SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Inquiry into the circumstances of the death of Alan Michael Mullin

Determination

by

Sheriff Principal Sir Stephen S T Young Bt QC

Inverness, 15th September 2008

In terms of the undernoted sub-sections of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976 the sheriff principal determines as follows:-

Section 6(1)(a)

1. The late Alan Michael Mullin (date of birth 25th February 1973) died at H M Prison, Porterfield, Inverness at about 9.50 am on 9th March 2007.

Section 6(1)(b)

2. The cause of Mr Mullin's death was suicide by hanging.

Section 6(1)(e)

3. In the months before his death there was a very high risk that sooner or later, and whether he was in prison, in hospital or at large in the community, Mr Mullin would attempt to commit suicide, and would succeed in doing so.

4. Within the framework of the current law, and so far as the evidence disclosed, there was nothing that could reasonably and properly have been done by anyone with whom he came into contact significantly to reduce this risk.

Note

[1] Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that at the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction –

(a) where and when the death and any accident resulting in the death took place;
(b) the cause or causes of such death and any accident resulting in the death;
(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
(e) any other facts which are relevant to the circumstances of the death.

[2] In many cases following a fatal accident inquiry I have not thought it necessary to make detailed findings in fact under sub-section 6(1)(e) of the Act. But there have been a few cases where I have thought it necessary or appropriate to do so in order to illuminate my consideration of the question whether any findings should be made under sub-sections 6(1)(c) or (d). At the conclusion of the evidence and submissions in this particular inquiry I had anticipated that this would be one of those exceptional cases in which I would require to make such detailed findings, and indeed counsel for Mrs Mullin most helpfully proposed what I might say in this respect.

[3] On reflection, and having had an opportunity to review carefully the evidence, productions and submissions, I have come to the conclusion that it is unnecessary to make detailed findings in this case under sub-section 6(1)(e). I say this because at the end of the day I am persuaded that this is an essentially simple case in which the detailed events leading up to the death of Mr Mullin, which in other cases might form a very important part of the overall story, effectively pale into insignificance in the face of, and should not be allowed to deflect attention from, the overriding considerations which I have sought to summarise in my findings 3 and 4. Here it will be recalled in particular (a) that Dr Sundeep in his evidence (which was not contradicted) gave compelling reasons for concluding that Mr Mullin was at very high risk of attempting and completing suicide, (b) that in the two months or so before his death Mr Mullin had made two very serious attempts to take his own life, firstly by stepping in front of a passing motor vehicle in the vicinity of the Kessock Bridge, and secondly while a patient at New Craigs Hospital by breaking a cup and slashing his throat during the night of 28/29th January 2007, and (c) that on no less than three occasions in the six weeks before his death, namely on 1st, 16th and 26th February 2007, Mr Mullin was seen by three separate consultant psychiatrists, none of whom considered that his medical condition was such that he could lawfully be detained against his will under the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003.

[4] Counsel for Mrs Mullin submitted under reference to sub-section 6(1)(c) of the 1976 Act that there were two reasonable precautions whereby Mr Mullin's death might have been avoided. In the first place she submitted that his death might have been avoided if he had been remanded into psychiatric care (in other words to New Craigs Hospital) rather than to prison when he had first appeared before the sheriff at Tain Sheriff Court on 20th February 2007. This of course begs two questions, namely (a) what would have happened if the procurator fiscal at Dingwall had at that stage done what he ought to have done in terms of section 52 of the Criminal Procedure (Scotland) Act 1995, namely to bring before the court such evidence as might be available of the mental condition of Mr Mullin, and (b) whether an assessment order would thereafter had been made in respect of Mr Mullin under section 52D of the 1995 Act so that he could then have been detained in hospital. Here it will be recalled that, when she saw him at the police station in Inverness on 19th February 2007 Dr

Rajasundarum did not (according to what she said in examination-in-chief) apparently consider that Mr Mullin could lawfully be detained under the provisions of the 2003 Act at that time, or at least (according to what she said in cross-examination) did not consider it necessary to detain him. If, when he appeared before the sheriff the following day, the procurator fiscal had done what he ought to have done, the outcome would almost certainly have been that the case would have been continued without plea for a week and Mr Mullin in all likelihood would have been remanded in custody to prison pending the preparation of a psychiatric report upon him. This would have been carried out by someone such as Dr Hay, and his evidence (which again was not challenged) was that when he saw Mr Mullin in prison on 26th February 2007 his condition was such that he would have had no formal psychiatric recommendation to make. In other words, the probability has to be that, when he next appeared before the sheriff on 27th February 2007, far from making an assessment order under section 52D in respect of Mr Mullin, the sheriff would have again remanded him in custody to prison unless by then he had been able to produce a satisfactory bail address (and there was no evidence to suggest that he would have been able to do this). Moreover, even if he had initially been detained in hospital in pursuance of an assessment order under section 52D, his responsible medical officer would have been obliged within the succeeding 28 days or on a change of circumstances to submit a report in writing to the court under section 52G, and in my opinion the probable outcome of this in light of the apparent improvement in Mr Mullin's condition while in prison, and in light also of what had happened during his previous stay at New Craigs Hospital, would have been that the assessment order would have been revoked and Mr Mullin committed to prison under section 52G(3)(b) of the 1995 Act. And, even if he had been detained in hospital rather than in prison, I think that it has to be acknowledged that, given the constraints imposed by the current law on the freedom of others to take preventive action, it was very likely to have been only a matter of time before Mr Mullin succeeded in taking his own life, either in hospital or elsewhere.

[5] Counsel for Mrs Mullin submitted in the second place that Mr Mullin's death might have been avoided had a Transitional Action Plan or a medical marker been put in place after he ceased to be subject to the Act 2 Care procedures on 28th February 2007. She drew attention to the fact that, when he had ceased to be subject to these

procedures, he had been placed in a specially selected cell on the ground floor of B Hall in the prison with a specially selected cellmate, and she suggested that the morning of 9th March 2007 when he took his life was the first occasion on which he had been left in his cell alone and unobserved since his imprisonment. She submitted that, had a Transitional Action Plan or medical marker been put in place after Mr Mullin had ceased to be subject to the Act 2 Care procedures, then the fact that he was going to be on his own and unobserved in a cell for the first time on the morning of 9th March 2007 might have been flagged up and steps might have been taken to keep a closer eye on him in the new situation in which he found himself. Strictly speaking I dare say that it was true that the morning of 9th March 2007 was the first occasion on which he had been left in his cell alone and unobserved since his imprisonment, but whether in practice he had never been alone and unobserved for any length of time in his cell since 28th February 2007 is by no means clear in light of the evidence. Besides, even if a Transitional Action Plan or a medical marker had been in place, I do not think that the evidence justifies the conclusion that it might have prompted the residential officers in the hall to consider whether it would be prudent to leave Mr Mullin alone in his cell after the departure of his cellmate early in the morning of 9th March 2007. Nor do I think that he would necessarily have been observed by these officers any more closely had a Transitional Action Plan or a medical marker been in place than he was in any event. And, even if he had been more closely observed by the hall staff, it does not appear that there would have been anything in his behaviour that they would have seen which would have given them any particular cause for concern that he ought once again to be made subject to the Act 2 Care procedures. As for the point made by counsel that the operational officers on duty during Mrs Mullin's last visit to Mr Mullin during the afternoon of 8th March 2007 might have been more likely to have noticed the behaviour on his part that so concerned Mrs Mullin, I think that this must be considered doubtful in light of their evidence as to their duties at the time and the circumstances prevailing in the visiting room. Besides, as I understood the evidence, as operational officers they would not have been aware of the existence of a Transitional Action Plan or a medical marker, let alone any advice or warning that might have been given in either of these. Furthermore, as the solicitor for the Scottish Prison Service pointed out, it is by no means clear that, even if a Transitional Action Plan or medical marker had been put in place, it would have remained active, so to speak, for more than seven days after 28th February 2007.

Here the Guidance Notes at the head of the Transitional Action Plan document should be recalled. These read, *inter alia*:

> **Now that the person presents No Apparent Risk,** the purpose of this Transitional Action Plan is to ensure that any outstanding issues that were planned during his/her time on ACT are addressed. This should assist his/her safe return into his/her normal regime for the first seven days after closing the ACT Document. In relation to the Prisoner's location, the outcome of the Cell Sharing Risk Assessment should be taken into consideration.
>
> If there are no specific issues or actions identified: Chairperson completes this section and no further action is required.

[6] It is true that in his notes on the Care Plan Daily Report dated 26th February 2007 Dr Hay noted: "Suggest – continue ACT but look to dropping to medical marker if remains stable as at present". It is important to notice that this was not, as counsel appeared to indicate at times, an instruction but merely a suggestion, and for the reasons indicated I am not at all persuaded that the outcome to this case might have been any different if this suggestion had been acted upon by those present at the final Case Conference on 28th February 2007. All I will say here is that I hope that Dr Hay (who was a most impressive witness) will not think it remiss of me to comment that I cannot help wondering whether it was perhaps unfortunate that, in referring to a medical marker in the context of an Act 2 Care document, he should have used terminology that might have been appropriate under the previous version of the Act 2 Care strategy but it seems is not appropriate under the current version. Here I think that the solicitor for the Scottish Prison Service was right to emphasise the distinction between, on the one hand, the procedures under the Act 2 Care strategy which are designed to deal with those prisoners who are perceived to be at risk of suicide or self-harm and, on the other hand, the use of medical markers which may appropriately be issued for a variety of purposes related to a prisoner's physical or mental health not connected with the risk of suicide or self-harm. So long as there is such a risk, it may be said that the way to deal with it (and incidentally avoid any subsequent misunderstanding) is by the procedures under the Act 2 Care strategy.

[7] Both counsel for Mrs Mullin and the procurator fiscal drew attention to the fact that, on the assumption (which may or may not have been correct) that her opinion was that Mr Mullin was not fit to be detained when she examined him in police custody on 19th February 2007 and ought to be taken to New Craigs Hospital, Dr Rajasundarum certainly did not convey this clearly to Sergeant Ross at the police station. Her notes of her examination of Mr Mullin appear in a small section on the police form which is headed: "Injuries / Medical Conditions / Complaints / Medication Required". The section itself is headed: "Diagnostics and instructions regarding Medication and/or Treatment". In it Dr Rajasundarum wrote: "Self-harmed & taken into custody. Was an ex-pt of New Craigs. Willing to go voluntarily for re-assessment. New Craigs informed".

[8] From previous experience of seeing police surgeons' reports, I was surprised to see that Dr Rajasundarum had produced such a brief and, it may be said, unhelpful report in this particular case. Rightly it was not suggested here that any criticism should be levelled at the police. Nor was it suggested that the inadequacy of Dr Rajasundarum's instructions had made any difference to the eventual outcome in this case. But I agree that the police form ought perhaps to be recast, if this has not already been done, so that upon completion of it the examining doctor may leave the police in no doubt (a) whether in his opinion the accused is fit to be detained in police custody, (b) whether in his opinion the accused is sane and fit to plead, and (c) what are the doctor's instructions, if any, as to the future care of the accused.

[9] Quite apart from its possible significance in the context of sub-section 6(1)(c) of the 1976 Act, counsel for Mrs Mullin was also critical of the failure by the procurator fiscal at Dingwall to consider the provisions of section 52 of the 1995 Act when Mr Mullin was first brought before the sheriff on 20th February 2007. Plainly he ought to have done so, as he himself acknowledged, but I would add here that one ought perhaps not to be altogether surprised, given the plethora in recent years of reforms to the criminal law and procedure, that even someone as experienced as this particular procurator fiscal should have overlooked the amendment to the definition of mental disorder which was made by section 328(1) of the 2003 Act.

[10] Again apart from its possible significance in the context of sub-section 6(1)(c), counsel for Mrs Mullin was critical of the fact that no Transitional Action Plan or medical marker had been put in place on 28th February 2007 despite Dr Hay's advice (as counsel put it in her submissions) that this should be done. She submitted that this was an error in procedure, that it could not seriously be suggested that the were no outstanding issues in relation to Mr Mullin and that the Act 2 Care strategy required a Transitional Action Plan where such outstanding issues existed. She contended that Dr Hay had recommended (as she put it) that a medical marker should be put in place and that no evidence had been led to explain why his advice had not been followed. She also suggested that there had been some divergence of views among the prison officers and prison medical staff who had given evidence about the situation in which a Transitional Action Plan or a medical marker might be appropriate when a prisoner came off ACT, what such a plan or marker would require and what sort of information it should contain.

[11] I have already commented upon the potential danger of confusion between, on the one hand, the procedures under the Act 2 Care strategy, including the use of a Transitional Action Plan, and on the other hand the use of medical markers. In one sense of course it was true that there were outstanding issues in relation to Mr Mullin in as much as he was, for the reasons so clearly explained by Dr Sundeep, always going to be at very high risk of suicide. So in theory at least it may be said that he should not have been taken off the Act 2 Care procedure at all on 28th February 2007. But counsel did not suggest this, nor was the question explored in the evidence what, if anything, could or should be done in the context of the Act 2 Care strategy, or otherwise, to resolve the dilemma for prison staff created by a prisoner such as Mr Mullin who is permanently at very high risk of suicide or self-harm but who at a given point in time may quite reasonably be thought to be at no apparent risk of attempting suicide or self-harm in the immediate future and whose medical condition is such that compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 would not be justified. Nor at any stage during the evidence did it become clear what, if it had been put in place, a Transitional Action Plan (or for that matter a medical marker) would have said that might have altered the outcome in this case.

[12] Finally counsel for Mrs Mullin drew attention to the fact that Mr Mullin was not given his prescribed dose of Olanzapine on 7th March 2007. She did so, as she put it, not for the purpose of attributing blame, but in a spirit of constructive criticism so that the system might be addressed in the hope that this sort of thing would not happen again. She suggested that two copies of the drugs cardex should be kept, one in the room where medicines were issued and the other with the prisoner's main medical records. To this I would merely say that so long as a system requires to be operated by human beings it is almost inevitable that the occasional mistake will be made, that the fact that this was the first time that this particular mistake had been made in twenty years according to the witness Mr Hamilton (whom I had no reason to doubt) suggests that the system operated at the prison must be a most effective one, and that to keep two copies of the cardex as counsel suggested seems to me to be a recipe for the introduction of confusion which does not exist at present.