SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2018] FAI 13

B2488/17

DETERMINATION

BY

SHERIFF AF DEUTSCH

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

into the death of

MALCOLM SMITH

DETERMINATION

Glasgow 11 January 2018. The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that: –

Malcolm Smith, born 1 January 1978, a prisoner at HM Prison Barlinnie ("the prison") died on 5 February 2017 within the prison.

In terms of section 26(2)(a) determines that the death occurred at 08:43 hours within Cell 1/44 of A Hall at the prison.

In terms of section 26(2)(c) determines that the death was caused by hanging.

In terms of section 26(2)(e) determines that there were no precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death being avoided.

In terms of section 26(2)(g) finds the following facts relevant to the circumstances of the death to be established:

1. The deceased appeared on petition at Glasgow Sheriff Court on 19 January 2017 in relation to a contravention of section 47(1) of the Criminal Law (Consolidation) (Scotland) Act 1995. He made no plea nor declaration, was

committed for further examination and remanded in custody to the prison. He appeared again at Glasgow Sheriff Court on 27 January 2017, was fully committed for trial and again remanded in custody to the prison.

2. The deceased was in legal custody at the date of his death.

3. "Talk to Me" is the strategy used by the Scottish Prison Service to prevent suicides in prison. The deceased was assessed in terms of the Talk to Me strategy on 19 January 2017 by a reception officer. The deceased was considered to be "at risk" and was placed on Talk to Me as he was noted to have a previous history of self-harm, he was uncooperative and appeared to be of low mood and had poor eye contact. As a result, he was allocated a safe cell for observation and support and provided with anti-ligature clothing. He was also placed on 4 × hourly observations.

4. On 20 January 2017, a case conference was held at 7:55 AM which was attended by the deceased, a nurse, a prison officer and a hall manager. At this case conference, the decision was made that the deceased was still at risk and safeguards were implemented as follows: that the deceased should be allowed to wear his own clothes and could be placed in normal accommodation; but he was to be subject to observation every 30 minutes. These measures were to be reviewed on 23 January 2017. The deceased was content and agreed with the proposed safeguards.

5. Following the 20 January 2017 case conference, the deceased was taken to court in relation to another criminal matter. On being returned to the prison at 18:15 hours, a further reception risk assessment was carried out and a concern form was raised because a letter had been received from the procurator fiscal indicating that the deceased was a suicide risk. The deceased denied any suicidal thoughts and the prison staff had no concerns about him. He remained on Talk to Me as agreed at the case conference.

6. Between 19 January and 23 January 2017 the deceased was being monitored by prison staff and their observations noted. No concerns were raised by the staff during this period of time. On 23 January 2017, a further case conference was held at 10:30 hours. This was attended by the deceased, the hall manager, a prison officer and a prison nurse. The deceased was very talkative, and stated that he had no thoughts of self-harm. He was no longer deemed to be at risk and was removed from Talk to Me and all safeguards were removed. This was done with the agreement of the deceased.

7. Following the 23 January 2017 case conference the deceased attended court on 24, 26 and 27 January 2017. On his return on each occasion, the deceased was risk

assessed by a hall manager and no issues were identified which would require him to be placed back on the Talk to Me regime.

8. The NHS prison healthcare records pertaining to the deceased show that he had input from the medical staff, mental health staff and a psychiatrist throughout his period of remand between 19 January and 5 February 2017.

9. The deceased was assessed during reception by a nurse on 19 January 2017 and assessed again by a nurse at the Talk to Me case conference on 20 January 2017. He was further assessed by the prison GP on 20 January 2017. All of these healthcare professionals noted that the deceased was at risk in terms of the Scottish Prison Service suicide management strategy and accordingly safeguards were put in place.

10. The deceased was reviewed at the Talk to Me case conference on 23 January 2017 and although he was no longer classified as at risk of suicide/self-harm, because he was known to have mental health issues, the nurse in attendance made a referral to the mental health team of the prison.

11. A senior mental health nurse, Nicole Morrison, attempted to see the deceased on 24 January 2017 but was unsuccessful as he was at court. She did, however, meet with the deceased on 25 January 2017 when she carried out a mental health assessment. Nurse Morrison knew the deceased well, having cared for him on previous occasions when he had been in custody. She noted that the deceased denied any thoughts of self-harm and suicide, and she herself had no concerns about him in that regard. The deceased requested that he be recommenced on anti-psychotic medication. As a result of her assessment of the deceased, and taking account of his request for medication, Nurse Morrison made an appointment for the deceased to be assessed by a psychiatrist, Dr Louise Ramsay, at her next clinic. The nurse also telephoned Dr Ramsay on 24 January 2017 to advise her that the deceased was back in custody because he was well known to the doctor.

12. Dr Ramsay's psychiatric clinic took place on 31 January 2017 and she assessed the deceased on that date. He was as well as the doctor had seen him in a prison setting. On previous occasions, the deceased had been so unwell that he had refused to leave his cell and the doctor had required to attend there in order to assess him. He had also previously refused to take medication. On this occasion the deceased had actually come to see Dr Ramsay at the clinic actively seeking medication. His behaviour was symptomatic to a degree but this was normal for him. Doctor Ramsay had never known the deceased to be completely well, particularly in a prison setting after having been remanded in circumstances where he had been using illicit drugs and not taking his prescribed medication.

The deceased denied any thoughts of harming himself and displayed no obvious indicators such as to cause alarm to the doctor. He was not of low mood and had no significant mood difficulties which concerned her. He was not distressed, nor was he making final plans and no concerns had been raised by any of the prison staff, his friends or family. Dr Ramsay made the decision that the deceased was well enough to remain in prison and to commence antipsychotic medication. Her decision was to start on 10 mg of olanzapine because he had not had any prescribed medication for quite some time. The doctor recorded that, if he was managing with that dose, it could be increased to 50 mg in seven days and that she would review him in two weeks with a view to decreasing the dosage to 20 mg. Dr Ramsay did not think the deceased was ill enough to be detained in hospital and, given that he had approached her and asked for medication was satisfied that he could be given the opportunity to take medication without requiring to go to hospital. The doctor intended to review her decision at her next appointment with the deceased on 14 February 2017, which would allow time for the medication to take effect.

13. After Doctor Ramsay had prescribed medication to the deceased, Nurse Morrison noted the care plan in the medical records on 31 January 2017. The care plan detailed how and when the medication should be dispensed to the deceased. Nurse Morrison met the deceased on 1 February 2017 because he was questioning his dosage of medication. The nurse explained Dr Ramsay's instructions and the deceased accepted that explanation. Nurse Morrison and the deceased went on to have a discussion about his mental health in the course of which he denied any thoughts of suicide or self-harm; leaving the nurse with no concerns. Within the records there are two notes to the effect that later on 1 February 2017 the deceased refused to take his medication; after that there are no further entries.

14. The deceased was allocated cell 1/44 within A Hall of the prison where he resided by himself.

15. On Saturday 4 February at 17:00 hours, the prisoners within A Hall were locked within their cells for the evening. Prisoners are not checked in their cells again until 08:30 hours the following morning, unless they are on special observations or have pressed the buzzer requesting staff assistance. The deceased was not on special observations and only pressed his buzzer once that night, at around 17:45 hours. Prison officer Baris Dogan attended at the deceased's cell. The deceased asked the prison officer for assistance in requesting other inmates to provide him with smoking material. Baris Dogan tried to help but without success. He informed the deceased who did not ask for any further assistance or raise any further issues. At this time the deceased was safe and well and the prison officer

had no concerns about him. The deceased did not call for further assistance through the night.

16. At approximately 08:30 hours on Sunday, 5 February 2017, prison officer Edward McGrath began opening the prisoners' cells. Upon opening the deceased's cell, Mr McGrath observed the deceased to be suspended from the window with black string around his neck.

17. Mr McGrath summoned assistance and prison officers James Clydesdale and Colin Clark attended immediately. The prison officers at once obtained a first aid pack, which contained scissors. They used these to cut the ligature and release the deceased.

18. Christine Campbell and Jean Carson, both nurse practitioners attended at the cell. They observed that there were no signs of life and rigor mortis was present. The nurses confirmed that the deceased had died.

19. The deceased's life was pronounced extinct at 08:43 hours on Sunday 5 February 2017 by paramedics Peter Smith and Michael Jones.

20. Police officers attended at the cell and carried out an examination. Although they found several handwritten notes, no suicide note was found.

21. Following a post mortem of the deceased on 13 February 2017, the cause of death was certified by Doctor Julie McAdam of the University of Glasgow as by hanging.

Note

Introduction

[1] The fatal accident inquiry into the sad death of Malcolm Smith took place before me on 14 December 2017 under the Act. The date of death was reported to COPFS on 20 February 2017. The preliminary hearing took place on 12 December 2017.

The Legal Framework

[2] The inquiry was held under Section 1 of the Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The inquiry was a mandatory inquiry in terms of section 2(4)(a) in that the death occurred while the deceased was in legal custody. The purpose of the inquiry in terms of section 1(3) was to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. COPFS was represented by Miss Milligan. Ms Chalmers represented the Scottish Prison Service.

Summary

[3] The information presented at the inquiry principally took the form of a joint minute of agreement entered into between the procurator fiscal depute and the solicitor for the Scottish Prison Service, who were the only participants in the inquiry, and lodged in terms of rule 4.10. That joint minute of agreement derives from Crown productions numbers 1 – 5: an intimation of death form relating to the deceased; a post-mortem report relating to the deceased dated 20 March 2017; the deceased's NHS prison healthcare records; and the deceased's prison records. The joint minute was supplemented by parole evidence taken from Nurse Morrison who had met with the deceased just a few days before his death. She confirmed that on that occasion she had no concerns regarding the deceased. I formed the impression that the deceased was well liked by her and other staff. She described how most people had been shocked by what had occurred.

[4] When they came to make submissions both Ms Milligan and Ms Chalmers invited the court to do no more than make formal findings in relation to the date, time, place and cause of death.

[5] On the basis of the above facts I concluded that there were no reasonable precautions which, had they been taken, might realistically have resulted in the death being avoided. There was no information before me which could have prompted me to make any recommendations.