SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2017] FAI 21

B101/17

DETERMINATION

BY

SHERIFF JOHN C MORRIS QC

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

GWENDOLINE (WENDY) McMULLAN

FALKIRK -

The Sheriff, having heard evidence and having resumed consideration of the cause

Finds and Determines that:-

1) In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the 1976 Act) Gwendoline (known as "Wendy") McMullan who was born on 21 January 1987, a serving prisoner in Her Majesty's Prison, Cornton Vale, Stirling died at said Prison on 20 May 2016 at 14:43 hours.
2) In terms of Section 6(1)(b) of the 1976 Act: the cause of her death was hanging (suicide).
3) In terms of Section 6(1)(c) of the 1976 Act: there were no reasonable precautions which could have been taken whereby the death might have been avoided.

4) In terms of Section 6(1)(d) of the 1976 Act: there is no finding about defects in any system of working which contributed to the death.

5) In terms of Section 6(1)(e) of the 1976 Act: there are no other facts which are relevant to the circumstances of the death.

Introduction

[1] This is an Inquiry into the death of Gwendoline (known as "Wendy") McMullan who died in Her Majesty's Prison, Cornton Vale on 20 May 2016. She took her own life by tying a ligature around her neck and hanging herself in her cell at the prison. No members of the deceased's family attended or were represented at the Inquiry. This was a mandatory Inquiry in terms of Section 1(1)(a)(2) of the 1976 Act as the deceased was in legal custody at the time of her death.

[2] At the Inquiry the Crown was represented by Mr J O'Reilly, Procurator Fiscal Depute. Forth Valley Health Board was represented by Ms H Walls, Advocate, the Prison Officers' Association was represented by Mr A Phillips, Solicitor, the Scottish Prison Service was represented by Ms S Phillips, Solicitor and Martin Hattie, a Psychiatric Nurse who had seen the deceased shortly before her death, was represented by Mr A Pollok, Solicitor.

[3] The evidence to the Inquiry was led on 25 September 2017 and submissions were made thereon on 26 September 2017.

[4] The following witnesses gave evidence at the Inquiry:

a. Lesley Bremner, a serving Prison Officer at HMP Cornton Vale

b. Clare O'Hara, a serving Prison Officer at HMP Cornton Vale

c. Martin Hattie, a Mental Health Nurse employed by Forth Valley Health Board and stationed in HMP Cornton Vale

d. Dr Rhona Morrison, a Consultant Forensic Psychiatrist and Associate Medical Director at HMP Cornton Vale

e. Clare McBeath, Register and Enrolled Nurse and Team Leader for Mental Health at HMP Cornton Vale.

[5] CROWN PRODUCTION (1) was a post mortem report compiled by Dr Robert Ainsworth, Consultant Forensic Pathologist, following his autopsy examination of Gwendoline McMullan at Edinburgh City Mortuary on 27 May 2016. He gave the cause of death (as per the death certificate) as "1(a) Hanging". The deceased had taken her own life and there were no suspicious circumstances.

Background

[6] The background and the events leading up to Ms McMullan's death were not controversial and a great deal of the evidence was agreed by joint minute.

[7] The deceased appeared at Kilmarnock Sheriff Court on 19 February 2016 to answer 2 complaints at the instance of the Procurator Fiscal, Kilmarnock. In the result she was convicted of 2 offences in contravention of the Antisocial Behaviour etc (Scotland) Act 2004 Section 9(1) and one offence in contravention of the Criminal Justice & Licensing (Scotland) Act 2010 Section 38(1). Sentence was deferred until 22 March 2016 and Ms McMullan was remanded in custody to HMP Cornton Vale. On 22 March

2016 she was sentenced to consecutive sentences of 4 and 6 months back dated to 19 February 2016. (The earliest date of liberation was 19 July 2016.)

[8] In terms of the Management of Offenders etc (Scotland) Act 2005 Ms McMullan was entitled to apply for early release on Home Detention Curfew (HDC) up to 4 months and 2 weeks before her earliest release date. This she had done but there were problems establishing a suitable address for her.

[9] During her time in Cornton Vale, Ms McMullan had engaged with the in house NHS Mental Health team. She was managed using the ACT2Care process twice during her stay, firstly between 19 February and 24 February and latterly between 24 April and 25 April 2016.

[10] The ACT2Care process can be initiated by any member of staff (prison service or medical team) where that member of staff is of the view that the prisoner requires closer monitoring or mental health assistance or both.

Friday 20 May 2016 (Date of Death)

[11] On the morning of 20 May, Lesley Bremner, a prison officer with some 25 years' service, was on duty in Bruce House in HMP Cornton Vale when she heard the deceased on the phone. The deceased seemed angry and upset and was shouting down the phone. Ms Bremner formed the view that there was no-one on the other end of the phone and that was what was exasperating her.

[12] Ms Bremner took the deceased into the office to calm her down. It transpired that the deceased had been trying to contact her boyfriend to obtain a phone number of

a friend, which friend she hoped might supply her with an alternative address. The address she had given with a view to her early release, probably that of her boyfriend, had been deemed unsuitable and HDC had consequently been refused.

[13] The deceased was also concerned that the prison health centre be contacted because there was some problem regarding her weight (the deceased had in the past suffered from eating disorders.)

[14] Ms Bremner said she would arrange for the deceased to visit reception thereby having access to the mobile phone which contained the number of the friend she wanted to contact. Ms Bremner also spoke to the witness Clare McBeath with a view to arranging that a mental health nurse visit the deceased. She did that because the deceased seemed upset, but Ms Bremner was adamant that she had no concerns that the deceased was suicidal. If she had had such concerns she would have immediately invoked the ACT2Care procedure.

[15] Clare O'Hara, a prison officer of some 6 years' experience, also saw the deceased on the morning of 20 May. The deceased had come to see her because the HDC had been refused and she wanted assistance in securing another address. Ms O'Hara assured the deceased that she still had plenty of time to obtain another address and advised her to phone her friend and the deceased left Ms O'Hara to do that. Ms O'Hara was also able to assist the deceased in having some fresh clothing delivered to the prison. This involved completing a pro forma which, although late, Ms O'Hara assured the deceased that she would have the necessary paperwork done.

[16] Ms O'Hara saw the deceased again after lunch and it was apparent that she was upset and frustrated because her phone calls were going straight to answer phone. Ms O'Hara described the deceased as an emotional girl and it was not unusual to see her upset but again Ms O'Hara had no concerns for the deceased's mental well being or for her safety. If she had, she too would have activated the ACT2Care process immediately.

[17] In response to Lesley Bremner's request that someone from the Mental Health team speak to the deceased, Clare McBeath, a registered nurse and the team leader of the Mental Health team in Cornton Vale, spoke to Martin Hattie, a mental health nurse. She asked him, if he had time, if he could speak to the deceased. If not, someone in the afternoon shift could be asked. Mr Hattie was able to speak to the deceased.

[18] Mr Hattie spoke to the deceased for about 25 minutes some time after 11.30 on the morning of 20 May. She was upset during the interview and told Mr Hattie that she "hated" being in Cornton Vale. He also noted that she had some scratches on her upper arm (these were apparently the result of some previous self harm). Mr Hattie asked the deceased if she felt suicidal to be told in no uncertain terms that she was not and that that was all "you people" (meaning the Mental Health team) thought about.

[19] As with the other professionals, Mr Hattie had no concerns that the deceased may be minded to take her own life. All the indications were against it in that she was speaking about future events and she had plans for future visits.

[20] On his return to the Health Centre, Mr Hattie consulted the deceased's medical records and whilst still not concerned that the deceased was a suicide risk he felt it prudent to arrange a follow-up visit to her by a female member of the Mental Health

staff. He noted that one of the deceased's many problems had been an ectopic pregnancy and he felt that probably she may be more comfortable discussing such matters with a woman rather than a man. Mr Hattie was discussing these matters with his team leader, Clare McBeath, and was completing forms to keep the next shift up to date when a Code Blue alarm sounded - this being the indicator that the deceased had been found.

Submissions

[21] All parties agreed that I should make a formal finding of death and that no reasonable precautions could have been taken whereby the death could have been avoided.

Discussion

[22] All the witnesses who gave evidence were perfectly credible and reliable witnesses. The two prison officers who dealt with Ms McMullan on the morning of 20 May (i.e. Ms Bremner and Ms O'Hara) were thoroughly professional prison officers with a wealth of experience between them. They were both firmly of the opinion that the deceased did not exhibit any signs of intending to take her own life. Quite the contrary – her mind seemed to be focussed on future matters.

[23] Even so, both thought it prudent to have the deceased seen by one of the Mental Health team. This was an expediency with a view to having her comforted to some degree and was not an unusual course of action.

[24] Mr Hattie, like his two prison officer colleagues, whilst noting that the deceased was upset (and of course there were good reasons for her being upset), had no concerns that she was about to take her own life. Again, he is a man of vast experience.

[25] Tragically, Ms McMullan did take her own life. Why she did so will probably remain unknown. She was a young woman with numerous problems, both physical and mental, with little or no family support, but these problems had persisted for some time and all the signs were against her committing suicide.

[26] In my view all the professionals involved in this unfortunate case did their jobs properly and no precautions could have been taken to prevent what ultimately happened. Consequently, I have no recommendation to make. Why Ms McMullan was driven to take her own life at the point when she did will remain unknown.

[27] Finally, I am grateful to the Procurator Fiscal Depute and to Ms Watts Advocate, Mr Phillips, Ms Phillips and Mr Pollok for their contributions to the Inquiry and their helpful submissions.