

SHERIFFDOM of TAYSIDE CENTRAL and FIFE at PERTH

DETERMINATION

by

LINDSAY DAVID ROBERTSON FOULIS, Esquire, Sheriff of the Sheriffdom of Tayside Central and Fife at Perth following an INQUIRY held at Perth on 2nd, 3rd September and 19th November 2013 into the death of LAWRENCE DEVLIN, an inmate of Her Majesty's Prison, Perth.

PERTH, 5th March 2014. The Sheriff, having considered all the evidence adduced, Determines:-

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that the said Lawrence Devlin died within Cell 21 of A Hall at H M Prison, Perth, where he was a prisoner on 2nd April 2011 at approximately 11.50pm.
2. In terms of Section 6(1)(b) of the said Act, that the cause of death of the said Lawrence Devlin was suspension by his neck from a bedsheet ligature

NOTE

Evidence in the Fatal Accident Inquiry in respect of the death of Mr Lawrence Devlin was led on 2nd and 3rd September and 19th November 2013. I heard submissions on that last date. The Crown were represented by M/s Kynaston, Procurator Fiscal depute, Perth. Mr McIlravey, solicitor, Dundee represented Mr Devlin's family. M/s Walkinshaw, solicitor, Edinburgh represented the Scottish Prison Service and Mr Sibbald, solicitor, Glasgow represented the Prison Officers Association. The Crown led evidence from M/s Clare Pratt-O'Neill, M/s Diane Kelsey, M/s Susan Fraser, M/s Amanda Todd, Messrs David Wood, David Hatley, David Ramsay, William Kerr, Forest Dick, and Detective Sergeant Colin Lorimer. In addition they lodged affidavits taken from Doctor Laura Cochrane and Messrs Steven Keenan and George Stewart. No evidence was led from any other party represented at the inquiry. There were two joint minutes of agreement which agreed the post mortem report and letter from Doctor Pounder and various statements from witnesses.

In submission all parties were in agreement regarding the content of my determination in terms of section 6(1)(a) and (b) of the 1976 Act. M/s Kynaston submitted that all reasonable precautions had been taken in terms of section 6(1)(c). All persons who had contact with Mr Devlin over 1st and 2nd April 2011 had agreed on the same course of action. Doctor Shona Sinclair had seen him on 2nd April 2011. She had no particular concerns and suggested the ACT 2 Care procedure. M/s Amanda Todd considered that observations every sixty minutes was appropriate. All witnesses knew Mr Devlin from his previous sentences. His incarceration in

April 2011 was the first time he had been placed on ACT 2 Care. All the relevant personnel were trained in ACT 2 Care and all care had been taken in making the necessary assessments at the appropriate time. The assessments were based on the information provided and Mr Devlin's presentation. The ACT 2 Care form had followed Mr Devlin following his incarceration and thus the information contained in the form was known by all. A decision had to be made on that basis. The information provided by a prisoner had to be taken at face value. To place all on anti psychotic medication or with suicidal thoughts in an anti ligature cell was going too far. Hindsight was a wonderful thing but Mr Devlin's appearance was consistent with his constituting a low risk. Reasonable precautions had been taken in his assessment. No further determination required to be made in terms of section 6(1)(d) and (e).

Mr McIlravey submitted for the family that the ACT 2 Care procedure was a one size fits all one. The form was brief and provided no depth. He drew attention to the various parts completed in Crown productions 3 and 4. In page 3 of production 3 the only thing flagged up was 'withdrawal.' Some parts of the forms were not completed properly albeit other written information might offset this. The interview Mr Devlin had with M/s Todd lasted fifteen minutes. If she was the only person with 'hands on' psychiatric experience this was a limited period. A full assessment of a patient could take between one and a half and two hours. The training of other persons involved in the ACT 2 Care procedure consisted of prison officer training and refresher courses. The procedure was not 'hands on'. No independent psychiatrist was involved. The indications were that trained psychiatric involvement was needed albeit this did not need to be automatic. The ACT 2 Care form was not fit for purpose. The training was not sufficient to enable the necessary judgement call to be made. When persons were intent on killing themselves the level of risk was not identified. Mr Devlin's true intention was never

properly identified. There was no evidence that an anti ligature cell was not available. An incorrect assessment and decision had been made. Cues and clues had been available. The ACT 2 Care procedure had gone wrong but the way in which the system worked and the way in which the forms were completed inevitably meant that there were break downs in the system. No officer had been told about Mr Devlin's suicidal thoughts. The clues had been noted but not followed through.

M/s Walkinshaw submitted that there should be no determination apart from the formal determinations in terms of section 6(1)(a) and (b). The risk assessment was not a crystal ball. There was no evidence that there were defects with the ACT 2 Care forms or training. Messrs Wood, Hatley and M/s Todd all felt competent to carry out the assessments. Reference was made to Crown production 3 and pages 2 and 3. The different answers in the reception risk assessment and the health care risk assessment could be explained because these parts had been completed by different persons. In those circumstances it was reasonable for the assessments to differ. Mr Devlin may have given different answers to different persons. She made reference to the evidence from M/s Pratt-O'Neill. The officer at reception had not given evidence. The completion of the forms by M/s Pratt-O'Neill and her interview had been appropriate. There was no evidence to suggest her assessment had not been appropriate. She noted that it was possible for a comment to be made regarding the provision of psychiatric services. She referred to Crown production 4 and the evidence of the ACT 2 Care case conference. There was no evidence as to why Mr Devlin had committed suicide.

Mr Sibbald had little to add. The actions of the various prison officers were consistent with the appropriate care being provided in terms of ACT 2 Care procedure. They were experienced officers. Their actions were consistent with the assessments made by the medical staff.

A significant number of the facts were not really disputed. Mr Devlin had released from HM Prison, Perth on 22nd March 2011. He had attended his medical practice on 23rd March 2011 and had been prescribed Zopiclone. Two days later he attended the practice again and received further Zopiclone and Fluoxetine. The latter medication was increased due to his low mood. He attended the practice again on 28th March 2011 and complained of low mood and distress at his sister's disappearance.

Mr Devlin was detained on 31st March 2011 at his mother's home. He had gone there after the incident which resulted in his apprehension. In discussion with his mother at that time, he said that he was suicidal as he was devastated about his sister. He heard voices telling him to kill himself. On his detention it was recorded that he was assessed as 'Special Risk' and he was to be visited in the cells hourly. The self risk assessment questionnaire indicated that he had mental health problems, was on medication, and his mental health issue was depression, possibly bipolar. No attempts at self harm or suicide were noted. Following his court appearance on 1st April 2011, he was transferred to HM Prison, Perth and arrived at around 3pm. During the journey he was described as quite loud and was asking for 'smokes.' There was a discussion about his sister with another prisoner on arrival with Mr Devlin becoming slightly confrontational.

On admission to HM Prison, Perth, there was an initial assessment carried out at reception. He was then seen by Miss Pratt-O'Neill, a practitioner nurse. She required to assess the new prisoners physical and mental health prior to their seeing a doctor the following day. She knew Mr Devlin. She had received the ACT 2 Care Reception Risk Assessment form which indicated that he was neither suicidal nor liable to self harm. The form likewise indicated that he did not have mental health problems. It also indicated that he had never previously been made subject to the ACT 2 Care procedure. Miss Pratt-O'Neill noted that, whilst Mr Devlin had never attempted suicide or self harm previously, he did indicate that he felt suicidal albeit at that stage he did not feel like harming himself. He was down due to family issues and heard voices telling him to kill himself. She had a good relationship with him. He seemed fed up being back in custody. She did not consider that he was his usual self. He was tearful and she had concerns for him. He did not wish to be placed on suicide watch. However, Miss Pratt-O'Neill decided he should be placed on hourly observation in a normal cell notwithstanding his protestations. She had considered more regular observation but had decided to stick to the hourly checks in part due to Mr Devlin's protestations. She recollected that he said that he would not commit suicide. This assessment had lasted twenty minutes which was twice the normal duration for such an assessment. She had wanted to gauge his feelings during her assessment. She noted that he had poor eye contact. Her assessment was very much for the purposes of seeing Mr Devlin through his first night. He would be seen again the next day. She put in place phone and listener access. This would provide some support for him. She concluded that he should keep his own clothing to maintain normality and be placed in a normal cell in accordance with Mr Devlin's wishes. Such a cell had television which acted as a distraction. In the event of a prisoner being placed in an anti ligature cell, there were no distractions and the prisoner was very much left with his thoughts. The anti ligature cell consisted of a bed with a rip proof mattress and bedding. There

is no stimulation provided by the likes of radio or television in the cell. The cell has a stainless steel sink and toilet.

He was admitted to A Hall. He denied to the prison officer that he would commit suicide albeit he mentioned that his sister was missing. Mr Devlin sought a move to B Hall but the officer considered this request was not a genuine one. He was placed in a cell with another prisoner, Mr Eric Brown. He seemed keen to receive his medication. Mr Devlin called his mother. Apart from mentioning that he had been put on suicide watch at the beginning of the call, nothing else untoward was said during the call and there was nothing said giving an indication that he intended to commit suicide. He may have suffered a fit although the opinion formed by officers was that this was a means to obtain medication. He was noted as apparently sleeping through the night.

Initially when in the cell with Mr Brown, Mr Devlin was aggressive with him. He was on edge and made threats towards staff and later towards other prisoners. He made mention of his sister and that she was missing. He wrote a complaint about staff. Mr Devlin pretended that he had suffered an epileptic fit. His behaviour in the cell had made Mr Brown feel unsafe.

On 2nd April 2011 officers gained the impression that Mr Devlin was quite happy. He was a lot calmer. He appeared fine to Prison Officer Kelsey. He engaged in conversation. He was demanding asking for various items such as tea bags, sugar, and paper from her colleague Officer Hatley. He saw the doctor in the health centre at 11am. He asked for his cell mate to be moved. Following the appointment with the doctor, her assessment of Mr Devlin was that he should remain on ACT 2 Care pending the case conference later that day. The doctor noted that

whilst he felt low and needed support he was calm, maintained good eye contact and communicated well. He said that he did not wish to kill himself.

Mr Devlin attended a pre case conference with M/s Amanda Todd at 2.30pm. She noted the family suicides and that he would benefit from remaining on ACT 2 Care despite his denial of thoughts of suicide. He told M/s Todd that he heard voices telling him to kill himself. The pre case conference lasted fifteen minutes. Thereafter Mr Devlin attended a case conference with M/s Todd and Messrs Wood and Hartley. The general view of the staff was that Mr Devlin did not constitute a high risk of self harm. Hourly supervision was appropriate. The staff at the conference observed Mr Devlin's non verbal responses as well as considering his verbal responses. He presented well. He engaged with those in attendance. He had a photograph of his sister with him and a letter. He was forward thinking. The assessment of Mr Devlin reached at the conference was that he was communicating well and his eye contact was good. He repeated that voices told him to end his life but he was not feeling suicidal. He was assessed as low risk. The conference concluded that his behaviour would be monitored by staff and a referral would be made to a psychiatrist. Arrangements were made for him to see the psychiatrist the following Monday. The hourly observation regime was to continue in place. If Mr Devlin felt he required help, he could have persons to come and talk to him. Whilst a doctor was not on duty, one could be called in. The conference lasted twenty minutes approximately.

On 2nd April 2011 he was taken to surgery around 4.30pm to obtain medication. He only received a daily dose but argued for a weekly dose. He was told the reason for the daily dose was because he was on ACT 2 Care. He took the medication, which was an anti depressant whilst at the surgery. Susan Fraser, the nurse administering the medication, had no concerns

about suicide. Later on, he discussed with Prison Officer Ramsay how he could get off ACT 2 Care as he was not suicidal. He asked for paper, pens, and complaint forms. He did not appear suicidal to the officer, who was content he would be observed hourly.

He telephoned his mother on 2nd April 2011 in the late afternoon and asked her to send some money. He sounded down and they discussed whether there was any news concerning his sister. He also discussed the strengths of the case against him which had resulted in his remand. He thought it would be dropped.

During the evening of 2nd April 2011 until he was discovered hanging, Mr Devlin was observed at 8.15pm, 9pm, 10pm and 11pm. None of these observations raised anything of concern. He was found hanging at 11.50pm. At that time the observation hole was covered up with a piece of paper. Albeit this obstruction caused officer Kerr concern, he did not expect to find that Mr Devlin had taken his own life. In his cell was recovered a note from Mr Devlin to his mother.

Turning to the manner in which mental health issues are dealt with in the prison estate and Perth in particular, the mental health team at H M Prison, Perth consisted of two psychiatrists, a mental health nurse in M/s Todd, albeit her mental health training was learning disability, a mental health manager and perhaps another nurse. Prisoners on admission to the prison establishment are assessed for their physical and mental welfare. The initial document is an ACT 2 Care Reception Risk Assessment which is completed in part by the reception officer and part by the reception nurse. This assessment is to cover the first night in custody before the prisoner is seen the following day. If a risk is identified, the nurse then completes the first part of the ACT 2 Care document. The completion of these documents can be of necessity time

limited. Access can be gained to prior prison records if a risk is identified. The ACT 2 Care document deals firstly with an immediate care plan to be put in place until a case conference can take place. The documentation details what is required for that immediate care plan and that it has been complied with for twenty four hours.

Prior to the first case conference, a further health assessment takes place. Thereafter, the case conference, which requires the three prison staff attending to be trained in the ACT 2 care procedures, takes place. The staff in attendance consists of the manager, residential officer, and a nurse. If a risk assessment is made, a care plan is decided upon and a further case conference is arranged. The level of risk decided upon at the case conference is the one considered by any of the participants to be the highest having regard to the wellbeing of the prisoner. A doctor's assessment does not have to be carried out in all instances and in actual fact was not required in the case of Mr Devlin, albeit one took place.

All the staff concerned in the assessment of Mr Devlin were trained in the ACT 2 Care procedure. This involved attending an initial course then annual updates and refreshers which involved classroom and on line training.

In considering the issues raised by sections 6(1)(c) to (e), the focus has to be on what was decided at the case conference. I do not consider that any decision taken in the first twenty four hours of Mr Devlin's admission plays any real part in the matters I have to consider in terms of the relevant statutory provisions. The decisions taken by Miss Pratt-O'Neill were appropriate to get Mr Devlin through his first night. That was her remit and her decisions fulfilled their intended purpose. She clearly had some concerns about Mr Devlin's presentation and these

matters cannot be ignored when regard is had to the conclusion of the case conference the following day. These concerns notwithstanding however, she still concluded that Mr Devlin be made the subject of hourly observation and be accommodated in an ordinary cell. She decided against placing Mr Devlin in an anti ligature cell based on her assessment of him which included his responses to her. With the measures Miss Pratt-O'Neill considered appropriate, Mr Devlin got through his first night back in prison.

The following day all the evidence points to Mr Devlin being more upbeat. His mood seemed better than that observed by Miss Pratt-O'Neill. He was looking ahead. The case conference decided, in effect, to continue the measures Miss Pratt-O'Neill had put in place. Mr McIlravey criticised the ACT 2 Care procedure as one size fits all. There was pressure on the system and there were no in depth assessments made of prisoners on their admission. The procedure was not fit for purpose. Training was lacking. If the correct assessment had been made, a clear risk of Mr Devlin self harming would have been identified and he would have been placed in an anti ligature cell.

I disagree with Mr McIlravey's assessment. Firstly, the original assessment by Miss Pratt-O'Neill and the measures put in place by her were perfectly adequate for Mr Devlin's first night. He was in a better mood the next day when the case conference took place. The reasons for deciding against placing Mr Devlin in an anti ligature cell were explained and these explanations made clear sense to me. In addition, I have no difficulty in accepting that it is important for prison staff making the assessments to have a rapport with prisoners and for prisoners to have trust in such staff. Whilst what a prisoner tells staff cannot of itself be the basis of any assessment of risk, nonetheless it makes perfect sense that if a prisoner tells staff that he

has no intention of committing suicide but is nevertheless placed in an anti ligature cell, rapport and trust between the two will be damaged, perhaps irreparably. That is not in the interests of the prisoner's welfare. It should not be forgotten that a significant number of prisoners will, in any event, have a somewhat jaundiced view of authority figures. An anti ligature cell is Spartan to say the least. To be placed in such a cell when staff are being told by the prisoner that there is no question of self harm might well be considered a punishment as opposed to protection by the prisoner.

By the time of the case conference all indications were that Mr Devlin was planning ahead. He was engaging well. In the absence of any evidence to show that there were indicators pointing to his being likely to take his life and these were not picked up and acted upon, I am afraid Mr Devlin's suicide was something which no one could have reasonably foreseen. Not one witness said anything other than they were surprised at his suicide.

Turning to the ACT 2 Care procedure itself, there undoubtedly is an element of one size fits all. However, in the absence of any evidence indicating that this procedure is not fit for purpose and something else could be introduced which would do the job better, I do not consider that any determination can be made in terms of the remaining subsections. Undoubtedly, a significant number of prisoners will have psychiatric or substance abuse issues. Others may be facing the prospect of incarceration for the first time. These might all benefit from a more in depth psychiatric input but no evidence was led as to the availability of relevant resources, the cost, or the feasibility of actually carrying out such assessments. Thus there is nothing to justify any further determination in my opinion.

I would conclude by offering my sincere condolences to Mr Devlin's family.