SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2020] FAI 39

KIL-B125-20

DETERMINATION

BY

SHERIFF M S FORAN

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

into the death of

LEE TORTOLANO

Kilmarnock, 19 June 2020

The Sheriff, having considered the information presented at the inquiry, determines:

(1) in terms of s26(2)(a) of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the Act), that Lee Tortolano died at 12.27pm on 29 January 2019 within HM Prison Kilmarnock;

(2) in terms of s26(2)(c) of the Act, the cause of his death was by hanging;

(3) in terms of s26(2)(e) of the Act, there are no precautions which could reasonably have been taken that might realistically have resulted in his death being avoided;

(4) in terms of s26(2)(f) of the Act, there are no defects in any system of working which contributed to his death;

(5) in terms of s26(2)(g) of the Act, there are no other facts relevant to the circumstances of his death;

(6) in terms of s26(1)(b) of the Act, there are no recommendations to make.

There having been no accident, ss26(2)(b) and (d) of the Act do not arise.

NOTE

Introduction

[1] This inquiry was held into the death of Lee Tortolano, who was born on 5 February 1991. At the time of his death, Mr Tortolano was on remand within HM Prison Kilmarnock.

[2] A preliminary hearing was held on 27 May 2020 (after an earlier assigned diet was discharged due to Covid-19), and the inquiry was held on 17 June 2020. In light of the Covid-19 constraints the hearing was conducted remotely by teleconference.

[3] In the proceedings, the Crown was represented by Mr Faure, procurator fiscal depute. The deceased's father, Mr Tortolano senior, was represented by Mr McShane, solicitor. The Scottish Prison Service, and Serco Ltd, were represented respectively by Ms McCabe and Ms McDonald, solicitors.

[4] A joint minute of agreement was signed on behalf of all participating parties in which all material facts were agreed, obviating the need for evidence to be led.

The legal framework

[5] This was a mandatory inquiry under section 2(4)(a) of the Act, the purpose of which is to establish the circumstances of Mr Tortolano's death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

Summary

[6] The material facts in this inquiry were undisputed and uncontroversial. They are set out in full in the joint minute of agreement and as such do not require to be repeated here.

Discussion and conclusion

[7] All parties submitted that no issue arose from the circumstances of Mr Tortolano's death. I record my thanks to all parties who participated in the inquiry for their assistance, in particular for agreeing all the evidence by joint minute, the consequence of which was that I was able to determine this uncontroversial inquiry on the documents, productions and statements without the necessity of leading any witnesses. Accordingly, I have made the formal uncontentious findings as invited by the parties. Their obviously extensive and detailed preparation also meant that conducting the hearing remotely went particularly smoothly. All parties asked that their condolences be extended to the family of the deceased, and I am privileged to do so, and to include those of the court. I had been concerned that conducting this inquiry by teleconference might have excluded the participation of the deceased's father. I was reassured by his solicitor that unfortunately, due to shielding measures necessitated by Covid-19, Mr Tortolano senior would have been unable to attend in any event. This is a doubly unfortunate state of affairs, but I hope this determination might now offer him some degree of closure.

Appendix A

KM19000721/KIL-B125-20

SHERIFFDOM OF NORTH STRATHCLYDE, AT KILMARNOCK

JOINT MINUTE OF AGREEMENT

in

FATAL ACCIDENT INQUIRY

into the death of

LEE TORTOLANO

Fauré, Procurator Fiscal Depute for the Crown
McShane, Solicitor for Mr Tortolano Snr, next of kin
McDonald, solicitor for SERCO
McCabe, Solicitor for the Scottish Prison Service

do hereby concur in stating to the Court that the parties have agreed that the following facts have been agreed and can be admitted into evidence without the necessity of evidence being led:

1. Mr Lee Tortolano (hereinafter referred to as Mr Tortolano) was aged 27 years at the time of his death [redacted] 1991. He lived at [redacted] East Ayrshire.
2. He had appeared on petition on the 10th January 2019 at Kilmarnock Sheriff Court to answer two charges, one charge related to assault to severe injury with a domestic aggravation and the other charge was a s38 offence again with a domestic aggravation. He entered No Plea or Declaration and was committed for further examination; bail was applied for and refused.
3. He next appeared in relation to this matter on the 18th January 2019

and was fully committed. Again he was remanded in custody after a fresh bail application was refused.

4. He was housed within cell G10 which is located within HMP Kilmarnock's lower G wing on the ground floor.
5. At just before 10:50am on the morning of the 29th January 2019 Mr Tortolano was seen by Prison Officer Elaine McGauchie within his cell in the company of another inmate [redacted] The pair were friends and often in one another's company. [redacted] left the cell. The prison officer confirmed the deceased was well noting no concerns. The cell door was locked at approximately 10:50am to enable cleaning of the wing's floors to commence, leaving the deceased alone in his cell.
6. The cells were then re-opened approximately an hour and ten minutes later about 12 midday after the cleaning had been completed. G10, the deceased's cell was opened by Prison Officer Quinton Campbell.
7. On opening the cell he saw the deceased with a ligature around his neck hanging from the bathroom door. He summoned help, other prison officers arrived and the deceased was cut down and laid on the floor within his cell.
8. Others within the prison responded to the emergency call broadcasted by Prison Officer McGauchie over her personal radio including nurses who formed part of the full time healthcare team based within the prison and a general practitioner. They arrived and administered cardiopulmonary resuscitation (CPR). An emergency call was made to the Scottish Ambulance Service and paramedics attended. Efforts to revive Mr Tortolano proved unsuccessful and he was pronounced life extinct at 12:27pm. The deceased was left in situ until the arrival of police.
9. Detective Sergeant Barry Walker based within the Criminal Investigation Department at Kilmarnock police station attended. He arrived on scene at approximately 2:30pm. He was accompanied by other police officers. He found Mr Tortolano lying on his back

partially clothed.

10. The ligature was identified as coming from the deceased's duvet cover which had been ripped into various lengths one of which had been tied around his neck and secured over the bathroom door.
11. CCTV footage was reviewed and it was established that no other person entered the cell G10 between the hours of 10:50am and 12midday.
12. Mr Tortolano had spoken to his father, [redacted] on the evening of the 17th January 2019.
13. The cell was photographed with Mr Tortolano in situ.
14. The deceased was then moved to the mortuary at Crosshouse Hospital in Kilmarnock.
15. A protocol is in place for prisoners at risk of self-harm or suicide within HMP Kilmarnock. This protocol is called "Talk to Me" and all members of staff who come into contact with prisoners receive training in it.

16. Mr Tortolano's mental health had been assessed on his arrival at HMP Kilmarnock on the 10th January 2019 after being remanded in tune with internal protocols. The "Talk to Me" assessment was conducted by a member of the reception team who noted no concerns. He was assessed on a further two occasions, firstly on the 17th January 2019 when he returned from a court appearance (he had been on bail on an unrelated summary matter, bail had been continued) and secondly on the 18th January 2019 when he returned from his full committal. On all three occasions those assessing him noted no cause for concern.

17. His friend [redacted] told police Mr Tortolano had not expressed any suicidal thoughts to him.

18. Staff did not witness any clues or cues which made them think he was a suicide risk.

19. Mr Tortolano refused to allow drugs dogs to work close to him on return from court. He was sanctioned as a direct result. Mr Tortolano was segregated from other prisoners for a short period of time however that period passed without further incident.

Health Referral form. The referral process also now includes an opportunity to identify urgent referrals.

29. These findings were discussed with (FATHER) [redacted] together with his allocated social worker.

30. The delay in processing Mr Tortolano's referral request did not contribute to his death.

1) The following are Crown Productions in this Inquiry. In respect of these productions the following remarks are made:

Crown Production 1 : is a true and accurate record of the Post-Mortem report by Dr Alison Gilchrist into the death of Lee Tortolano, the Post-Mortem being conducted on the 4th February 2019 and the report dated the 8th May 2019.

Crown Production 2 : is a true and accurate copy of a toxicology report prepared by Dr Ann-Sophie Korb, a forensic toxicologist relating to Lee Tortolano dated the 24th April 2019.

Crown Production 3 : is a true and accurate copy of a supplementary report prepared by Dr Alison Gilchrist relating to Lee Tortolano dated the 8th May 2019.

Crown Production 4 : is a true and accurate copy of a "Talk to Me" risk assessment relating to Lee Tortolano dated the 17th January 2019.

Crown Production 5 : is a true and accurate copy of a "Talk to Me" risk assessment relating to Lee Tortolano dated the 18th January 2019.

Crown Production 13 : is a true and accurate record of medical records relating to Lee Tortolano

Crown Production 14 : is a true and accurate record of the "Talk to Me" risk assessment relating to Lee Tortolano dated the 10th January 2019.

Crown Production 15 : is a true and accurate copy of a transcript of a telephone conversation on 17th January 2019 between Lee Tortolano and his father [redacted]

Crown Production 16 : is a true and accurate copy of a Death in Prison Learning, Audit & Review (DIPLAR) dated the 26th February 2019 relating to a review of the circumstances of the death of Lee Tortolano.

Crown Production 17 : is a true and accurate set of photographs of the deceased in the cell area at HMP Kilmarnock where the deceased was discovered. The photographs were taken on 29th January 2019 by the Scenes of Crime Officer. These photographs are true and accurate and have not been retouched.

Crown Production 18 : is a true and accurate copy of NHS waiting times relating to referral to specialist services as at the week commencing the 14th January 2019 and were in place when Mr Tortolano made his application for referral.

Crown Production 19 : is a true and accurate copy of the Significant Adverse Event Review dated the 23rd March 2020 relating to the care and treatment of Lee Tortolano

In respect whereof

Stuart Fauré

Procurator Fiscal Depute

Neal McShane for NOK

Solicitor

Julia McDonald for SERCO

Solicitor

Laura McCabe for SPS
Solicitor