SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2019] FAI 19

B348/19

DETERMINATION

BY

SHERIFF LINDSAY WOOD

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

into the death of

MICHAEL AITKEN

GLASGOW, 4 June 2019. The sheriff, having considered the information presented at the Inquiry, determines in terms of section 26 of the said Act, that:

(1) Michael Aitken, born 17 November 1972 and residing latterly at HM Prison, Barlinnie, 81 Lee Avenue, Glasgow, died there at 0846 am on 25 March 2017.

(2) In terms of section 26(2)(a) the death occurred at HM Prison, Barlinnie when Mr Aitken was in custody.

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

1(a) Hanging.

(4) No findings were sought or are made in respect of section 26(2)(b), (d), (e), (f) and (g).

NOTE:

Introduction

[1] This is a Fatal Accident Inquiry in terms of section 2(4)(a) of the 2016 Act as Mr Aitken was in legal custody at the time of his death.

[2] Mr Aitken's death was reported to the Crown Office and Procurator Fiscal Service on 27 March 2017.

[3] A preliminary hearing was held on 1 April 2019. The representatives of the participants were Laura Knox, procurator fiscal depute for the Crown; Anne-Marie Chalmers, solicitor for the Scottish Prison Service; Elaine Goodwin, solicitor, for the Prison Officers' Association; and Kevin Henry, advocate for Greater Glasgow & Clyde Health Board.

[4] The Inquiry heard evidence over 2 and 3 May 2019. The following witnesses were called by the Crown and gave evidence:

(1) Mr Anthony Coia;

(2) Mrs Lynne McCrindle;

(3) Dr Suchitra Senthill;

(4) Ms Lynsey Slater;

(5) Mr Frank Wilson;

(6) Dr Richard Parkins;

(7) Mrs Tracy Stafford;

(8) Mrs Lesley McDowall.

No other witnesses were led.

[5] A joint minute of agreement was entered into by all parties and lodged.

Legal Framework

[6] A Fatal Accident Inquiry was held under section 1 of the 2016 Act.

[7] The Inquiry is governed by the Fatal Accident Inquiry Rules 2017.

[8] In terms of section 1(3) of the 2016 Act, the purpose of an Inquiry 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.

[9] The matters to be covered in the Determination under section 26 are when and where the death occurred and the cause or causes of the death.

[10] The Crown in the public interest was represented by the procurator fiscal depute. A Fatal Accident Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

[11] The following facts summarise the evidence before the Inquiry:

(1) On 10 March 2017 the said Michael Aitken (hereinafter referred to as "Mr Aitken") first appeared on petition at Glasgow Sheriff Court. The petition contained a charge alleging an assault to severe injury and to the danger of life and attempted murder. The offence was aggravated by domestic abuse. He was committed for further examination and remanded in custody. On 17 March 2017 Mr Aitken was fully committed for trial and was further remanded in custody. He was on remand until the date of his death within HM Prison, Barlinnie, on 25 March 2017. He was accordingly in legal custody.

On 10 March 2017 Mr Aitken was allocated a cell within the first night centre, occupying cell DNL 2/30. On Monday, 13 March 2017 he attended induction prior to being transferred to C Hall. During the induction process he stated that he had no thoughts of suicide or self-harm. He was located in C Hall level 3; cell C3/13, initially sharing with another prisoner. On 14 March 2017 the other prisoner vacated the cell. Mr Aitken attended at Glasgow Sheriff Court on 17 March 2017. On return to HM Prison, Barlinnie, he was subject to a Reception Risk Assessment. According to this assessment, he was deemed as no apparent risk. He had previously served three custodial sentences which included periods housed within HM Prison, Barlinnie.

(2) Mr Aitken was 44 years of age at the time of his death. He was last seen at The Cairns Practice by his general practitioner, Dr Richard Parkins, on 7 February 2017. A referral was sent to the community mental health team. Mr Aitken was offered an appointment for psychiatric assessment on Tuesday, 14 March 2017 at Auchinlea House, however he was in custody at the time of his appointment.

(3) On 6 May 2012 whilst in custody at HM Prison, Barlinnie, Mr Aitken cut both his wrists. These were superficial cuts which required to be sutured.

(4) On 11 March 2017 within HM Prison, Barlinnie, Mr Aitken was treated for opiate and alcohol withdrawal by use of reducing doses of dihydrocodeine and diazepam. He was also prescribed mirtazapine an anti-depressant he had been receiving before entry to prison.

(5) At approximately 2035 pm on 24 March 2017 Prison Officer James McArthur completed a routine "lock up body check" or numbers check on level three. Mr Aitken was housed in cell 3/13 within C Hall. A "lock up body check" is when the officer walks down a section or row of

cells and opens the cell doors to ensure the prisoner is alive and well. This was carried out in Mr Aitken's cell and there was nothing unusual noted. There was no indication he intended to self-harm. There were no further checks on this cell until about 0820 am on Saturday, 25 March 2017.

(6) At this time, Prison Officer Alistair Tait opened the cell and noted Mr Aitken to be lying face down on the cell floor next to the bed. The witness Tait noted a ligature around Mr Aitken's neck and declared a "Code Blue". A "Code Blue" is the code used when a prisoner is non-responsive with breath. Prison Officers Stuart McFadzean also declared a "Code Blue" using his radio before entering the cell. Prison Officer John Stokes also attended. Stuart McFadzean saw Mr Aitken lying face down alongside the bed. John Stokes saw a blue ligature around Mr Aitken's neck which he noted was extremely tight. Prison Officer James McArthur went to get a crash pack which was passed to John Stokes who cut the ligature with a knife. John Stokes assisted by colleague Stuart McFadzean turned Mr Aitken onto his back and Stuart McFadzean started chest compressions. Prison Nurses, Catherine Bell and Lynne McCrindle, arrived at Mr Aitken's cell. Nurse McCrindle inserted an airway into his mouth in order to use an airbag and chest compressions continued. A defibrillator was attached to his body.

(7) The on-call Prison Doctor, Dr Joseph Daly, also arrived to assist. He observed Mr Aitken to be unconscious and unresponsive. A short time later paramedics, Heather Findlay and Douglas McMath, arrived. Attempts to resuscitate Mr Aitken continued but were unsuccessful. Dr Daly pronounced life extinct at 0845 am, same day. A short time later, Police Constables Marc McFarlane and Billy Craig arrived and were advised of the circumstances. Detective

Constables John Semple and Craig Fee attended in connection with their role as CID officers and thereafter conducted relevant enquiries, confirming there to be no suspicious circumstances and that no suicide note was found.

(8) On 30 March 2017 at the Queen Elizabeth University Hospital, Glasgow a post mortem examination was carried out on Mr Aitken by Dr Julia McAdam, Forensic Pathologist. The post mortem report and a toxicology report were prepared by Dr Hazel Torrance. The cause of death was found to be hanging. Analysis of post mortem blood revealed 0.03 mg/L of mirtazapine, an anti-depressant. A single 20 mg oral dose of mirtazapine gives an average peak plasma concentration of 0.032 mg/L. The post mortem blood sample contained a low concentration, less than 0.05 mg/L of desmethyldiazepam, a benzodiazepine. This indicated the previous use of diazepam, chlorazepate, medazepam, prazepam or chlordiazopoxide. A low level, less than 0.05 mg/L of dihydrocodeine was detected in urine consistent with previous use of this drug.

(9) Mr Aitken died on 25 March 2017 within cell 3/13, HM Prison, Barlinnie, 81 Lee Avenue, Glasgow, G33 2QX. The time of his death was recorded at 0846 am on that date.

(10) Professor Bateman, former Consultant Physician at the Royal Infirmary of Edinburgh and Director of the National Poison Information Service (NPIS) Edinburgh, was asked to provide an opinion on the potential effect of a failure to prescribe propranolol and whether a prescription of mirtazapine was appropriate.

(11) In the course of his report, Dr Bateman noted that propranolol was not recorded in Mr Aitken's prescriptions in late 2016 or 2017. Propranolol is a beta-adrenoceptor which has been in use since the late 1960s. The adverse side-effects of propranolol include tiredness, sleep

disturbance, nightmares and depression. In more severe cases psychosis and hallucinations can occur. Beta-blockers such as propranolol do not have any fundamental effect on the incidence of anxiety and the now known adverse effects may contribute to psychiatric symptoms in some patients.

(12) The dose of propranolol previously prescribed to Mr Aitken was 10 mg, three times per day. This was the lowest level of dosing that would normally be given to a patient. Such a dose has no benefit in reducing sudden impulsive self-harm episodes or suicide.

(13) Tachycardia and anxiety are features of drug withdrawal and are regularly monitored by clinicians managing withdrawal in order to optimise preventive therapy. Use of propranolol in a patient undergoing a withdrawal regime would be somewhat paradoxical and not good medical practice.

(14) Mirtazapine is an anti-depressant which is widely used in practice. It is the safest of the currently used anti-depressants if taken to overdose. Its use is very highly appropriate in patients with depression and a history of self-harm and drug abuse.

(15) Anxiety and depressive feelings are sometimes features of drug withdrawal. Managing these symptoms is a challenge in patients for whom drug withdrawal is being treated but suicide in this context is very rare.

(16) Professor Bateman made the following conclusions in part 4 of his report:

- Mr Aitken was suffering from drug withdrawal features on admission which were treated appropriately.

- Prior to admission, Mr Aitken was prescribed mirtazapine, the anti-depressant drug associated with the least risk if taken to overdose and this was continued. This was appropriate.
- Mr Aitken requested propranolol therapy but Professor Bateman could identify no indication for giving that drug.
- In his view, Professor Bateman states prescribing propranolol would have had no effect whatsoever on reducing Mr Aitken's feelings of depression, risk of self-harm or suicide. Indeed he states that it may, if prescribed, have increased feelings of tiredness and depression, which are known adverse effects of the drug.
- That while use of beta-blockers in patients with anxiety was common in the past it is now recognised not to have a fundamental role in the management of the psychological component of this condition. Failure to use a beta-blocker would not be regarded as unusual or indeed poor practice.

Submissions and Conclusion

[12] The procurator fiscal depute invited the court to make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act in respect of Mr Aitken's death which submission was adopted by the three other parties. Having considered the terms of the joint minute, the productions lodged and the evidence led, I am satisfied that such a Determination is appropriate in the circumstances of Mr Aitken's death. No submissions were made in terms of section 26(2)(e) (any precautions which could reasonably have been taken and which might

realistically have resulted in the death being avoided) or section 26(2)(f) (any defect in the system of working which contributed to the death). I was satisfied there was no basis on which to make any finding in terms of either of these provisions. Nor were there any other facts relevant to the circumstances of the death which fell to be included in my determination under section 26(2)(g). Mr Aitken had hung himself in his prison cell and there was no indication beforehand that he intended to take his own life. Prison officers are trained to spot cues and clues that a prisoner intends to self-harm or commit suicide. There was nothing identifiable in Mr Aitken's presentation or behaviour that would have led prison officers to believe he was planning to commit suicide. If prison officers have any concerns, they will discuss these with the prisoner, raise such concerns with their Manager and initiate "Talk 2 me" if required. Further, Mr Aitken was properly risk assessed by various members of staff within HM Prison, Barlinnie and seen by various members of the prison health care staff. There was no evidence that any member of staff having contact with Mr Aitken had any concerns that he was at risk of suicide. In the days leading up to his death, Mr Aitken received visits from his mother, made telephone calls to family members and made purchases from his prison account. There was compelling evidence that individuals can suffer a rapid deterioration of their mental health. The decision to take their own life can be made impulsively. Sometimes the signs that someone is considering taking their own life are not there. Sadly, this applied in relation to Mr Aitken. Reference to Mr Aitken's request to be prescribed propranolol was covered at the Inquiry. He had stated in a self-referral form that he had recently been prescribed propranolol but records showed that the last time he received it was on 25 May 2016. Professor Bateman made it quite clear in his report that the prescribing of propranolol would not have been good medical

practice in all the circumstances and would not have reduced Mr Aitken's feelings of suicide. Nothing could have been done to save Mr Aitken's life and he was treated, cared for and assessed appropriately throughout his time in Barlinnie.

[14] All the witnesses who gave evidence were, in my view, entirely credible and reliable and of considerable assistance to the Inquiry.

[15] I wish to commend the procurator fiscal depute and those representing the other parties for their helpful and professional contributions to this Inquiry. They assisted in agreeing a joint minute which considerably shortened the length of the Inquiry hearing and avoided certain witnesses having to attend to give evidence.

[16] As is also my practice, I formally and genuinely express my condolences to the family and friends of Mr Aitken and in particular to his mother, son and sister. His mother and son were present throughout the Inquiry and his sister for the second day. They behaved with the utmost dignity in what must have been a difficult and stressful experience.