submitted a complaint as he had been allocated an outside job in waste management instead of working on the garden. That complaint was still ongoing at the date of death. He attended education regularly. He took classes in maths and modern studies. He was generally compliant and engaged well with the prison regime.

Contact with family

[11] Mr Roe had five children aged between 27 and 7 years of age. The son who had been victim of the offence giving rise to imprisonment had forgiven him and they spoke occasionally on the telephone. He remained on good terms with his ex-wife. He had regular visits from members of his family and friends. This included his middle son who was resident within a children's home and was brought to visit him, the last such visit being on 14 November 2019. Mr Roe also had regular telephone contact with

family and friends on an almost daily basis. Either the day before or the day of his death he ordered a 16th birthday card for his daughter.

Mental health and medical oversight.

[12] There had been previous episodes of depression for which he had been described trazodone. In HMP Low Moss, Mr Roe advise prison staff of his desire to meet with the general practitioner to review his medication. He was issued with a prescription for mirtazapine in place of trazadone.

[13] Mr Roe made a Mental Health self-referral on 8 August 2019 and an appointment was made for him to meet a senior nurse from the mental health team on 16 August 2019. The deceased disclosed concerns about sharing a cell. He had a poor sleep pattern and he snored and this caused tension between him and his cellmate. The senior nurse told Mr Roe that he would speak with his line manager regarding Mr Roe's wish to have a single cell.

[14] During the interview the deceased had become emotional disclosing the death of a child many years ago and discussing his shame in relation to the offence for which he received the sentence of imprisonment in which his son was the victim. His mood was noted as "low but appropriate to context". He denied any historical or current suicidal ideation. A follow-up appointment was arranged for 5 September 2019.

[15] He made a further mental health self-referral on 30 August 2019 at which time it was noted that he already had a follow-up appointment. On 5 September 2019 the deceased raised the same concerns about sharing a cell. On making enquiries the senior

nurse was concerned that Mr Roe might be subject to bullying by his cellmate who was a relative, although no complaint was made by Mr Roe. At that meeting Mr Roe sought an increase of mirtazapine and a further GP appointment was scheduled to discuss the request

[16] A further mental health review was carried out on 10 October 2019. Mr Roe's concerns remained the same, single cell status, and antidepressant medication; he also sought pain control medication. He was advised that his request for single cell status had been raised with the first line manager who was considering his request.

[17] Given the suspicion about Mr Roe being bullied, he was moved into a different cell which he still required to share (Cell D 27); this took place approximately 8 to 10 weeks prior to his death.

[18] Mr Roe attended an appointment with a general practitioner on 8 October 2019. 25mg of amitriptyline was prescribed to assist with ongoing pain. A further review was arranged for 4 November 2019. On that date Mr Roe had a consultation to review his medication. He indicated that he suffered from insomnia. The general practitioner considered reducing the dosage of one of his medication to aid his sleep.

[19] During the contact which the deceased had with healthcare and mental health professionals in the months leading up to his death he gave no indication that he was at risk of suicide. The assessment of his behaviour and mood listed a number of positive factors including planning future events and good family relationships.

Circumstances of 16 November 2019

[20] Approximately three weeks previously, HMP Low Moss had introduced cell keys for prisons allowing prisoners to lock themselves within the cell for privacy, such arrangement being able to be overridden by staff. Mr Roe shared a cell with another prisoner; at approximately 15:27 on 16 November 2019 Mr Roe left the cell, returning within 10 minutes; the door to the cell was then closed over. Mr Roe was the sole occupant of the cell at that time. At approximately 16:17 hours, Mr Roe's cellmate returned to find that the cell door was locked. He approached a prison officer seeking help to open the door, assuming that the cell was unoccupied.

[21] At 16:19 hours the prison officer unlocked the cell door at which time Mr Roe was discovered hanging from a ligature which had been tied to the rail of the top bunk bed.

[22] Code blue was called alerting medical staff that the urgent attendance was required. A personal alarm alerted other prison officers to attend the cell. The prison officer assisted in supporting the Mr Roe's weight to alleviate the pressure on his neck. The ligature was cut from his neck. He was lowered to the floor. A faint pulse could be detected. CPR was commenced and maintained until responding nurses took over. Mr Roe vomited; the prison medical team continued CPR until the arrival of an ambulance technician and a paramedic at which stage Mr Roe was intubated. A neck brace was applied. The attending ambulance man and paramedic took over CPR which at that stage had been carried out for a period of 25 minutes. Electrical activity was noted but no heartbeat. CPR was continued for a further 20 minutes

[23] A decision was taken that Mr Roe be transferred to Glasgow Royal infirmary for further treatment. The ambulance left Low Moss at approximately 17:41 hours; further attempts to resuscitate ceased at 18:00 hours when Mr Roe was pronounced dead

Post death review

[24] After the death, as part of the Death in Prison Learning Audit and Review (DIPLAR), his cellmate advised the review that Mr Roe had been carrying a ligature. This was not known prior to the disclosure by his cellmate. The DIPLAR concluded that there was nothing to indicate that in hindsight Mr Roe's actions could have been predicted, or action taken to prevent the death.

Submissions

[25] In submissions, all parties invited me to make formal findings in terms of sections 26(2)(a) and (c) of the 2016 Act and no findings in terms of sections 26(2)(b), (d), (e), (f) and (g). Similarly, the parties invited me to make no recommendations under section 26(4) of 2016 the Act. The parties offered their condolences to the family of Mr Roe

Discussion and conclusions

[26] From the information available to the inquiry, and in accordance with the findings of DIPLAR, there was nothing to indicate that there was a risk of Mr Roe taking his own life. Although he had expressed concerns about seeking single cell status, pain

relief, depression medication, sleep patterns and his work arrangements none of these factors (including, but not restricted to, his own self reporting), either individually or cumulatively, had given rise to any concerns about suicidal ideation. He had been moved from a potential bullying environment. He was both working and taking advantage of the prison educational facilities. He had regular and frequent contact with family and friends. The fact that he had arranged to buy a birthday card at on the date of his death indicates a degree of future planning.

[27] He had been monitored in accordance with the SPS suicide prevention strategy, had made self-referrals and had regular meetings with the general practitioner, none of which interactions gave rise to any concerns about suicidal ideation; his mood was monitored as confirmed by the fact that it was noted on 16 August 2019 that his mood was low but "appropriate to context".

[28] Accordingly, while it is clear that Mr Roe suffered from depression and had other ongoing concerns he did not during his time at HMP Low Moss present as an individual who appeared to be at risk of suicide or self-harm. There are no identifiable precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

[29] I am satisfied that I should make formal findings of the time, place and cause of Mr Roe's death in terms of sections 26(2)(a) and (c) of the 2016 Act respectively, and that I should make no findings in terms of sections 26(2)(b), (d), (e), (f) and (g). Likewise, I have no recommendations to make in terms of section 26(4) of the Act.

[30] Finally, I join with all parties in offering my condolences to the family of Mr Roe.