**SHERIFFDOM** OF LOTHIAN AND BORDERS AT EDINBURGH

**[2017] FAI 28**

B390/17

DETERMINATION

BY

SHERIFF A W NOBLE

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

**PAUL JAMES McMAHON**

Edinburgh, 20 November 2017

The Sheriff, having considered the evidence adduced and submissions thereon at the Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter "the Act"), Determines:

(a) in terms of section 6(1)(a) of the Act that Paul James McMahon (hereinafter "the deceased"), born on 13 May 1968, ordinarily residing in Penicuik, and latterly a remand prisoner within HMP Edinburgh, 33 Stenhouse Road, Edinburgh, died between about 22.00 hours and 22.50 hours on 30 May 2016 within Cell 2/02, Glenesk Hall, at said prison (life being pronounced extinct at 23.15 hours on said date);

(b) in terms of section 6(1)(b) of the Act that the cause of the deceased's death was hanging;

(c) in terms of section 6(1)(c) of the Act that there were no reasonable precautions whereby the death might have been avoided; and

(d) in terms of section 6(1)(d) of the Act that there were no defects in any system of working which contributed to the death.

**NOTE**

**Introduction and parties represented at the Inquiry**

[1] This fatal accident inquiry was held in terms of section 1(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter "the Act"). It was a mandatory inquiry because the deceased at the time of his death was a remand prisoner at HMP Edinburgh. Three parties were represented. The Procurator Fiscal was represented by a procurator fiscal depute, Mrs Rollo. Mr Scullion, solicitor, Edinburgh, appeared for the Scottish Prison Service ("SPS") and Mr Holmes, solicitor, Edinburgh, appeared for the National Health Service. A solicitor had appeared for the Prison Officers Association (Scotland) ("POAS") at the stage of the preliminary hearings, but in light of the circumstances of the deceased's death, it was not considered necessary that POAS have representation at the inquiry itself. Although aware of the inquiry, the deceased's brother adhered to the view which he had expressed earlier to Mrs Rollo and did not attend it. The deceased's partner, TD, also did not attend the inquiry, although she had been cited as a witness for the Crown and knew that her attendance was necessary in that capacity. No motion to adjourn the inquiry on account of her absence was made by any party.

[2] Oral evidence was led by the Crown from the following eight witnesses:

- Dr Rachel Petrie, a consultant psychiatrist, working *inter alia* at Midlothian Substance Misuse Service;
- Mark Glendinning, a prison officer at HMP Edinburgh at the time of the deceased's death and now;
- (Joseph) Keith Buick, also a prison officer at HMP Edinburgh then and now;
- Jean Wallace, a practice nurse at HMP Edinburgh at the time of the deceased's death and now a practice nurse elsewhere;
- Margaret Cairns, a mental health nurse at HMP Edinburgh then and now;
- Shelly Jones, an addictions nurse at HMP Edinburgh then and now;
- Dr Angela Maxwell, at the time lead GP, HMP Edinburgh (and HMP Addiewell) medical services, and now, following retirement, an ad hoc GP; and
- Kenneth Barbour, community mental health charge nurse, Midlothian Substance Misuse Service.

The parties entered into a joint minute agreeing a number of matters, including that the statements of five witnesses, appended to the joint minute, could be considered equivalent to parole evidence, the witnesses being:

- Edwin McKervail, first line manager, Hermiston Hall, HMP Edinburgh;
- Craig Jones, prison officer, HMP Edinburgh;
- Andrew Dunn, prison officer, HMP Edinburgh;
- Colin Brown, first line manager (nightshift manager), HMP Edinburgh; and

- Paul Connolly, police constable, Police Service of Scotland, Gayfield Square, Edinburgh.

**Legal framework**

[3] The duties of a sheriff at a fatal accident inquiry are set out in section 6(1) of the Act, which is in the following terms:

> "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."

**Cause of deceased's death**

[4] There was no dispute that the cause of the deceased's death was hanging. Between about 20.30 hours and 20.45 hours on 30 May 2016 the deceased was locked within his cell (Cell 2/02, Glenesk Hall) at HMP Edinburgh. He was the sole occupant of the cell. At about 22.00 hours that day Prison Officer ("PO") Andrew Dunn saw him lying on the bottom bunk of the bunk bed within the cell, apparently sleeping. At some point within the following 50 minutes the deceased tied the sleeve of a jumper round the upper bunk bed bar and wrapped the rest of the jumper around his neck. At about 22.50 hours on 30 May 2016 PO Dunn observed him in a kneeling position by the bunk bed. Initially and erroneously PO Dunn suspected that the deceased was pretending to have

hanged himself, but in any event despite that initial suspicion he contacted other prison officers by means of a Code Blue. The deceased's cell was entered and the deceased was lifted and his ligature untied. Cardiopulmonary resuscitation was commenced and an ambulance was called. Paramedics attended and further attempts were made to resuscitate the deceased, but at 23.15 hours on 30 May 2016 life was pronounced extinct. The prison officers who attended at about 22.50 hours formed the view that the deceased was already clearly dead at that time. No suicide note was found.

[5] A post-mortem examination of the deceased was carried out on 2 June 2016 by Dr Ian Wilkinson, a consultant forensic pathologist at the University of Edinburgh. Crown Production 2 is the final post-mortem report issued on 26 July 2016, incorporating a toxicology report relating to an analysis of samples from the deceased carried out by scientists at the University of Glasgow. Dr Wilkinson determined that death was as a result of hanging. There was no obvious injury to the structures of the neck, and there was also no obvious ligature mark identified on the neck, but in Dr Wilkinson's view this potentially reflected the length of time that the deceased was partially suspended as well as the dimensions and type of material of the reported ligature. There were rib fractures and a possible fracture of the sternum, but Dr Wilkinson identified these as relating to the attempted resuscitation of the deceased. Four substances were identified in the samples taken from the deceased, methadone (a low level), dihydrocodeine, diazepam and a metabolite of diazepam. According to Dr Wilkinson, the concentration of dihydrocodeine identified lay above the range

typically said to be associated with therapeutic effects and within the range which can be associated with toxic effects, but he did not consider it likely that the direct toxic effects of the drugs played any role in the deceased's death.

**Events leading up to deceased's death**

[6] The deceased was a prolific housebreaker. On 24 May 2016 he appeared on petition at Edinburgh Sheriff Court charged with theft by housebreaking. He was remanded in custody, bail having been refused. The deceased was also someone who abused illicit drugs. He was in receipt of a methadone prescription from the Midlothian Substance Misuse Service, but due to his non-engagement with the service, the dosage he was receiving was being reduced, with a view to its complete cessation. Because of his non-engagement, the service had no idea of the extent of his illicit drug usage, and to continue with methadone in these circumstances posed risks to the deceased's health. As at the date of his appearance in court, the deceased was in receipt of a methadone prescription of 20 mls per day, which was in fact below the minimum amount prescribed at HMP Edinburgh, which was 25 mls per day. On arrival at HMP Edinburgh, he was seen by PO Mark Glendinning, who worked exclusively in prisoner reception. He told PO Glendinning that he was feeling suicidal and might harm himself. As a result, in terms of the ACT 2 Care procedures then in force, he was given anti-ligature clothing to wear and placed in a safe cell in Hermiston Hall. He was seen every 15 minutes. During the morning of the following day, a case conference was held, attended by the deceased, First Line Manager ("FLM") Edwin McKervail, PO Craig

Jones, a residential officer, and Margaret (Maggie) Cairns, as noted a mental health nurse at the prison. The conference lasted about 20 minutes. The deceased indicated that he had only said that he was feeling suicidal in the hope that he would be prescribed methadone. This was not an unusual occurrence with prisoners in terms of Nurse Cairns' experience. (Nurse Cairns was the only witness to mention this in her oral testimony. It does not appear in the other witnesses' statements. However, no difference of view is implied, and I accepted Nurse Cairns' evidence. Nurse Cairns also indicated that prisoners might attempt to use the Act 2 Care procedures to keep themselves safe from other prisoners, if for example they owed money, but she did not get the impression that that was the case with the deceased.) The deceased's mood and overall presentation seemed normal. He was spontaneous in conversation. He responded to humour. There was no evidence of distress. Given the deceased's presentation and answers, the three members of staff came to the view that he was not in fact suicidal. The deceased was subsequently moved from the safe cell in Hermiston Hall, a wing for convicted prisoners, to Cell 2/02 in Glenesk Hall, the remand wing. Although that cell contained a bunk bed, the deceased was the sole occupant of the cell throughout the period until his death. The deceased remained subject to ACT 2 Care procedures, in the form of enhanced observation, at the lowest level of once per hour. That remained the position until the deceased's death. In relation to medication, the deceased was seen by the lead prison medical services GP, Dr Angela Maxwell, and the addictions nurse, Shelly Jones. They sought and obtained information about the deceased from the Midlothian Substance Misuse Service. In the circumstances,

Dr Maxwell did not prescribe the deceased methadone, but diazepam and long acting dihydrocodeine.

[7] At the time of his death, the deceased was in an on-off relationship with TD. The deceased's place of residence was TD's tenancy. TD had many difficulties of her own, including drug misuse and ill health. She also attended Midlothian Substance Misuse Centre, and the doctor supervising her was Dr Rachel Petrie. On 6 June 2016, at an appointment she had with Dr Petrie, TD stated that she had killed the deceased. She told Dr Petrie that she had written a letter to the deceased which he received on the date of his death, ending their relationship. According to TD, the deceased had written back to say that he loved her, that she was not to blame but that he couldn't face life without her. TD also said that she felt that the deceased had had other problems in prison, previously having been sought out for drug debts, although she also said that he had seemed fine when she saw him on the day before his death. She also said that the previous twice when the deceased had made threats – it may be assumed of suicide – he had made sure he was found or had not taken enough tablets. On 17 August 2017 Police Constable Paul Connolly attended at TD's home in relation to the deceased's death. TD was reluctant to discuss the matter. She did tell PC Connolly that she had received a letter from the deceased written on the day of his death. According to TD, the deceased said that he loved her and that she should keep reading her Bible and pray every day. This was in keeping with the letters he wrote to her every day from prison. There was no mention of him wishing to commit suicide and she did not believe that he had hanged himself. In relation to the deceased's last letter, TD said that she did not know

where it was, and presumed it had been discarded at some point. As noted earlier, although cited as a witness (and also separately spoken to by the police), TD did not attend the inquiry. Regrettably, Dr Petrie provided TD with the absolute opposite of a certificate of credibility. Not only in relation to her drug consumption, but also across a broad range of matters, TD was someone who did not tell the truth. On the basis of the evidence led before me, I am unable to make findings about any correspondence between the deceased and TD. As noted, TD has given two different accounts of a letter the deceased allegedly wrote to her on the day of his death, one pointing towards suicide, the other not – at least as interpreted by TD, on the basis of her knowledge of the deceased's previous correspondence, although looked at in isolation the alleged terms of version number 2 might be viewed as equivocal. I am also unable, on the basis of TD's statements to Dr Petrie, to make any findings about any previous instances of parasuicide or attempted suicide on the part of the deceased.

**Submissions and determination**

[8] Mr Scullion for the SPS and Mr Holmes for the NHS both submitted that only formal findings should be made in terms of paragraphs (a) and (b) of section 6(1) of the Act. Mrs Rollo also suggested that some findings should be made in terms of section 6(1)(e), but this did not reflect any fundamental disagreement between her and the other representatives. Mrs Rollo's proposed findings related to matters which I have mentioned in this note. It may be a matter of style, but I would tend to confine section 6(1)(e) to particular facts which I would wish to highlight as significant. I agree that

findings need only be made in terms of paragraphs (a) and (b) of section 6(1). There was no evidence led before me which called into question the way in which the decision made at the case conference on 25 May 2016 was reached, nor was there any evidence suggesting that the decision itself was wrong, despite the fact that the deceased's life ended on 30 May 2016. I cannot say that he was not telling the truth when he indicated to those present at the case conference that he had only claimed to be suicidal in an attempt to obtain methadone. I cannot be satisfied, given the somewhat unusual circumstances of the deceased's death, that he had formed a positive intention to end his life by wrapping a jumper round his neck. In relation to Dr Maxwell's decision not to prescribe methadone, I clearly cannot say that it was wrong, indeed it is difficult to see that any other decision could have been taken in the circumstances, and in any event no positive link has been established between the fact that the deceased was not prescribed methadone and his subsequent death.