SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNFERMLINE

[2024] FAI 22

DNF-B105-24

DETERMINATION

BY

SHERIFF KRISTA JOHNSTON

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

into the death of

VICTORIA TERESA BLACK

DUNFERMLINE, 20 May 2024

DETERMINATION

The Sheriff having considered all the evidence and the submissions of parties, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 ("the Act") that:

1. In terms of section 26(2)(a) Ms Black died within Forth Valley Royal Hospital, Larbert on 11th January 2022 at 16:05 hours.

2. In terms of section 26(2)(b) no accident took place.

3. In terms of section 26(2)(c) the cause of death was:

    1a Primary (probable hypertensive) intracerebral haemorrhage

4. In terms of section 26(2)(d) no accident having taken place, no finding is made in terms of this subsection.

5. In terms of section 26(2)(e) there were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided.

6. In terms of section 26(2)(f) there were no defects in any system of working which contributed to the death.

7. In terms of section 26(2)(g) there were no other facts which are relevant to the circumstances of the death.

Recommendations

In terms of section 26(1)(b) of the Act, there are no recommendations to be made 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] This inquiry was held under section 1 of the Act into the death of Victoria Teresa Black d.o.b. 26 April 1979. It was a mandatory inquiry in terms of section 2(1) and (4) of the Act as Ms Black was in legal custody. The procurator fiscal lodged a notice of the inquiry on 8 March 2024. There was a preliminary hearing on 22 April 2024, and the inquiry itself took place on 20 May 2024.

[2] Three parties were represented at the inquiry. Ms Evans, procurator fiscal depute, appeared for the Crown. Ms Iridag, counsel, appeared for Forth Valley Health Board. Ms Arnott, solicitor, appeared for the Scottish Ministers acting through the Scottish Prison Service. Ms Black's family were present at the inquiry but took no part in the proceedings.

[3] No oral evidence was led at the inquiry. A joint minute was entered into by the parties which included formal agreement of witness statements, the post mortem and toxicology reports and other relevant productions. All parties invited me to make only formal findings in terms of paragraphs (a) and (c) of section 26(2) of the Act.

The Legal Framework

[4] The inquiry was held under section 1 of the Act and governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[5] The purpose of an inquiry under section 1(3) of the Act 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.

[6] 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 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

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

[7] 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.

Facts

[8] That Ms Victoria Teresa Black (hereinafter referred to as "Ms Black") was born on 26 April 1972 and died on 11 January 2022, aged 49 years.

[9] At the time of her death, Ms Black was in the lawful custody at His Majesty's Prison Cornton Vale, Cornton Road, Stirling, under transfer to Forth Valley Royal Hospital.

[10] Ms Black's death occurred within Forth Valley Royal Hospital, Larbert on 11 January 2022 and her life was pronounced extinct at 1605 hrs by Doctors Simon Evans and Helen Taylor.

[11] On 14 September 2020, Ms Black pled guilty to a contravention of the Misuse of Drugs Act 1971, section 4(3)(b). That on 9 October 2020 Ms Black was sentenced to 5 years, 219 days imprisonment; she was imprisoned to HMP Edinburgh. The sentence was backdated to 14 September 2020. Ms Black's earliest release date was 20 October 2025, her parole qualifying date was 3 July 2023, and her sentence would have expired on 20 April 2026. On 11 November 2021, Ms Black was transferred to HMP Cornton Vale.

[12] Ms Black had a past medical history of intravenous drug misuse, viral hepatitis C (hepatitis C infection), and had previously suffered a deep vein thrombosis and leg ulcers.

[13] Ms Black received routine health care during her time in custody and engaged with healthcare services. She was prescribed methadone (Medicated Assisted Treatment) and was engaged with the Substance Abuse and Recovery Team. Ms Black also engaged with the Primary Health Care Team during her time in custody for ongoing wound treatment (ulcer on left ankle), which included regular wound dressing by the Primary Care Team.

[14] Ms Black was prescribed regular medication and ordered as repeat medication by the pharmacy, as follows: Mirtrazapine, 45mg, one to be taken at night (in possession and issued weekly) - last issued on 4 January 2022; Amitriptyline, 75mg, administered

twice a day (in possession and issued weekly) - last issued on 4 January 2022; Co-amoxiclav, 625mg, administered three times daily (in possession and issued monthly) - last issued on 3 January 2022; Methadone mixture, 35ml, once daily (supervised administration), last issued on 8 January 2022 by Nurse Nichola Docherty; Evoril patches, 1 patch every 3 days, last issued on 3 January 2022.

[15] Ms Black was also prescribed certain medications which were ordered by Ms Black when required, which included Co-codamol: 30/500mg, administered three times daily (in possession and issued weekly). This medication was last issued on 31 December 2021.

[16] Ms Black contacted Prison Health Care on 7 January 2022. She met with Doctor Jack Kildare. She reported extreme pain in her legs, a chronic ongoing issue caused by a leg ulcer. Ms Black was referred to vascular services due to poor healing of ulcers. Ms Black was re-prescribed co-codamol for pain relief.

[17] On Saturday 8 January 2022 at 0830 hrs, Ms Black exited from her cell at HMP Cornton Vale and was escorted to the health centre to receive her regular daily prescribed medication of methadone mixture. Nurse Nichola Docherty dispensed the usual 35ml of methadone mixture prescription to Ms Black which was witnessed by Senior Staff Nurse, Fiona Conway.

[18] At 0846 hrs, Ms Black returned to her cell/room. At 0850 hrs, she gathered as usual with fellow prisoners, within a fellow prisoner's room.

[19] Ms Black presented as well at that time, other than complaining to her fellow prisoners of headaches and pain from the ulcers in her leg which she attributed to withdrawal from co-codamol.

[20] At 0919 hrs, Ms Black left to use the toilet after which she returned to her own room at 0923 hrs.

[21] At 0925 hrs, Residential Prison Officer, Andrew Taylor entered the Unit 6 and called on Ms Black to attend for work detail. Ms Black did not respond.

[22] At 0929 hrs, both fellow prisoners in whose company Ms Black had been earlier attended at Ms Black's room, knocked on her door, opened it and found Ms Black sitting on the floor. Both immediately alerted Residential Prison Officer, Andrew Taylor who attended at Ms Black's door. Ms Black was sitting upright on the floor and was not responding to him.

[23] At 0930 hrs, Andrew Taylor radioed for a Nurse to attend Unit 6 in Peebles House. At 0930 hrs, a radio call for health centre staff was received from Residential Prison Officer, Andrew Taylor who had requested attendance of a Nurse.
Nurse Docherty attended. At 0930 hrs, First Line Manager, Christine Crossley also responded to a radio call from Residential Prison Officer, Andrew Taylor and attended.

[24] At 0932 hrs Christine Crossley observed Ms Black to be slouched and non-responsive. At 0934 hrs Nurse Nicola Docherty attended Ms Black's cell whereby she observed Ms Black sitting on the floor of her room and able to hold her own position. Ms Black was pale. She presented as though she was snoring heavily and she

was slouched in posture. Ms Black did not respond to any verbal prompts and had minimal response to pain stimuli.

[25] Nurse Docherty checked Ms Black's vital observations immediately. Ms Black's BP was 159/97 and her pulse was 100 beats per minute. Ms Black's pupils were dilated and sluggish to respond to light but equal in size, her temperature was 38 which was within normal range. Ms Black's breathing was not laboured and there were no signs of cyanosis although respirations were noted to be slightly reduced.

[26] Nurse Docherty was unconcerned regarding restrictions of Ms Black's airways. She was unable to obtain Ms Black's oxygen saturation level initially because, she believed, nail polish may have been applied to Ms Black's fingerprints.

Nurse Docherty's initial clinical assessment of Ms Black was that she may possibly have been under the influence of a substance. SPS Officers supplied information and intelligence which suggested this may be the case however this was unconfirmed. The SPS' MORS procedure, which is the procedure of monitoring of a person suspected of being under the influence of a substance, was initiated as a precaution which included 15-10 minutes observations both visual and responses, whilst Nurse Docherty contacted the Doctor.

[27] Residential Prison Officer, Christina Hogg, and Residential Prison Officer Caitlin Duncan completed the relevant MORS paperwork in relation to Ms Black at this time. Ms Black presented to Nurse Docherty with a brief episode of "snoring" which subsided when her position was slightly altered. Pillows were used to facilitate comfort for Ms Black as she was unable to sit upright at this point.

[28] At 0948 hrs, Nurse Docherty and Christine Crossley left Ms Black's room and returned to the health centre to check Ms Black's medication Kardex, to update Staff Nurse Fiona Conway and to contact Doctor Craig Sayers for guidance. Ms Black was left in the care of Residential Prison Officers and a First Aider. Nurse Docherty contacted the Prison General Practitioner, Doctor Craig Sayers, by telephone for advice. Ms Black's GCS 3 was discussed. At this time it was agreed that it would be appropriate to request an ambulance if there was an ongoing concern.

[29] That at 1010 hrs, Nurse Docherty returned to Unit 6, Peebles House where it was noted that Ms Black remained unresponsive, and that "snoring" had recommenced. Ms Black was deemed to be GCS 4 (unconscious) with her condition not improving. Nurse Docherty requested an ambulance to attend at 1019 hrs. Nurse Docherty checked Ms Black's oxygen levels again and obtained a reading of 90%. The use of oxygen was considered but Ms Black started to vomit and was placed in the recovery position to ensure vomit would not be retained in her mouth or compromise her airways.

[30] At 1024 hrs, a First Responder Paramedic from the Scottish Ambulance Service arrived at HMP Cornton Vale and entered Unit 6, Peebles. The First Responder Paramedic conducted an electrocardiogram (ECG) and confirmed Ms Black was bradycardic, her pulse had lowered to 55bpm (beats per minute), and her oxygen saturation levels had increased to 94% independently. The First Responder administered Naxolone however this had no effect. Ms Black remained unresponsive.

[31] At 1035 hrs, an ambulance arrived and attended to Ms Black. The ambulance departed at 1109 hrs to convey Ms Black to Forth Valley Royal Hospital. Two escorting

SPS staff member Christina Hogg and Stacey Patterson, travelled with Ms Black to Forth Valley Royal Hospital. Handcuffs were not used but a closet chain was attached to allow ambulance crew to work.

[32] At 1125 hrs, Ms Black arrived at Forth Valley Royal Hospital and was taken under the care of Consultant Anaesthetist, Doctor Simon Evans. Ms Black was unconscious but breathing spontaneously with stable blood pressure at this point. Ms Black was formally identified as being 8/15 GCS with asymmetric limb movement. A decision was taken to sedate and intubate/ventilate Ms Black to provide airway protection and facilitate CT scanning.

[33] At approximately 1240 hrs, Residential Prison Officer, Christina Hogg contacted HMP Cornton Vale and requested permission to remove the closet chain, as Ms Black was intubated. This was done. A CT scan of Ms Black showed a large intracerebral bleed with obstructive hydrocephalus, generalised brain swelling and signs of cerebellar herniation. Ms Black's condition was discussed with the Tertiary Neurosurgery in Edinburgh. No neurosurgical intervention was available. Ms Black was then admitted to the Intensive Care Unit at the hospital for neuroprognostication.

[34] At approximately 1415 hrs, Residential Prison Officer, Christina Hogg contacted FLM Christine Crossley at HMP Cornton Vale to inform her of the severity of Ms Black's condition. At that point, FLM Nicola Luti contacted Ms Black's next of kin.

[35] Ms Black's condition failed to improve in the following days. A repeat CT scan was performed which showed her condition had worsened. Further neurosurgical advice was obtained, and it was confirmed that no surgical intervention was possible.

Ms Black demonstrated physiological responses that were consistent with "coning" and brain stem death.

[36] On 11 January 2022 at 1000 hrs, Chaplain Sheena Orr was requested to attend Forth Valley Royal Hospital by Prison Governor Jacqueline Clinton due to Ms Black's deterioration. Chaplain Sheena Orr attended the hospital to be with Ms Black and her family and provide them support.

[37] That at 1605 on the 11 January 2022, Ms Black was declared brain stem dead and life was pronounced extinct.

[38] That a post mortem examination was completed on 27 January 2022 by Doctor Robert Ainsworth, Consultant Forensic Pathologist. The medical cause of death was found to be: 1a Primary (probable hypertensive) intracerebral haemorrhage.

[39] A toxicology report compiled by Doctors Peter Maskell and Fiona Wylie (Forensic Toxicologists) confirmed that Methadone, mirtazapine and amitriptyline were found to be present within the deceased's blood samples. Ms Black was prescribed:
(1) Methadone mixture (35ml) which was administered on a supervised basis,
(2) Mirtazapine (45mg) which was provided to her in-cell on a weekly basis and
(3) Amitriptyline (75mg) and was provided in-cell. Ms Black had been prescribed and had consumed these medications between 4 and 7 January 2022. The prescriptions for Mirtazapine and Methadone mixture had been reviewed on 12 November 2021.

[40] The toxicology report additionally confirmed the presence of trace amounts of alcohol within Ms Black's blood and urine samples which most likely reflected post mortem formation.

[41] Doctor Ainsworth referred sections of Ms Black's brain tissue to Professor Colin Smith, Consultant Neuropathologist at the University of Edinburgh for examination which confirmed a left sided parenchymal haematoma with axial displacement and early brainstem haemorrhage. This is entirely in keeping with the hypertensive haematoma found on post mortem examination.

Submissions

[42] All parties submitted that on the agreed facts I should make determinations only in terms of section 26(2)(a) and (c).

Conclusions

[43] As set out in section 1(3) of the Act, the purpose of a fatal accident inquiry is to establish the circumstances of the death and consider what steps, if any, might be taken to prevent other deaths in similar circumstances. Section 26, set out fully in written submissions, details the matters which the sheriff requires to consider relative to the circumstances of the death, and the issues to which the sheriff must have regard in considering whether to make a recommendation.

[44] In this case, the whole evidence took the form of an agreed joint minute, parts of which I have used to frame the findings in fact set out above. (I have not set out, although of course I accept, the more formal matters agreed in the joint minute.) The position of all the parties was that the only positive findings which could be made were,

where and when the death occurred, and the cause or causes of death. I accept that submission. No other findings are warranted on the evidence.

[45] The findings of the post mortem report and the neuropathy by Professor Smith note that acute drug toxicity may produce sudden-onset hypertension ie high blood pressure. I did not find any facts to support that in the days and hours prior to her death Ms Black had consumed any drugs other than those properly prescribed to her. The most likely explanation then for the intracerebral haemorrhage from which she died is as stated within the post mortem report, namely underlying hypertension. Ms Black's death was due to natural causes.

[46] All the parties at the inquiry expressed condolences to Ms Black's family on their own behalf and on behalf of those whom they represented, and to these I add my own condolences.