SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT ALLOA

[2022] FAI 29

ALO-B147-21

DETERMINATION

BY

SHERIFF M LABAKI

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

into the death of

GARY GALLAGHER

21 April 2022

The sheriff, having considered the information presented at an inquiry on 20 April 2022 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the Act", finds and determines:

(1) Mr Gary Gallagher was born on 9 September 1981. He died sometime in the morning of 12 October 2020 at HMP Glenochil. He was pronounced dead at 09:00hours on 12 October 2020.[1] He committed suicide.

(2) The cause of death was suspension by the neck by means of a ligature made from a dressing gown cord (hanging)[2].

[1] Section 26(2) (a)
[2] Section 26 (2) (c)

(3) I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26 (2) of the Act.

(4) I have no recommendations to make under section 26 (1) (b) of the Act.

NOTE

Introduction

[1] This is a mandatory inquiry into the death of Mr Gary Gallagher in terms of section 4(a) of the 2016 Act.

The proceedings and the parties

[2] Preliminary hearings took place at Alloa Sheriff Court on two occasions before the inquiry itself, which was held on 20 April 2020. Ms Swansey, procurator fiscal depute, appeared for the Crown. Mr Devlin, solicitor, appeared for the Scottish Prison Service ("SPS"), Ms Toner, counsel, appeared for NHS Forth Valley and Mr Rogers, solicitor, appeared for the Scottish Prison Officers Association Scotland.

The sources of evidence

[3] A joint minute of agreement was entered into on behalf of the parties. It formed the entirety of the evidence. The joint minute detailed the circumstances of Mr Gallagher's death and his care and treatment within HMP Glenochil. Affadavit evidence was incorporated into the joint minute. This was from Doreen Doull, and

Rebecca Stoker, mental health Nurses at HMP Glenochil and Graeme MacDonald, the deceased's personal officer within HMP Glenochil. In addition, the following productions were lodged and referred to in the Joint Minute:

- Prison medical records relating to Mr Gallagher;
- Prison custody records relating to Mr Gallagher;
- Minutes from the Order for Lifelong Restriction Sentence Prisoner Tribunal hearing of 1 June 2020;
- Post mortem report dated 11 December 2020 by Sally Anne Collis, Consultant Forensic Pathologist;
- Death in Prison Learning Audit & Review (DIPLAR) report in respect of Mr Gallagher;
- Personal Officer Report.

At the inquiry the Joint Minute of Agreement was read out by the procurator fiscal. The crown productions and affidavit evidence was agreed. Written submissions were provided in advance of the inquiry by all parties. All parties submitted that I should make formal findings only. The result was that both the evidence and submissions were completed in one day. I have read and considered all of the evidence, none of which was in dispute. I am grateful to parties for their assistance in the preparation and conduct of the inquiry.

The legal framework

[4] The inquiry was held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"). The purpose of such an inquiry is set out in section 1(3) of the 2016 Act and is 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."

Section 26 of the 2016 Act states, among other things, that:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out –
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> (a) in relation to the death to which the Inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
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> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1) (a) are—
>
> (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.

(3) For the purposes of subsection (2) (e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—

(a) if the precautions were not taken, or

(b) as the case may be, as a result of the defects.

(4)The matters referred to in subsection (1) (b) are—

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working,

(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances."

A summary of the parties' positions

[5] The procurator fiscal depute submitted that the court should make formal findings only in terms of section 26 (2) (a) and (c). She submitted that Mr Gallagher was found within his cell on 12 October 2020 by prison custody officer Douglas Nimmo who found him slumped and unresponsive in his cell with his head behind the curtain. When the curtain was moved Mr Gallagher was observed to have a ligature around his neck. PCO Nimmo activated a "Code Blue" alert and staff Nurses Ashlea Wright, Alexandra Johnstone and Healthcare Assistant Kirsten Lennox responded, attending at 07:54 hours. Having been discovered in his cell Mr Gallagher was pronounced dead at

09:00 hours although it appeared he had been dead for several hours. It was agreed that the accused had committed suicide.

[6] None of the parties made any criticism of the care which had been provided to the deceased within HMP Glenochil. The deceased had regular contact with his personal officer, residential officer Graeme McDonald, based in Abercrombie hall prior to the deceased's death. Officer McDonald had regular contact with the deceased and was familiar with his presentation. No suicidal thoughts or thoughts of self-harm were ever expressed by the deceased to Mr McDonald. The deceased was not subject to any observations at the time of his death.

[7] None of the parties made any criticism of the care which had been provided to the deceased by the mental health nurses Doreen Doull and Rebecca Stoker. No independent medical evidence was presented which would have entitled the court to conclude that there had been any failings in the care provided by the mental health nurses.

[8] Seeking to put the matter into context, Ms Toner for Forth Valley Health Board submitted that the Death in Prison Learning, Audit and Review, "DIPLAR" which sets out the medical history of the deceased and his engagement with health care services within the prison environment, recorded no incidents of self-harm or attempted suicides in the twelve months prior to his death. It was submitted that the death of the deceased by suicide could not have been foreseen and that there were no precautions which could reasonably have been taken by NHS Forth Valley whereby Mr Gallagher's death might realistically have been avoided.

[9] Both Ms Toner for NHS Forth Valley and Mr Rogers on behalf of the Prison Officers Association Scotland submitted that there was no evidence of any defects in any system of working. It was submitted by Mr Devlin on behalf of the Scottish Prison Service that the deceased was provided with adequate care and support whilst in prison and there were no reasonable precautions that could have been taken which would have realistically resulted in Mr Gallagher's death being avoided. Mr Devlin submitted that no recommendations ought to be made in terms of section 26 of the Act.

[10] Prior to the discovery of Mr Gallagher on Monday 12 October, staff on duty on Sunday 11 October gave no cause for concern. Mr Gallagher seemed to follow his normal daily routine. He did not request anything from the staff and offered little in the way of communication. The prisoners in adjacent cells gave no indication that he was showing any signs of potential harm. He had been in telephone contact with his sister, Julie Gallagher, who noted no change in his health or mood when speaking to him on 9 October 2020. On that basis, I conclude that there were no signs or clues to indicate any risk of suicide.

The circumstances of the deceased and his death

[11] At the time of his death Mr Gallagher was serving a sentence of an Order for Lifelong Restriction with a punishment part of 5 years imprisonment, imposed in July 2016.

[12] An order for Lifelong Restriction Sentence Prisoner Tribunal hearing took place on 1 June 2020. At this hearing the parole board unanimously denied the release of

Mr Gallagher from custody. The next tribunal hearing was scheduled to take place in 12 months' time.

[13] Mr Gallagher had been diagnosed with Charcot Marie Tooth disease which affected his mobility. He was declared medically unfit for work within HMP Glenochil between 17 January 2017 and 16 January 2019 and between 13 May 2019 and 12 October 2020. Assessment on Mr Gallagher's cognitive functioning concluded that Mr Gallagher functioned on a borderline level. He had difficulties with verbal comprehension, perceptual reasoning and processing speed. However, he managed day to day tasks well.

[14] On 1 June 2020 Mr Gallagher was assessed by Mental Health Nurse Rebecca Stoker. This was as the result of a referral made by the Scottish Prison Service Staff on 28 May 2020 due to Mr Gallagher not eating prison issue meals. At that time Mr Gallagher showed no evidence of distress or distraction. He reported feeling symptoms of grief since his brother died in 2017. It was recommended that Mr Gallagher be provided with bereavement counselling. Ms Stoker assessed Mr Gallagher as not being pale or lacking in energy. He presented as well fed and Ms Stoker confirmed with prison staff that he was eating canteen food and prison meals. Ms Stoker confirmed that Mr Gallagher was listed for weekly weights and there were no issues in that regard. No suicidal feelings were reported to Miss Stoker who assessed Mr Gallagher as having no apparent risk of suicide. A referral was made to the prison Chaplain who is a trained bereavement counsellor.

[15] Mr Gallagher maintained regular contact with his mother, Alison Gallagher and his sister Julie Gallagher. Mr Gallagher telephoned his sister on 9 October 2020. She noted no change in his health or mood at that time and their relationship was such that Mr Gallagher would always speak to his sister about how he was feeling physically and mentally. Julie Gallagher was shocked to learn of her brother's death.

[16] Mr Gallagher was allocated to Mr Graeme McDonald, residential officer based in Abercrombie Hall at HMP Glenochil. The role of a residential officer is to maintain the security of the hall that they work on and to ensure that the needs of the prisoners on their hall are being met. The prisoner can approach their personal officer if they have any problems or issues that need to be addressed. Mr McDonald would speak to Mr Gallagher often, and although Mr Gallagher presented as "quite down and gloomy" that was his normal presentation and at no time did Mr McDonald think that there was a risk of suicide as Mr Gallagher never expressed any suicidal thoughts or thoughts of self-harm. Mr Gallagher complained about his pain medication, however made no complaint about his mental health with regard to suicidal thoughts. No impression was formed by Mr McDonald that Mr Gallagher was having such thoughts.

[17] Mr Gallagher was not subject to any observations at the time of his death.

[18] On 12 October 2020 at approximately 07:45 hours, Prison Custody Officer Douglas Nimmo conducted a prisoner number check within HMP Glenochil. On checking cell A2-38, Mr Gallagher's single occupancy cell, he noted that the lights were off. PCO Nimmo received no verbal response from Mr Gallagher so switched on the cell lights. PCO Nimmo saw Mr Gallagher slumped between his bed and the cell unit with

his head behind the curtain. He shouted for assistance and once in the cell moved the curtain. He observed Mr Gallagher with a ligature, a dressing gown cord, around his neck. He noted no signs of life and activated a radio "Code Blue" alert.

[19] Staff Nurses Ashlea Wright, Alexandra Johnston and Healthcare Assistant Kirsten Lennox responded to the code blue radio message, attending at 07:54 hours. Staff Nurse Wright checked Mr Gallagher for signs of life. All noted that he appeared to have been deceased for several hours. CPR was not attempted.

[20] Doctor Fiona Collier, locum GP for Forth Valley prisons, attended at HMP Glenochil at approximately 08:50hours. She carried out an examination of Mr Gallagher and life was formally pronounced extinct at 09:00 hours.

[21] Mr Gallagher's body was taken to Edinburgh City Mortuary, Cowgate, Edinburgh, and was examined by Consultant Forensic Pathologist Dr Sally Anne Collis on 16 October 2020. She concluded that the cause of death was hanging.

[22] At the time of Mr Gallagher's death the SPS operated a suicide prevention policy known as "Talk to Me" in respect of which all members of staff who have contact with prisoners are trained. Any member of staff can intimate a concern about a prisoner in writing. If that step is taken a case conference is organised and an assessment of the risk the prisoner poses to himself is undertaken. It was submitted by the Crown that a DIPLAR report was prepared after Mr Gallagher's death. The DIPLAR report considered the circumstances surrounding Mr Gallagher's death and confirmed that there were no causes for concern and no indicators of risk. Mr Gallagher's telephone calls were reviewed as part of the DIPLAR process and no concerns were raised.

Indeed, Mr Gallagher made reference to future communication while on the phone to his sister.

Conclusion

[23] It was common ground that Mr Gallagher had committed suicide by hanging. There was no dispute about where and when he died and I am satisfied that there is a proper basis for the findings recorded at the beginning of this determination.
Mr Gallagher was not regarded as a suicide risk. He did not show any sign of his intention and there was no basis upon which the Scottish Prison Service should have treated him as if he posed a risk of suicide.

[24] Having considered the Joint Minute of Agreement, the productions and the submissions of the parties, I consider that only formal findings in respect of section 26 (2) (a) and section 26 (2) (c) of the Act should be made.

[25] The parties extended their condolences to Mr Gallagher's family and I would like to join them in expressing my condolences.