

2015FAI13

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

***INQUIRY HELD UNDER
FATAL ACCIDENTS AND
SUDDEN DEATHS
INQUIRY (SCOTLAND)
ACT 1976
SECTION 1(1)(a)(ii)***

DETERMINATION BY LINDA MARGARET RUXTON, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on 17, 18, 19, 20, 21 November, 10 December 2014 and 6 February 2015 into the death of **DAVID THOMAS CAMERON** born 28 January 1973, formerly of 4 Garmouth Gardens, Govan, Glasgow.

GLASGOW, 17 April 2015. The sheriff, having considered the evidence, productions, affidavits, joint minute and submissions DETERMINES

(1) In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths (Scotland) Act 1976 that David Thomas Cameron, born 28 January 1973, formerly of 4 Garmouth Gardens, Govan, Glasgow died on 27 March 2013 at 0900 hours in Her Majesty's Prison, Barlinnie, 83 Lee Drive, Glasgow where he was lawfully incarcerated.

(2) In terms of section 6(1)(b) of the said Act the cause of death was multiple injuries due to a fall from a height, Mr Cameron having jumped to his death from a fourth floor landing in the said prison.

(3) In terms of section 6(1)(c) of the said Act there were no reasonable precautions whereby the death and any accident resulting in the death might have been avoided.

(4) In terms of section 6(1)(d) of the said Act there were no defects in any system of working which contributed to the death and any accident resulting in the death.

(5) In terms of section 6(1)(e) of the said Act there were no other facts which are relevant to the circumstances of the death.

NOTE

Introduction

[1] This is a fatal accident inquiry in terms of section 1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. On 27 December 2012, at the High Court of Justiciary, David Cameron was sentenced to a term of imprisonment for 3 years and 9 months having been convicted on a charge of assault to severe injury, permanent disfigurement and danger to life. He had previously been on remand in respect of that matter since 6 September 2012. Accordingly, at the time of his death he was in legal custody.

[2] The Crown were represented in the public interest by Ms Elizabeth Ross, Senior Procurator Fiscal Depute; Mr Cameron's family were represented by Miss Janice Green, Advocate; Dr Robert Mair was represented by Mr James Stewart, Solicitor; Miss Una Doherty, Advocate, appeared on behalf of Greater Glasgow Health Board; and Mr Douglas Ross, Advocate appeared for the Scottish Prison Service.

[3] Evidence was heard over six days between 17 and 21 November and 10 December 2014. Submissions were heard on 6 February 2015. The following witnesses were called by the Crown and gave evidence to the Inquiry:

- 1 Louise Park (Mr Cameron's sister)
- 2 William Whitelock (fellow-prisoner)
- 3 Stephen Blair (fellow-prisoner and friend)
- 4 Andrew McCormack (fellow-prisoner and friend)
- 5 Alastair Steven (Prison Officer)
- 6 Karen Reilly (Nurse Practitioner)
- 7 Robert Mair (General Practitioner)
- 8 Gai Kural (General Practitioner)
- 9 Margaret Millar (Clinical Manager)
- 10 Sherine Lawson (Nurse Practitioner)
- 11 Mary Mitchell (Clinical Manager)
- 12 James Kane (Area Maintenance Manager)
- 13 Frank Gibbons (Health Care Manager)

[4] Two expert witnesses assisted the Inquiry. The Crown led:

- 14 Dr Kennedy Roberts (General Practitioner)
- 15 Dr Pradeep Pasupuleti (Consultant Forensic Psychiatrist)

was led by the family.

[5] Evidence was admitted by affidavit under Rule 10 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Rules 1977 from two witnesses

- 16 Jonathon Forrester (General Practitioner)
- 17 David Strang (HM Chief Inspector of Prisons)

[6] There was a joint minute of agreed facts.

The witnesses

[7] There was very little by way of dispute as far as the factual evidence was concerned. Nor was there any real disagreement between the expert witnesses. They were in agreement on the substantive issues. Dr Kennedy Roberts was an experienced general practitioner and had worked in H M Prison, Cornton Vale as senior medical officer and as the sole medical officer in H M Prison, Greenock. He is a senior specialist

in substance misuse (primary care) and has an interest in the treatment of those with addictions to drugs and alcohol. In 2010, he carried out an independent review of health care in the Irish Prison Service during which task he reviewed health care in a number of different prisons. He has worked as an independent national expert for the Council of Europe. Dr Roberts' *curriculum vitae* was most impressive. It was, however, only his fourth time in giving evidence at a fatal accident inquiry and his third as an expert witness. I did find that on occasion, in an effort to be helpful to the court, Dr Roberts strayed into areas of speculation. However, he struck me as a man of great compassion and integrity.

[8] Dr Pradeep Pasupuleti, consultant forensic psychiatrist, likewise was an impressive witness, clearly well-versed in his subject and with considerable experience as a visiting psychiatrist in a number of prisons, including H M Prisons at Corntonvale, Edinburgh, Perth and H M Young Offenders Institution, Polmont. He is currently the Clinical Director of the Ayr Clinic and is Vice-Chairman of the Scottish Division of the Royal College of Psychiatrists Forensic Executive Committee. Dr Pasupuleti gave his evidence in a professional and measured manner. Unlike Dr Roberts, he was careful not to speculate and would not be drawn into doing so, despite persistent attempts by certain parties to have him do just that.

David Cameron

[9] David Thomas Cameron was 40 years old when he died having been born on 28 January 1973. When in the community he resided at 4 Garmouth Gardens, Govan, Glasgow. Although single, Mr Cameron had a 15 year old son and was part of a close family. He was described by his sister as a very reserved person: a very deep, private

person, who kept himself to himself and rarely volunteered anything. During regular visits with herself and her mother, her brother would say little. They always had to encourage him to talk. He would sit quietly, just smiling and listening to them talk. He asked about the family on these occasions but otherwise his conversation was very limited. What conversation there was on his part tended to focus on problems he was having with his medication. Miss Park described how he was finding his sentence difficult because he was very ashamed of what he had done: his sentence was in connection with an assault on his partner.

[10] Those who knew him in prison confirmed his sister's assessment. He was described as "a deep guy" who "never gave anything away and kept his cards close to his chest". It was generally noted that Mr Cameron was not one to initiate a conversation and on occasion would respond in a fairly monosyllabic way. However, there was evidence also that he would, at times, enjoy and join in "banter". His closest friend in the jail was Andrew McCormack. He and Mr Cameron used to go to the gym together, four or five times a week. He described how he and David Cameron used to "bicker and banter" because they supported different Glasgow football teams. He, too, described Mr Cameron as a deep guy who never gave much away. He rarely opened up but did so on occasion. He talked to David Cameron "every day, umpteen times, and we'd have banter". Mr McCormack described how "Davy could give as good as he got" and how "he always jumped in" although he would never start off the banter. This was a rather different aspect of Mr Cameron's character, something perhaps of some comfort to his family that he was at times animated and participated in life in the prison, rather than being the withdrawn, silent person who appeared at visiting times. He was described as someone whose mood rarely changed – Prison Officer Steven described him as "neither

up nor down". He was always the same - a comment reflected by others. However, it was significant that Mr McCormack said that David Cameron had said that he was "struggling" with his sentence. He thought that was a brave thing for Mr Cameron to have said.

[11] This was not Mr Cameron's first prison sentence. It is relevant to note that he had served a number of custodial sentences in the past, most recently earlier in 2012. Therefore, he was not new to the prison regime and was familiar with what incarceration involved. Mr Cameron was appointed to the role of "pass man". Mr McCormack was a fellow pass man. Indeed it was he who had recommended Mr Cameron to be considered for the job. This is a privileged position within the prison. Pass men assist the prison officers in the daily routines in the prison. They enjoy a position of trust within the prison setting and work closely with the residential officers. They help with various tasks including delivering breakfasts to fellow inmates, delivering mail and visit request slips. They also help with certain cleaning duties, including clearing and sweeping the landings and cleaning the offices. They collect washing from the prisoners and distribute laundry. Thus, the duties involve physical work which requires a degree of fitness.

[12] There are certain "perks" associated with such a duty. Specifically, a pass man is entitled to a cell to himself and he receives enhanced wages. He is not confined to his cell but is allowed out for most of the day as he goes about his duties. He, therefore, enjoys considerable freedom. Prison officers rely on pass men. In 2013, there were four allocated to each flat or landing. Qualities important in a pass man include reliability, politeness and a good, non-aggressive manner when dealing with prison officers and other prisoners, and someone who demonstrates good standards of hygiene. [13]

However, Mr Cameron had experienced significant problems in the community.

He had developed a dependency on alcohol and drugs. He abused both street drugs and prescription drugs. Associated with this he suffered from depression, anxiety and had difficulty sleeping. His sister explained that during the year prior to his sentence he had felt "lost". Things were not going right for him at all. This was confirmed by his GP, Dr Mair, who knew Mr Cameron well. Dr Mair explained that in the year prior to his death, Mr Cameron had been despairing about the way his life had gone. He felt that his life was out of control. He had commented that it might be better if he was not around although had not expressed any positive plans to take his own life. Dr Mair had referred him to local community psychological and psychiatric services for support for his depression.

[14] In the community he was a regular visitor to his general practitioner. In addition to his alcohol and drug problems, Mr Cameron suffered from three other complaints: irritable bowel syndrome or IBS; chronic testicular pain; and depression and anxiety thought to be related to his addiction difficulties.

[15] His IBS had caused him trouble for a number of years. This had been investigated and was receiving medication to alleviate the symptoms. He was variously prescribed mebeverine hydrochloride, co-phenotrope (2.5/0.025 mg twice daily) and loperamide, all of which were to control his diarrhoea.

[16] His chronic testicular pain had been investigated too. It was described as generalised scrotal pain which was chronic. It had started in one testicle and had spread to both. He had been referred to the urology departments and clinics at the Southern General Hospital and the Victoria Infirmary. He had suffered from this condition for over a decade and it seemed to have been one which had caused him some distress. Despite these investigations, no physical source had been identified to account

for his discomfort. He had been referred to a hospital pain clinic for management of his chronic pain. He had, over the years received a number of different medications but had settled on Co-Codamol (30/500 mg 1-2 four times a day) and Pregabalin (300 mg twice a day). These medications work in different ways acting on different neuro-pathways and in combination can provide effective pain relief for many chronic conditions. He was also prescribed prochlorperazine (5 mg three times a day) for nausea and cyanocobalamin (50 mg twice daily) for vitamin B deficiency.

[17] Dr Mair had prescribed two different drugs to help with Mr Cameron's depression and anxiety. The first was fluoxetine (20 mg daily) which was to manage his depression. He also received a regular prescription of trazodone (150 mg at night). Trazodone has a sedative effect and was additionally prescribed to reduce anxiety and help Mr Cameron sleep. In relation to his anxiety, he was prescribed diazepam – at a fairly low dosage (2 mg three times a day) given his propensity to become dependent on drugs. Mr Cameron had been prescribed these drugs for some time.

Circumstances of death on 27 March 2013

[18] The Inquiry heard evidence from a number of witnesses who had seen and interacted with Mr Cameron shortly before he fell to his death. Only one person, Mr William Whitelock, actually witnessed the incident in full.

[19] According to Andrew McCormack, Mr Cameron had started the day as normal going about his pass man duties. Together they had been down to the bottom floor to collect the milk and rolls for breakfast and had thereafter distributed the breakfasts to the

other prisoners in their cells. Mr McCormack thought that Mr Cameron had seemed a bit cheerier and had commented that it was nice to see him in a better mood. Indeed, Mr Cameron at one point burst into a U2 song. Mr Cameron then had breakfast and the two decided that they would not go to the gym that morning. There was a brief conversation between them when Mr McCormack asked David Cameron if he was going to clean the stairs – this was part of his duties. Mr Cameron said that he would “do it in a wee bit” and Mr McCormack had made some comment like “quite right, have a wee break”. Mr McCormack went to make up his roll and turned is back on Mr Cameron. He had just lit a cigarette paper when he heard a horrible noise, ran out of his cell and saw Mr Cameron on the bottom landing.

[20] Officer Steven had been working with Mr Cameron shortly before this. They had done the breakfasts. That day was bedding and towel change day. Mr Cameron had appeared on time and there were no problems at all. The officer had helped him tie up the dirty towel bag which David Cameron then took to the bottom flat. Officer Steven last saw David Cameron at about 0800/ 0815. He had given Mr Cameron prison visiting slips to distribute. Officer Steven was away doing paperwork when he heard what had happened over his radio.

[21] Stephen Blair was a fellow pass man on the top landing in A hall. As he was coming out of a door, something caught his eye. It was Mr Cameron falling. He looked over the bannister and saw him lying on the floor. He had spoken to Mr Cameron just before that, about four or five minutes before he died. Mr Cameron had come to his cell door and asked to speak to him. Mr Blair had been talking to Andrew McCormack at that point and said “Aye, just a minute”. Mr Cameron had seemed just the same as normal – “just normal, quiet David”. He never came back to speak to him.

[22] William Whitelock was a pass man on the floor below Mr Cameron and witnessed what happened. He was sweeping the landing directly below brushing on the opposite side from David Cameron. Mr Whitelock watched as David Cameron delivered letters and put visitor slips under the doors of some cells. He delivered about five or six pieces of mail. It was a quiet time as most of the prisoners were having breakfast. He watched as Mr Cameron climbed up and over the bannister and fell to his death. He described how Mr Cameron walked past the showers,

“calm as you like, as if he didn’t have a care in the world...He was 100 per cent calm as you like. He climbed up on the metal railings, using the square meshes to climb – he took seconds to do it – and just went right over, head-first.”

It happened, he said, very fast and was over in a matter of seconds. There was no-one in the immediate vicinity and nothing that anyone could have done to prevent it.

[23] Everyone was completely shocked by events. No-one had any inkling that this was about to happen. William Blair said there was “no warning, nothing at all”. Andrew McCormack said that there was nothing to suggest that he was going to do that. He thought that Mr Cameron the night before had been frustrated, but just frustrated. Mr McCormack was not concerned enough to report it. Stephen Blair said that he had no reason to suspect that he would take his life. He was not aware of anything causing Mr Cameron concern and was shocked and surprised as was Officer Steven. It had happened out of the blue. Nor, of course, had Mr Cameron’s mother or sister had any concerns that he would have taken his own life.

[24] An emergency call was made to the health team who responded immediately. Dr Forrester hurried to A Hall in response receiving a call at about 0850 hours. On arrival, he saw one of the staff nurses performing CPR. Several rounds of resuscitation were

attempted. However, Mr Cameron had no pulse and his pupils were fixed and dilated. He had suffered extensive and un-survivable head injuries. Dr Forrester pronounced life extinct at 0900 hours. A post mortem examination carried out at the Southern General Hospital on 3 April 2013 by Dr Julie McAdam and Dr Michael Parsons, both forensic pathologists concluded that David Cameron had died from multiple injuries in keeping with a fall from a height. The cause of death was certified as 1(a) multiple injuries due to 1(b) fall from a height. Toxicology examination of blood samples taken at autopsy identified codeine and metabolites of trazodone, in keeping with the therapeutic use of codeine (in his co-codamol) and trazodone before his death.

Events leading up to death

[25] Evidence was led about David Cameron's mood and demeanour in the days leading up to his death. There was a suggestion that he had been quieter than usual in the period immediately before his death although, if correct, this change appeared to have been subtle and only noticed in retrospect. Looking back, Miss Park thought that he had been getting increasingly quiet and uncommunicative during visits. However, she did not notice this at the time.

[26] Mr Cameron's friend, Andrew McCormack, said that in the weeks before his death "Davy was just Davy; just a deep guy". He thought, again looking back, that he "went down a wee bit" in the weeks leading up to his death and remembered him saying

that he wanted anti-depressants and that he had put in a slip to get them. On the day before his death, Mr Cameron had seemed a bit down. Mr McCormack qualified this by saying "but then again, that was nothing off the normal. His mood was much the same – some days a bit chirpier than others but no extremes". Mr McCormack had asked him if everything was okay to which Mr Cameron replied that everything was fine. The night before his death, Mr Cameron had been in another pass man's cell watching the Scotland football match. At that time he was complaining about not getting his co-codamol. He was "humping and heaving, just 'p'd of', and not best pleased about it".

[27] Stephen Blair thought that Mr Cameron had been just about the same in the days before his death. He had not gone to the gym with him so much but that might have been because some pass men had to stay behind, only one being allowed to go from each flat at a time. In hindsight there was no real change but he was "just a wee bit different, a bit quieter, but he was like that". In the course of his evidence it was put to him that he had told the police at the time that David Cameron had a "vacant look". He agreed that he had but qualified this remark by saying that most people in the jail had a vacant look.

[28] I was not convinced by the evidence that Mr Cameron had been quieter and seemed a bit down. No-one, including his family, had noticed this at the time and I considered it likely that the witnesses who commented on this had, quite unintentionally, been influenced by the knowledge of what happened rather than there having been any tangible change. Certainly there was nothing very different in Mr Cameron's behaviour and nothing that gave rise to any concerns about him.

[29] Officer Steven, who worked with Mr Cameron regularly, had not noticed any change in his behaviour in the days leading up to his death. He was "neither up nor down". The officer described how Mr Cameron was always the same. He never showed

any emotion. If he was not working, he was in his cell. Prison officers are trained to look out for signs that a prisoner could be struggling or in need of help. He saw no cause for concern as far as Mr Cameron was concerned. On the day of his death, Mr Cameron was no different from any other day.

[30] Much of the Inquiry focused on the reasons for Mr Cameron's suicide. In particular, concerns were expressed over certain problems which Mr Cameron had experienced with his medication while in prison and whether these had impacted on his decision to take his own life.

Admission

[31] On admission to prison a person is first processed by the Admissions Section. One of the primary functions of this process is to assess whether a prisoner is considered to be at risk of self-harm. This is a thorough process of risk assessment under a protocol known as "Act 2 Care". On his admission on 6 September 2012 as a remand prisoner, Mr Cameron was not found to be showing any signs of being at risk of self-harm or suicide and was showing no cause for concern. Accordingly, he was formally assessed as being of no apparent risk of self-harm. No issue was taken with that assessment.

[32] As part of the admissions procedure, each prisoner must be seen by a doctor within 24 hours of admission. On 7 September, Mr Cameron was seen by Dr Jonathon Forrester whose evidence was presented by way of affidavit. An important aspect of this procedure is to ensure that medication which is being prescribed for existing conditions in the community is continued within the custodial setting. At that time, the procedure was to obtain a mandate from the prisoner permitting the relevant information to be disclosed to the prison by his general practitioner. This was done by faxed

communication. In Mr Cameron's case, a fax was sent to Dr Robert Mair's practice at Shaw Street in Govan. A prompt reply was received, signed by Dr Mair, purporting to give accurate information about current prescriptions. Unfortunately, the information from the practice was incomplete and did not include details of the prescription for pregabalin. Moreover, part of Dr Mair's signature had been written over the numeral "1" of the 150 mg dose for trazodone so that it was obscured. As a result, Mr Cameron was not prescribed pregabalin at all and was prescribed trazodone at a third of the dose, namely 50mg, instead of 150mg. All other prescriptions were continued by the prison doctor. In view of his addiction to diamorphine (heroin) and benzodiazepines (including diazepam or valium) Dr Forrester decided that Mr Cameron should be put on a detoxification programme. This was a twelve-day reducing course of dihydrocodeine used for prisoners with addictions to opiates, and a similar twelve-day diazepam programme used for prisoners with alcohol addictions.

[33] The lack of pregabalin, the wrongly reduced dose of trazodone and concerns about his IBS medication were matters which caused distress and frustration for Mr Cameron in the weeks and months that followed and were the subject of several self-referrals made by him in an effort to obtain help with his various symptoms. The prison health team's response to these requests for help and the on-going problems with his medication were explored during the Inquiry. There were also issues surrounding the prescription of one of his anti-depressant drugs, trazodone. Specifically, the question arose whether these matters, individually or cumulatively, contributed to Mr Cameron's suicide and, if so, whether there were any reasonable precautions which should have been taken whereby his death might have been avoided in terms of section 6(1)(c).

Self-referrals in connection with medication

[34] As has been noted, David Cameron made a number of self-referrals to the health team between September 2012 and January 2013. There were seven in total and a formal complaint.

Irritable Bowel Syndrome

[35] Two self-referrals asking to see a doctor mentioned problems with his irritable bowel syndrome. Shortly after his admission to prison, Mr Cameron made two self-referrals (on 17 and 19 September 2012) in which he mentioned problems with his IBS and the need for medication. In a self-referral slip dated 14 January 2013, Mr Cameron again made reference to his IBS. He complained that his symptoms were getting worse and that he was having to run to the toilet all the time. He also complained that he had not been receiving his co-phenotrope for three weeks.

[36] The court heard evidence that his referral requests were responded to by the health team. The medical records contained on a document called the "Discharge Summary" were difficult to interpret as entries were prefixed with the word "consultation" when that did not necessarily mean that the prisoner had actually seen a doctor or a nurse in person. However, it was clear that the referrals were acted upon.

[37] The court heard evidence from Margaret Millar, one of the clinical nurse managers. With reference to the Kardex which contained a note of current prescriptions, she reported that Mr Cameron had received medication regularly for his IBS while in Barlinnie. The prescription in the community had been continued until the end of

December when there had been a manufacturing/supply problem with co-phenotrope. The pharmacy had been unable to obtain supplies of the drug. Accordingly, Mr Cameron was prescribed a substitute drug – mebeverine - by Dr Forrester who saw him on 4 January 2013.

[38] During that consultation, Dr Forrester noted in the discharge summary that Mr Cameron's IBS was discussed. It was recorded that he was complaining of a swollen abdomen, that his cramps were getting worse and that he had loose stools. Dr Forrester carried out a full examination and found Mr Cameron's abdomen to be soft and tender. Nothing of concern was noted. Dr Forrester advised that he would refer Mr Cameron for a colonoscopy. He explained about the supply problem with co-phenotrope and issued a substitute prescription for mebeverine. This was the drug most similar to co-phenotrope and designed to do the same thing. During this time Mr Cameron also received loperamide (lomotil) which was another medication prescribed for IBS which helped to regulate the bowel.

[39] The treatment for IBS afforded to Mr Cameron while in prison was reviewed by Dr Roberts. In his opinion, it was reasonable that Dr Forrester prescribed mebeverine which was an appropriate alternative to co-phenotrope. Dr Roberts was satisfied that Mr Cameron had received medication for his IBS throughout his time in prison and had no concerns with the medical treatment given in respect of the IBS complaint or any criticism of that treatment.

[40] Thus it is clear that Mr Cameron's concerns and his difficulties controlling his symptoms were listened to and acted upon. He was given the appropriate medication and Dr Forrester was to take matters further by referring Mr Cameron for further investigation including a colonoscopy. However, it might have been the case that

Mr Cameron did not fully appreciate what or why it was that he had been prescribed a different drug. The fact remains that he continuously received appropriate treatment for his condition.

[41] There was evidence from his sister that Mr Cameron had found the condition difficult to cope with in the prison setting. He told her he had to go to the toilet constantly. Understandably, he found this highly embarrassing while sharing a cell. It was obvious that he found his condition distressing. However, it is important to note that when Mr Cameron became a pass man he moved into a single cell. This, according to his sister, was what he had wanted the most. Thus, the source of much of his distress and embarrassment had been removed. In the months before his death, he was able to cope with his symptoms within the privacy of his own cell.

[42] I am entirely satisfied that matters concerning IBS were appropriately treated by the health team and that there were no grounds for suggesting that his condition or any aspect of his treatment therefor had anything to do with his death. This was a long-standing condition in respect of which he had been in regular receipt of appropriate medication. His concerns were listened to by the health team and acted upon appropriately.

Trazodone

[43] Unfortunately, it was some weeks before the error concerning the proper dosage of trazodone was rectified. Mr Cameron had on a number of occasions brought this matter to the attention of the health team and his efforts were largely ignored until 4 November 2012 when it appears that Mrs Millar had a careful look at the fax, realised what had happened and that Mr Cameron had been right all along. Immediate steps were

taken to increase the dose to the prescribed 150mg. Thereafter Mr Cameron was in receipt of 150 mg of trazodone until his death. During his evidence, Dr Mair fully and frankly accepted responsibility for the omission of pregabalin from his fax to the prison and expressed his regret for that error.

[44] Dr Kural admitted that the time taken to rectify the problem was unacceptable and he acknowledged that during that period, Mr Cameron's mood would have been affected by the low dose. However, thereafter he received his prescription at the correct dosage.

[45] The expert witnesses were in agreement that this earlier problem with the trazodone would have had no clinical bearing on Mr Cameron's death. Like Dr Kural, they acknowledged that the reduced dose would have adversely affected him during the period when he was receiving the reduced dose. Dr Roberts commented that the time taken to rectify the dose was unfortunate but put the matter down to human error. He could easily understand how it had happened. However, it was rectified long before Mr Cameron's death and would have had no effect by that time. Thus, there was no evidence to suggest that the reduced dose of trazodone in September and October had any causal link to Mr Cameron's death the following March. Dr Roberts explained that any anxiety or sleeplessness caused by the reduced dose of trazodone would have quickly resolved - "almost instantly" - once he was back on the correct dose. Dr Pasupuleti, likewise, was of the opinion that the reduced dose of trazodone would have had no clinical effect at the time of death.

[46] Accordingly, unfortunate as this was, I am satisfied that there was no connection between this early mistake and Mr Cameron's subsequent death. Any sense of

frustration he was experiencing in this connection would long since have resolved. This was a matter of simple human error.

Pregabalin, Co-Codamol and Pain

[47] The mistake over the pregabalin prescription undoubtedly caused Mr Cameron considerable worry and distress. Between his admission and January 2103, he repeatedly attempted to persuade the health team that he *had* been prescribed the drug in the community and needed it to control his testicular pain. This was the subject of several self-referrals. Although she could not remember exactly when her brother complained about this, Miss Park's impression was that it was a constant source of frustration and distress for him. While it was accepted by Dr Kural that a cross-check with the GP in these circumstances would have been good practice, there was evidence that prisoners often declared that they were on additional drugs or at higher doses than they actually were in order to obtain more medication in prison. This was a common feature and therefore it would not be practical to cross-check directly with GPs in every case. However, it was clear from the evidence that had it been known that Mr Cameron had been receiving pregabalin in the community, it would (and should, according to Dr Roberts) have been continued, at least initially, on his admission to Barlinnie.

[48] The Inquiry heard that pregabalin is used primarily as an anti-epilepsy drug and as an analgesic (painkiller) for neurological pain. It also helps relieve anxiety. Dr Kural emphasised that its use was in the relief of neurological pain and, from a perusal of the medical records, questioned whether there was any evidence that Mr Cameron suffered from such pain. However, Dr Roberts confirmed that pregabalin is a potent drug that can

be effective in the control of chronic pain and Dr Mair's evidence was that Mr Cameron had found it beneficial. Dr Mair considered it appropriate to prescribe pregabalin for chronic testicular pain.

[49] There is another important feature of this drug which is relevant in Mr Cameron's circumstances. It is a drug very much sought after within the prison setting and as such has a high tariff among inmates. It is highly addictive and abused widely for its effect. As a result, the prescribing of pregabalin is subject to strict control in prisons. Dr Kural pointed out that the current guidance from the British Medical Association advises that it should not be prescribed in prison, such is its potential for abuse. David Cameron had a long history of abusing prescription drugs.

[50] Like Dr Roberts, I consider that Mr Cameron's efforts to obtain assistance in respect of pregabalin were polite, articulate and persistent and it would therefore have been reasonable for the position to have been checked with Dr Mair during the initial stages of Mr Cameron's sentence. As it was, such checks that were carried out simply involved a re-reading of the erroneous fax. His requests for help should have been responded to more thoroughly. However, it must be appreciated that once Mr Cameron consulted with Dr Forrester on 4 October and again on 3 January, the decision whether to prescribe pregabalin was properly a matter for Dr Forrester. It would have been open to him, regardless of any previous position, to have prescribed pregabalin had he considered it clinically appropriate.

[51] It was unfortunate that this matter was not directly explored with Dr Forrester in the course of preparing his affidavit. The position should have been clarified with him. In the absence of direct evidence on the matter, the court heard from Dr Kural that it was his impression that Dr Forrester had not considered pregabalin to be indicated clinically.

Furthermore, Dr Kural explained that even if it had been known that Mr Cameron had been prescribed the drug by Dr Mair, it would have been continued but with an early review date fixed with the clear view of reducing and stopping it in due course. Thus, it was by no means certain, even if his prescription had been continued initially, that Mr Cameron would still have been in receipt of pregabalin at the time of his death, particularly as he had been off the drug for several months by the time he was seen by Dr Forrester in January.

[52] From the fact that Mr Cameron made no further requests for pregabalin from January onwards, it would seem reasonable to assume that Dr Forrester had decided not to prescribe it and that Mr Cameron was aware of that decision. Dr Roberts agreed that at that point Mr Cameron might just have realised that pregabalin was a “non-starter”. Dr Forrester examined Mr Cameron on 4 January. He was aware that Mr Cameron’s chronic testicular pain had persisted for a number of years and of the history of the investigations that had already taken place, including hospital investigations. At that consultation, Mr Cameron thought that his left testicle was more swollen than his right one. Dr Forrester examined him and found that his left testicle was indeed swollen, tender and red. However, he felt no lumps. In case this was an infection, Mr Cameron was placed on a course of antibiotics (ciprofloxacin) and it was planned to review his left testicle in two weeks. He was also referred to a sexual health nurse. At that consultation, Dr Forrester noted that Mr Cameron had told him again that he had been receiving pregabalin prior to his incarceration. It can, therefore, be reasonably inferred that Mr Cameron asked for pregabalin but that Dr Forrester concluded that it was not clinically appropriate to prescribe it. This was entirely a matter for his professional judgment. He was not obliged to continue to prescribe a drug even though it had previously been prescribed in the

community. He was now dealing with prescriptions in the prison setting where pregabalin is not readily given.

Co-Codamol

[53] During this time (with the exception of a short period in December when his dosage was cut and a short period when he appeared to be without this medication) Mr Cameron was receiving the maximum dose of co-codamol, a drug used effectively for relief of moderate to severe pain. (At the beginning of his sentence, Mr Cameron did not receive his co-codamol as he was on a detoxification programme which included dihydrocodeine, a powerful opiate which likewise would have relieved pain.) Apart from a short period between 11 to 17 December, Mr Cameron was never without some pain relief throughout his time in prison. It was not entirely clear how he had come to be without medication for that period. However, from the Discharge Summary it seemed that the prescription was “re-started” following a consultation on 17 December with one of the prison GPs. This consultation was arranged in response to a self-referral dated 10 December. Mr Cameron also made some complaint about not receiving his co-codamol shortly before his death but that was contrary to the information contained in the dispensing records and I did not pay any regard to that aspect of the evidence.

[54] The expert witnesses reviewed the issue of pregabalin. Dr Pasupuleti emphasised that, as a psychiatrist, he was not an expert in pain relief and properly declined to comment on the merits of prescribing the drug. Dr Roberts, however, was of the opinion that it was clear that Mr Cameron had been suffering from a distressing and painful condition for which he was not receiving adequate pain relief. That said, Dr Roberts

acknowledged that he did not know what level of pain Mr Cameron was experiencing. In reaching his conclusion, he seemed to place weight on what Mr Cameron had stated in his self-referrals. I suspected that Mr Cameron tended to exaggerate his degree of pain.

[55] There was evidence, too, about the correlation between levels of pain and levels of anxiety. Dr Pasupuleti explained that it was difficult to make generalisations about the effect of long-term pain and anxiety as much depended on the individual. Some people got used to pain as the tolerance of their pain receptors increased. According to Dr Pasupuleti, the fact that Mr Cameron had been psychologically dependent on his medication in the community might have been another reason for any increase in his level of distress, rather than pain itself.

[56] Dr Pasupuleti found it difficult to identify Mr Cameron's degree of pain. Without having examined him, it was impossible to say. However, usually the severity of pain affects the day to day functioning of the individual. For someone to take his own life because of pain, Dr Pasupuleti explained that pain would have to be extremely severe pain. Pain of that degree would be obvious to others. There was no evidence to suggest that in Mr Cameron's case. Dr Roberts, on the other hand, viewed the lack of pregabalin as more significant. He believed that Mr Cameron would have been considerably distressed by this.

[57] Mr Cameron told his sister that he was "in agony" – a term he used in several of his self-referrals – that the pain was unbearable and that he could not handle it. It has to be said that this was not reflected in the objective evidence before the court. None of Mr Cameron's fellow inmates noticed anything untoward, nor did the prison officers. He made no complaint to any of them and certainly made no mention or showed any signs of being in severe, unbearable pain. He visited the gym regularly, sometimes as much as

four or five times a week. He was able – without interruption – to carry out the physical duties of pass man. None of that evidence pointed to his being in agonising pain. From the evidence, I did not accept that he was suffering from severe pain or pain that interfered with his normal daily routine at the time of his death or in the days leading up to it. To suggest otherwise, as Dr Pasupuleti recognised, would be speculative and contrary to the objective evidence. That is not to say that Mr Cameron did not continue to suffer from chronic pain from this distressing condition as he had done for many years.

[58] Therefore I agree with Dr Pasupuleti that pain was not a definitive factor in Mr Cameron's suicide. Objectively on the evidence before the court it cannot be concluded that he was in pain of such severity as to have impacted on his decision to end his life. This, taken with the fact that it was clearly open to Dr Forrester to have prescribed pregabalin had he considered it clinically necessary, meant that the absence of pregabalin from Mr Cameron's medication did not play any accountable part in his death for the purposes of my determination under section 6.

[59] In connection with the prescription issues concerning trazodone, pregabalin and co-codamol, counsel for Mr Cameron's family invited me to make a finding under section 6 (1)(c) that it would have been a reasonable precaution for the nurse who had dealt with the earlier complaints in September 2012 concerning the pregabalin and the wrong dose of trazodone to have had a direct discussion with Mr Cameron's GP to ascertain the correct prescription information. While counsel accepted that neither of these issues was proximate to the date of Mr Cameron's death, the fact that it would appear that Mr Cameron was not believed in connection with these matters added to his distress and contributed to his feelings of frustration and helplessness. His failure to obtain pregabalin for pain relief is likely to have caused him some distress and contributed to

his decision to take his own life. Similarly, the pain and distress caused as a result of alteration in his co-codamol prescription in December 2012 were likely to have contributed to Mr Cameron's feelings of frustration and helplessness.

[60] I have already indicated that I do not find it proved that there was a connection between any of these events and Mr Cameron's death. Counsel's submission relied on vague inferences which were not supported in the evidence and amounted to little more than speculation. There was no basis of fact on which I could confidently make such a finding, either in connection with any one of these issues or cumulatively.

Fluoxetine

[61] In the community, Mr Cameron was prescribed the anti-depressant fluoxetine. This is a commonly prescribed drug. It was continued on his admission and noted on the prison Kardex as one of his regular medications. He would have had to submit a request for the drug on a weekly basis, whereupon a packet containing a week's supply would have been dispensed to him. Thereafter, it was his responsibility to take his medication as prescribed, as he would have done as a patient in the community.

[62] It seemed that Mr Cameron decided to stop taking this medication of his own accord. After receiving his weekly amount on 20 September, 2012 Mr Cameron did not receive another supply until 18 January 2013. Thus he had not requested the drug for a period of three months. He asked for and received another week's supply on 29 January. Notwithstanding this, he was seen the following day by Nurse Practitioner Sherine Lawson apparently because he had been refusing to take his medication. It was not immediately clear from the available evidence how that interview had come about. It seemed somewhat incongruous given that he had just received his weekly supply the day

before. According to Nurse Lawson, if a prisoner refused medication that had previously been requested, the care assistant dispensing it would refer the matter to the hall nurse to explore the reasons behind the refusal. However, it would appear that Mr Cameron had received a week's supply of the drug the day before and before that on the 18 January. It was, therefore, unlikely that anyone had approached Nurse Lawson because he had refused to receive medication that he had previously ordered. What had prompted the interview was not established.

[63] Nurse Lawson had worked in Barlinnie for only four months at that time. She gave evidence about her interview with Mr Cameron by reference to the medical records as she had no specific recollection of the interview with Mr Cameron. From her contemporaneous note, Nurse Lawson explained that Mr Cameron had told her that he did not want the drug, that he did not need it and that it disagreed with him. In the course of the discussion with Mr Cameron, Nurse Lawson assessed Mr Cameron's demeanour. She recorded that he had good eye contact and was talking freely. He assured her that he would talk to officers or nursing staff if his mood became low. As she was not a trained mental health nurse, Nurse Lawson properly discussed his request to stop the fluoxetine with the mental health team who agreed that it was appropriate to discontinue the medication. Mr Cameron signed a refusal form. Nurse Lawson advised Mr Cameron that if his mood declined, he should advise nursing staff or prison officers so that he could be referred to the mental health team. (It should be noted in this connection that it was obvious from the number of self-referrals made by him that Mr Cameron was not slow to tell health team about low mood.) None of the medical and expert witnesses took issue with Nurse Lawson's decision that it was appropriate that the fluoxetine be stopped.

[64] Having granted his request to stop taking fluoxetine, Nurse Lawson did nothing further. Specifically, she did not refer the matter to the prescriber or one of the other prison doctors as she should have done. There was general agreement that such a referral would have been the proper course so that the prescription could have been scored off the sheet. Only a doctor could score out and therefore remove a prescription from the Kardex. As it was, the prescription remained active and therefore available if requested at a later date. In the event, that was what Mr Cameron did. Issues concerning his intermittent requests for the drug and the consequences of the prescription not having been scored out became an important focus of the Inquiry.

[65] After he had asked to be taken off the medication, Mr Cameron then requested it again on two separate occasions during February (15 and 19) and on 5 March. This was his last request for fluoxetine, some two weeks before his death. Of course, although he requested and received fluoxetine, it is not known whether he actually took it.

[66] It was clear from the evidence that had the fluoxetine been scored off the Kardex by one of the GPs, Mr Cameron would not have been able to request it intermittently. Any re-request would have been picked up by the health care staff and passed to a nurse because of concerns about low mood and if he had insisted in his request, he would have been seen by a doctor.

[67] The system for prescribing and dispensing medication in Barlinnie, as in other prisons, was described by various witnesses. In particular, in addition to Dr Kural, the court heard evidence from the Health Care Manager and the Clinical Manager in Barlinnie, Mr Frank Gibbons and Ms Margaret Millar. They described how the system in prison is modelled on and designed to reflect the primary care arrangements in the community. Thus, a prisoner, like a patient in the community, is responsible for

requesting repeat prescriptions and responsible for taking his medication. In prison, as in the community, if a person does not wish to take medication, he does not have to do so. The exception to this is anti-psychotic medication which is supervised within the prison setting to ensure compliance. Most prisoners do not wish to be supervised and prefer to manage their own medication as they would do outside prison. As in the primary care model, a person is responsible for his own medication. The court heard that it was common for prisoners to stop taking their medication and they would not be compelled to take it. With the caveat in relation to anti-psychotic medication, it was not seen as part of the role of the health team to monitor what individual prisoners were taking.

[68] The fact that a prisoner was able to stop taking anti-depressant medication without that being known to the health team was raised some concerns. There was evidence from Dr Kural and the clinical managers that it was felt to be impracticable and very resource- intensive to have a system in place whereby Kardex information and dispensing records were compared to see if each prisoner was taking his prescribed medication. Upwards of 300 prisoners received prescribed drugs, most on multiple prescriptions. The system was a paper-based system. There were thousands of paper-based Kardexes in the system. Given the volume of prisoners and the volume of medications dispensed, it would be extremely difficult to collate the dispensing records against the Kardex for each prisoner. There was no way in which a report might be generated. It was really a matter for prisoners to advise if they had stopped taking particular medication. That a patient either stops taking or does not request medication happens all the time in the community. It was unrealistic to think that in prison such a decision should prompt a full medical review in every case.

[69] Dr Roberts commented on the system. He was critical of the fact that Mr Cameron was able to receive the fluoxetine intermittently without that prompting some intervention. He was critical of a system whereby the stopping of an anti-depressant drug would not be flagged up in some way. He found that to be a matter of concern and considered that intermittent requests for fluoxetine should have flagged up a review held within a reasonable time of seven days. He said that he hoped that would happen in the community but no evidence was led as to whether that was the case. Dr Roberts accepted that there were significant logistical difficulties involved and that it would be “very, very difficult” to carry out such checks but commented that prisons had to get the necessary resources to enable them to do so. However, he did not refer in any detail to any other systems or practices elsewhere in the prisons service or primary care system or suggest how this might realistically be achieved. This was not a matter on which I could reach any firm conclusions on the basis of the evidence before me.

[70] Each drug written up on the Kardex has beside it a review date. At this review, one of the prison doctors decides whether or not to continue the prescription. Dr Kural confirmed that such a “review” was something of a paper exercise at which the prescription tended simply to be re-written. It was not expected that the reviewing doctor would check the prisoner’s file to see whether the medication was being requested and dispensed. Most of the time, a prescription was continued unless there was a particular reason to review it further. Prescriptions would normally be reviewed between three to six months. This was considered to be an acceptable timescale by the experts and reflected the practice in the community. Mr Cameron’s prescription for fluoxetine was reviewed by Dr Raman on 7 January 2013. Dr Raman was not called as a witness to the inquiry. However, from the medical notes, it would appear that Mr

Cameron was actually seen by Dr Raman on that day. Thus it might be that Mr Cameron did not tell Dr Raman that he had stopped taking his fluoxetine.

[71] In connection with the review procedure, the Crown invited me to make a finding under section 6(1)(e) as a fact which was relevant to the circumstances of Mr Cameron's death. The basis of the Crown's submission appeared to be that had Dr Raman been aware that David Cameron had not been taking his fluoxetine, he would have cancelled the prescription thereby provoking a full review of the prisoner's mental health in the event that he re-requested the medication.

[72] The court did not hear evidence from Dr Raman as to the circumstances of the review that he carried out. It is not known what facts he took into account or what information he had before him. From the information contained on the discharge summary, it would appear that Dr Raman actually saw Mr Cameron personally on that date. The information on the record discloses that the appointment with Dr Raman was arranged in response to Mr Cameron's request (via a self-referral) to see a doctor concerning his IBS. At the consultation, Mr Cameron also raised the issue of his testicular pain. Mr Cameron was apparently asking for lomotil and co-codamol. It was not clear whether the review of medication took place on a different occasion on that same date or during the consultation. In the absence of direct evidence on the matter, I was not persuaded that I could confidently make any finding in respect of that particular review procedure.

Submissions in connection with prescribing issues

[73] In terms of section 6, the Crown invited me to make a finding under section 6(1)(c) in the following terms:

“It would have been a reasonable precaution for the nurse, following her meeting with David Cameron 30th January 2013, to have advised a doctor within the Health Centre that it had been agreed that David Cameron was to stop taking his fluoxetine medication.”

The prescription for fluoxetine would have been scored off the Kardex. Thus when Mr Cameron later re-requested the medication, it would have triggered a review of his mental health. It was suggested that such a review would have provided Mr Cameron with an opportunity to air all his frustrations and anger concerning the various problems with his medication, including in particular his frustration about not receiving pregabalin and his anxieties with regard to co-codamol, co-phenotrope and fluoxetine. He might as a result have been prescribed pregabalin or the matter referred to the prison GP. The Crown argued that in this way his death “may” have been prevented. The Crown referred to Mr Cameron’s self-referral letters in connection with the pregabalin issue, his frustration in connection with his co-codamol prescription the night before his death, issues concerning his medication for IBS and having to go to the toilet a lot, his self-referral on 8 March when he said he had difficulty sleeping and the re-request for fluoxetine. The Crown accepted that no one would ever know the definitive reason behind Mr Cameron’s suicide but submitted that there was a lively possibility that a mental health review in February 2013 “could” have resulted in the prescription of pregabalin and additionally that David Cameron’s anxieties in respect of his other medication “could have been discussed and possibly resolved” whereby his death “may” have been prevented. However, the Crown accepted that the appropriateness of any such finding under section 6(1) (c) was “borderline”.

[74] Counsel for the family invited me to make a similar finding. Had the prescription for fluoxetine simply been discontinued on the 30 January, when Mr Cameron sought to re-start the prescription the following month this would have triggered a full review by a mental health officer, a medical officer of a visiting psychiatrist. There was the possibility of further pain medication being prescribed at this stage. At the very least such a review would have given Mr Cameron the opportunity to air his issues and grievance and lessen the feelings of frustration and helplessness and might have avoided the death.

[75] In the course of very full submissions, Miss Doherty, counsel for the Greater Glasgow Health Board, submitted that the totality of the evidence did not suggest that Mr Cameron had ongoing problems with testicular pain not properly managed by medication in the period immediately before his death. On that basis, she argued that it was speculation to suggest that had the prison doctor checked the position with the GP and prescribed pregabalin that the death might have been avoided. In any event, it remains unknown why Mr Cameron decided to jump to his death on 27 March.

[76] Miss Doherty rejected the Crown's claim that there were unresolved anxieties about Mr Cameron's medication and submitted that this claim was simply not supported by the evidence. Nor did the evidence support the Crown's submission that there was a realistic possibility that any review following a re-request for fluoxetine,

"could have resulted in the prescription of pregabalin or an appropriate alternative and additionally that David Cameron's anxieties in respect of his other medication could have been discussed and possibly resolved and thereby his death might have been prevented".

I was invited to make no such finding.

[77] Before the court can make a finding under this section, the sheriff must be satisfied that not only was the precaution reasonable but that it was one whereby the death might have been avoided. The court has to be satisfied on a balance of probabilities. The term “might” means something more than possible but less than probable. It means a realistic possibility, a “lively possibility”.

[78] There can be little doubt that Nurse Lawson should have told a doctor about the discontinuation of the fluoxetine following her discussion with Mr Cameron on 30 January. Thus it can be said that such a course would have been a reasonable precaution. I am satisfied from the evidence that had she done so, it was very likely that the prison GP would simply have put a line through the prescription. Accordingly, I am satisfied that any future re-request for the drug would have prompted some response which would have involved some review of Mr Cameron’s reasons for requesting it. However, the exact nature of the response was not clear. It could have been a referral to a nurse practitioner or the mental health team. Or, it could have resulted in a review of varying depth by the prison GP or led to a full mental health review by a visiting psychiatrist. The issue here is whether the outcome of any such review might have prevented Mr Cameron’s death. Therefore, it is necessary to consider what such a review might have involved, the potential outcomes and whether it could be concluded that the death might have been avoided.

[79] Dr Roberts and Dr Pasupuleti explained that such a review would have involved a more in-depth examination of Mr Cameron’s mental health than simply observing him. Probing questions would have been asked in order to explore issues such as low mood; Mr Cameron’s reasons for stopping and then re-requesting the fluoxetine; his various medications; sleep pattern; appetite; concentration levels; anxieties and suicidal ideation.

There were various potential outcomes of such a review. The fluoxetine might have been re-started (perhaps without much discussion) or an alternative anti-depressant might have prescribed had that been clinically appropriate. Alternative treatment such as cognitive behaviour therapy might have been suggested. It should be noted that David Cameron had been listed for relaxation classes independently of any formal review.

[80] I have already given my conclusions as to the absence of any causal link between the issues surrounding the prescription of trazodone, co-phenotrope, co-codamol and pregabalin and Mr Cameron's death. The extent to which they influenced his decision to take his own life, if any, was *de minimus*. The only remaining question is whether the holding of a mental health review might have prevented Mr Cameron's death. Given the variety of potential outcomes, it is difficult to reach any firm conclusion as to what was likely to have happened. That would involve a degree of speculation. However, some assistance can be obtained from the opinions of the two expert witnesses as to the state of Mr Cameron's mental health around the time of his death.

Mr Cameron's mood at the time of his death

[81] Both Dr Roberts and Dr Pasupuleti were of the opinion that at the time of his death, Mr Cameron was not suffering from a depressive illness. Nor did he appear to have a diagnosable psychiatric illness.

[82] Dr Roberts explained that having a depressive illness and "feeling depressed" were often confused. The former is a diagnosable and treatable condition while the other is not: someone who is simply feeling depressed often will not be helped by drugs. Those who are clinically depressed will be uniformly flat, showing no elation or sorrow. They do not respond to stimulus. They lose interest in things, they have a lack of appetite

being off their food and may be losing weight. They have difficulty sleeping or experience sleep disturbance. They lose memory and concentration. The key feature is that they are consistently flat.

[83] Dr Pasupuleti agreed. Depressive illness, he said, had three basic symptoms: low mood, lack of interest in usual daily activities and easy fatigability associated with low energy levels. Additional features of someone presenting with a depressive illness would be a lack of attention and concentration, self-harming behaviour, self-neglect and self-isolation. Within the umbrella of depressive illness there were three categories: mild, moderate and severe. In order to have an impact such as to cause someone to commit suicide, the depression has to be severe.

[84] Neither expert witness considered that Mr Cameron's behaviour demonstrated someone with a depressive illness. The fact that Mr Cameron was functioning normally was an important aspect. Dr Roberts noted that in the days before his death, Mr Cameron was functioning normally. He was able to work, his mood was not consistently down, he engaged in banter albeit he was by nature a quiet, reserved person. In particular, on the day of his death he was said to be "quite chirpy" and broke into song at one point. That, according to Dr Roberts, was not the behaviour or demeanour of a man suffering from a depressive illness. Accordingly, he found no evidence that Mr Cameron was suffering from a depressive illness when he died.

[85] Dr Pasupuleti likewise concluded that there was no objective or substantive evidence that suggested that Mr Cameron was suffering from a depressive illness or any diagnosable mental illness at the time of his death. He did not find any symptoms of depression whether mild, moderate or severe. It was clear that Mr Cameron had a *history* of depressive illness and had had mental health problems in the past. He explained that

feeling low mood did not necessarily mean illness which is treatable. Mental illness has to be treatable and Mr Cameron's symptoms did not meet that criterion. Mr Cameron's low mood and anxiety were not acute problems but were longstanding. He was predisposed to such symptoms but from the evidence before him, he did not find any evidence of acute, active symptoms at the time of Mr Cameron's death.

[86] Significantly, both Dr Roberts and Dr Pasupuleti explained that fluoxetine would not have helped Mr Cameron. Dr Roberts' opinion was that fluoxetine would not have made a difference to the way Mr Cameron was feeling because there was no clear evidence of depressive illness. Dr Pasupuleti agreed.

[87] Dr Roberts was satisfied that there was no doubt that David Cameron was "depressed" in the sense of feeling low. Dr Pasupuleti was less certain about that. He explained that it was possible that Mr Cameron's mood was low but from his behaviour this was not constant. When asked if the intermittent requests for fluoxetine indicated low mood, Dr Roberts was of the opinion that it did and that it suggested that Mr Cameron was struggling during those periods. Dr Pasupuleti did not think that was necessarily the case. He considered that the intermittent requests were made very much on the basis of how Mr Cameron felt on the day. If he were feeling low, he would have taken it. On the days when he felt fine, he would not have asked for the drug or taken it. The medication in such circumstances would not have helped. Likewise, poor sleep was not a primary symptom of active depression. On the matter of any frustration Mr Cameron might have expressed on the night before he died, Dr Pasupuleti explained that a single episode of frustration or irritability was not significant to a psychiatrist. On this issue of low mood, I preferred the evidence of Dr Pasupuleti: I considered he was more

qualified to comment on this and his evidence explained the intermittent nature of the requests.

[88] At the conclusion of his report, Dr Roberts listed a number of factors that he considered might have contributed to Mr Cameron's decision to take his own life. He regarded them as contributory factors but not the sole cause of his suicide. These included the earlier issues in relation to trazodene, pregabalin, co-phenotrope and co-codamol. However, in cross-examination, he accepted that he was just listing all the matters that could possibly have caused Mr Cameron to take his own life. He acknowledged that he could not say whether they had, or what weight could be attached to any feature, individually or cumulatively. He had simply listed these features to assist the court but accepted that it would be speculation to say what had affected Mr Cameron's decision. No-one knew. It could even have been a spontaneous decision.

[89] Dr Pasupuleti was clear that he could not say either why Mr Cameron took his own life. He would not be drawn into speculating about such matters.

[90] In Dr Pasupuleti's opinion, the lack of obvious signs and symptoms, the chances of anyone appreciating that he was about to take his own life were very slim. It was not obvious that he was suffering from any difficulty such as to make him take his own life. Accordingly, Dr Pasupuleti was firmly of the view that Mr Cameron's death could not have been avoided.

[91] Given the opinion of both experts that Mr Cameron was not suffering from mental illness at the time of his death and Dr Pasupuleti's clear opinion that Mr Cameron's death was not preventable, I consider that there is no basis for concluding that a mental health review might realistically have prevented Mr Cameron's death. The evidence disclosed that Mr Cameron had things on his mind of much more fundamental

significance than problems with his medications that had been largely resolved and, in any event, were remote in time from the date of his death. These more fundamental problems had existed prior to his sentence. Dr Mair said that Mr Cameron had been in despair about the way his life had turned out. His sister confirmed that during 2012 his life had been going wrong and that he was feeling “lost”. Mr McCormack told the Inquiry that Mr Cameron had confessed that he was finding it difficult to cope with his sentence. No-one could have predicted his death and the definitive reasons that caused him to jump from the landing on that morning must remain undetermined. Accordingly, I make no findings in terms of section 6(1)(c). There were no reasonable precautions whereby Mr Cameron’s death might have been avoided.

NETS

[92] In the course of the Inquiry, concerns were raised by the family as to the absence of safety nets in the prison which they believed might have provided some protection against prisoners jumping or falling from heights. They were angry that Mr Cameron had managed to climb over the bannister and fall to his death without much hindrance. Nets might have saved him. This was not an issue raised by the Crown in the public interest but given the family’s concerns, the Crown investigated the matter and called several witnesses to give evidence on the subject. The court heard evidence from Mr James Kane, the current Area Maintenance Manager, West Region for the Scottish Prison Service and evidence was led in affidavit form from Mr David Strang, Her Majesty’s Chief Inspector of Prisons in Scotland.

[93] Mr Kane had worked in the prison service for 34 years. Before he took up his present post, he was Head of Estates in Barlinnie Prison. Accordingly, he had extensive

knowledge and operational experience. He explained that there was no national policy in relation to the presence or absence of nets. However, where nets were used, they were fitted to a specific design standard. There are currently no nets in Barlinnie. Previously there was a net in C Hall which, as a remand hall, was considered to be the rowdiest hall and the most difficult to manage. However, that net was removed in 2008. There were currently nets in HMP Greenock and HMP Inverness. Modern prisons tend to be flatted so that nets are not a relevant consideration.

[94] Barlinnie is a traditional Victorian prison. There are galleries or landings on four floors overlooking a central atrium. There are balustrades and railings of approximately five feet around the edge of the landings. The nets used in the prison setting are rigid structures. Although referred to as a “net” such a net is more accurately described as a mesh, made up of 2” square mesh akin to that used to reinforce concrete. The net is fixed by a series of springs so that there is some element of bounce should an object land on it but in reality the net is a rigid, robust and unforgiving structure. Mr Kane explained that nets had never been installed in order to protect against suicides. They had always been installed first and foremost in the interests of officer safety. Indeed they were referred to as “officer safety nets”. Apparently, there was a period in the 1970s when prisoners commonly threw debris and missiles, including batteries, at prison officers. Those prisoners on protection housed on the bottom flat were also the subject of abuse and at danger from missiles thrown from above.

[95] In 2007, following a fatal accident inquiry in the previous year, a review paper *Suicide Risk Management: Death by Falling from a Height* was prepared by Dr Andrew Fraser, the then Director of Health and Care. In that report, he commented that there was a dearth of research on the subject and in particular there was a general lack of evidence

or evaluation of the effectiveness of nets and other restraining design features. The conclusion of this limited study was fairly equivocal: there was no strong case to remove nets that existed and no strong reason to install them where they did not.

[96] Following Mr Cameron's death, senior managers met with members of his family to listen to their concerns. An options appraisal report, *Safety at Height in HMP Barlinnie's Prisoner Accommodation Halls* was produced by the SPS Estates and Technical Services Directorate. Its purpose was "to investigate the possible options of introducing physical measures to help prevent such incidents from recurring in future". Three options were identified, each representing fabric alterations to the open galleries designed to prevent an inmate from accessing locations which would provide an opportunity to jump or fall from a height. These were: (i) increase the height of the balustrade; (ii) install nets in the atrium; or (iii) retain the existing arrangement. The recommendation was to retain the status quo.

[97] A brief historical examination of the history of nets confirmed that they were never intended as a measure to prevent injury or death to those falling from the upper floors. Rather, the purpose of this netting was to prevent injury to staff, visitors or prisoners on the ground floor from missiles deliberately or accidentally falling from the galleries above.

[98] Several disadvantages were associated with the use of nets. First, maintenance was a significant problem. Keeping them clean and allowing safe access by staff in a live operational environment was difficult in practice. Nets attracted dust and fluff which built up and gave rise to health and safety concerns. Prisoners regularly threw food (and sometimes excrement) onto the nets creating an obvious health hazard. Secondly, the presence of nets created an oppressive atmosphere which was not conducive to a

supportive environment: they cut out light and created an atmosphere that was enclosed and claustrophobic. They were unpopular with staff and prisoners alike. Thirdly, there were security issues associated with nets: officer sight lines were obscured, blind spots were created, communication was made difficult, potentially compromising officer and prisoner safety. Lastly, serious injury was likely if a prisoner jumped onto the nets in jest. Mr Kane described how a prisoner had previously thrown himself from the third floor and landed on the net sustaining severe neck and spinal injuries. There were logistical problems in accessing the prisoner in order to deliver emergency medical assistance and it was a laborious and potentially dangerous task of extricating the prisoner. It was after that that the operational decision was taken by the Governor to remove the last remaining net in C Hall at Barlinnie.

[99] The report examined the various options and concluded that additional physical alterations had a number of disadvantages which outweighed the potential advantages. Moreover, they were not considered to be cost effective. In particular, it was felt that the reduced sightlines and natural light provision, coupled with the increased sense of enclosure in the galleries could impact on prisoner and staff behaviour. The existing balustrades were considered robust and were already at a height that exceeded the legal requirement.

[100] Mr Kane also emphasised that jumping from a height was an uncommon method of committing suicide in prisons: death by hanging was most common. There had been two other suicides by falling from a height in Barlinnie in the past decade, one in 2005 and one in 2006.

[101] Mr Strang's evidence was that since the formation of the Inspectorate in 1981, the Inspection Reports had not contained any comments on either the presence or absence of

nets in Barlinnie. Mr Strang's own inspection report in October 2013 likewise did not comment upon the issue of nets. Had any such concerns been raised, the report would have addressed these. Accordingly, the view of HM Inspectorate of Prisons is that the absence of nets in Barlinnie did not raise serious concerns.

[102] In the course of his investigations, Mr Strang had discussed the matter of nets in prisons with several academics in the field and others with extensive experience in the field. He, too, had discovered a dearth of definitive research on the subject and there was thus no authoritative position as to whether there should or should not be nets in gallery prisons such as Barlinnie. At the end of the day, it was recognised that any decision was an operational one for the Governor and the Scottish Prison Service.

[103] In light of the evidence before the Inquiry, the Crown made no submissions on the issue of nets. Neither was I invited to make any findings under section 6 by counsel for Mr Cameron's family. Mr Ross for the Scottish Prison Service likewise invited me to make no formal finding in respect of the issue of nets.

[104] I am entirely satisfied that no issues arise in the public interest in connection with the absence of nets in A Hall in Barlinnie. Moreover, there were cogent reasons against the installation of such nets. These included logistical difficulties, health and safety concerns, operational and security issues and aesthetic reasons. It was clear that the nets were never designed or used as a means of protecting against prisoners falling from balconies. On the contrary, they were only designed as a safety feature for the protection of officers. Modern risk assessments and strategies to avoid self-harm in prisons provide a method of protection that is far more sophisticated. This involves a prison-wide culture of observation and risk assessment under the Act 2 Care policy.

Concluding remarks

[105] I am grateful to Ms Ross for her efficient and meticulous presentation of the evidence at this Inquiry on behalf of the public interest. Likewise, I express my appreciation to the legal representatives for their careful and courteous attention throughout the Inquiry and for their detailed submissions.

[106] Finally, I should like to pay tribute to David Cameron's mother and sister for the way in which they listened to the evidence with dignity and fortitude. Their grief at the loss of a much-loved son and brother was obvious. It remains for me, once more, to express my condolences to them.