SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2019] FAI 37

B349/19

DETERMINATION

BY

SHERIFF LINDSAY WOOD

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

into the death of

SEAN COLLINS

Glasgow, 9 August 2019

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

(1) Sean Collins, born 15 June 1968 and residing latterly at HM Prison, Barlinnie, 81 Lee Avenue, Glasgow, died there at 0848 am on 11 December 2016.

(2) In terms of section 26(2)(a) the death occurred at cell 2/29, D Hall South Lower, HM Prison, Barlinnie when Mr Collins 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 Collins was in legal custody at the time of his death.

[2] Mr Collins' death was reported to the Crown Office and Procurator Fiscal Service on 22 December 2016.

[3] A preliminary hearing was held on 1 April 2019. The representatives of the participants were Laura Knox, procurator fiscal depute for the Crown; Sarah Phillips, 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 on 29 and 30 April and 1 and 31 May 2019. There was a hearing on submissions on 22 July 2019. The following witnesses were called by the Crown and gave evidence:

(1) Scott Murrin;
(2) Alison Rodger;
(3) Dr Abolaji Badejo;
(4) Dr Alina Kopric;
(5) Vivian Hughes;
(6) Dr Dominque Van Den Meersschaut;
(7) Dr Allan Scott;
(8) John Patrick;
(9) 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:

Prison Background

(1) On 13 June 2016 Sean Collins (date of birth 15 June 1968) (hereinafter referred to as "Mr Collins") first appeared on petition at Dundee Sheriff Court. The petition contained charges alleging two contraventions of Section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010 and a contravention of Section 5(2) of the Misuse of Drugs Act 1971. The charges were alleged to have been aggravated by being committed

whilst on bail and by religious prejudice. Mr Collins was committed for further examination and remanded in custody. On 21 June 2016, he was fully committed for trial and detained until liberated in due course of law. He was initially detained within HM Prison, Perth.

Between 13 June 2016 and 17 August 2016 Mr Collins was allocated cell 13/6 within A Hall. On 17 August 2016 he was moved to cell 01/55 within C Hall. On 12 July 2016 at Perth Sheriff Court Mr Collins was convicted of assaulting a member of the prison staff on 8 August 2015 and sentence was deferred. On 17 August 2016 he was sentenced to 32 months' imprisonment.

On 24 August 2016 Mr Collins was transferred to HM Prison, Barlinnie and was allocated to cell 1/14 within D Hall. On 25 August 2016 he was moved to cell 3/10 within A Hall. On 2 September 2016 Mr Collins was allocated cell 2/32 within D Hall South Lower (DSL). On 13 September 2016 at Dundee Sheriff Court Mr Collins was convicted of a contravention of Section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010, aggravated by being committed whilst on bail and by religious prejudice.

Mr Collins was sentenced to 3 months' imprisonment to be served consecutively to the sentence which he was serving at that time.

On 6 October 2016 Mr Collins was placed on Act 2 Care and allocated cell 1/21 within D Hall North Lower (DNL) and on 16 October 2016 he was moved to cell 1/50 within C Hall because he had damaged the lock in cell 1/21. On 17 October 2016 Mr Collins was moved to cell 2/32 within DSL as his risk had been reduced and was finally moved to

cell 2/29 within DSL, as his Act 2 Care process recorded him as no apparent risk. He remained there until his death. Mr Collins was previously incarcerated between:

08.04.96 – 07.05.96 at HMP Perth

23.11.00 – 25.11.00 at HMP Perth

25.03.15 – 18.09.15 at HMP Perth and HMP Glenochil

General Psychiatric History prior to 13 June 2016

(2) Mr Collins was 48 years of age at the time of his death and had an extensive psychiatric history. His first documented contact with adult psychiatric services was at the psychiatric out-patient department at the Royal Dundee Liff Hospital, Dundee on 9 May 1996. He was admitted as a voluntary in-patient to Ninewells Hospital, Dundee for further assessment and diagnosed with probable paranoid schizophrenia which was treated with antipsychotic and antidepressant drug treatment.

On 30 April 1997 he had an appointment at the psychiatric out-patient department of the Royal Dundee Liff Hospital and was admitted as a voluntary in-patient to Ninewells Hospital for assessment. He was diagnosed with schizoaffective disorder and prescribed a combination of antipsychotic and antidepressant drug treatment.

(3) Mr Collins had a number of other contacts and admissions throughout the 1990s with regard to his mental health. On November 2000 and February 2001 he was admitted as a compulsory patient to Royal Dundee Liff Hospital for assessment. He was diagnosed with a schizoaffective disorder during both admissions. In March 2006 he

was admitted as a voluntary patient to the Carseview Centre. His main clinical problem appeared to be substance abuse. The diagnosis on discharge was polysubstance abuse.

(4) On 5 February 2012 Mr Collins was admitted to the Carseview Centre as a voluntary patient. The diagnosis on discharge was polysubstance misuse and a psychotic disorder associated with polysubstance misuse. In August 2014, it was documented that Mr Collins' progress had been complicated by his use of so-called legal highs and the illegal methcathinone, a stimulant drug. The consultant psychiatrist noted that his diagnosis was drug-induced psychosis rather than paranoid schizophrenia. On 29 January 2015 Mr Collins was reviewed on an out-patient basis. There were no signs of psychiatric illness observed. Mr Collins denied the use of any drugs.

(5) Between May and July 2015 Mr Collins was reviewed several times by Dr Niyaz Ahammed Parakkandi, Consultant Forensic Psychiatrist, whilst he was an inmate at HM Prison, Perth. Dr Ahammed Parakkandi had access to Mr Collins' psychiatric medical records at this time.

(6) On 7 June 2016 Mr Collins was reviewed as an out-patient by Dr Sridhar Kommuri, Locum Consultant Psychiatrist. Dr Kommuri did not have any major concerns regarding his mental state. Dr Kommuri did not diagnose Mr Collins as suffering from any kind of psychotic illness.

(7) On 14 June 2016 Mr Collins' General Practitioner confirmed to medical staff within HM Prison, Perth that his prescribed medication was olanzapine, promethazine, procyclidine and propranolol and an acute four week prescription for zopiclone commencing on 8 June 2016. His prescribed medicines were documented in his prison

medical records. On 14 June 2016 he was seen by Dr Auld and was prescribed olanzapine, procyclidine, propranolol and promethazine from 16 June 2016.

(8) On 12 August 2016 Dr Niyaz Ahammed Parakkandi assessed Mr Collins at HM Prison, Perth for the purpose of providing a pre-sentencing report for Perth Sheriff Court. During the course of the assessment there was no evidence of him suffering from any depressive or psychotic symptoms. In preparing this report, Dr Ahammed Parakkandi had access to, *inter alia*, Mr Collins' psychiatric records. Dr Ahammed Parakkandi noted that while Mr Collins had been diagnosed with paranoid schizophrenia and schizoaffective disorder in the past, more recent psychiatric assessments had concluded that his psychotic symptoms were related to his substance abuse. Dr Ahammed Parakkandi concluded Mr Collins was fit for any disposal the court may deem appropriate. Following this assessment Dr Ahammed Parakkandi issued a clinical letter dated 15 August 2016 to HMP Perth confirming that Mr Collins' mental health appeared stable and that no changes required to be made to his medication.

(9) On 24 August 2016 Mr Collins underwent a triage assessment at HMP Barlinnie. He reported that he had a history of deliberate self-harm with the last episode having been twenty years previously. He reported that he had been diagnosed as paranoid schizophrenic. It was documented that he had no thoughts of self-harm. He was assessed as being of no apparent risk of suicide. The medicines which had been prescribed regularly in HM Prison, Perth were re-prescribed from 25 August 2016. Zopiclone was not prescribed. Mr Collins was referred to the mental health team. On

25 August 2016 his electronic GP medical records were received by HM Prison, Barlinnie.

Events of 11 December 2016

(10) At 1645 hours on Saturday, 10 December 2016 Mr Collins was returned to his cell as is normal working practice on a Saturday evening. Prisoners are then locked in and confined to their cells for the remainder of the evening. Prison staff at this time conduct a door check and body check ensuring they receive both a verbal and visual response from all prisoners before moving onto the next cell. At this time nothing untoward was noted. At 2045 hours the same evening, prison officer David Poliri carried out a random check of all cells within DSL and noted Mr Collins was safe and well. This involved looking through the spy hole on the cell door to make sure every prisoner was accounted for and nothing was untoward. Mr Poliri noted Mr Collins was safe and well. If David Poliri had seen anything unusual or concerning, he would have radioed for a patrol officer to come and assist. At 0820 hours, the following day, Sunday 11 December 2016, prisoner first line manager, John Patrick began his working day and tasked prison officer, Michael Swords to carry out a numbers check of all prisoners on DSL. This involved opening the cell doors and counting the prisoners. The prisoners are expected to give a verbal response. Mr Swords then carried this out and at just after 0830 hours attended at Mr Collins' cell 2/29, DSL. On opening the cell door Mr Swords observed Mr Collins facing the window with a blue ligature around his neck which was attached to the window latch.

(11) Upon closer inspection, Mr Swords noted that Mr Collins' feet were not touching the ground. He ran out of the cell and shouted, "CODE BLUE" which is prison officer terminology for a prisoner having hanged himself. Mr Patrick and a fellow prison officer John McGrattan attended to assist immediately. Mr Swords then tried to support Mr Collins' weight by holding him round the knees in a rugby tackle position and holding him up.

(12) Mr Patrick then attempted to remove the ligature from Mr Collins' neck but it was too tight. Mr Patrick then attempted to remove the ligature from the window but this also was too tight. Mr Patrick had to climb onto a chair and pull the ligature from the window latch. Mr Collins was then placed on his back within the cell floor with his head nearest the window. At this time, Karen Reilly, an NHS Nurse within HM Prison, Barlinnie arrived at the cell. She had an emergency bag with her. Ms Reilly was unable to find Mr Collins' pulse. Rigor mortis was visible.

(13) Prison officer Thomas Allison used an anti-ligature knife to cut the ligature from Mr Collins' neck and this was placed on the desk located to the left of the cell. Ms Reilly was unable to find any signs of life. Mr Collins had a large indentation around his neck where the ligature had been. His body was cold. Those present then left the cell to await the attendance of paramedics. Approximately, ten minutes later, paramedics Jonathan Cardiff and Stephen Mason attended the cell. They pronounced life extinct at 0848 hours.

Pathology

(14) On 14 December 2016 at the Queen Elizabeth University Hospital, Glasgow, a post mortem examination was carried out on Mr Collins by Dr Julia McAdam, Forensic Pathologist. The post mortem report and a toxicology report were prepared by Dr Fiona Wylie, Forensic Toxicologist. The cause of death was found to be 1a: Hanging. Analysis of the post mortem blood revealed a level of 0.068 mg/L of mirtazapine. Daily administration of 20 mg of mirtazapine gives peak plasma concentration of 0.046 mg/L. The analysis of post mortem blood revealed a level of 0.18 mg/L of promethazine. A single 50 mg oral dose of promethazine gives an average serum concentration of 0.029 mg/L. Promethazine may be subject to post mortem redistribution which may increase the concentration of the drug in the blood from that at the time of death. The level was not considered significant.

(15) Mr Collins died on 11 December 2016 within cell 29 at D Hall South Lower, HM Prison, Barlinnie, 81 Lee Avenue, Glasgow, G33 2QX. The time of his death was recorded at 0848 hours on that date.

The agreed evidence of prison officer John Gribbin

(16) John Gribbin is a Prison Officer having served approximately 27 years at the time of Mr Collins' death. He is also an Act 2 Care trainer and familiar with the Act 2 Care process. When Mr Collins was placed on ACT 2 Care on 6 October 2016 the witness worked in DSL which is a High Dependency Unit (HDU). The purpose of HDU is to house those who struggle in mainstream prison halls. Mr Gribbin knew Mr Collins from

the hall. Mr Gribbin confirmed that Mr Collins was popular with peers and staff and that he could be both "up and down".

On 6 October 2016 Mr Gribbin spoke to Mr Collins who told him that someone was talking to him in his cell and telling him to hang himself. Mr Collins then made an attempt to grab the aerial lead from his television however Mr Gribbin took that from him and tried to reassure him that there was only the two of them in the cell. However Mr Collins was sure there were others in the cell. Mr Gribbin called his supervisor, Mr Patrick, who attended and both placed Mr Collins on Act 2 Care. The grounds for this action were that Mr Collins told Mr Gribbin that he was going to kill himself. The Act 2 Care form was raised by Mr Gribbin and he completed the immediate care plan.

(17) Mr Gribbin had concerns as Mr Collins told him he was seeing ghosts in his cell, his behaviour was erratic, he was speaking of hanging himself and complaining that his medication was inadequate.

(18) Mr Gribbin discussed with Mr Collins the precipitating factors which had led to this behaviour and noted he said he had been fine until then, that his medication was late and prescribed wrongly.

(19) Mr Gribbin interviewed Mr Collins for a period of 25 minutes. The immediate plan was to get him to safety. He was placed in a safe cell with a maximum contact time interval of 30 minutes. No sharps or normal association clothing were permitted within the cell because Mr Collins had been threatening to make a ligature and may have cut himself.

(20) The Act 2 Care form records that Mr Collins was informed of the outcome of the Immediate Care Plan by John Patrick on 6 October 2016 at 13.45 hours.

(21) Once the Immediate Care Plan had been completed, Mr Collins was housed in cell 21 DNL which is a safer cell with no moveable furniture. The cell includes stronger bedding and is more sparse. Mr Gribbin wanted Mr Collins to be seen by the mental health team as soon as possible as there had been a dramatic change in him.

(22) At a case hearing on 20 October 2016 Mr Collins' level of risk was assessed as being of no apparent risk. He was rehoused back to DSL 2/29. Mr Gribbin found no reason to place Mr Collins on Act 2 Care again. After 20 October 2016 Mr Gribbin found Mr Collins to be fine. His mood could still be "up and down" but there were no signs of suicide.

Zopiclone

(23) During the period Mr Collins was on Act 2 Care, he complained that he was entitled to zopiclone. Mr Patrick stated that in his opinion the dramatic change in Mr Collins' behaviour during that period was an attempt to get the medication he wanted, namely zopiclone. Mr Patrick stated during the period between 20 October 2016 and Mr Collins' death, he found no reason to initiate the Act 2 Care procedures again. He described Mr Collins as a jocular character who always had a joke to tell, that he appeared settled and had formed good relationships with the other inmates and prison staff. Zopiclone was not requested by Mr Collins from 20 October 2016 onwards. He had requested zopiclone after his arrival at Barlinnie and this was considered by various

medical professionals who uniformly said that zopiclone would only be prescribed on a short-term basis and only in certain instances, eg a patient dealing with a significant family bereavement. It was explained to Mr Collins that zopiclone should not be prescribed for any length of time due to its addictive properties but he seemed unwilling to listen. Dr Allan Scott, Consultant Psychiatrist, made it quite clear in his evidence that the prescribing of zopiclone to Mr Collins would not have been good medical practice in all the circumstances and the long-term use of the drug would not have helped Mr Collins sleep. The medical records confirmed that Mr Collins was prescribed an acute 4 week prescription of zopiclone on 8 June 2016 whilst he was in Perth Prison.

(24) Dr Scott provided a report which concluded that there was no evidence that Mr Collins was mentally ill between 20 October 2016 and the time of his death, that there was no evidence of a risk of self-harm or suicide during that time and that any such thoughts were denied by Mr Collins. Dr Scott concluded that the actions and care offered by those involved in the care and treatment of Mr Collins during his time in HMP Barlinnie were reasonable in all the circumstances.

(25) During his time in HM Prison, Barlinnie, Mr Collins made various self-referrals which demonstrated a degree of normal thinking and these were as follows:

5/9/16 – request for dental treatment.

25/9/16 – request for smoking cessation.

19/10/16 – request for dental treatment.

19/10/16 – request for smoking cessation.

23/10/16 – request for a hearing aid.

17/11/16 – request to see a nurse due to a sore foot caused by a corn.

30/11/16 – addictions team, smoking assessment.

Submissions and Conclusion

[12] The procurator fiscal depute and all of those representing the other parties invited the court to make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act in respect of Mr Collins' death. 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 Collins' 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 Collins 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 Collins' presentation or behaviour which 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 "Act 2 Care" or its successor "Talk 2 Me" if required. The latter came into force on 5 December 2016. Further, Mr Collins

was properly risk assessed by various members of staff within HM Prison, Barlinnie and in HM Prison, Perth beforehand. He was seen by various members of the health care staff across both prisons. There was no evidence that any member of staff having contact with Mr Collins had any concerns that he was at risk of suicide. Dr Scott gave compelling evidence that individuals can suffer a rapid deterioration of their mental health. The decision to take their own life can be made impulsively and spontaneously. Sometimes the signs that someone is considering taking their own life are not there. Sadly, this applied in relation to Mr Collins. Nothing could have been done to save Mr Collins' life and he was treated, cared for and assessed appropriately throughout his time in prison.

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

[14] 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 which was not in dispute.

[15] As is also my practice, I formally and genuinely express my condolences to the family and friends of Mr Collins.