INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 INTO THE DEATH OF MICHELLE MCELVER v.

SHERIFFDOM of TAYSIDE CENTRAL & FIFE

DETERMINATION

by

ROBERT ALASTAIR DUNLOP, QUEEN'S COUNSEL, Sheriff Principal of the Sheriffdom of Tayside Central and Fife following an INQUIRY held at Stirling on 4th, 5th, 6th and 7th March 2002 into the death of

MICHELLE McELVER

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STIRLING, 2 April 2002. The Sheriff Principal, having considered all the evidence adduced, Determines:-

- In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that Michelle McElver, born on 7th May 1973, died on 24th October 2001 at 1803 hours in Stirling Royal Infirmary as a result of the consequences of hanging herself in the bathroom area of Unit 1, Younger House, HM Prison, Cornton Vale, Stirling between the hours of 1455 and 1715 on that date.
- In terms of Section 6(1)(b) of the said Act, that the cause of Michelle McElver's death was hanging by the neck.

NOTE:

- **Parties Represented at the Inquiry**

In this Inquiry evidence was presented on behalf of the Procurator Fiscal by his Depute Miss Orr. Mr Mowat, Solicitor, appeared for the Prison Officers Association Scotland and certain prison officers cited as witnesses; Mr Watson, Solicitor, appeared for Dr. Sayers; and Mr Lindsay, Advocate, appeared for the Scottish Prison Service. The family of Michelle McElver was not represented although evidence was led from her sister. Evidence was heard on 4th, 5th, 6th and 7th March 2002.

2. Legal Framework

The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides that a public inquiry should be held into the death of any person held in legal custody. The reasons for making such inquiry compulsory are obvious. It is clearly appropriate that, where somebody has been deprived of his or her freedom by legal process and

then dies while in custody, a Court should investigate the circumstances of the death in public.

The purpose of the Inquiry is defined in Section 6(1) of the Act which is in the following terms:-

"At the conclusion of the evidence and any submissions thereon .... 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;

- the cause or causes of such death and any accident resulting in the death;
- the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- any other facts which are relevant to the circumstances of the death."

In terms of the Act the Procurator Fiscal has the responsibility in the public interest of investigating the circumstances of the death and placing before the court evidence bearing upon those circumstances. This procedure accordingly allows the circumstances surrounding a death to be brought under judicial and public scrutiny. It should be emphasised however that the Sheriff should make a determination in relation to each of the matters in section 6(1) only so far as the circumstances have been established to his satisfaction. The Court can only proceed on the basis of the evidence placed before it and should not speculate about whether other circumstances exist which have not been raised in the evidence. Having said that, there was nothing to indicate that the investigations of the Procurator Fiscal had been anything other than thorough. Nevertheless it is with these considerations in mind that I have confined my determination to the circumstances set out in Section 6(1)(a) and (b), a course of action urged upon me by all parties to the Inquiry.

3. The Context of the Inquiry

The death of Michelle McElver was one of two deaths at HMPrison, Cornton Vale within a period of days and that circumstance, when set against a background of a spate of suicides at this prison in the mid 1990s, may be thought to give rise to public concern. This fatal accident inquiry was held immediately before the inquiry into the death of the other prisoner and, as one might expect, the evidence in each had many common features, not least in relation to the Suicide Risk Management Strategy in operation at the prison. This strategy was introduced in about 1998 and represented a change of approach which, so far as the evidence discloses, sets the two deaths under consideration in a different context to that which surrounds the earlier deaths in the 1990s. Each Inquiry has been conducted separately and, despite the common features in the evidence, my determination falls to be made in relation to the evidence led regarding each death separately.

4. Factual Circumstances

The evidence led at the Inquiry gave rise to little controversy. The key facts were as follows.

4.1 Personal circumstances

Michelle McElver was married and was the mother of two children. She was separated from her husband however and the two children resided with him. She was an intravenous drug user and had been addicted to heroin for about five years. She became involved in crime. She had sought treatment to break her addiction but had been unsuccessful in sustaining the benefits of such treatment.

4.2 Admission procedure

In the early evening of 23rd October 2001 Michelle McElver was admitted to HM Prison, Cornton Vale following a remand on a charge of assault and robbery. She had been a prisoner at HMP, Cornton Vale on five or six prior occasions. Her first contact when arriving at the Prison was with a prison officer, Christine Crossley, who was responsible for taking possession of her property. Michelle McElver was known to her. Christine Crossley found her to have good eye contact and there was nothing which gave her any cause for concern.

On admission to the Prison all prisoners are seen by a reception officer. At about 7.40pm Michelle McElver was seen by a reception officer, David Sharkey, who completed a reception risk assessment form. One of the questions put to prisoners during this procedure is "Are you feeling suicidal?" to which Michelle McElver replied in the negative. According to Mr Sharkey, she was speaking freely and had good eye contact. She asked if she could get a job in the packing department. Mr Sharkey had no concern about Michelle McElver and assessed her as being at no apparent risk.

The next stage of the admission procedure required Michelle McElver to be interviewed by a nurse. Such an interview was carried out by Lynda Hart, a registered mental nurse, at about 9pm. The interview lasted 10-15 minutes. She took notes of her interview and completed a nurse risk assessment form. She was looking for signs of suicidal intent and found none. Michelle McElver stated that she did not feel suicidal nor did she feel like hurting herself. Nurse Hart noted obvious signs of drug withdrawal and Michelle McElver was anxious to discuss her medication requirements with her. She informed her that she was on a methadone prescription.

The nurse confirmed with the doctor that a prescription of dihydrocodeine and diazepam could be given to her to help her with the symptoms of drug withdrawal. A urine test carried out at that time disclosed the presence of opiates, benzodiazepines and methadone. The normal admission procedure required her to be examined by the doctor the following morning.

4.3 Act Strategy

The foregoing admission procedure was an important part of the Suicide Risk Management Strategy adopted by the Scottish Prison Service in about 1998. That Strategy was commonly referred to as "Act and Care" (hereinafter referred to as the "Act Strategy"). The key aim of the strategy is -

"To assume a shared responsibility for the care of those "at risk" of self-harm or suicide. To work together to provide a caring environment where prisoners who are in distress can ask for help to avert a crisis. To identify need and offer assistance in advance, during and after a crisis."

The strategy identifies (a) groups of prisoners who are more likely to harm themselves, (b) events or triggers that might make self harm or suicide more likely and (c) non verbal and verbal signs that might be found in a particular prisoner which may indicate a risk of self-harm. (Production 6 pages 14 and 15). The strategy is aimed at reducing the risk of self-harm or suicide, but it is recognised that not all suicides are preventable. An important function of the admission procedure was to ensure that an assessment was carried out of whether newly admitted prisoners were at risk of self-harm.

All prison staff receive training in the operation of the Act Strategy, both at their induction to the Prison Service and on annual refresher courses and it was clear from the evidence that the scope of the strategy and the manner of its operation were well understood. In the event that a prisoner is identified as being at risk she will be made subject to the Act Strategy and to a number of measures intended to prevent self-harm. The nature of the measures will vary according to the assessed degree of risk but in most cases will involve increased regular observation of the prisoner, which in extreme cases can involve a 24 hour guard.

4.4 Post admission circumstances

On completion of the interview with the nurse, Michelle McElver was admitted to Unit 1 of Younger House. This was primarily a block for convicted prisoners but it was also used to house remand prisoners if necessary. She was allocated a cell which she shared with another prisoner Georgette McEwan, who had also been admitted that evening. After she had been admitted to Younger House she was seen by another prisoner, Sharon Hunter, whom she knew. She asked Sharon Hunter who else was in the Prison. She seemed to be scared about someone else in the Prison with whom she had had a problem on some earlier occasion. From the terms of this conversation it appeared to Sharon Hunter that Michelle McElver might be thinking of harming herself. She told her not to do anything and Michelle McElver replied that she would not.

The following morning nurse Hart again saw Michelle McElver when she attended at the doctor's clinic in Younger House. At that time Michelle McElver asked her for a pregnancy test and she was informed that she would be listed for that test in the afternoon. According to Nurse Hart she was still showing signs of going through drug withdrawal but was otherwise fine. She then had a 10-15 minute interview with and medical examination by the prison medical officer, Dr Sayers. He considered that she was struggling physically as a result of withdrawing from a fairly heavy drug habit. She had good eye contact and was calm. He concluded that she had settled well and was not at risk of self-harm. She was given a prescription for detoxification of the drugs within her system. At the time of this interview Dr Sayers was aware that she had been seen by the psychiatric team when in Prison during 1999.

Sharon Hunter also saw her that morning at breakfast at about 7.30am when she seemed a bit anxious about who was going in and out of her cell. Sharon Hunter stayed with her until lock up at about 9am. After lock up it seemed to Georgette McEwan that Michelle McElver was worried about her children. She was also continuing to show signs of drug withdrawal.

At lunchtime the cell doors were open between about 12.30pm and 2pm. Michelle McElver had her lunch in her cell and was joined by Sharon Hunter. Sharon Hunter thought that she was still anxious but seemed to be calming down a bit. When Sharon Hunter left it appeared to her that Michelle McElver was all right. She asked her to come back and see her before 2pm, which she did. Sharon Hunter last spoke to Michelle McElver at about 2pm when she said something about seeing the nurse.

At 1.41pm Michelle McElver telephoned her sister Karen Jack. The electronic recording equipment at the Prison recorded this telephone conversation and production 5 is a transcript of it. She said that she was phoning to say cheerio and asked her sister to make sure that her children knew everything. In her evidence Karen Jack said that she didn't really understand what she was saying but that nothing that had been said gave her any cause for concern about Michelle's well being.

Another prisoner, Leona Laing, also saw Michelle McElver at about 1.45pm. She was passing Michelle McElver's cell on her way to the work party. At that time the door was open and Michelle McElver was alone. According to Leona Laing, she was upset and saying that she couldn't handle the jail any more. She said she would be out of there tonight and Leona Laing understood this remark to indicate that she might be thinking of harming herself. She was concerned at this remark and made her promise that she wouldn't do anything. Michelle McElver replied that she was just being stupid and asked Leona Laing to promise that she would not say anything to the staff.

After the work parties had left the block Michelle McElver and Georgette McEwan were locked in their cell until sometime after 2.30pm when a nurse, Arlene Johnston, came to administer the pregnancy test as requested. Michelle McElver was released from her cell by prison officer Marie Daley and accompanied Arlene Johnston to the nurse station in Unit 1. There was a conflict in the evidence at this point between Arlene Johnston and Marie Daley. According to Arlene Johnston, Michelle McElver was asleep when she called for her and required to be woken up. On the other hand Marie Daley said that Michelle McElver was awake. According to Arlene Johnston, during the medical consultation, Michelle McElver appeared lethargic. She had tried to initiate conversation with her but she did not appear to want to answer. She was displaying quite closed body language and appeared to be struggling with her drug withdrawal. There was nothing in her demeanour or manner however which raised any question in Arlene Johnston's mind that Michelle McElver might be at risk of harming herself.

Michelle McElver provided a urine sample and it was subjected to the pregnancy test with negative results. She was then asked to dispose of the remainder of the sample in the toilet. The time of this test was noted in the medical records as 1445 hours. Arlene Johnston had another prisoner to see and when Michelle McElver left the

nursing station Arlene Johnston assumed that she would then go to the Unit office to gain entry back into her cell. At about 2.55pm Marie Daley, who was the Unit 1 officer, was on the point of leaving the block at the end of her shift. She saw Michelle McElver going into the bathroom area with a polystyrene cup and assumed that she was going to give a sample.

Marie Daley was replaced in her duties as Unit 1 officer by Jacqueline Laird. There was no formal hand over between the two and indeed Marie Daley had left the Unit before Jacqueline Laird started work. When she came on duty Jacqueline Laird had paper work for her supervisor and went to see him first. She then required to take cash to the general office and thus left Younger House, returning to the block at about 3.55pm. By that time she had still not been to Unit 1. On her return she then distributed shopping and mail to prisoners, which took about an hour, before participating as one of the officers lining the route for the return of the work party. Once the work parties had returned a numbers check was carried out, when it was discovered that Michelle McElver was missing. A search was carried out and at about 5.15pm she was discovered by prison officer Amanda Martin hanging by her shoelaces on a hook in the bathroom of Unit 1. Amanda Martin immediately raised the alarm and attempted to support her. She was assisted by prison officer Mark Skinner who managed to release the laces from the hook. Almost immediately thereafter medical staff arrived in Unit 1 in response to the alarm. There were no signs of life. She was connected to a defibrillator but there were difficulties in starting it up. An ambulance was called and arrived at about 5.24pm. The paramedics connected their own defibrillator machine to Michelle McElver but no electrical activity in the heart was detected.

Michelle McElver was conveyed to Stirling Royal Infirmary and arrived there at 5.50pm. There was no sign of life and resuscitation was discontinued at 6.03pm when life was pronounced extinct.

4.5 Medical findings and Cause of Death

A post mortem examination was carried out on 25th October 2001. The only significant findings were the presence of a ligature mark and petechial haemorrhages, which were suggestive of asphyxia. The cause of death was certified as hanging by the neck. During the post mortem examination a sample of blood was taken which was subsequently analysed. The results of the analysis are contained in Production 13. The analysis showed the presence of benzodiazepines in quantities typical of regular therapeutic usage. It also showed the presence of methadone at a level higher than one would expect from someone on a maintenance programme and who has built up a large tolerance. The picture presented by the analysis was consistent with Michelle McElver having had an addiction to heroin over a number of years with a build up of a large tolerance.

4.6 The Regime in Younger House

There are 6 Units in Younger House and when fully staffed there is one supervisor and a residential officer for each Unit. Younger House was fully staffed on 24th October. The Unit 3 officer has overall responsibility for co-ordinating activities in the block. The Unit 3 officer on that day was Avril McMurtrie, who came on duty at

1pm but did not assume the responsibilities of Unit 3 officer until 3pm. The Unit 3 officer is responsible for checking anyone in and out of Younger House, including prisoners. If any officer requires to leave the block it is the responsibility of the Unit 3 officer to delegate to others the responsibility for covering for that absence.

Prisoners in Younger House were allowed free association, that is to say that if they wished to leave their cells they were allowed to do so, apart from specific periods when a lockup was in force. This facility was dependent however on the level of staffing and whether the staff were otherwise fully engaged, since the cell doors were kept locked at all times and it was necessary for prisoners to be let in and out of their cell by a prison officer. After 3pm on 24th October, when Jacqueline Laird left the block to go to the general office her responsibilities as Unit 1 officer were covered by Avril McMurtrie the Unit 3 officer.

5. Scope of Determination

In her closing submissions the Procurator Fiscal Depute submitted that I should confine my determination to those circumstances outlined in paragraphs (a) and (b) of Section 6(1) of the Act. This submission was adopted by each of those represented at the Inquiry and in my view it is well founded.

It is clear from the evidence that Michelle McElver took her own life. The precise reasons for her doing so remain a mystery and it would be pure speculation to offer any explanation. It was also clear from the evidence that the prison staff had been adequately trained in the Act Strategy and knew the signs to look for in assessing whether any particular prisoner was at risk of self-harm. I am satisfied that Michelle McElver was appropriately assessed at reception on 23rd October and by Dr Sayers the following morning. These assessments were all made independently of each other and reached the same conclusion, namely that she was apparently not at risk. The Procurator Fiscal Depute submitted that in these circumstances it was safe to conclude that during that period Michelle McElver had not displayed any of the signs that one might expect in someone who was at risk of self-harm. On my assessment of the evidence of the relevant witnesses I agree.

The evidence of Sharon Hunter and Leona Laing was of a different character. Although their evidence was not entirely consistent, I have no reason to doubt the general tenor of what they were speaking to. Although initially concerned, both Sharon Hunter and Leona Laing seem to have been reassured to a degree, since neither took Michelle McElver's comments seriously enough to report it to staff and appeared to have been satisfied by her assurance that she was not going to do anything stupid. Had these comments been made to the staff it seems to me entirely possible that the staff would have taken a different view. In the same way, the terms of the conversation between Michelle McElver and her sister on the telephone might now be seen as significant and giving cause for concern. At the time however they did not raise any concern about her well being in the mind of Karen Jack.

In making these observations I do not attach criticism to any of Sharon Hunter, Leona Laing or Karen Jack. In my view there is much force in the submission of the Procurator Fiscal Depute that these comments and the terms of the telephone conversation only take on any real significance in light of the subsequent knowledge

of Michelle McElver's death. In short it is only with the benefit of hindsight that one can see that, at least after 1pm, Michelle McElver had thoughts of self-harm. In what I thought was a very candid assessment, Sharon Hunter said in her evidence that with hindsight Michelle McElver "had it in her head that she was going to do something and she didn't want anyone to know."

The only other evidence that I should comment on was that which I have already narrated concerning the appearance of Michelle McElver during the pregnancy test administered by Arlene Johnston. It might be thought that her presentation at that time would have suggested to Nurse Johnston that something was amiss. Arlene Johnston however attributed her demeanour to the fact that she had been sleeping. As I have already indicated there was a conflict in the evidence about whether Michelle McElver had been sleeping. This issue was not tested by cross-examination and the conflict may arise only as a result of a difference of impression. Furthermore it was not explored in the evidence whether the demeanour of Michelle McElver was capable of being interpreted as an indication of a risk of self-harm, if it could not be attributed to the fact of her having been asleep. In these circumstances I do not think that I can safely conclude that there were such signs at that time.

The system for the prevention of such events depends on the existence of what is referred to in the Act Strategy as "cues and clues". The Act Strategy does not guarantee that there will never be any suicides. According to the evidence of Dr Sayers someone who has taken the decision to commit suicide can often take steps to conceal that intention. It is reasonable to infer that that was the position of Michelle McElver, having regard to her anxiety that neither Sharon Hunter nor Leona Laing should report her conversation with them to staff.

For all these reasons I am satisfied that there was no evidence which would entitle me to conclude that there was any failure in the implementation of the Act Strategy.

It is relevant then to consider whether there were any other steps that might have been taken to prevent this tragic death. The only possible basis for concern related to the question of general observations. It seems clear from the evidence that nobody saw Michelle McElver between 2.55pm, when she was seen by Marie Daley going into the bathroom area with a polystyrene cup, and 5.15pm when she was finally discovered hanging in that bathroom. The purpose of general observation is to ensure that prisoners who should be in the unit are indeed in the unit. It is self evident that if general observations are to have any effect it is necessary to know who is in the block and where they are.

According to Marie Daley, as she was going off duty just before 3pm, she told the Unit 3 Officer, Avril McMurtrie, that Michelle McElver was in the unit and had been let out to see the nurse. Avril McMurtrie accepted that this was the case. Avril McMurtrie also accepted that she was covering for Jacqueline Laird when she was absent from Unit 1 on other duties after she started work at 3pm. Avril McMurtrie could not say one way or the other whether she carried out general observations of Unit 1 and Jacqueline Laird did not do so in view of her other duties. Although the evidence is not entirely clear, I was left with the distinct impression that the general observations were not carried out between at least 3pm and 5.15pm, and to this extent that that system had broken down.

Without being able to identify the precise time of death it is impossible to say whether the death might have been avoided had the general observations been carried out. If it might have been avoided it would only have been by chance, since the evidence clearly supported the view that death would have ensued within a very short period and accordingly it would have required an almost exact coincidence between the time of the observation and the time that Michelle McElver hanged herself. The system of general observations was not part of the Act Strategy and was not therefore directed to the protection of prisoners at risk, although it might have had an incidental benefit for such persons. In these circumstances there is no basis for making any determination under section 6(1)(c) in this regard.

There was some confusion in the evidence regarding the issue of whether Michelle McElver should have been returned to her cell after the consultation with Nurse Johnston. There was a widespread view that it was for the prisoner to go to the Unit officer to secure entry back into her cell. That is an understandable point of view given that there was a regime that allowed prisoners to be out of their cell at their own choice, operational circumstances permitting, but the supervisor Mr Mackenzie took the view that staff did have a responsibility to ensure that a prisoner was returned to her cell after a visit to the nurse. He also emphasised that it was important that at a handover information should be passed on regarding those who were out of their cell for whatever reason. He would expect an officer coming on duty to check the position.

It seems to me that there is in this area a lack of clarity in the precise operational instructions that applied. In my view this could with benefit be re-examined, but I do not consider that this issue can otherwise be reflected in a determination under either section 6(1)(c) or (d).

In the course of the evidence the Procurator Fiscal Depute raised with a number of witnesses the questions of a) whether prisoners should be allowed to retain shoelaces and b) whether the bathroom areas should be subject to regular patrols. The evidence clearly supported the view that there was no reason why prisoners not identified as at risk should not have their shoelaces. The evidence also did not suggest that patrols of the bathroom area were appropriate within a regime of free association, not least for reasons of prisoner privacy. I have no reason to take a different view.

Finally I should refer to the evidence of some difficulty experienced by the nursing staff in operating the defibrillator when first attending Michelle McElver after she was discovered to have hanged herself. I accept the evidence of Nurse Masterson that the machine was working and it may be that it was the urgency of the situation that prevented the other nurses operating it correctly. Whatever be the position I am quite satisfied that it had no bearing on the treatment offered to Michelle McElver or on the consequences that ensued from her act of self-harm.

In conclusion therefore I do not consider that there is any basis for making any determination of the circumstances of the death of Michelle McElver beyond the formal circumstances referred to in paragraphs a) and b) of section 6 of the Act.

I have attached hereunder a list of those witnesses who gave evidence to the Inquiry and the order in which they did so.

List of Witnesses who gave evidence in the Inquiry

- Norman George Bradley, Photographer, Identification Bureau, Police Headquarters, Stirling
- Michael Hoeck, Photographer, Identification Bureau, Police Headquarters, Stirling
- Karen Mullan or Jack, 144 Torbrex Road, Cumbernauld
- Annette Riley, BSc(Hons) MB ChB FRCPath, c/o Stirling Royal Infirmary, Livilands, Stirling
- John S Oliver, BSc PhD CChem FRSC, Reader in Forensic Medicine (Toxicology), University of Glasgow
- David Dryland, Paramedic, Ambulance Depot, Lovers Walk, Stirling
- Lynn Cowie, MB ChB, Senior House Officer, Stirling Royal Infirmary, Livilands, Stirling
- Evelyn Huntley, Prison Officer, HM Prison, Cornton Vale, Stirling
- Christine Crossley, Prison Officer, HM Prison, Cornton Vale, Stirling
- David Forrest Sharkey, Prison Officer, HM Prison, Cornton Vale, Stirling
- Lynda Hart, Nurse, HM Prison, Cornton Vale, Stirling
- Craig Lee Sayers, MB ChB, MRC GP, HM Prison, Cornton Vale, Stirling
- Georgette McEwan, 19M Sutherland Drive, Newfarm, Kilmarnock
- Leona Marie Collins Laing, c/o HM Prison, Cornton Vale, Stirling
- Avril McMurtrie, Prison Officer, HM Prison, Cornton Vale, Stirling
- Mark Skinner, Prison Officer, HM Prison, Cornton Vale, Stirling
- Arlene Johnston, Nurse, HM Prison, Cornton Vale, Stirling
- Jacqueline Mary Margaret Laird, Prison Officer, HM Prison, Cornton Vale, Stirling
- Stephen Swan, Governor, HM Prison, Cornton Vale, Stirling
- Marie Daley, Prison Officer, HM Prison, Cornton Vale, Stirling
- Pauline Janet Fitzpatrick, Prison Officer, HM Prison, Cornton Vale, Stirling
- William McKenzie, Residential Manager, HM Prison, Cornton Vale, Stirling
- Amanda Martin, Prison Officer, HM Prison, Cornton Vale, Stirling
- Karen Tricia Williamson or Thomas, Nurse, HM Prison, Cornton Vale, Stirling
- Owen Masterson, Nurse, HM Prison, Cornton Vale, Stirling
- Sharon Hunter, Braeview, Forgandenny, Bridge of Earn, Perth
- Russell Penman, Detective Constable, Central Scotland Police, CID, Stirling
- Ian Motion, Detective Sergeant, Central Scotland Police, CID, Stirling.