SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2018] FAI 31

KIL-B41-18

DETERMINATION

BY

SHERIFF PRINCIPAL DUNCAN L MURRAY, WS

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

into the death of

KENNETH ALEXANDER MONK

Kilmarnock, 13 September 2018

DETERMINATION

The Sheriff Principal, having considered all of the evidence, the productions, the terms of the joint minute of agreement and the submissions of parties, finds and determines in terms of section 26 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the Act):

[a] In terms of section 26(2)(a) Kenneth Alexander Robert Monk, born 18 January 1962, died, at HMP Kilmarnock, at 23:47 on 9 June 2016.

[b] In terms of section 26(2)(c) the cause of the death of Kenneth Alexander Robert Monk was: hanging, the cause of death as recorded in the post-mortem report.

[c] In terms of section 26(2)(e) of the Act the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided:

There were no reasonable precautions by which the death may have been avoided.

[d] In terms of section 26(2)(f) of the Act the defects, if any, in any system of working which contributed to the death or any accident resulting in the death:

There were no defects in any system of working which contributed to the death.

[e] In terms of section 26(2)(g) of the Act any other facts which are relevant to the circumstances of the death:

There were no other facts which were relevant to the circumstances of the death.

Representation at the Inquiry:

For the Crown: Mr Quither, Procurator Fiscal Depute.
For the family of Kenneth Alexander Monk**:** Mr McLatchie, solicitor.
For Serco Limited: Mrs Duff, Counsel.
For Scottish Prison Service: Ms Chalmers**,** solicitor.
For NHS Ayrshire and Aran: Ms Watts, Counsel.

General Legal Framework

[1] This was an inquiry held under section 2(4)(a) of the Act, on the ground that the person who died was, at the time of his death, in legal custody.

[2] The purpose of an inquiry held in terms of the Act is for the sheriff to establish the circumstances of the death, and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The sheriff is required in terms of section 26 of the Act to make a determination setting out the circumstances of the death, so far as they have been established to his satisfaction:

(a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred and any accident resulting in the death,

(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 the 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] The sheriff must also make such recommendations as to the taking of reasonable precautions, the making of improvements to any system of working, the introduction of any system of working and the taking of any other steps which might realistically prevent other deaths in similar circumstances (section 26(1)(b) and 26(4)).

[4] The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the Inquiry. The determination must be based on the evidence presented at the Inquiry and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act sets out that the determination of the sheriff shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death. It also reflects the position that a Fatal Accident Inquiry is not a forum designed to establish legal fault.

The Proceedings, Witnesses and Evidence

[5] Preliminary hearings of the inquiry were held on 12 March, 16 May and 12 June. The Inquiry heard evidence on 16, 17, 19, 20 and 23 July 2018. Oral submissions were made on 28 August 2018.

[6] Evidence was led principally by the Procurator Fiscal Depute, in accordance with the duty under section 20 of the 2016 Act. The Crown witnesses were as follows:

1. Morag Gallacher
2. Dr. Joseph Daly
3. Michael Brown
4. Emmanuel Hammond
5. James Gordon
6. Dr. Abha Paulina
7. John Dewar
8. Rebecca Joyce
9. Janet McCartney
10. Richard Dunsmuir
11. Steven Erskine
12. Stephen Clark
13. John Carroll
14. Lesley McDowall

In addition evidence was led for Ayrshire and Arran Health Board from Dr Dawn Carson. A Joint Minute of Agreement and an affidavit from Dr Marjorie Turner, Forensic Pathologist, were lodged.

The Circumstances

[7] Kenneth Alexander Robert Monk (Mr Monk) was born on 14 June 1981. He lately resided in Stranraer. He received an eight month custodial sentence at Kilmarnock Sheriff Court on 12 May 2016 in respect of contraventions of the Misuse of Drugs Act 1971. This was not his first custodial sentence and he had previously been a prisoner in HMP Kilmarnock. He had a history of mental health issues.

[8] Following sentence he was initially taken to HMP Barlinnie. On arrival at HMP Barlinnie he went through the usual procedures which included an Act 2 Care Reception

Risk assessment. He was assessed as being at no apparent risk. While in HMP Barlinnie Mr Monk was in telephone contact with Ms Gallacher, with whom he had been in a relationship for some months, and was positive about his forthcoming transfer to HMP Kilmarnock. This took place on 27 May 2016. HMP Kilmarnock was and is operated by Serco Limited on behalf of the Scottish Prison Service under contract with Scottish Ministers.

[9] On arrival at HMP Kilmarnock Mr Monk was given a further Act 2 Care Reception Risk assessment. This was completed by Prison Officer Kevin Rowe, who noted the deceased to have "no thoughts of suicide or self-harm" and assessed him as being of "no apparent risk". At about 3pm, same date, a Nurse Risk Assessment of the deceased was completed by Nurse Denise Ramage at the prison's health centre, who similarly assessed the deceased as "Denies any risk to self….or suicidal intent". The deceased was then seen the following morning, at about 9-50am at the prison by Dr Abha Paulina, who noted nothing of concern regarding his physical or mental health and also assessed the deceased as being of "no apparent risk". Following what appeared to be a suicide attempt on 29 May Mr Monk was taken to Crosshouse Hospital, Kilmarnock. His return to HMP Kilmarnock on 30 May triggered another Act 2 Care Risk assessment. This was undertaken by Prison Officer Dewar and Nurse Hammond. They both independently concluded that Mr Monk was at high risk and he was placed "on Act." As a result he was made the subject of an immediate care plan which was approved by Thomas Loy, a custody supervisor.

[10] Act 2 Care was at the material time the suicide and self-harm risk management strategy within Scottish prisons. Since Mr Monk's death it has been updated by the Talk to Me: Prevention of Suicide in Prisons Strategy (PSPS). The ethos of Act 2 Care was for shared care, with all concerned parties having an equal say in the assessment of a patient and this

shared responsibility has been maintained with PSPS. Under Act 2 Care all staff working in the prison had a responsibility to assess any prisoner who they may perceive to be at heightened risk of suicide. Once a prisoner is placed on Act 2 Care an immediate care plan is put in place. This is followed up by an initial case conference, generally held the following day, and by regular care reports and further case conferences to maintain regular assessment of the prisoner while they are on Act.

[11] The immediate care plan for Mr Monk required that he be placed in a safe call, in strip conditions, which means he was provided with anti-ligature clothing. It also provided that he was to receive finger food and he was to be monitored every 15 minutes. This plan was put in place within minutes of his being assessed by Prison Officer Dewar as being at risk.

[12] A case conference was convened the following day at 15:00. Mr Monk declined to attend; although the care report which had been prepared following his being placed on ACT recorded his appearing "more settled." The immediate care arrangements were maintained.

[13] Mr Monk was seen by Nurse James Gordon prior to the case conference on 1 June. Mr Gordon found him to be more settled. Mr Monk then attended the case conference along with Thomas Loy, James Gordon and Michael Brown. He was noted to be communicating well and making good eye contact. Mr Monk reported that he was feeling a lot better and no longer had thoughts of self-harm or suicide. The conference determined that he was now of low risk. This resulted in his being returned to his own cell, with no restrictions on his clothing or food. The frequency of monitoring was reduced to hourly intervals.

[14] A further case conference took place on 4 June. Mr Monk declined to attend as he complained of having a sore head. His status was maintained as low risk. A few hours after this case conference Mr Monk was placed on report for causing damage to prison property within his cell, as he had smashed his prison issue kettle and television. He initially reported to staff following the incident that he had been hearing voices, had drug withdrawal and wanted time out in the SRU. In the subsequent care plan daily reports he is noted as having described himself as having a "panic attack".

[15] Between damaging the items in his cell and the case conference on 7 June the daily case reports record that Mr Monk was remaining in his cell, not interacting with staff and declining his medication and not eating. Mr Monk refused to engage with Prison Officer Clark, a custody supervisor, prior to the case conference on 7 June. The Care Plan note at 21:00 by Prison Officer Richard Dunsmuir records that "he will need to be monitored by a Nurse". The entry of 13:00, the next day, states that "he wants protection".

Prison Officer Clark, who had not been involved with Mr Monk in the immediately preceding days, reviewed the Act 2 Care book in advance of the case conference on 7 June. He focused on the recent entries and reports and may not have looked at the entries about why Mr Monk was originally placed on Act. The conclusion of the case conference was to maintain Mr Monk's status as low risk with 60 minute observations and to fix a further case conference for the following day.

[16] Despite Mr Monk initially declining to engage with staff, Prison Officer Clark and Nurse Gibb went to his cell on 8 June to encourage his participation in the case conference. This approach was commended by Ms McDowall, the Scottish Prison Service Heath Strategy and Suicide Prevention Manager, as reflecting good practice, and Mr Monk engaged. Prison

Officer Clark found his presentation to be different from the previous day, albeit with some mild cajoling, he interacted and made good eye contact. His position was that he wished to be kept apart from other prisoners. The assessment of Prison Officer Clark and Nurse Gibb was that he posed "no apparent risk" and that he could be taken off Act.

[17] About 11.10pm on 10 June 2016, Prison Officer Anthony (aka Brian) McGovern was on routine duties in G Wing when he looked inside Mr Monk's cell. He saw Mr Monk whom he initially thought was standing against the back wall of his cell. When he checked further, he noticed Mr Monk's feet were off the ground and he appeared to be suspended from the window, with something dark around his neck. He was wearing only shorts and his face was extremely pale and a different colour from his body. McGovern radioed for medical assistance and intimated he was going to enter the cell, which he then did. He shouted at Mr Monk but there was no response. He attempted to cut the ligature but Mr Monk was too heavy. He again called for assistance and was soon joined by his colleagues, Prison Officers Scott Hunter and then Steven Lorimer. Prison Officers McGovern and Hunter tried but were not able to cut Mr Monk down, but did so with the assistance of Prison Officer Lorimer. Prison Officer Lorimer then commenced CPR and was later assisted in this by Prison Officers Christopher Robertson, Colin Gray and Steven Brawley, pending the arrival of paramedics. During the preceding week or so, Prison Officer McGovern had had regular contact with Mr Monk and had had no cause for concern about him. He was aware Mr Monk had been on Act 2 Care until the previous day or so.

[18] About 11:20pm on Thursday 9 June 2016, Ambulance Technicians Martin Moore and Robert Carrigan were instructed to attend at the prison regarding a report of a prisoner exhibiting no signs of life after apparently hanging himself. They attended as quickly as

they could and arrived at the prison at about 11:30pm. Upon arrival, they were taken immediately to the deceased's cell, where prison staff were carrying out CPR on the deceased who was on the floor. Prison staff were requested to continue with CPR whilst Moore and Carrigan set up their resuscitation equipment. The defibrillator showed the deceased had no heartbeat and was not breathing. The Ambulance Technicians then fitted a laryngeal mask airway to keep the deceased's airway open and continued to perform CPR. They were shortly joined by Paramedic Donald Hamilton and continued the CPR for a further short time but without success. Paramedic Hamilton pronounced life extinct at 11:47pm. When police officers DS McCulloch and DC Moore arrived they were advised of the circumstances by Prison staff. The police secured the cell and police examiner David Robertson attended and took photographs of the cell which were produced to the Inquiry.

[19] Serco Limited as the prison operators carried out an internal investigation and a Death in Prison Learning Audit and Review meeting (DIPLAR) was held on 12 August 2016. This is a multi-disciplinary team meeting, the purpose of which is to understand the events leading up to a death in custody. The overall conclusions of the investigation and the meeting are in line with the findings of the Inquiry.

Submissions

[20] There was a broad consensus amongst the parties to the Inquiry about the findings which I should make. These reflected the terms of the joint minute. In respect of section 26(2)(a) as agreed in terms of the joint minute that Mr Monk was found in his cell (Cell 18, G Wing, HMP Kilmarnock) at or about 23:10 on 9 June 2016, having apparently hanged himself. After sundry attempts at resuscitation within his cell life was pronounced

extinct at 23:47. It was accepted by all parties that the deceased took his own life and no finding falls to be made under section 26(2)(b) or section 26(2)(d). In respect of section 26(2)(c) it was accepted in the joint minute, in terms of the post mortem report, that the cause of death was hanging. This was consistent with the oral evidence to the Inquiry. No party invited me to make a finding under section 26(2)(e) (f) or (g).

Conclusions

[21] In relation to subsections (a) – (d) of Section 26, there is effectively no dispute between the parties.

[22] I accept the evidence of Dr Carson, a consultant forensic psychiatrist that suicide is difficult to predict. As a consequence it is unfeasible within a realistic regime to totally eliminate the risk of suicide. Even if Mr Monk had remained on Act for another couple of days or been under a fifteen-minute observation regime, he may have been able to take his own life, if he was intent on doing as he did.

[23] As far as section 26(e) is concerned, I accept the Crown submission, particularly when regard is had to its precise wording, that it is difficult to identify precautions which might reasonably have been taken which might have avoided Mr Monk's death. There was no evidence before the inquiry which provides a basis to conclude that there were any reasonable precautions which could reasonably have been taken which would have prevented the death.

[24] In relation to the decision to remove Mr Monk from low risk Act 2 Care monitoring at the case conference on 8 June, as Ms McDowell indicated and Mr Clark readily accepted it was an option to leave Mr Monk on at Act at low risk. I am however satisfied that the

decision not to do so was one which was open to Mr Clark and his colleagues given Mr Monk's improved presentation and denial of any suicidal ideation or inclination to self-harm. On the information available it was a judgement which they were entitled to reach, even if with the benefit of hindsight it may be seen as have being wrong in the sense that Mr Monk's subsequent actions demonstrate that he remained at risk.

[25] But even if the decision had been taken to retain Mr Monk on Act it is relevant to note that accepting the terms of Dr Turner's affidavit, the hanging probably resulted in the occlusion of the blood vessels in Mr Monk's neck which would have caused Mr Monk to lose consciousness and to have died within four to six minutes. On the basis of that evidence, even with more regular monitoring there was a real risk that Mr Monk could have succeeded in committing suicide irrespective of the regime which was in place. I therefore conclude that the removal of Mr Monk from hourly monitoring cannot be said to have had any impact on the tragic outcome. There was no evidence to support Mr Monk being held in a safe cell under strip conditions after the case conference on 8 June.

[26] As far as section 26(f) is concerned I accept the evidence of there being a robust system in place ensuring all staff, both prison and medical, were trained in the relevant suicide prevention regimes. Reference was made in the DIPLAR meeting to staff being aware that any change in a prisoner's mood could be an indication of increased risk. The inquiry heard no evidence about this. I simply note that Ms McDowall and her team may wish to give some consideration as to whether future training might highlight the possibility that an individual who has reached a decision to take their own life may appear more composed as a consequence of having settled on such a plan.

[27] There was one area of evidence about which I must comment. This relates to the efforts of Ms Gallacher and Ms Joyce of Families Outside on her behalf to raise concerns about Mr Monk's wellbeing with the prison authorities. It is unfortunate that the records of the Families Outside database were no longer available and that these had not been secured prior to the new database being introduced. Those records may have assisted the Inquiry.

[28] I do not accept the implied criticism which Ms Joyce made of Prison Officer McCartney. Ms Joyce was unsighted that Prison Officer McCartney would have the opportunity to identify Mr Monk either from her own knowledge or by accessing his computer based prison record during the course of the conversation. As a consequence, that Prison Officer McCartney did not seek details of Mr Monk's prison number did not justify Ms Joyce's inference that she did not take the report seriously. I accept that the concerns passed on by Ms Joyce were brought to the attention of staff on the wing. Mr Monk was at the time on Act and the only enhancement which could be anticipated has been addressed with the formalised recording of such information in the notice of concern form to which I shall return. I accept there were some difficulties faced by the Serco Limited staff in communicating with Families Outside, particularly where the Families Outside contact was not a recognised next-of-kin in the prison data records. Mr Erskine and Ms Joyce were both credible in their differing understanding of whether Mr Erskine was to call Ms Gallacher forthwith, or was to do so only if anything changed. I find this to have been a genuine misunderstanding on which nothing turns. I simply observe that such a conversation should now be recorded in a notice of concern form.

[29] Serco Limited responded to the tragic loss of life of Mr Monk by reviewing their processes and it appears that the introduction of the notice of concern form is an

improvement to the recording of concerns expressed by relatives. It initially appeared that this was in response to a Governor's and Managers' Action, however when this document was produced it became apparent that this followed an earlier Fatal Accident Inquiry and dated from December 2013. While Serco Limited had taken certain steps to implement that instruction, it is clear that the introduction of the notice of concern form adds greater clarity and direction to ensure that those involved are aware of such concerns. Had this system been in place when Morag Gallacher and Families Outside had been enquiring after Mr Monk, it would have also provided an audit trail of the actions taken in relation to those calls. There was no evidence before the Inquiry however which suggested that the earlier introduction of the notice of concern form would have had any material impact on any of the actions given that the Serco Limited staff had themselves identified that Mr Monk was at risk and had placed him on Act.

[30] There may be a question as to whether there is scope for greater engagement with next-of-kin when a prisoner is placed on Act, but I heard no material evidence in the Inquiry which would make it appropriate for me to make any further comment on this, save to say that this may be an another area which Ms McDowall and her team will wish to explore. No doubt they will wish to give consideration to the submission made on behalf of the family that it is to be hoped that PSPS provides for greater family inclusion in the lives of prisoners under the care of prison authorities.

[31] The evidence before the Inquiry was that Mr Monk himself determined to take his own life, and that there was no further action which could reasonably have been taken to prevent this tragic loss of life. I make no recommendations following the Inquiry. I note that this Inquiry commenced nearly two years after Mr Monk's death, which is significantly

quicker than is sometimes the case; it is however desirable that Inquiries are convened as soon as possible after a death. As was made clear in the submissions on behalf of the family, the airing of evidence before the Inquiry has given answers to Mr Monk's family. While in this case there is no basis to make any recommendations, the dual objectives of giving answers to the family of a deceased and to allow recommendations to be made which may prevent a similar occurrence should give a focus for Inquiries being commenced expeditiously.

[32] In conclusion I would reiterate and join with parties in offering my sincere condolences to Mr Monk's family and friends for their loss.