SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2018] FAI 32

B1819/17

DETERMINATION

BY

SUMMARY SHERIFF SHONA GILROY

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

JOHN WILLIAM HAY

Glasgow, 19 September 2017

The Sheriff having considered the information presented at the inquiry determines in terms of section 26 of that Act that:-

John William Hay, born 28 August 1977, formerly of Glasgow, and residing latterly at Her Majesty's Prison, Barlinnie, 51 Lee Avenue, Glasgow, died at 0902 hours on 19 February 2017 within a cell at HMP, Barlinnie, Glasgow.

In terms of section 26(2)(a), death occurred at HMP, Barlinnie on 19 February 2017, when the deceased was in legal custody.

In terms of section 26(2)(c) the cause of death was hanging.

No findings were sought or are made in respect of section 26(2)(b), (d), (e), (f) and (g).

NOTE:

Introduction

[1] This is a Fatal Accident Inquiry in terms of section 2(4)(a) of the 2016 Act as

Mr Hay was in legal custody at the time of his death.

[2] The deceased's death was reported to the Crown Office and Procurator Fiscal Service on 19 February 2017.

[3] No preliminary hearing was held.

[4] The representatives of the participants were: Ms McRobert, Procurator Fiscal Depute, for the Crown; Mr Gillies, Solicitor, for the Prison Officers Association Scotland; and Ms Thornton, Solicitor, for the Scottish Prison Service.

[5] No witnesses were called and the facts relating to the circumstances of death were presented to the Inquiry in a joint minute agreed by all parties.

The legal framework

[6] A Fatal Accident Inquiry was held under section 1 of the aforesaid 2016 Act

[7] The Inquiry is governed by the Fatal Accident Inquiry Rules 2017

[8] In terms of section 1(3) of the 2016 Act: The purpose of an Inquiry is to—

(a) establish the circumstances of the death, and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[9] The matters to be covered in the determination under section 26 are when and where the death occurred and the cause or causes of the death.

[10] The Crown in the public interest is represented by the Procurator Fiscal Depute. A Fatal Accident Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

[11] The following facts summarise the evidence before the Inquiry:

a. Following a plea of guilty at Glasgow Sheriff Court on 14 February 2017 the deceased was remanded in custody for preparation of reports for the court until 7 March 2017. As at the date of his death on 19 February 2017 he was incarcerated in HMP Barlinnie (hereinafter referred to as "Barlinnie" or "the prison"). He was accordingly in legal custody as at the date of his death.

b. On 14 February 2017 the deceased was transported from Glasgow Sheriff Court to Barlinnie. Upon his arrival, the deceased was interviewed by Reception Officer, James McAughey, at 5.37pm. The role of the Reception Officer is to book in a prisoner and carry out an initial interview before the prisoner meets with the nursing staff. The initial interview usually lasts around 20 minutes and covers any issues the prisoner may have for example mental health issues and self-harming issues which may require the prisoner to be put on 'Talk to Me.' 'Talk to Me' is the strategy used by the Scottish Prison Service to prevent suicides in prison.

c. Following his interview with the deceased, Mr McAughey had no concerns. He completed the Reception Risk Assessment form and noted "John gave no cause for concern throughout interview" and "John was upbeat and very talkative throughout". Mr McAughey asked the

deceased if he was suicidal and he replied “no”. Mr McAughey thereafter arranged for the deceased to meet with nurse, Gillian McNally.

d. On 15 February 2017 the deceased attended at an Induction ‘Core Screen’ with prison officer Andrew Healy. This is a one to one interview which covers the basic social needs and welfare background of a prisoner as they enter the system. The officer explains the facilities and prisoner routine and will ask about mental health or specific prisoner needs. If a prisoner does not wish to engage with the officers directly, they explain that the prisoner can speak to a nurse, chaplain or the 'Samaritan’s Listeners' who are a confidential charitable service. If any concerns are highlighted, officers will refer prisoners as appropriate. Mr Healy had no concerns following his interview with the deceased. Following the interview he arranged for the deceased to attend a ‘Day 2 Induction.’

e. The deceased attended a ‘Day 2 Induction’ with prison officer Norman Sutherland on 15 February 2017. The induction is a 2 hour presentation to a maximum of 7 prisoners to give an insight as to what to expect when they come into prison for the first time or from a juvenile background. It is to help to put them at ease and answer any questions or concerns they have. The deceased raised no concerns during this induction.

f. The deceased was allocated Cell 4.06 within C Hall. The deceased was residing alone within the cell, however the cell contained a bunk bed.

g. On Saturday 18 February 2017 at approximately 4.45pm, the prisoners within C Hall were locked within their cells for the evening. The deceased was observed to be within his cell by prison officer John McMullan who noted that he was safe and well.

h. Prisoners are not checked on during the night unless they are on special observation or have pressed their buzzer requesting staff assistance. The deceased was not on special observations and did not summon assistance through the night.

i. At approximately 8.25am on Sunday 19 February 2017, prison officer John McMullan began opening the prisoners' cells. Upon opening the deceased's cell, Mr McMullan observed the deceased to be suspended from the bunk bed. He had wrapped a length of bedding around his neck and tied it to the upper bunk bed.

j. Mr McMullan summoned assistance and prison officers Kenny Wallace, Paul Hamilton and Michael McCusker attended immediately. Mr Wallace and Mr McCusker supported the deceased's weight whilst Mr McMullan and Mr Hamilton untied the ligatures from around the deceased's neck and the top bunk.

k. Deborah Byrne, a nurse practitioner, and Sunny Agbomeirele, a senior nurse practitioner, attended at the cell. They observed rigor mortis and hypostasis in the deceased and confirmed that the deceased had died.

l. Life was pronounced extinct at 9.02am on 19 February 2017 by Mairi Baxter, a paramedic.

m. Police officers attended at the cell and carried out an examination. They found a note sitting on the worktop which appeared to be written by the deceased.

n. Following a post mortem on the deceased on 23 February 2017, the cause of death was certified by Doctor Marjorie Turner of the University of Glasgow as:

1(a) Hanging.

Discussion and conclusions

[12] The Procurator Fiscal invited the court to make a formal determination in respect of Mr Hay's death, which submission was adopted by both Mr Gillies and Ms Thornton. Having considered the terms of the joint minute and the productions, I am satisfied that such a formal determination is appropriate in the circumstances of Mr Hay's death.