SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2022] FAI 28

LIV-B166-21

DETERMINATION

BY

SHERIFF JOHN A MACRITCHIE SSC

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

into the death of

STEVEN GUNN

26 July 2022

Determination

[1] The Sheriff having considered the evidence presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 that:

[1.1] In terms of section 26(2)(a) of the Act, on or about 7 October 2018 at 08:17, Steven Gunn, aged 41, born 1 September 1977, then in lawful custody at Her Majesty's Prison Addiewell, 9 Station Road, Addiewell, West Lothian, died within cell 26, Lomond C Wing of said prison.

[1.2] In terms of section 26(2)(b) of the Act, Mr Gunn accidentally fatally overdosed by consuming shortly prior to his death unprescribed diazepam, phenazepam, alprazolam and mirtazapine.

[1.3] In terms of section 26(2)(c) of the Act, the cause of the death was multi-drug intoxication and ischaemic heart disease.

[1.4] In terms of section 26(2)(d) of the Act, the specific cause of the said accidental fatal overdose was the consumption by Mr Gunn of said unprescribed drugs.

[1.5] In terms of section 26(2)(e) of the Act, there were, on the available evidence, no precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or the accident resulting in the death, being avoided, other than Mr Gunn refraining from consuming said unprescribed drugs.

[1.6] In terms of section 26(2)(f) of the Act, there were, on the available evidence, no defects in any system of working which contributed to the death or the accident resulting in the death.

[1.7] In terms of section the 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

Recommendations

[2] In terms of section 26(1)(b) of the Act, there are, on the available evidence, no recommendations to be made.

NOTE

Introduction

[3] The inquiry was held under the Act into the death of Mr Gunn.

[4] The date that the death was reported to the Crown was 7 October 2018.

[5] The dates of preliminary hearings were 18 August, 29 September and 13 October 2021 (at which there was a lengthy adjournment to allow for criminal investigations to be completed), 6 April, 11 May and 8 June 2022 and the hearing was on 26 July 2022.

[6] The representatives of the participants at the inquiry were Ms Siobhan Ramage, procurator fiscal depute, for the Crown; Ms Louise Houliston, solicitor for Sodexo Justice Services; Ms Louise Jardine, solicitor for NHS Lothian; and Mr Niall McIntosh, solicitor for the Scottish Prison Service.

[7] All evidence was agreed by way of a Joint Minute of Agreement lodged on 9 June 2022.

The legal framework

[8] An inquiry was held under section 1 of the Act. This was a mandatory inquiry in terms of section 2(1)(a) and (b), (4)(a) and (5)(a) of the Act, as at the time of his death, Mr Gunn was in legal custody

[9] The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[10] The principal purpose of the inquiry under section 1(3) of the Act was to (a) establish the circumstances of the death, and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[11] The matters which require to be covered in this determination under section 26 of the Act in relation to the death to which the inquiry relates, are my findings as to:

> (1) (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, (g) any other facts which are relevant to the circumstances of the death; and

(2) such recommendations (if any) as to (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.

[12] This determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

[13] The procurator fiscal represents the public interest, an inquiry is an inquisitional process and it is not the purpose of an inquiry to establish civil or criminal liability.

Summary

[14] On 1 September 1977, Steven Gunn ("Mr Gunn") was born.

[15] On or about June 2006, the Scottish Ministers through the Scottish Prison Service ("SPS") contracted with Addiewell Prison Limited for them to design, construct, manage and finance Her Majesty's Prison Addiewell ("HMP Addiewell"). Addiewell Prison Limited then subcontracted the management of HMP Addiewell to Sodexo Justice Services ("Sodexo"). While Sodexo is

contractually obliged to adopt and implement some SPS policies, HMP Addiewell is operated independently of the rest of the prison estate in Scotland with its own management chain and directly employed staff.

[16] Since 1 November 2011, NHS Lothian have been responsible for the provision of healthcare to prisoners in HMP Addiewell.

[17] On 7 August 2017, Mr Gunn was remanded in custody to HMP Addiewell by the Sheriff at Hamilton.

[18] On 8 August 2017, Mr Gunn was assessed by a doctor and nurse and noted to have a history of drug addiction. Mr Gunn was considered to be at no apparent risk of suicide and expressed no thoughts of deliberate self harm.

[19] On 3 November 2017, Mr Gunn was sentenced to 3 years imprisonment backdated to the date of his said remand.

[20] On 1 February 2018, a doctor at HMP Addiewell prescribed Mr Gunn 30mg of Methadone to be taken daily to treat Mr Gunn's said ongoing drug addiction. Mr Gunn was warned by the doctor about the dangers of overdose and using other unprescribed substances.

[21] On 19 February 2018, Mr Gunn attended a review appointment at the addictions clinic within HMP Addiewell. Mr Gunn reported smoking heroin and taking unprescribed white tablets that he believed were Diazepam. Mr Gunn's methadone prescription was increased to 40mg daily. Mr Gunn was

warned by the nurse about the risks of poly-drug use and of overdose by using other unprescribed drugs.

[22] On 30 April 2018, Mr Gunn self-referred to the addictions team using the referral kiosk. Mr Gunn advised in his referral that he felt his methadone prescription required to be further increased.

[23] On 10 May 2018 Mr. Gunn attended a review appointment at the addictions clinic within HMP Addiewell. Mr Gunn advised the healthcare team that he had been using heroin in the prison "as often as possible" but now that he had been sentenced he was keen to stabilise. Blood samples were taken from Mr Gunn to test for drugs prior to the review of his methadone prescription. Said test was positive for methadone and pregabalin, both of which were medications prescribed to Mr Gunn.

[24] On 17 May 2018, Mr Gunn's methadone prescription was increased to 50mg daily.

[25] On the morning of 17 June 2018, when Mr Gunn attended to collect his prescribed medication, he was suspected by prison staff of having taken unprescribed drugs in that he appeared drowsy, unsteady on his feet and his speech was slurred. Mr Gunn was assessed by medical staff and placed on 30 minute observations. Mr Gunn's daily prescribed medication was withheld

for that day. He was reassessed by medical staff later in the day and was found to be alert. Observations were continued until the following day as a precaution.

[26] On 21 August 2018, Mr Gunn was sentenced to a consecutive 2 years imprisonment on another matter.

[27] On 3 September 2018, Mr Gunn was again suspected by prison staff of having taken unprescribed drugs in that Mr Gunn appeared drowsy with slurred speech. He was assessed and found to have dilated pupils and was slow to react. He was placed on 30 minute observations.

[28] On 4 September 2018, Mr Gunn was re-assessed by prison staff. He was found to have a steady gait and his speech was normal at that time. He was removed from observations.

[29] On 5 September 2018, Mr Gunn was moved from a cell within Lomond A Wing to cell 26, Lomond C Wing following a management review of his location. This was an attempt to interrupt his access to unprescribed drugs within the prison.

[30] On 4 October 2018, Mr Gunn attended a triage appointment at the addictions clinic within HMP Addiewell. He complained of issues with his sleep. He requested a further increase in his methadone prescription. His prescription was increased to 60mg daily. Mr Gunn also indicated that he was feeling of low mood. He indicated, however, that he had no thoughts of suicide

or self-harm. A full mental health assessment appointment was booked for him for the week commencing 8 October 2018.

[31] Of even date, an in-cell and online distance learning instructor at HMP Addiewell, attended at Lomond C Wing to speak with another prisoner. Mr Gunn approached her in an upset state. He stated that he was struggling with his addiction to drugs and felt unable to refrain from taking drugs.

[32] On 6 October 2018, at approximately 1000 hours, Mr Gunn received his mediation as scheduled. At this time Mr. Gunn was prescribed 60mg of Methadone and 600mg of Pregabalin daily under supervision. No abnormalities were noted at that time by the Addictions Nurse.

[33] Of even date, between approximately 1445 hours and 1600 hours Mr Gunn received a visit from his family. During the course of the visit Mr Gunn appeared to be tired but in good spirits. Mr Gunn was thereafter not considered by any HMP Addiewell staff who interacted with him to be under the influence of an unknown substance and no concerns had been raised about him by staff or by his visitors.

[34] Of even date, at approximately 1745 hours, a Prison Custody Officer ("PCO") locked Mr Gunn in his cell for the night. The PCO noted that Mr Gunn was his normal self and that there were no issues or concerns at that time.

[35] On 7 October 2018, at approximately 0754 hours PCOs were unlocking cells and conducting the morning welfare checks in Lomond C Wing. When they arrived at cell number 26 they received no response from Mr Gunn, who was lying on his bed. Mr Gunn appeared to be deceased. A "code blue" alarm was raised to alert staff to there being a prisoner who was unresponsive.

[36] Of even date, at approximately 0755 hours NHS Lothian staff from the healthcare team within HMP Addiewell arrived at Mr Gunn's cell. Rigor mortis was present and there were no signs of life. Paramedics from the Scottish Ambulance Service arrived and at 0817 hours they formally pronounced that Mr Gunn was deceased.

[37] On 10 October 2018, a PCO found a package of 21.75 white rectangular Alprazolam tablets whilst clearing Mr Gunn's said former Cell 26.

[38] On 10 October 2018, Mr Gunn's body was taken to Edinburgh City Mortuary, Cowgate, Edinburgh, and was examined by two Consultant Forensic Pathologists. Mr Gunn was found to have ischaemic heart disease.

[39] Analysis of Mr Gunn's blood taken at the post mortem also revealed that he had had taken not only prescribed methadone and pregabalin but also diazepam, phenazepam, alprazolam and mirtazapine shortly prior to his death.

[40] After said post mortem examination and consideration of said toxicology results Drs Shearer and BouHaidar certified Mr Gunn's cause of death as:

1a. Multi-drug intoxication and Ischaemic heart disease.

[41] The unprescribed drugs which Mr Gunn had taken had a respiratory depressant effect on Mr Gunn's breathing placing further strain on his already diseased heart. The cause of death was from a combination of multi-drug intoxication and significant natural disease, namely ischaemic heart disease.

[42] Mr Gunn had accidentally fatally overdosed by consuming shortly prior to his death the said unprescribed diazepam, phenazepam, alprazolam and mirtazapine.

[43] Despite extensive police investigations regarding the unprescribed drugs taken by Mr Gunn and those found in his cell, their source remains unknown.

Submissions

[44] The Crown submitted that formal determinations in terms of section 26(2)(a) and(c) of the Act were required and that any determinations in terms of sections 26(2)(b), (d) and (e) of the Act as to whether Mr Gunn's death was accidental, were a matter for the court. The Crown referred to the undernoted evidence from which they suggested the court could infer that Mr Gunn's death was accidental. Sodexo submitted that only said formal determinations should be made. NHS Lothian submitted that the evidence may be "suggestive" of Mr Gunn's death being accidental but that this did not mean

that such was "probable" and accordingly also submitted that only said formal determinations should be made. The SPS submitted there was insufficient evidence to make any determination as to whether Mr Gunn's death was accidental and likewise that only said formal determinations should be made.

Discussions and conclusions

[45] There presented no difficulties in making said formal findings in terms of section 26(2)(a) and (c).

[46] As stated by Sheriff Cubie in the *Inquiry into the death of Elizabeth Lowrie* 2011 WL 5105556:

> "The purpose of a fatal accident Inquiry is to enlighten and inform those persons who have an interest in the circumstances of the death. It is to ensure that members of the deceased person's family are in possession, so far as possible, of the full facts surrounding the death".

Accordingly, whether in the circumstances a death was accidental or otherwise may be of considerable importance to a grieving family left behind. "Accident" is not defined in the Act and can therefore cover a "wide area" and not just an industrial or occupational accidents (Ian Carmichael, *Sudden Deaths and Fatal Accident Inquiries* (3rd edn, W Green 2005). Para 1-21).

[47] From the evidence, Mr Gunn was assessed regularly by and engaged well with medical and prison staff in relation to his drug addiction. There were no indications that Mr Gunn had any thoughts of deliberate self harm. Mr Gunn

had previously used unprescribed drugs in addition to his prescribed medication as he felt unable to refrain from taking such unprescribed drugs. On the day preceding his death Mr Gunn appeared to be in "good spirits" when meeting with family members. After this visit prison staff who interacted with Mr Gunn also assessed him as being his "normal self" and had no concerns about him. Mr Gunn had not consumed all of the unprescribed drugs available to him, in that the said alprazolam was discovered after his death in his cell. It is probable in considering the entirety of these circumstances that Mr Gunn had accidentally fatally overdosed in consuming the said unprescribed diazepam, phenazepam, alprazolam and mirtazapine. Relative determinations are therefore required in terms of section 26(2)(b),(d) and (e), as aforesaid.

[48] The medical and general treatment of Mr Gunn was adequate. While *ex facie* the said unprescribed drugs should not ideally have been available to Mr Gunn in a secure prison environment, despite extensive police investigations the source of these unprescribed drugs taken by Mr Gunn and those found in his cell after his death could not be ascertained. There accordingly was no evidence on which to base any substantive determinations in terms of section 26(2)(e), (f) or (g) of the Act or to make recommendations in terms of section 26(1)(b) of the Act.

Any other information, observation or comment

[49] I would finally like to repeat my condolences, which I also gave at the inquiry, as likewise were shared by all participants, to the family and friends of Mr Gunn, for their loss.