INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY ACT 1976 INTO THE DEATH OF MICHAEL STEVENSON LYLE

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

SECTION 1(1)(a)

SECTION 1(1)(b)

DETERMINATION by JAMES KENNETH MITCHELL, Esquire, Advocate, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on the Nineteenth and Twentieth days of October Two Thousand and Five into the death of MICHAEL STEVENSON LYLE, aged 26 years, who normally resided at 109 Beechwood Road, Mauchline, Ayrshire.

GLASGOW, October 2005.

The Sheriff, 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 MICHAEL STEVENSON LYLE, born 26 May 1979, who resided at 109 Beechwood Road, Mauchline, Ayrshire died at a time not precisely established about 2000 hours on Wednesday, 8 June 2005 whilst alone in Cell A3/53, A Hall, HM Prison Barlinnie, Glasgow where he was detained in legal custody. He was formally pronounced dead at 2100 hours on that date, at which time resuscitation efforts were discontinued.

In terms of section 6(1)(b) of the Act that the cause of death was hanging as a result of the deceased using a shoelace as a ligature around his neck suspending it from the top bar of the bunk-bed in the cell whilst he was alone there.

Sheriff

NOTE:

This Fatal Accident Inquiry was held in terms of section 1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Michael Stevenson Lyle who was pronounced dead on Wednesday, 8 June 2005 in Cell A3/53, A Hall HM Prison, Barlinnie, Glasgow where he was detained in legal custody.

The procurator fiscal was represented by Mr J McKenna, acting principal procurator fiscal depute. Miss Gardiner, solicitor, Edinburgh appeared for Scottish Ministers for and on behalf of the Scottish Prison Service. Miss Gorman, solicitor, Glasgow, appeared for the Prison

Officers' Association Scotland and in particular for its members Ann Marie Tobin, Derek Brown, Robert McKay and Albert Matusavage. There was no other representation at this Inquiry. The parents and sisters of the deceased were present during the Inquiry and I am indebted to Mr McKenna for the solicitousness which he displayed in assisting them.

The procurator fiscal led evidence from 13 witnesses. No evidence was led on behalf of any other party.

In his closing submission, the procurator fiscal sought only formal findings in terms of sections 6(1)(a) and (b) of the 1976 Act. He submitted that on the evidence no other findings could be made in terms of paragraphs (c) or (d) or (e). The procurator fiscal submitted that the evidence disclosed no indication as to why the accused had taken his own life. He submitted, however, that the evidence did establish that there was no indication that the deceased was at risk of suicide or self harm at any time from his admission to HM Prison, Barlinnie until his death later the same day.

Miss Gardiner was content to adopt the submissions of the procurator fiscal as was Miss Gorman. Miss Gorman went on to submit that the evidence disclosed that the deceased had given no indication or sign of what he was about to do, that there were no defects in the system operated within the prison; and that there were no reasonable precautions which were not taken and ought to have been taken which might have avoided the deceased's death. Miss Gorman submitted that on the evidence nothing could have been done to avoid the death of the deceased and that there was no basis for any finding in terms of paragraphs (c), (d) or (e).

Mr Lyle was 26 years old when he died. He appeared at Ayr Sheriff Court on summary complaint on 8 June 2005 and was sentenced to a period of 5 months of imprisonment from that date.

Mr Lyle was taken to HM Prison Barlinnie, Glasgow where he went through the normal admission procedures. He was seen by a reception officer between 1735 hours and 1740 hours. I am satisfied that Mr Scott Mannion, prison officer, who saw Mr Lyle at that time conducted the interview properly and that his conclusion that the deceased was "no apparent risk (of suicide)" was justified. Mr Lyle was seen by two practitioner nurses, Katie Bell and Ann Marie Tobin. Proper procedures were carried out by them and neither of these nurses considered that there was any apparent risk of suicide on Mr Lyle's part. All these witnesses were experienced and trained in the appropriate procedures. I am satisfied that had there been any concern about Mr Lyle then he would have been put on suicide watch. I accept that Mr Lyle was showing none of the signs that could be associated with drug withdrawal such as sweating, shaking, agitation or a runny nose.

Mr Lyle was allocated to A Hall and was received there at about 1930 hours by Prison Officer Derek Brown and Prison Officer Robert McKay. As he ascended the stairway Mr Lyle had a conversation with Prison Officer Ian McLaughlin, whom he knew from a previous

sentence of imprisonment. Mr McLaughlin spoke to a brief exchange of pleasantries and to the deceased saying to him "I'm fine, I'll catch you later on Mac." Mr McLaughlin was clear that the deceased's manner had been pleasant and calm and that he appeared to be absolutely fine. This was confirmed by Mr Brown and by Mr McKay. Mr Brown took Mr Lyle to Cell A 3/53. He was to share with a cell-mate Christopher Law, who was away at recreation. Mr Brown recollected that Mr Lyle had told him that he had been in prison before. Mr Lyle enquired with whom he was to share a cell and Mr Brown told him the name of his cell-mate. Mr Lyle then entered this cell, where he was alone and, in accordance with normal procedure, Mr Brown locked him in. That was the last time that Mr Lyle was seen alive.

At some time between 2015 hours and 2030 hours the prisoners from A Hall who had been at recreation returned and had to be locked into their cells for the night. About 80/90 prisoners returned and so there were a number of prisoners to be locked into their cells. One of these prisoners was Christopher Law. In common with normal practice prisoners stood outside their cells until the prison officer came along to open the cell door. Christopher Law stood outside Cell 53 and saw that he was to have a cell-mate. He was inquisitive and looked through the spyhole on the cell door. He said that he "saw a boy hanging off the bed off the top bunk". He said that he told the prison officer who was next to him. There was some discrepancy between the evidence of Christopher Law and Prison Officer Robert McKay. Insofar as there was a discrepancy I accepted and preferred the evidence of Prison Officer McKay as being credible and reliable. His account was given in a more open and straightforward way than that given by Christopher Law. Christopher Law said the officer ignored him but he did not see fit to mention that to the police when they took a statement from him. Mr McKay's position, which I accept, was that Mr Law approached him and said "Boss my co-pilot's hanging". Mr McKay said that he ran up to open Cell No. 53; he saw Mr Law in there sitting on the bottom bunk; and he also saw a boot lace attached to the retaining bar of the top bunk which went round Mr Lyle's neck. He described Mr Lyle as being ashen grey when he went in and he could detect no sign of life.

I am satisfied that Prison Officer McKay acted promptly when his attention was drawn to the situation by Christopher Law. I am satisfied that he promptly summoned assistance and did everything he could to assist Mr Lyle. I am satisfied that assistance arrived promptly and that every effort was made to resuscitate Mr Lyle.

Mr Lyle was certified dead at 2100 hours by Dr Graeme Bingham who attended. At that time all resuscitation efforts were discontinued. Dr Bingham was an impressive witness and I accepted his estimate that the deceased had been dead for about an hour when death was certified at 2100 hours.

The deceased's parents decided to leave the court during the evidence of the Pathologist, Dr Julie McAdam. She spoke to her post-mortem report and was able to assist the court with the mechanism of death. She considered that Mr Lyle would have lost consciousness quickly and that he would have been "brain dead" within 4 minutes. She considered that his death had taken not longer than a few minutes and that he would have been unconscious very quickly. She considered that the cause of death was hanging. There were no pathological features to indicate which of the three possible causes of death had actually occurred. The

first possible cause was lack of oxygen to the brain; the second was that the blood already in the brain could not leave and return to the heart with the result that fresh oxygenated blood could get to the brain; and the third was the stimulation of the vagus nerve which led to cardiac arrest.

The evidence does not disclose any reason why Mr Lyle acted as he did. The parents and relatives of the deceased had no criticism to make in respect of any party. I expressed my sympathies to them in court and repeat these now. This Inquiry has provided no insight for them as to why Mr Lyle did what he did but it is clear that after suspending himself he was only unconscious for a brief period and died quite quickly, certainly within 4 minutes. It is established on the evidence by the time the prisoners including Christopher Law returned from recreation Mr Lyle was dead.

I agree that only formal findings are appropriate. I also agree with Miss Gorman that the evidence discloses no reasonable precaution which ought to have been taken or any defect in the system operated within the prison. I agree with her that nothing could have been done to avoid Mr Lyle's death. In terms of Rule 8(2) of the Prisons Young Offenders Institutions (Scotland) Rules 1994 Mr Lyle would have had to have been examined by a doctor within 24 hours of his reception to prison. I can find no reason to suspect that had he been seen on his arrival at Barlinnie the doctor would have reached any other conclusion from that reached by Mr Mannion, Katie Bell, Ann Marie Tobin, Ian McLaughlin, Derek Brown and Robert McKay, all of whom were experienced and trained to look for any signs that a prisoner might be at risk of self-harm.

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