SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT ABERDEEN

DETERMINATION

by

SHERIFF KIERAN McLERNAN

in

FATAL ACCIDENT INQUIRY

into the death of

MARK DIXON

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1. On 4th January 2008 Mark Dixon died in cell 2-23 A Hall in HM Prison, Craiginches, Aberdeen.

2. The time of death was between 5.15 am and 6.20 am.

3. The cause of death was hanging by means of a ligature around the neck.

4. The effect of body weight or partial body weight being supported by a ligature around the neck is to apply pressure to the ligature. Sufficient such pressure cuts off the supply of air to the lungs and blood to the brain. The cutting off of blood to the brain will result in unconsciousness generally within the period of 30 seconds. The cutting off of air to the lungs deprives the blood of oxygen even if blood were getting to the brain; deprivation of oxygenated blood will result in unconsciousness generally within less than 2 minutes.

5. Hanging by means of a ligature around the neck is a very rapid and effective way of stopping oxygenated blood getting to the brain and leading to unconsciousness and death.

6. Mark Dixon appeared before the High Court at Aberdeen on 3rd December 2007 and was remanded to HM Prison, Aberdeen until 8th January 2008.

7. He was taken to HM Prison, Aberdeen and arrived at 15:40.

8. The Scottish Prison Service operates a system for assessing the care needs of every prisoner they receive. The general title given to the system is the ACT2 care system.

9. An initial assessment is carried out immediately on admission of the prisoner by the receiving officer and recorded in a form entitled Act 2 Reception Risk Assessment Document. The form indicates that the receiving officer must have received training in the Act 2 care procedures. Risk in this context means risk of self-harm or suicide. The reception document commenced on the admission of Mark Dixon recorded that he had previously been in custody.

10. Section 2 of the document requires the receiving officer to ask 10 questions with yes/no answers designed to elicit information relevant to an assessment of likely risk. In addition the receiving officer has to record his observations of whether the inmate is suffering from anxiety, anger, confusion, disturbance in demeanour or action and any factor giving rise to suspicion of him having a learning or mental health difficulty.

11. The form opened for Mark Dixon records that Mark Dixon was observed to be suffering from the effects of drink and that he found his imprisonment unexpected. The receiving officer recorded him as being "no apparent risk".

12. The next phase of the Act 2 admission procedure is for a further assessment to be carried out by a prison nurse. Mark Dixon was assessed by the prison nurse at 16:50 on the same day. The nurse recorded that he had not received or asked for any

treatment for mental health or psychological problems but that he had burnt his arms in custody before and felt like hurting himself.

13. She recorded that he had been subject to the Act 2 Care system when in custody before and he may now be suffering from a hangover. She assessed that there may be a risk and queried if he should be regarded as low-risk.

14. The next phase of the reception document procedure is for the prison doctor to assess the risk. This assessment has to be done within 24 hours of admission. Dr Gamba completed his assessment at 10.30 hrs on 4th December and concluded that there was no risk and he recorded on the form "no thoughts of self-harm or suicide".

15. The system provides that where any risk is identified by any of the assessors a file is created called an ACT2 Care Document. In accordance with that system, as the nurse had identified a possible risk, the nurse opened an ACT2 Care Document on 3rd April 2007. That document records that at 16.30hrs. on 3rd April Mark Dixon had stated he was not suicidal but he may harm himself although he later retracted that suggestion in interview under the explanation that he was hung-over having taken large amounts of alcohol. He did state however that he was very anxious and had on a previous occasion burnt himself.

16. The system provides that decisions on what care is to be provided are arrived at by a multi-disciplinary team who attend the case conference to discuss the assessment of risk and further procedure.

17. In the light of the nurse's query about whether or not he was low risk, a case conference was convened almost immediately at 5.00 pm on 3rd December 2007 and was attended by the residential manager, the nurse, a prison officer and Mark Dixon. The case conference found that he was seemingly still under the effects of alcohol although able to communicate satisfactorily. He stated he had no thoughts of suicide. The case conference decided to classify him as low risk as a precaution and to monitor him for 48 hours.

18. The system provides that once a prisoner is classified as low risk certain procedures are followed. First, action is taken to address any precipitating factors that may have been identified. None were identified at that time. Second, a care regime in the context of remand in custody has to be agreed by the team. In the case of Mark Dixon the Hall regime was thought to be appropriate but with contact between him and staff every 30 minutes. He was allocated to a standard cell in A Hall. Third, a further case conference is fixed. The date allocated for that was 5th December 2007.

19. At 21:00 hours on 3rd December Mark Dixon was transferred to A Hall and reports were recorded by staff in the morning, afternoon and night shifts until 15:40 on 5th December.

20. The system which calls for observation and contact with the prisoner at intervals I shall refer to as the contact regime.

21. The regime adopted by the prison service as part of the ACT2 strategy is based on the primary proposition that the best chance of preventing suicide is to create an environment where prisoners feel able to talk about their problems to the staff. A secondary proposition is that an environment of isolation, of bare cells shorn of any furnishings which may be foreseen to be a cause of harm, and provision of anti-ligature clothing is not likely to encourage prisoners to talk openly to staff about their problems. Such latter environment may exacerbate an inclination to suicide or self-harm.

22. Accordingly when seeking to implement the strategic aims of the system prison staff are encouraged to foster an approach of personal caring contact with the prisoner rather than deprivation of comfort and support.

23. A prisoner classified as low risk will therefore normally be treated with a regime which allows him the usual comforts of a normal cell supplemented with a specific increased contact with the prison staff. The rate of contact is determined by the case conference in the light of the particular circumstances of each prisoner.

24. The only problem noted over the next two days was that he was desperate for his medication namely methadone and diazepam when his cell was unlocked on 5th December. After some delay all medication required was supplied and by noon he was recorded as being "happier now".

25. The next case conference was convened in A Hall office at 14:30 on 5th December. In attendance were Mark Dixon, the gallery officer, the nurse and the residential manager.

26. Prior information was reviewed and an assessment made of the effect of the current regime. He was recorded as having stated that he now had no thoughts of suicide or self-harm and that he would approach staff if he had any concerns and that he was communicating with staff and seemed much happier. Accordingly, the case conference reduced the classification risk to no apparent risk. That file was then closed.

27. Between 5th December 2007 and 29th December 2007 Mark Dixon received 14 visits from his girlfriend. The longest period between visits was the interval of 5 days between 24th and 29th December.

28. On 27th December Prison Officer Young had a discussion with Mark Dixon. At 13:55 he opened another ACT2 care document file as he had found that Mark Dixon was very agitated as he had not got a visit slip to show that his girlfriend would be visiting him on that day and he had stated that unless he got a phone call to her to find out why she had not come then they (the prison staff) would find him hanging from the bars. The prison officer had ascertained from him that Mark Dixon had been told that his wife had been seen to leave the prison hand in hand with another person and Mark Dixon had indicated that he was not in control of his thoughts at that time.

29. In addition to opening a further care document file the officer decided to take immediate action and took Mark Dixon to a place of safety, namely the segregation unit and a case conference was arranged. In the segregation unit there was phone listening access and direct observation at intervals at not less than 1 hour.

30. At 14:55 the nurse, having been asked by the residential manager to assess Mark Dixon, interviewed him and noted that he had maintained good eye contact and answered all the questions. She had ascertained however that he was not getting on well with his cell mate and was apprehensive and suspicious of an anticipated visit from his girlfriend.

31. At 20:00 hours on the same day a case conference was convened attended by Mark Dixon, the residential manager, a prison officer and nurse. By this time the anticipated visit from his girlfriend had taken place. Mark Dixon is recorded as being much happier and apologising to the case conference for the trouble that he had caused and he stated that his relationship with his girlfriend was okay. He was reassured that the conference was there to help him.

32. The case conference identified that the precipitating factors which gave rise to concern were his perception that his relationship with his girlfriend was over and further that he did not have enough to occupy his mind meantime.

33. The case conference decided that he would be classified as low risk subject to normal remand regime in a normal cell but with contact with staff at intervals of not more than 60 minutes. The date for the next case conference was agreed for 3rd January and the file kept open.

34. On 28th December Mark Dixon was noted to be very agitated as his girlfriend had not visited and also that he had fallen out with his cell-mate.

35. Given his classification the prison staff had made arrangements for the removal of his cell-mate to another cell. In addition further arrangements had been made to allow Mark Dixon another phone call to his girlfriend after tea.

36. At 21:30 on the same day it was recorded that he had had that telephone call and he felt a little better and that a visit had now been booked for the following day. He was given a model car to construct to keep his mind occupied.

37. The visit did take place and he was recorded as saying that he was a lot more at ease on the Saturday afternoon.

38. On 30th December he was reported to be in good form despite some aggressive message from a fellow prisoner who Mark Dixon felt was trying to wind him up.

39. Over the next two days he was recorded as appearing more cheerful and associating with prisoners and staff and by 17:30 on 2nd January the prison officer recorded that he was "appearing content".

40. On 3rd January the next case conference was convened at 10:30 am in A Hall. In attendance were the manager, the nurse, the gallery officer, Mark Dixon and this time the social worker. The case conference noted the underlying issue of continuing relationship difficulties with his girlfriend and the earlier statement that he would be found hanging if he didn't get a visit from her. Mark Dixon reported that he had been trying to contact his girlfriend but without any success and he had not had a visit from her. It had helped to discuss these issues with the staff and he stated that he had moved from thoughts of self-harm to thoughts of harming others but that was under control.

41. The conference decided that he was still in low mood although he had expressed no thoughts of self-harm at present he was content to continue to be monitored. Mark Dixon had indicated that he would have another try at contacting his girlfriend though he was feeling the relationship may now be over.

42. By 12:40 on 3rd January it was recorded that he had been given exceptional phone credit in order to contact his girlfriend and that he had agreed at the case conference to remain on low risk. By nine o'clock in the evening however he was recorded as having been "fairly agitated all afternoon" regarding the ongoing situation with his girlfriend. He had also been told that he was being transferred to Edinburgh on 4th January (presumably in anticipation of his trial fixed for 8th January). However he had "settled down slightly" in the evening.

43. The night report for 3rd/4th January records that he watched TV until approximately 11.00 pm then appeared to sleep but was up again at approximately 3.00 am watching TV. He was reported as still watching TV at 4.00 am.

44. The practical consequence of the contact regime is, first, that it regularly reassures the staff that the prisoner is well and second, that it reassures the prisoner that he is being kept under attention and observation and will have another contact within the hour. The case conference on 3rd January having determined that it was appropriate to continue the 1 hour contact regime the prison officer on duty visited his cell at approximately one hour intervals.

45. There is however no contemporary written record of the extent of the implement of the contact regime prescribed.

46. There is no provision in the daily duties of the prison staff for the making of such a record and accordingly there is no clear method of supervising to check that the prescribed contact regime is being followed.

47. During and following upon the case conference the staff had been particularly sympathetic to Mark Dixon recognising that he was concerned at the seeming end of his relationship and had granted extra phone credit to him to enable him to contact his girlfriend and also provided a model for him to take his mind off brooding over the relationship. He had also been given the unusual privilege of having a cell to himself. All three factors appeared to make Mark Dixon feel happier.

48. At approximately 5.30 in the morning he was seen to be standing at the end of his bed facing the window. In accordance with the usual practice Prison Officer Rait stopped to make verbal contact. She recollects what she thought was an acknowledgement by a movement of his arm.

49. At approximately 6.20am. he was seen again to be standing at the end of his bed but this time the window curtain was hanging behind his head. Prison Officer Rait called and knocked on the door but was unable to obtain a response. She ran to obtain a more experienced colleague who was in B Hall and he came and both tried to obtain

a response. A radio message was sent to the manager on duty who came and arranged for the cell to be opened and he entered. He immediately called for the crash pack. Prison Officer Rait ran to get it. The time lapse between the attempt by Prison Officer Rait to elicit a response and the entry into the cell was about 5 minutes.

50. When the curtain was lifted a piece of material was seen to be tied around a bar at the window and also around Mark Dixon's neck. The manager, Mr David Stewart, who is trained in first aid untied the material from the bar and lowered the body to the floor and put it in the recovery position and checked for a pulse. On finding no pulse the manager asked for the ambulance to be called. The nurse on duty was called who checked for a sign of life and found none. The prison doctor Dr Gamba was called and he certified life extinct. He deduced from what he found to be an unusual position of the body, given the report he had received from the prison staff, that the deceased had not been suspended but had been slumped forward with a stricture round his neck which had produced the same effect as suspension.

51. Prison Officer Rait confirmed that she had followed the recommended practice of observing the low risk prisoner approximately every hour. She had received informal advice from a colleague to vary the regularity of visits and did not adhere rigidly to intervals of 60 minutes.

52. In the light of the evidence a practice of recording the precise time of each visit would not have had any effect on preserving the life of Mark Dixon. During 3rd January there had been no indication of any intention to self-harm in any respect. There had been no apparent cue or clue to indicate any change in his apparent state of relative contentment. He had apologised to the case conference for appearing to cause trouble and had been apparently co-operative with staff for some days. There is no basis for a finding that more frequent visitations would have had any practical benefit.

53. Managers and supervisors, however, may feel more assured that the staff are following their training if a practice was followed of recording what was observed on each visit. Such attention to detail might reveal that a prisoner was writing an

unusual number of letters for example and might give an indication of a change in pattern of behaviour which could be regarded as significant. Such change might indicate the need for greater, or indeed lesser, degree of alertness by staff to the support needs of the prisoner. A balance has to be struck between the perception by the prisoner of intrusiveness and availability of support. The former can generate resentment an exacerbate any emotional instability.

54. It is a matter for those charged with implementing the system, bearing in mind the balance fore-mentioned to consider whether a modification of the system to require a prison officer to make and record more detailed observation of each contact visit would be of assistance in spotting cues or clues of changes of mood which may be significant. While the adoption of such a modification of the system may have some advantages there is on the information available no basis for a finding that there was a defect in the system which contributed to the death of Mark Dixon.

55. The discovery after his death of various letters written by Mark Dixon clearly imply an intention to self-harm that night. The existence of these writings was not disclosed to prison staff prior to his death. There was no practicable means whereby the prison staff could have become aware of an intention by Mark Dixon to adopt the course of action that night that led to his death.

56. In the circumstances there were no reasonable precautions which could have been taken but were not whereby the death of Mr Mark Dixon could have been avoided.

57. In the course of submissions a number of criticisms were made of the ACT2 care System. The Court requires to make a determination on the basis of the information before it and not indulge in speculation. Nevertheless the Court can comment on any aspects of the result of the enquiry that may be relevant.

58. It was argued that social work and medical reports should be called for and examined by case conferences prior to reaching conclusions. I do not consider that that is at all practical and immediate decisions require to be taken by prison staff. Prison is an unusual environment. For those with emotional vulnerability there is no time to wait for delivery of reports which may have no bearing on the immediate presentation of

a prisoner in the prison environment. There provision for a medical professional to obtain a history from the prisoner and I do not consider that the absence of a provision for seeking more social work and medical reports is a defect in the system.

59. It was submitted that there was a defect in the system of recording information in ACT2 files in that there is no provision for noting on subsequent ACT2 files that may be opened the existence of prior ACT2 files. That submission appears to me to assume that file is the only source of information. On the evidence before me it is plainly not by any means the only source of information. One of the main provisions in the system in use is to convene together a team to include a manager, a prison officer and medical staff. On the basis of the evidence before me it is inconceivable that information of prior history would not be known to the staff.

60. It was suggested that the absence of provision for a doctor to attend each case conference was a defect in the system. There was no submission to explain why that would assist in arriving at an appropriate care management decision. If a diagnosis of mental health deterioration was required a doctor was available on 24 hour call. All prison staff are trained to identify signs of disturbed mood and potential for self-harm. No criticism was directed to the level and quality of the training to that end. There was no evidence to suggest that the training was inadequate or ineffective and any absence of some indication that a qualified doctor's opinion be required to determine the level of risk I can make no finding on that submission.

61. It was argued that a special person should be allocated to each prisoner at risk. No reasonable argument was presented as to what benefit would flow from that suggestion.

62. It was submitted there should have been provided an intermediate cell between the normal cell and the stark and potentially emotionally damaging anti-ligature cell. In the light of the evidence in this case, that proposition runs counter to the underlying psychology of the Act 2 Care system. Availability of "normal" comfort and patently available personal support is deemed to be more effective than deprivation (no matter how well intentioned) of what might be regarded as normal comfort in that environment. There was no evidence to suggest that the psychological reasoning

behind the practical provisions was fundamentally, or in any way, flawed. The clear evidence from witnesses who spoke to this matter was that an anti-ligature cell is a distinctly unfriendly place to be avoided if at all possible. I see no reason to dispute that conclusion and make no finding on this submission.

63. It was submitted that as an electronic counter is used when checking high-risk prisoners then this should be available for low-risk prisoners also.

64. The evidence indicated that an electronic counter is used in certain circumstances as a method of confirming that staff have been to certain areas in the course of their shift. An electronic counter however is simply no more than that. It may be that a system for recording comment on each observation is far more likely to be useful for future decision-making at a subsequent case conference than electronic box-ticking. It seemed to me from the evidence the senior staff were already aware that the system for positive recording of observation may well be helpful in providing information in future to assist discussions in case conferences. I make no recommendation on the provision of electronic counters.

65. It was argued that the system for opening a cell door was too cumbersome and too long. There are plainly many factors to be taken into account when devising a system which allows a cell door to be unlocked during the night. There is no evidence at all to indicate that slowness in opening a cell would have been of any significance at all in this case. Clear evidence is that death had occurred long before the final visit.

66. It was submitted that curtains and bedclothes should not be in a cell where there is any risk at all of suicide. This matter has already been dealt with in respect of the psychological environment in which a prisoner is being kept as aforementioned. In light of the evidence available before me there is insufficient evidence to draw any conclusion on this matter.

67. In conclusion it is appropriate that I express my thanks to Miss Johnston, Mr Purdie, Mr Anderson, and Mrs Martin-Brown for their sensitive and focussed assistance in eliciting the facts.

68. The Court expressed sympathy to the family of the late Mark Dixon and I do so again especially to the mother of the late Mark Dixon who sat stoically through the whole of the evidence surrounding her son's sad death and I hope the family were reassured that it was plain from the evidence that the prison staff cared for the late Mark Dixon and were shocked and saddened at his death