

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

Inquiry held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

B17/13

DETERMINATION

by

SHERIFF J GILCHRIST QC

Following an Inquiry at Inverness Sheriff Court
into the circumstances of the death of

RYAN JAMIE McNEIL

Inverness 11 October 2013

The Sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Ryan Jamie McNeil, determines in terms of Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 as follows:

- (1) **In terms of section 6(1)(a):** that Ryan Jamie McNeil (b.22.11.92) of 15 Glassgreen Brae, New Elgin, Elgin died between 1730 hours and 1925 hours on Saturday 13 October 2012 within cell 1/08 located in B Hall of HMP Prison Inverness, Porterfield, Inverness-shire IV2 3HH.
- (2) **In terms of section 6(1)(b):** that the cause of death was hanging.
- (3) **In terms of section 6(1)(c):** that there were no reasonable precautions whereby the death might have been avoided.
- (4) **In terms of section 6(1)(d):** that there were no defects in any system of working which contributed to the death.

- (5) **In terms of section 6(1)(e):** that there are no other facts relevant to the circumstances of the death in respect of which any determination falls to be made.

NOTE:

Introduction

[1] This Fatal Accident Inquiry was held in terms of section 1(1)(a)(ii) of the 1976 Act before me at Inverness Sheriff Court on 30 September and 1 October 2013. This was a mandatory Inquiry because the deceased was in legal custody at the time of his death.

[2] At the Inquiry parties were ably represented as follows:

The Crown:	Alasdair MacDonald, SFIU North Principal Investigator
Father of the deceased:	Laura Thomson, Solicitor, Inverness
Mother of the deceased:	Martin Smith, Solicitor, Inverness
Highland Health Board:	Neil MacLeod, Solicitor, Edinburgh
Scottish Prison Service:	Catriona Watt, Solicitor, Edinburgh

I am grateful to all of them for their efficient conduct of the Inquiry and their careful, clear and helpful submissions.

[3] Many of the facts were agreed by the parties and incorporated into a Joint Minute which was read into the record at the outset of the Inquiry. The following witnesses then gave evidence, some by giving oral evidence in person and others by affidavit evidence which was read into the record:

1. Donald McNeil, father of the deceased (by affidavit)
2. Marian MacPherson, Scottish Prison Service, HMP Inverness
3. Andrew Reid, Scottish Prison Service, HMP Inverness
4. Adrian Clark, Scottish Prison Service, HMP Inverness
5. Michael Irvine, Scottish Prison Service, HMP Inverness
6. Jennifer Rankine, Scottish Prison Service, HMP Inverness (by affidavit)
7. DS Derek McGillivray, Police Service of Scotland (formerly Northern Constabulary)
8. Laura Goddard, Scottish Prison Service, HMP Inverness
9. Jacqueline Forbes, NHS Scotland, HMP Inverness
10. Dr Lynn Kelly, Southside Road Surgery, Inverness

[4] The following facts were admitted or proved:

- (i) Ryan Jamie McNeil ("the deceased") was first admitted to HMP Inverness on 15 March 2012. It was his first time in prison and he was facing a charge of attempted murder. He was remanded in custody from 15 March until he was admitted to bail on 23 March 2012.
- (ii) At the time of the deceased's remand in March 2012, the Procurator Fiscal at Elgin faxed HMP Prison Inverness to alert the institution that the deceased was considered to be a suicide risk, having been very distressed during his court appearance and his agent having expressed concern.
- (iii) The deceased was promptly and appropriately dealt with in terms of the Scottish Prison Service's suicide risk management strategy (known as ACT 2 CARE). Upon admission it was noted that he was low in mood and apprehensive about being in prison. He was immediately referred to a case conference, in which he participated, which resulted in him being assessed as low risk. However a number of measures were put in place to provide him with appropriate support. No less than five case conferences took place during the deceased's period of remand, as a result of which the degree of supervision and observation afforded to him was adjusted (on more than one occasion) as considered appropriate in the light of the most up-to-date assessment of his condition.
- (iv) All prison staff at HMP Inverness are trained in and familiar with the ACT 2 CARE strategy. The aim of the strategy is to identify prisoners who are more likely to harm themselves, to identify any trigger or event which might make self-harm or suicide more likely and to recognise signs, referred to as "cues and clues" (both verbal and non-verbal) which might indicate a risk of self-harm or suicide.
- (v) On admission to HMP Inverness, every prisoner (whether being admitted for the first time or returning from court or another institution) is made the subject of a careful consideration as to risk of self-harm or suicide. This is a three stage process involving the use of a reception risk assessment (conducted by SPS reception staff), followed by a health care risk assessment (conducted by prison nursing staff). These two stages are conducted as soon as the prisoner arrives at the prison. The final stage is conducted the following morning, when there is a final assessment of the prisoner by a medically qualified doctor.
- (vi) While making a prisoner subject to ACT 2 CARE procedures is designed to reduce instances of self-harm and prevent possible suicide, it can result in a prisoner being subjected to a considerable degree of scrutiny and suffering

additional loss of already restricted personal freedoms. If not used appropriately it can have an adverse effect on a prisoner's state of mind.

- (vii) The deceased was again admitted to HMP Inverness on 11 October 2012, having been remanded in custody by Elgin Sheriff Court pending sentencing on 8 November 2012.
- (viii) As part of the deceased's admission process, he was once again the subject of the risk assessment process described at paragraph (v) above. The officer conducting the initial reception risk assessment was aware that the deceased had previously been subject to the ACT 2 CARE procedures. This was a factor which she took into account when conducting the risk assessment.
- (ix) During the risk assessment process, the deceased displayed none of the cues and clues which would have given rise to cause for concern. All of the staff involved in the assessment process conducted the assessments in the correct manner and none found any reason for concern. Each one was familiar with the process for making the deceased subject to the ACT 2 CARE regime and would have done so if she felt it to be appropriate.
- (x) On admission to B Hall, the deceased was given the appropriate induction information. His demeanour gave no cause for concern on the part of the prison staff who came into contact with him.
- (xi) On the afternoon of 13 October 2012 the deceased was visited by his father and brother. His father noted nothing untoward about his demeanour or behaviour and had no cause for concern about his son. At the conclusion of the visit, the deceased spoke to prison staff about arranging a further visit for the following Monday. He showed no signs of distress or upset.
- (xii) The deceased was locked up in his cell for the night at about 5.15 p.m. At that time he was spoken to by prison staff who noted nothing in his demeanour or behaviour which gave rise to cause for concern.
- (xiii) At about 7.25 p.m. a prison officer patrolling outside B Hall saw the deceased hanging from a jumper within cell 1/08 which was brightly lit. She raised the alarm and other prison staff immediately attended at the cell, lifted the deceased down and attempted to resuscitate him pending the arrival of paramedics who had been timeously summoned in accordance with prison procedures.

(xiv) The paramedics who attended did everything possible to attempt to revive the deceased, but pronounced him dead at approximately 8.05 p.m.

(xv) The deceased took his own life. The cause of death was hanging.

(xvi) A subsequent search of the deceased's cell disclosed a number of writings left by him. Whilst these cast some light on his state of mind, they present a far from clear or consistent picture. Some of the writings suggest that the deceased was overwhelmed by feelings of guilt and self-loathing as a result of the offence which he had committed. They are not, however, indicative of a determined or pre-planned suicide. The writings include a letter intended to be presented to the Sheriff at the forthcoming sentencing diet and a letter to the deceased's girlfriend talking about the future. These do not appear to be the writings of a person who, at the time of writing, was intent on ending his life.

(xvii) At the time of his death the deceased was in lawful custody

[5] It was apparent from the evidence that the procedures in place within HMP Inverness to identify those potentially at risk of suicide or self harm are well understood and well put into practice. I had no difficulty in concluding that the system strikes the necessary balance between being effective and proportionate (in other words it provides a mechanism for providing appropriate care and support where necessary without imposing undue or unwarranted restrictions on personal liberty or dignity). I also concluded that all of the prison staff who interacted with the deceased conducted themselves entirely appropriately and could not have anticipated what was, on any view, a tragic death.

[6] It was common ground among all the parties represented at the Inquiry that the evidence did not warrant the making of any findings in terms of s.6(1)(c), (d) or (e) or the 1976 Act. The representatives of the deceased's parents explained that the parents had wished to participate in the Inquiry because they wanted to do the best for their son. They wished to hear the evidence which they hoped would answer questions about their son's death. In the event it had done so. I did not consider that the deceased's parents needed to explain their participation in the Inquiry, but I was entirely satisfied that it was entirely appropriate for them to have taken part.

[7] It would have been impossible to listen to the evidence in this case without feeling heartfelt sympathy for the family of the deceased. I extend my condolences to them for the loss of their son in such sad circumstances.

Sheriff J Gilchrist QC
Inverness 11 October 2013