SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2019] FAI 28

KIL-B52-19

DETERMINATION

BY

SUMMARY SHERIFF MICHAEL HANLON

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

into the death of

RYAN ANDREW FORBES

Kilmarnock, 4 April 2019

The Summary Sheriff, having considered the information presented at the inquiry, the terms of the joint minute of agreement 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 2016 Act") that:-

(1) In terms of section 26(2)(a) of the 2016 Act, Ryan Andrew Forbes ("the deceased"), born 16 November 1993, died at Her Majesty's Prison, Kilmarnock ("Kilmarnock Prison") while in lawful custody on 26 September 2017, life having been pronounced extinct at 07:19 hours; and

(2) In terms of section 26(2)(c) of the 2016 Act the death was caused by hanging.

No findings were sought and none are made in relation to sections 26(2)(b), 26(2)(d), 26(2)(e), 26(2)(f) or 26(2)(g) of the 2016 Act.

Recommendations

In terms of section 26(1)(b) of the 2016 Act there are no recommendations to be made.

NOTE

Introduction

[1] An inquiry into the death of the deceased was required by virtue of section 2(4)(a) of the 2016 Act in respect that it occurred while he was in legal custody.

[2] The Form 3.1 Notice of an Inquiry under the 2016 Act was sent to Kilmarnock Sheriff Court on 17 January 2019 by the Procurator Fiscal for Kilmarnock. A Preliminary Hearing for the Inquiry took place at Kilmarnock Sheriff Court on 20 March 2019.

[3] On 4 April 2019 the Inquiry was held at Kilmarnock Sheriff Court. Ms C Gallagher, Procurator Fiscal Depute, presented the information following upon the investigation by the Procurator Fiscal into the circumstances of the death. Mr L Smith, Solicitor, represented the Scottish Prison Service, and Ms J McDonald, Solicitor, represented SERCO Ltd, the private company which operates Kilmarnock Prison on behalf of the Scottish Prison Service. The family of the deceased did not wish to be represented.

[4] A joint minute was signed by all parties represented at the Inquiry, agreeing facts to be admitted into evidence. There were no identified issues in dispute.

[5] The following witnesses gave evidence:

(i) William Barclay, Custody Officer, c/o Kilmarnock Prison;

(ii) Emmanuel Hammond, NHS Mental Health Nurse, c/o Kilmarnock Prison; and
(iii) Dr Robert Church, NHS General Practitioner, c/o Kilmarnock Prison.

The legal framework

[6] The 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 of the 2016 Act are when and where the death occurred, and the cause or causes of the death.

[10] The Crown, in the public interest, is represented by the Procurator Fiscal Depute. A Fatal Accident Inquiry is an inquisitorial process. It is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

[11] On 21 September 2017 at Kilmarnock Sheriff Court, the deceased pled guilty to three charges of theft by shoplifting. His case was adjourned until 10 October 2017 for the preparation of a Criminal Justice Social Work report and to call alongside another case. He was remanded in custody to Kilmarnock Prison and as at the date of his death on 26 September 2017 he was lawfully incarcerated.

[12] The deceased's community medical records were lodged as a production at the Inquiry. They show that he had sought medical assistance after having overdosed on drugs on five occasions prior to his date of death: 19 September 2007; 29 September 2008; 10 December 2010; 13 August 2012; and 25 May 2015. In addition he sought assistance on 12 January 2013, having self-harmed by cutting his arm.

[13] On 21 September 2017 William Barclay, Custody Officer, carried out an admission interview with the deceased within a private interview room at the reception area of Kilmarnock Prison and completed an admission form. This interview lasted around 5 to 10 minutes, and, as per standard procedure, included an assessment of the deceased's wellbeing and state of mind. During an earlier spell within Kilmarnock Prison in May 2017 the deceased had received a marker for "Act 2 Care", a protocol of observation and intervention for those considered at risk of self-harm. The admission form completed by Mr Barclay noted that marker. Mr Barclay asked the deceased about this directly and the deceased indicated he had no thoughts of self-harm. The deceased appeared upbeat. Mr Barclay had no concerns about his state of mind. He completed the "Assessment of Behaviour, Attitude and Risk" section of the admission form, noting that there was "no apparent risk".

[14] Shortly thereafter on the same day, Emmanuel Hammond, NHS Mental Health Nurse, carried out a physical health check on the deceased within the reception area of Kilmarnock Prison. He also asked him about his mental health. This was standard procedure. Mr Hammond completed the "Healthcare Risk Assessment" section of the admission form. He could not recall if he had read the section of the form completed by

Mr Barclay, accepting that he may not have. His responses on the form indicated that the deceased had not previously attempted self-harm or suicide. He could not recall if he was aware of the previous "Act 2 Care" marker. Nevertheless, he could clearly recall talking to the deceased, who was laughing and joking. He did not present any signs of low mood or feelings of anxiety and presented no cause for concern.

[15] Following his admission, and while remanded in custody at Kilmarnock Prison, the deceased was placed in single occupancy cell G51 within G Wing. That wing is used primarily for remand prisoners awaiting trial or sentencing. He had not exhibited any signs suggesting he was likely to self-harm to any prison staff who interacted with him during his period on remand.

[16] On 22 September 2017, Robert Church, NHS General Practitioner, carried out an assessment on the deceased within a consulting room of the Healthcare Centre at Kilmarnock Prison. He was aware of the deceased's previous "Act 2 care" marker and took this into account in his assessment. He carried out a physical health check. He asked the deceased if he had any suicidal ideation or thoughts of deliberate self-harm. The deceased responded that he had no such thoughts and gave no concerns for his mental health. Dr Church had access to the deceased's prison medical records by means of a case-management system called "VISION". He did not have access to his community medical records. These would normally be held on a separate case-management system in the community.

[17] On 24 September 2017 the deceased spoke to Claire Southgate, NHS Staff Nurse, about toothache. He was prescribed one box of paracetamol containing 16 tablets for the

pain. Other than said toothache, the deceased appeared positive. Later the same day, the deceased was seen by Denise Ramage, NHS Staff Nurse, for a spot check of medication. There were no concerns noted and nothing arising concerning the deceased's mental health at this time.

[18] The deceased entered his cell at 20:23 hours on 25 September 2017. At approximately 20:30 hours on the same date, Stuart Murdoch, Custody Officer, locked the deceased within the cell. Shortly before lock-up, the deceased was described as laughing and carrying on. He did not give staff any cause for concern. Shortly thereafter, Jim Paton, Custody Officer, checked on the deceased as part of his roll count: he was safe and well.

[19] At approximately 06:36 hours on 26 September 2017 Natasha Halliday, Custody Officer, opened cell G51 and discovered the deceased hanging over the top of the bathroom door facing towards the top left corner of the cell. He had wrapped a length of bedding around his neck and tied it to the bathroom door. Prison Officer Joanne Barrie offered immediate assistance and radioed for additional prison staff and for NHS health care staff to attend. Alan Wraith, Custodial Operations Manager, and John Carroll, Duty Director, attended and cut the deceased down from the door and supported his weight to the ground. Members of the NHS health care staff also attended and attempted CPR.

[20] Ambulance Technician Christopher Rice arrived at the cell at around 07.10 hours and set up a defibrillator while NHS staff continued CPR. The defibrillator having shown asystole, no shock was advised. Shortly thereafter, Ambulance Technician Derek Sneddon and paramedic Iain Macleod arrived and took over CPR. It was quickly

established that the deceased had post mortem staining and rigor mortis in both of his arms and jaw. It was agreed that the deceased had been dead for a few hours and a clinical decision was made to stop CPR and confirm the death. Life was pronounced extinct at 07:19 hours. The cell was secured and the police were contacted to attend.

[21] Police Officers attended at the cell and carried out an examination. They found several sealed envelopes containing letters to friends and family on a metal desk within the cell. These were distributed to the named addressees. They contained no information material to the Inquiry.

[22] Following a post mortem on the deceased on 3 October 2017, the cause of death was certified by Doctor Gemma Kemp of the University of Glasgow as:

1(a) Hanging

Submissions

[23] Each of the participants expressed their sympathy and condolences to the family and friends of the deceased. There being no issues in dispute, I was not asked to make any finding or recommendation beyond those required by 26(2)(a) and (c) of the Act.

Discussion and Conclusions

[24] There is a protocol in place for prisoners at risk of self-harm within prisons in Scotland. These were described by the witnesses, particularly William Barclay. All members of staff interacting with prisoners in Kilmarnock Prison receive training on this protocol. It was previously called "Act 2 Care", but the updated protocol is now called

"Talk to Me". If a prisoner exhibits any sign which raises concerns about self-harm the protocols provide for a rapid concerted intervention of observations, multi-professional case-conferences and a protection plan. Mr Barclay also spoke to a system of "suicide risk" alerts which can be put in place by other agencies such as Social Work, COPFS and Scottish Court Staff prior to a prisoner's arrival.

[25] It is clearly best practice that the nurse assessing any prisoner on arrival carefully reads the admission form prepared by a custody officer. In the case of the deceased it was not clear that this was done, and this may be a matter which could be addressed in future training. Nevertheless, I am satisfied that Mr Hammond conducted a careful assessment of the deceased, taking into account his responses, behaviour and demeanour. Mr Hammond indicated in evidence that, standing his observations, he would have had no cause for concern even had he known of the previous marker. His assessment was not, in my view, materially affected by any failure to note the previous marker.

[26] Similarly, it is, in my view, best practice for a doctor to have access to prisoners' full medical records and not simply previous prison medical records. Dr Church confirmed that in his community NHS practice he would have access to all community records, even where these had initially been recorded on a separate case-management system at a different practice. He also indicated that an inability to access community medical records can cause some difficulties with prisoners who have more complicated health needs. Prisoners' community medical records may obviously contain information about previous incidents of self-harm outwith the prison system. Dr Church did state

that he would have access to "emergency case summaries" which would highlight any medication prescribed to a prisoner in the community.

[27] Taking into account the safeguards and protocols currently in place, I do not consider there to have been an evidential basis in this case for any formal recommendation regarding access to the community health records of prisoners by prison medical staff in order to prevent other deaths. Nevertheless, I do consider that this is something to which the Scottish Prison Service should give consideration: it is in the best interests of those for whom it is responsible and likely to assist in achieving the best standard of care for them.

[28] My formal findings are therefore limited to those under sections 26(2)(a) and (c) as set out above. I make no formal recommendations. I express my thanks to the Procurator Fiscal Depute and solicitors for their assistance in the Inquiry. As they have done, I offer my sincere condolences to the family and friends of Mr Forbes.