SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN PERTH

[2019] FAI 36

B95/19

DETERMINATION

BY

SHERIFF GILLIAN A WADE QC

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

into the death of

GEORGE MCCALLUM CAMERON

Perth, 9 August 2019

The Sheriff, having considered all the evidence adduced,

Determines

1. In terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, that George McCallum Cameron born on 7 April 1979 died on 5 June 2016 at 1931 hours on 29 May 2018 at Perth Royal Infirmary, Taymouth Terrace Perth.

2. In terms of section 26(2)(b) of the said Act, makes no finding.

3. In terms of Section 26(2)(c) of the said Act, that the cause of his death was:

   I (a) suspension by the neck from bedsheet ligature (Hanging).

4. In terms of section 26(2)(e), that there are no precautions which could reasonably have been taken to prevent the death.

5. Makes no findings in terms of sections 26(2)(d), (f) and (g).

NOTE

[1] The fatal accident inquiry into the death of George Cameron McCallum was held on 7 August 2019. The Crown was represented by Mrs Whyte, Procurator Fiscal Depute, Dundee. Ms Stronach, solicitor, appeared to represent Tayside Health Board. Mr Scullion, solicitor, appeared to represent the Scottish Prison Service. Miss MacNeill, appeared to represent the interests of the Prison Officers' Association Scotland.

[2] A preliminary hearing was assigned to take place on 4 June 2019. At that hearing I considered an application by BB under and in terms of Rule 3.5 of the Act. It was submitted that BB wished to participate as he considered himself to be the deceased's next of kin. It was submitted that his position as such was acknowledged by the Scottish Prison Service. It was submitted that the deceased and BB had regarded themselves as partners for some 16 years prior to the deceased's death in custody.

[3] It was submitted that BB's participation would further the purpose of the inquiry from the perspective of understanding the deceased's state of mind around the time of the death.

[4] I made enquiry of the agent acting on behalf of BB as to the whereabouts of BB. It transpired that he was serving a life sentence at HMP Glenochil in relation to the murder of a child. The deceased had met the deceased while within the custodial setting. The agent was unable to tell me when the two had last had contact and what the nature of that contact had been. When asked specifically what the applicant could contribute to the inquiry no further elaboration could be provided. The Crown did not formally oppose the application and neither did any of the other parties but my

attention was quite properly drawn to the provisions of section 11 of the 2016 Act. It was clear that the section under which the applicant sought to participate in the inquiry was section 11(1)(e) in terms of which I require to be satisfied that the applicant has an interest in the inquiry.

[5] This matter was recently discussed by Sheriff Principal CD Turnbull in relation to the Inquiry into the deaths resulting from the helicopter crash into the Clutha bar in Stockwell Street, Glasgow. There he dealt with an application by a Mrs Evelyn Mitchell which is reported under reference *2018 SC GLA 55 and 2018 WL 04933602*. In commenting upon the statutory test he observed, between paragraphs 11 and 14 of his decision, that the rule is that in order to be permitted to participate in an inquiry an applicant must have an interest to participate and that participation must further the purpose of the inquiry. While observing that it was difficult to conceive of circumstances in which any family member would not have an interest in an inquiry into the death of a relative that is not necessarily to mean that the participation of more than one family member or in this case another individual would necessarily further the purpose of the inquiry. In that case, as in this case, the submissions did not set out a basis upon which it could be legitimately inferred that the applicant's participation would further the purpose of the inquiry namely, (a) to establish the circumstances of the death, and (b) to consider what steps if any might be taken to prevent other deaths in similar circumstances. On the information before me I was not satisfied that the applicant had either seen or communicated in any meaningful way with the deceased in the weeks leading up to his death. On that basis it was difficult to see how he could

comment upon the deceased's state of mind at around that time. Further and in any event I was advised that it would not be the intention to lead BB as a witness. It is clear that many mental health professionals had had direct contact with the deceased over a period of time prior to his death and in my view are better placed to comment upon such matters. Accordingly I refused the application.

[6] Under reference to a draft joint minute of agreement I was advised that a number of matters had been agreed and a joint minute would be provided in due course. The Crown indicated that due to the extent of the matters agreed there would be no requirement to hear any oral testimony and that at the conclusion of the proceedings all parties would be inviting me to make formal findings only.

[7] I reminded the parties of the observations of Sheriff Foulis in a recent fatal accident inquiry which is reported under reference *[2018] FAI 40.* In that case there were no contentious matters and parties also sought to proceed by way of joint minute in terms of section 18 of the Act under reference to the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In that case the learned sheriff observed that:

> "It should not, however, be lost sight of that the role of the sheriff at an inquiry is different from that played in adversarial proceedings. This is made clear by reference to the provisions of section 20(2) of the 2016 Act. It accordingly appeared to me that the parties entering a joint minute and intimating to me that this dealt with the matters which were to be the subject matter of the inquiry did not constrain me from seeking certain information to ensure that there were not matters upon which I should consider evidence in an appropriate form to be presented to me."

[8] In that case the learned Sheriff ordered the Crown to lodge a list of witnesses and a synopsis of the matters to which they spoke in order that he could determine whether there were indeed any matters upon which he required further information.

[9] In this case I considered that would be appropriate for me to consider the list of witnesses and the productions lodged in light of the draft joint minute and to consider whether there were any other matters upon which I might seek affidavit evidence.

[10] It seemed to me that the focus of the inquiry would be a consideration of the assessments and reviews which were carried out in relation to the deceased following his remand to HMP Perth.

[11] I therefore indicated that I would intimate administratively should I consider any such affidavits to be necessary.

[12] I took some time to consider the records which had been lodged which contained very full statements from the officers who had been on duty on the day of the deceased's death. They provided as much if not more detail than would be expected in an affidavit and I formed the view that ordering of affidavits would therefore be duplication and would incur unnecessary expense which would not inform me any further as the content of the statements was not in dispute.

[13] At the inquiry itself the Crown sought to rely on the evidence contained in the productions and the joint minute of agreement. The other parties led no evidence and made no substantial contribution in the course of the hearing. I was therefore satisfied that it was indeed appropriate for me to make formal findings in relation to the cause of

death and the place of death only. I did not consider that any additional findings or recommendations in terms of the 2016 Act were required.

[14] George McCallum Cameron ("the deceased") was born on 7 April 1979. At the time of his death he was an inmate at HMP Perth where he was allocated cell number 2.59 in C Hall, Flat 2.

[15] Crown Production 8 at pages 534 to 537 is a letter from a community mental health team to the deceased's general practitioner documenting history of self harm from the age of 8 and two previous attempts to take a drugs overdose in September 2001. The content of this letter was agreed to be accurate and was admitted as evidence.

[16] Similarly Crown Production 8 pages 502 and 509 contained a report by Dr Lesley Steptoe following an interview and assessment of the deceased on 10 May 2010 and pages 400 to 402 of the same production detail the deceased's admission and treatment at Accident and Emergency and the Carseview Centre at Ninewells Hospital between 2 and 3 January 2016. The discharge letter from that two day admission between 3 and 5 January 2016 was also available. His history of self harm was therefore well documented.

[17] Page 374 to 378 contains a further assessment of the deceased on 12 January 2016 and pages 383 to 385 contain a discharge letter from the Crisis Team which states that the deceased confirmed to them that his self-harm was not a suicide attempt but a way to relieve stress. Pages 394 to 398 contain a letter from a crisis resolution and home treatment team to the deceased's general practitioner. Page 364 is a letter from the

deceased's General Practitioner dated 18 May 2016 urgently referring the deceased to Tayside Substance Misuse Service.

[18] Whilst in police custody at Police Headquarters West Bell Street, Dundee the deceased was found to have self harmed and was taken to the Carseview Centre at Ninewells where he was assessed before being returned to police custody. The details of that assessment are contained in pages 362 and 363 of Crown Production 8.

[19] On 3 June 2016, the deceased appeared at Dundee Sheriff Court having been fully committed on a petition matter and was remanded in custody, having been refused bail. Crown Production number 4 is the committal warrant issued by Dundee Sheriff Court on 3 June 2016.

[20] The deceased had been in custody and occupying the said cell since 27 May 2016, when he was committed for further examination on the same Petition matter.

[21] On admission to HMP Perth on 27 May 2016 the deceased was assessed and asked a number of welfare questions which indicated that he could be at risk of suicide or self-harm, this led to a further ACT2 assessment being undertaken which resulted in the deceased being placed on 60 minute checks. Crown Production number 9 is said ACT 2 Care document prepared by the Scottish Prison Service. The said ACT 2 Care ("ACT") document is the Scottish Prison Service Suicide Risk Management Strategy. ACT was introduced by the Scottish Prison Service in its most recent form in 2005, with a version of the strategy having been in place since 1998. ACT stands for Assessment Context Teamwork. On 5 December 2016, ACT 2 Care was replaced by a revised strategy known as "Talk to Me", the Prevention of Suicide in Prison Strategy.

[22] On the evening of 30 May 2016 at about 1853 hours, the deceased was assaulted by another Prisoner. The assault was captured by CCTV cameras and footage had been lodged on a DVD (Crown Label 3). Following a review of CCTV footage the other Prisoner was removed from C Hall and accommodated within the Segregation and Integration Unit. At around 2130 hours the deceased was found slumped in a chair and advice was sought from Perth Royal Infirmary. Crown Production number 8 page 360 and Crown Production number 10 page 661 provide entries relating to advice. The deceased was assessed by Scottish Ambulance Staff and no further treatment was required.

[23] Between 31 May 2016 and 1 June 2016, the deceased inflicted self harm wounds to his right arm. The wounds were discovered at 0830 hours on 1 June 2016 when the deceased told prison officers about them. He was taken to the nurses' station for assessment. At that time he stated that he had found a razor blade but later confirmed that he had received this razor blade from another inmate. The deceased was taken to Perth Royal Infirmary for treatment of his wound which consisted of cleaning, closing, suturing and applying a pressure dressing. Crown Production number 9 page 28 documents this incident and confirms that a case conference was held once the deceased returned from hospital. Crown Production number 10 pages 662 to 667 are the Accident and Emergency notes from said treatment.

[24] Following his return from hospital on 1 June 2016 a case conference was held. This was attended by Colin Young, a nurse, a prison officer and the deceased. The record of that case conference was available to me as Crown Production 5 page 16. At

that time the frequency of the deceased's checks was increased to every 30 minutes. On 2 June 2016 a further case conference was held. This was attended by Andrew Hoey, Gordon King, a nurse and the deceased. Crown Production number 5, page 20 contains an accurate record of that case conference. Following that conference on 2 June 2016 the frequency of the deceased's checks remained unchanged at 30 minute intervals. On 3 June 2016 at 1430 hours the deceased returned from Dundee Sheriff Court to HMP Perth where he was assessed and asked a number of questions which indicated that he could be at a risk of suicide or self-harm. A decision was made to maintain his current ACT2 status and maintain 30 minute checks. During said assessment the deceased was found to be very positive and in a good mood; the assessing officer had no concerns. Said assessment is documented in Crown Production number 5; pages 64 and 65 contain details of said assessment. The final assessment was carried out by Officer Grant Peletier. There was no statement available from that individual. However I was assured that following queries raised on behalf of the Prison Service and The Prison Officers' Association the Procurator Fiscal did attend at HMP Perth and spoke to him to confirm his position. He was clear that his evidence was correctly reflected as in the joint minute of agreement.

[25] In the early evening of 3 June 2016 the deceased was checked at 1632 hours, 1646 hours, 1713 hours, 1740 hours, 1819 hours, 1835 hours, and 1851 hours. Crown Label number 4 is a disc containing footage of C Hall and captures the said checks being undertaken.

[26] Prison Officer Stuart Kerr carried out a check on the deceased at 1851. At that time he was found suspended by a ripped bedsheet tied around his neck. He had tied the bedsheet in a knot and wedged it in the safe door. This was illustrated in photographs which were made available to the Inquiry as numbers 10 to 15 of Crown Production number 6. Mr Kerr immediately moved the deceased to loosen the ligature. He was quickly joined by another officer (Mr Anderson) who pulled the ligature from the safe and helped to lower the deceased to the floor with the loose ligature still in situ. A short time later said ligature was cut and placed within an evidence bag at the request of Mr Alston, Security Manager at HMP Perth.

[27] On discovery of the deceased, immediate help was summoned using the command "code blue". Attending prison officers began CPR within minutes which was continued by nursing staff and prison officers until paramedics and ambulance crew arrived at 1910 hours. From 1910 hours until arrival at Perth Royal Infirmary, Taymount Terrace, Perth, at approximately 2023 hours Paramedics, nurses and prison staff continued CPR, gained intravenous and airway access and prepared the deceased for transport to Perth Royal Infirmary. Crown Production number 10 page 668 to 674 documents treatment on arrival at Accident and Emergency, Perth Royal Infirmary, Perth.

[28] Between 3 June 2016 at 2023 hours until 4 June 2016 the deceased was closely monitored by medical staff but showed no improvement.

[29] Robert Vaessen is a Consultant Anaesthetist with NHS Tayside. On 4 June 2016 he provided continuous care to the deceased who showed no sign of improvement.

During the early hours of 5 June 2016 the deceased began to deteriorate significantly and showed signs of brain stem compression and offered no breathing or pupil reflex. At 1915 hours brain stem tests were carried out and it was established that the deceased was brain dead.

[30] Life was pronounced extinct at 1931 hours.

[31] A post mortem examination was carried out on 8 June 2016 by Dr David William Saddler. Crown Production number 2 is a report containing the findings of that post mortem examination. The deceased's cause of death was established as Suspension by the neck from bedsheet ligature (hanging).

[32] That report also observes that the deceased had a history of depression, anxiety and problems with alcohol. He was also previously thought to have been a heroin user. At the time of his death he had been prescribed Nortriptyline, Pregabalin and Tramadol. He had been imprisoned on a number of occasions since 1998 for a variety of sexual offences. He had been returned to prison on 27 May following an alleged breach of his sexual offences prevention order.

[33] Examination of the body showed an irregular indistinct ligature mark encircling the neck which came to a point of suspension behind the right ear. The pattern and distribution would be in keeping with the knotted bedsheet causing markings of variable widths around the neck. The absence of petechial haemorrhages over the skin of the face and eyes would suggest rapid and complete occlusion of the carotid arteries. This would typically be associated with the loss of consciousness within a matter of a few seconds and death within a minute or two.

[34] I had sight of Crown Productions number 1, an Intimation of Death from the Registrar, and Crown Production number 5, a Death in Custody Folder prepared by the Scottish Prison Service. This folder contains a disc of two calls made by the deceased to his friend HT during these calls he asks him to send him some money and requests that he lets BB know his whereabouts.

[35] I reviewed Crown Production number 9 being records held by the Scottish Prison Service pertaining to the said deceased's admission between 27 May 2016 and 3 June 2016 and Crown Production number 8 is General Practitioner records pertaining to the deceased. I also had sight of Crown Production number 10, the medical records held by Perth Royal Infirmary, Accident and Emergency Department, detailing the deceased's admissions to hospital on 1 June 2016 and 3 June 2016.

[36] I had sight of Crown Production number 6, a book of photographs taken on 5 June 2016 at 1955 hours at C Hall and the photographs therein are more particularly described as follows:-

- Photographs 1-2 show C Hall, Flat 2, cell 59
- Photograph 3 shows cell 59 with the door opened
- Photographs 4-9 show the interior of cell 59
- Photographs 10-15 show views of the wall safe
- Photographs 16-17 show medical equipment on lower bunk
- Photographs 18-19 show deceased's belt (Crown Label 1) looped over the top bunk
- Photographs 20-22 show a blanket on the floor
- Photographs 23-24 show hand written letter opened by Detective Constable Stan Gilroy

- Photographs 25-26 show the toilet cubicle

[37] Crown Label number 1 is a belt which was recovered by Police Constables Robert Stirling and Detective Constable John Smith at 2010 hours on 5 June 2016 from C Hall cell 2.59 occupied by the deceased.

[38] Crown Label number 3 is a DVD containing a digital recording of images of events captured by a CCTV system at C Hall, HMP Perth on the evening of 30 May 2016 and Crown Label number 4 is 4 discs containing a digital recording of images of events captured by a CCTV system at C Hall, HMP Perth on 3 June 2016 between 1629 and 1934 hours.

[39] Two letters addressed to deceased arrived at HMP Perth after his death. Both were opened by a Detective Constable and found to be from a friend named HT who had enclosed £30 and the other was from BB, a prisoner at Glenochil Prison.

[40] Crown Production number 3 is a report containing toxicology findings in respect of samples of the deceased's blood and serum which were collected from him on 3 June 2016. Said samples were found to contain therapeutic levels of Diazepam and its metabolite, Desmethyldiazepam, together with high therapeutic levels of Pregablin and Tramadol.

[41] I have had sight of all statements noted by Officers of the Police Service of Scotland from witnesses. The content of these is not disputed. They are referred to at paragraph 34 of the joint minute of agreement and form Crown Productions 17 to 30 and 11 to 16.

[42] I was satisfied that in this case the deceased's propensity to self-harm was well documented and appropriate measures were taken to monitor him in line with the then current ACT2 policy. All possible measures were taken when his suicide was detected and every effort was made to resuscitate him. He was well cared for and received all appropriate treatment before his death. There were clearly no issues in contention and accordingly I was content to allow the inquiry to proceed on the basis of the agreed documentary evidence which is referred to in detail above and the joint minute of agreement only.

[43] No failings or issues have been identified which may have caused or contributed to the deceased's death. There are no reasonable precautions which might realistically have prevented his death and there are no systemic defects which have been identified or require to be addressed.

[44] On behalf of the court and all parties condolences are extended to the family and friends of the deceased.