Judgment 1/2010 **Alan Terrence Schofield – Magistrate's Court (Inquest into cause of death) – 11 January 2010**

Magistrate's Court (Guernsey) Law, 2008 (s.21) – Inquest into cause of death - in practice English Coroners Rules 1984 are followed in Guernsey subject to necessary modifications (Rules 36 and 42) – death in the States Prison – narrative verdict delivered

IN THE MAGISTRATE'S COURT OF THE ISLAND OF GUERNSEY

The 11th day of January, 2010 before John Russell Finch, Esquire, Judge of the Royal Court

IN THE MATTER of the inquest into the cause of death of ALAN TERRENCE SCHOFIELD, aged 64 years, of Atrice Alai, Barras Lane, in the parish of the Vale, who died at the States Prison, Les Nicolles, in the parish of St Sampsons between 00.40 hours and 03:15 hours on Friday, 11th July, 2008;

WHEREAS on the 5th day of September, 2008, Assistant Magistrate Philip Robey, Esquire, GRANTED permission to release the body of the said Alan Terrence Schofield for burial or cremation and ADJOURNED the inquiry sine die;

AND WHEREAS on the 4th and 5th days of January, 2010, the Judge of the Royal Court, John Russell Finch, Esquire, having heard Her Majesty's Comptroller who presented the evidence, Advocate A.M. Merrien Counsel for Mrs Patricia Mary Schofield and Mr Sam Alan Schofield, Advocate G.K. Bell, Counsel for Doctors Mary Elizabeth Hotton and Timothy Robert Gill, Advocate G.S.K. Dawes, Counsel for Doctor Thomas Jenkins and Advocate J.A.S. White, Counsel for the States of Guernsey Home Department and Health and Social Services Department, and having considered the Post Mortem Examination Report of Dr. C. Chinyama, Consultant Pathologist, the witness statements and evidence presented and having heard the evidence of Dr. Stuart Morgan, ADJOURNED the inquiry;

AND WHEREAS the Judge considered the written submissions of Counsel;

THE COURT this day DELIVERED its written narrative verdict, in the terms attached hereto, and found the cause of death to be:-

1. (a) Acute myocardial ischaemia;

(b) Coronary artery thrombosis;

(c) Coronary artery atheroma;

2. Hypertensive heart disease.

M A TOSTEVIN
Her Majesty's Deputy Greffier

Approved Text
11 January 2010

INQUEST TOUCHING THE DEATH OF ALAN TERRENCE SCHOFIELD

(Note – Paragraphs 1-3 do not form part of the Narrative Conclusion)

1. Introduction

Unlike England and Wales there is no separate office of Coroner in Guernsey – the main reason being the limited case-load. Under the Magistrate's Court (Guernsey) Law 1954 the Stipendary Magistrate was empowered to hold Inquests and the decision whether or not to do so was a responsibility of the Law Officers of the Crown (HM Procureur and HM Comptroller). However decisions were only taken after consultation with the Magistrate. Now in place of the Magistrate there are two Judges of the Magistrate's Court, who still hold inquests. As Judge of the Royal Court, who generally enjoys a jurisdiction akin to that of a Circuit Judge in England, I have power ex officio to sit in the Magistrate's Court and that still includes the ability to act as Coroner. The other principal differences between Guernsey and England are that there is no Jury and no Coroners Rules. In practice the 1984 Rules are followed in Guernsey, subject to necessary modifications.

Two very important Rules are 36 and 42. As indicated, they are, in essence, followed in Guernsey.

Rule 36 provides:

"(i) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely –

(a) who the deceased was;
(b) how, when and where the deceased came by his death;
(c) the particulars for the time being required by the Registration Acts to be registered concerning the death.

(ii) Neither the Coroner nor the Jury shall express any opinion on any other matters."

Rule 42 provides:

"No verdict shall be framed in such a way as to appear to determine any question of –

(a) criminal liability on the part of a named person; or

(b) civil liability."

Also worthy of note is that although interested parties are entitled to be legally represented no one is permitted to address the Coroner as to the facts in evidence at an inquest (Rule 40 of the Coroners Rules 1984). Matters of law may be dealt with. These may include submissions on the possible conclusions to be left to the Court and in making such submissions it will usually be necessary to refer to the evidence given. There is also no prohibition on submissions as to areas of factual investigation to which the inquest should address itself – see the observations in *Jervis on Coroners para 12 – 149, page 297.* I have received helpful written submissions from counsel for the parties and HM Comptroller and I express my thanks for them.

Above all it has to be emphasized that an inquest is not a trial, nor is it adversarial in nature. It is an enquiry or inquisition.

2. Narrative Verdicts

The normal procedure is to list the cause(s) of death as shown at any post-mortem and the appropriate finding, such as "accidental death" or "natural causes" or "suicide" etc. This familiar procedure will still remain the norm in the majority of cases. A recent development in England and Wales connected with the requirements of the European Convention for the protection of Human Rights and Fundamental Freedoms, Article 2, has introduced the concept of the "Narrative Verdict". The leading case on this is *R (MIDDLETON) v WEST SOMERSET CORONER AND ANOTHER [2004] AC 182.* This decision of the House of Lords is not technically binding on me in Guernsey, but is of the highest persuasive authority, especially as the judges are also members of the Judicial Committee of the Privy Council, our highest appellate court. Guernsey of course is also bound by the Convention and it is applied in Bailiwick Courts. Accordingly I shall follow the *MIDDLETON* case. What does that entail?

There is no need to set it out in great detail as the concept can be plainly understood. Under Article 2 of the Convention (Right to Life) where a person in the custody of the State (such as a serving prisoner) dies, an investigation is required to ensure the accountability of state agents for the death occurring under their responsibility. In the words of Lord Bingham of Cornhill in the *MIDDLETON* case (supra) at paragraph 5 of his speech:–

"Compliance with the substantive obligations referred to above must rank among the highest priorities of a modern democratic state governed by the rule of law. Any violation or potential violation must be treated with great seriousness."

An inquest is such an independent investigation as is required under the Convention. The *MIDDLETON* case decided that the ordinary form of verdict in an inquest did not meet the obligations enshrined in Article 2. Accordingly the inquest should determine "*how*" (rule 36 (1) (b) of the 1984 Rules) the deceased came to his death more broadly, entailing deciding "*by what means and in what circumstances*."

The *MIDDLETON* case also made it clear that there must be no finding of criminal liability on the part of a named person nor must a verdict appear to determine any question of civil liability. Acts or omissions may be recorded but expressions suggestive of civil liability in particular "*neglect"* or *"carelessness"* and related expressions should be avoided (see para 37 of Lord Bingham's speech).

In cases such as the present, an expanded narrative form of verdict is required where the Court's factual conclusions are summarised. Such a narrative verdict may record judgmental conclusions of a factual nature. However it should be noted that the phrase referred to above *"by what means and in what circumstances"* should be given a narrow interpretation i.e. a *"circumstance"* that is relevant to the death in question must be one that bears a causal relationship to the death; see e.g. *R (LEWIS) v H M CORONER FOR THE MID AND NORTH DIVISION OF THE COUNTY OF SHROPSHIRE [2009] EWHC 661 (ADMIN) paras 87, 93 and 99.*

3. Preliminary Matters

The legal representation at the inquest comprised:

HM Comptroller (R J McMahon QC), who presented the evidence and assisted the Court;

Advocate J A S White for the States of Guernsey (i.e. Home Department and HSSD);
Advocate G K Bell for the Primary Care Prison Doctors;
Advocate G S K Dawes for the "Night Owl" Doctor;
Advocate A M Merrien for the family of the deceased

The statements and documents were agreed and submitted to the Court in good time properly-presented. The witness statements were all read with the exception of the expert witness Dr

Morgan, who gave detailed evidence in person. An important part of the documentation was a report from the Prisons and Probation Ombudsmen for England and Wales dated June 2009. This was produced at the invitation of the Minister for the Home Department and was of considerable assistance. It is to the credit of the Home Department that they called for a full and independent report which has offered detailed conclusions, plus a wide ranging list of recommendations for the future. I express my gratitude to those responsible for this very thorough and objective investigation.

In reaching the required narrative conclusion I have applied the civil burden of proof, namely a fact is established if found more probable than not, i.e. on the balance of probabilities.

INQUEST TOUCHING THE DEATH OF ALAN TERRENCE SCHOFIELD

Narrative Conclusion

On 26th June 2008 Mr Alan Schofield, deceased (hereafter referred to as "D") was sentenced to 6 weeks imprisonment for a second offence of drink driving. D was 64 years old and had admitted to drinking alcohol to excess over some time. His wife regarded him as a generally fit and healthy man. He was not under medical treatment at the time of his admission to Prison. D died in the early morning of 11th July 2008. A post-mortem held on 14th July 2008 revealed that death was occasioned by coronary artery thrombosis, which cut off the blood supply to the heart muscle resulting in sudden death. In addition the heart was enlarged. The official causes of death are those set out by Dr Chinyama in her post-mortem report.

Upon arrival at the States Prison D went through a normal reception health screen conducted by one of the nursing staff. D explained that he had been experiencing chest pains with exertion and breathlessness. The nurse found raised blood pressure (176/90) and performed an ECG and lung function test. The ECG revealed some enlargement of the heart and the lung test mild obstructive airway disease. The nurse rang the duty doctor who was due to visit the next day, but did not record the conversation in D's medical record. D did not have pain at the time and appeared well. The doctor indicated that D would be seen the next day. The initial assessment was very thorough and a clear history was obtained. The notification to the doctor due to visit the next morning was appropriate.

The doctor examined D the next day, 27th June 2008. The examination, on the preponderance of expert medical evidence, was in accordance with recognised primary care practice. However the doctor's management plan should have been made clear in the notes and the nurse present at the examination should have ensured that the case was noted on the central prison notice board (the "white board") to identify a potential problem that discipline officers needed to be made aware of. No note of the plan was made in the nurses` diary or the appointment/handover notes either.

On 30th June 2008 D complained of chest pain to an officer. The officer took D to the nurse on duty, who had been present when D was examined by the doctor. No action was taken as D's pain had passed by the time he saw the nurse, but after he returned to the Wing she did not assess him nor was the situation notified to a doctor, which may well have led to further testing. This failure to act was a loss of opportunity to deal with these problems. The officer acted very properly, and sensibly made a full note of the occurrence.

At 2.00 a.m. on 3rd July 2008 D pressed his emergency cell alarm button; the preponderance of evidence is that he complained to the responding officer of a headache and then was given 2 Paracetamols, which was good practice. Later that morning, D applied to see the doctor citing bad chest pain, duration approximately 40 minutes. The nurse who dealt with the application was the same person who had been present at the doctor's examination and dealt with D on the 30th June 2008. Apart from recording that D had a follow-up appointment fixed for the doctor the next day, no further action was taken. This was a further and significant failure to act after a reported episode of 40 minutes chest pain, which was not dealt with by seeing D and informing a doctor.

The next day D saw a doctor (a different one from the person seen on 27th June 2008). The doctor regarded the cause of the chest pain as not being obvious and not typical of heart disease. Higher blood pressure was again found and a drug which treats hypertension (and angina) was prescribed. A blood test to check for further evidence of heart disease was ordered. The preponderance of expert medical evidence is that the doctor acted in accordance with common and acceptable primary care practice.

On the 9th (or possibly 10th) July 2008 D made another written request to see a doctor, referring to chest pains for 40 minutes. The officer who was handed the form conscientiously took the trouble to give it personally to a member of the nursing staff, who cannot now be identified. There is no evidence of any action at all being taken other than the affixing of a date stamp for the 10th July 2008. This is a further significant failure to assess D and refer the matter to a doctor with the real possibility of hospital admission. Another episode of chest pain had resulted in inaction and a loss of opportunity to respond to D`s symptoms.

Around 12.35 a.m. on 11th July 2008 D once more used his cell emergency button and officers responded. The officers were unaware of D's history and had to rely on what he imparted to them. His episode of pain subsided and he declined the offer of a doctor or ambulance. The senior officer in charge that night and other officers were under the misapprehension that a single officer was precluded from entering a cell. Instructions had been updated on 19th March 2008 and were available to staff, but not disseminated by way of a Notice to Staff, to the effect that in an emergency situation an officer could enter a cell on his own. This had important consequences later on. The senior officer, who acted throughout in good faith and humanely, did not have access to D's medical history and there was no information on the "white board", however he made himself aware of D's visit to the nurse on 30th June 2008 and that D had been seen before with similar symptoms.

In due course the senior officer contacted the "Night Owl" service at the Princess Elizabeth Hospital and ensured he spoke to the doctor on duty. The senior officer was under the misapprehension that D's full medical details were on the hospital computer, whereas it was only their own record. The

doctor on duty took a thorough record and in the light of the information available to him acted, as was indicated by the expert medical evidence, appropriately and in accordance with accepted primary care practice. The doctor concluded that it was appropriate for D to remain in the Prison but that an ambulance should be called immediately if symptoms recurred. The doctor was under the misapprehension that someone would be remaining with D.

At about 1.45 a.m. an officer (who had been present at the earlier episode) was carrying on security checks and saw D slumped in his chair, his head held back and gently rocking from side to side. The officer under the common misapprehension alluded to above did not enter the cell but radioed for assistance, not using the urgent message procedure. The senior officer was not aware of the nature of the problem from the message and therefore did not take the emergency medical bag with him containing resuscitation equipment. The original officer left the vicinity of D's cell and carried on with his security procedures instead of remaining available at the scene. By the time the senior officer entered the cell it is likely that D was already beyond help. Officers then engaged in protracted and praiseworthy resuscitation attempts with the assistance of paramedics who had arrived, only discontinuing when it was manifestly obvious they were unsuccessful. It is not possible to say on the evidence whether resuscitation initiated some minutes earlier when the first officer saw D's condition might have been more fruitful, but D did appear alive at that stage.

The following specific points emerge on the facts found on the preponderance of the evidence:-

(i) communication at the Prison was ineffective, especially between medical practitioners/nursing staff and discipline officers;

(ii) members of the nursing staff did not deal effectively or at all with D's episodes of ill health on 30th June, 3rd July and 10th July 2008 – a very significant failing;

(iii) officers were not aware of the new Instruction of 19th March 2008 on entering cells – no general Notice to Staff having been issued;

(iv) the first officer who saw D's condition on 11th July 2008, even with his mistaken understanding of the policy on entering cells alone, neither remained at the scene nor sent out an effective urgent medical emergency message. This was another very significant failing. The rest of the evidence demonstrates that the individual officers referred to acted decently and with good intentions towards D throughout his incarceration.

<u>Observations (not part of the Narrative Conclusion)</u>

The recommendations set out at pages 41-2 of The Ombudsmen's Report are, it is understood, being implemented or have been implemented – see the Action Plan on pages 2135-9 of the bundles. I shall write to the Home Department Minister enclosing a copy of my findings and requesting that he ensures that all staff fully understand what is involved in this process.

I express my gratitude to Counsel for their sensible and measured approach.

I express deep sympathy to Mr Schofield's wife and son, relatives and friends. One can never remove human error from being a possibility in a situation, but it is a good idea to have systems in place that seek to minimise it.

J R Finch
Judge of the Royal Court
11th January 2010

