SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2019] FAI 41

Court Ref: LIV/B22/19

DETERMINATION

BY

SHERIFF PETER G L HAMMOND

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

into the death of

KEVIN ARCHIBALD CAMPBELL (formerly McCARRISON)

For the Crown: Mrs. Bell, Procurator Fiscal Depute
For Sodexo: Mr Hill
For Scottish Prison Service ("SPS"): Mr Shand
For NHS Lothian: Mr Ashkanian

Livingston 28 August 2019

The Sheriff, having considered the evidence presented at an Inquiry under section 1 of the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 ("the Act") finds and determines that:

(i) In terms of section 26(2)(a) of the Act that Kevin Archibald Campbell (formerly McCarrison), born on 12 May 1985, died at HM Prison, Addiewell, 9 Station Road, Addiewell, West Lothian on 22 September 2017, life being formally pronounced extinct at 15.15 hours on that date;

(ii) In terms of section 26(2)(c) of the Act, that the cause of death was: 1(a) hanging.

NOTE:

[1] This Inquiry was held under section 1 of the 2016 Act. This was a mandatory Inquiry in terms of section 2(1) and 2(4) of the 2016 Act, as Mr Campbell was in legal custody at the time of his death.

[2] The Crown in the public interest is represented by the Procurator Fiscal. A Fatal Accident Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability. The purpose of such an Inquiry is to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[3] The Procurator Fiscal issued a notice of the Inquiry on 4 June 2019. A Preliminary Hearing took place at Livingston Sheriff Court on 22 July 2019, when the date for the Inquiry was set for 23 August 2019.

[4] At the Inquiry on 23 August 2019, in addition to the Crown, the other represented parties were NHS Lothian, Scottish Prison Service (SPS) and Sodexo. Mr Campbell's next of kin did not enter appearance in the proceedings, and were not represented.

[5] At the Inquiry, the Crown tendered a joint minute signed by all the parties. It was indicated that the joint minute would represent the sole evidence at the Inquiry and it was not proposed by any party to lead any parole evidence from witnesses. The parties invited the court to make only formal findings in terms of section 26(2)(a) and (c) of the Act in relation to the time, place and cause of death. No parties suggested any other findings or recommendations.

Circumstances

[6] The agreed evidence at the Inquiry, as set out in the agreed joint minute, is as follows:

[7] Kevin Archibald Campbell was born on 12 May 1985 and died on 22 September 2017 at HM Prison, Addiewell. He was 32 years old.

[8] At the date of his death Mr Campbell was in lawful custody at HM Prison, Addiewell, having been remanded for trial in respect of an alleged domestic assault and contravention of section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. He was remanded in custody on 20 September 2017.

[9] That prior to Mr Campbell's remand on 20 September 2017, he had been at liberty since his release from prison on 7 July 2017. He attended an appointment with his general practitioner, Dr Gautam Soma Reddy on 24 July 2017. He complained of low mood and suicidal thoughts but confirmed that he had no active plans and stated that his family were a protective factor. At that stage the dose of his prescribed Mirtazapine was increased from 15mg/day to 30mg/day.

[10] Historically, Mr Campbell suffered from depression and the following episodes of self harm are documented in his records:

(a) on 30 May 2014 he told his general practitioner that he had been self harming by cutting his right wrist. He was referred to the community mental health team, but subsequently failed to attend and was discharged on 6 August 2014 without being seen;

(b) on 31 May 2014 he stabbed himself on the left forearm after ingestion of alcohol and a large dose of Diazepam. He was assessed by a psychiatrist; and

(c) on 20 February 2017, he cut the right side of his neck with a razor blade. He had ingested alcohol, smoked cannabis and had been involved in a domestic altercation. He was assessed by a psychiatric nurse.

This is documented within a letter provided by Dr Reddy dated 17 December 2018. Crown production number 4 is a copy of that letter, and is treated as the evidence of Dr Reddy.

[11] At the date of his death, Mr Campbell was accommodated within Cell 54, Douglas Bravo Wing, at HM Prison, Addiewell. He was the sole occupant of that cell.

[12] Crown production number 2 is the death in custody file relating to Mr Campbell and contains the records of HM Prison, Addiewell relating to Mr Campbell.

[13] Prior to his final period of remand, Mr Campbell had been imprisoned on 21 previous occasions. According to prison records, Mr Campbell had only two recorded episodes of having been placed on the Act2Care suicide prevention strategy:

(a) On 23 March 2004 for a period of one day; and

(b) On 3 July 2005 until removal from the strategy on 11 July 2005.

[14] Mr Campbell had never been placed on the "Talk to Me" suicide prevention strategy during any of his previous periods of imprisonment.

[15] On arrival at HM Prison, Addiewell on 20 September 2017, Mr Campbell was interviewed and subject to a reception risk assessment. That assessment was completed by Sharon Wilson, senior prison custody officer, and Kirsty Scott, staff nurse, in line with the requirements of the "Talk to Me" suicide prevention strategy. That assessment is contained within Crown production number 2. It is recorded that Mr Campbell was of low mood but states, "Kevin does not feel suicidal. He is gutted he has returned after eight weeks", and "during discussion he has no thoughts of self harm or suicide". Mr Campbell was not

assessed as presenting a risk of self harm or suicide. He was deemed to be "no apparent risk".

[16] On 21 September 2017 Mr Campbell was further assessed by a trainee advanced nurse practitioner (while overseen by an advanced nurse practitioner, Louise Anthony). At no time during the assessments on 20 and 21 September 2017 did Mr Campbell display any verbal or non-verbal indications that he might be at risk of suicide or self harm while in prison. It is documented that he openly disclosed his previous history of self harm, anxiety, depression and alcohol abuse. He was prescribed continuation of Mirtazapine, along with medication to assist with alcohol and Diazepam detoxification. He was referred for review by the Mental Health Team, but there was no clinical indication that the referral required to be urgent or high priority.

[17] Crown production number 5 is a true copy of Mr Campbell's prison medical records.

[18] During his final period of remand, Mr Campbell made three telephone calls to his partner, Samantha Brown. Miss Brown was aware of his history of self-harm in the past but had no concerns for his wellbeing within HM Prison, Addiewell at that time. She did not consider him to be at risk of suicide.

[19] Mr Campbell was last seen alive at approximately 12.30 hours on 22 September 2017 during routine cell checks. He was sitting within his cell rolling a cigarette. He made no complaints and did not speak to the prison custody officer, Caitlin Turner. She had no concerns for his welfare, and the cell was thereafter secured.

[20] At approximately 15.00 hours on 22 September 2017, Caitlin Turner, prison custody officer, unlocked and entered Mr Campbell's cell. At that time he was found hanging from the shower cubicle door. The bedsheet had been used as a ligature around his neck. There

was a plastic chair nearby, and it appeared that he had used it to elevate himself prior to hanging himself.

[21] Post mortem staining had already developed on Mr Campbell's face and hands, and his tongue was swollen. His clothing was wet and it was apparent that he had defecated himself. After placing him on the floor and removing the ligature from around his neck, he had no pulse and a defibrillator confirmed that he had no shockable heart rhythm.

[22] CPR was commenced, and continued until the arrival of Helen Conley, Senior Nurse Practitioner, who pronounced life extinct at 15.15 hours on the same day.

[23] Mr Campbell's body was taken to Edinburgh City Mortuary, Cowgate, Edinburgh and was examined by Dr Kerryanne Shearer, Consultant Forensic Pathologist, on 27 September 2017. A report of Dr Shearer's findings was prepared. Crown production number 1 is said post mortem examination report dated 7 December 2017. The report is true and accurate in its terms, and is treated as the evidence of Dr Shearer.

[24] The medical cause of Mr Campbell's death was stated in Crown production number 1 as:

(1a) Hanging.

[25] Following Mr Campbell's death, the Scottish Prison Service completed the Death in Prison Learning Audit and Review ("DIPLAR") process. A report of the review findings was prepared. Crown production number 3 is the said DIPLAR report.

[26] The DIPLAR process did not identify any learning points which might have prevented the death of Mr Campbell.

Conclusion

[27] Taking into account the circumstances of Mr Campbell's death as set out in the joint minute and in the productions lodged, and having regard also to the parties' submissions, I am satisfied that only formal findings should be made in this case. Mr Campbell's death was due to hanging, as indicated in the post mortem report.

[28] Although Mr Campbell historically gave rise to concerns following episodes of self harm and indications for his welfare, he was appropriately assessed and dealt with during his final period of incarceration in HM Prison, Addiewell according to the protocols in place. During this time, there were no indications or warnings that he was at risk of committing suicide. Even his partner did not have concerns at this time. There is no evidence that any warnings were missed or that the authorities could have prevented the death.

[29] For that reason, no submissions were made to the effect that any precautions could reasonably have been taken which might realistically have resulted in his death being avoided (section 26(2)(e)); or that any defect in any system of working had contributed to his death (section 26(2)(f)). Nor were there any other facts relevant to the circumstances of his death which fall to be included in this determination (section 26(2)(g)).

[30] My formal findings are set out at the outset of this determination.