

**SHERIFFDOM OF GLASGOW AND
STRATHKELVIN AT GLASGOW**

DETERMINATION by JOHANNA JOHNSTON,
Queen's Counsel, Sheriff of Glasgow and Strathkelvin
following an Inquiry held at Glasgow into the death of
WILLIAM JAMES MILLEN, born 21 July 1980, who
normally resided at 30 Woodside Avenue, Rutherglen,
Glasgow.

Glasgow, 15 November 2013

PART I: INTRODUCTION AND LEGAL FRAMEWORK

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of William James Millen who died within H.M. Prison Barlinnie, Glasgow on 7 June 2010.

[2] Mr Graham, Procurator Fiscal Depute appeared in the public interest. Mr Ross, advocate, represented the Scottish Prison Service. Mr Sibbald, solicitor, represented the Prison Officers' Association. Mr Stewart, solicitor, represented Doctor Adnan Malik. Ms Toner, advocate, represented the family of Mr Millen. Mr Fordyce, solicitor, represented Mrs Hutton and Mrs Morrison.

[3] The Inquiry heard evidence and submissions over the course of the 12, 13 and 14, August 2013. The Crown led eighteen witnesses. The parties entered into a joint minute of agreement, which covered much of the more formal evidence.

Legal Framework

[2] The Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act) Section 1(1) (a) (ii) provides that a Public Inquiry should be held into the death of any person held in legal custody. The purpose of the Inquiry is for the sheriff to 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 may have been avoided;
- (d) the defect, if any, in the system of working which contributed to the death or any accident resulting in the death;
- (e) any other facts which are relevant to the circumstances of the death.

[3] The court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the sheriff's powers do not go beyond making a determination in relation to the circumstances established to his or her satisfaction

by evidence following upon investigation by the procurator fiscal and any other party if so advised.

PART II: DETERMINATION AS TO THE CIRCUMSTANCES OF THE DEATH

The Sheriff having considered all the evidence adduced FINDS AND DETERMINES in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

- (1) In terms of Section 6(1) (a) that William James Millen, born 21 July 1980, who normally resided at 30 Woodside Avenue, Rutherglen, Glasgow died at H.M. Prison Barlinnie, Glasgow at 07.50 hours on 7 June 2010.
- (2) In terms of Section 6(1) (b) that the cause of his death was hanging.
- (3) In terms of section 6(1) (c) of the 1976 Act there were no reasonable precautions whereby the death might have been avoided.
- (4) In terms of section 6(1) (d) of the 1976 Act that there were no defects in any system of working at H M Prison, Barlinnie, Glasgow which contributed to the death.
- (5) In terms of section 6(1) (e) that there were no other facts which are relevant to the circumstances of the death.

PART III: FINDINGS IN FACT

- (1) As at 7 June 2010 William James Millen was 29 years of age. He was a prisoner in the prison of Barlinnie at the time of his death. He normally resided at 30 Woodside Avenue, Rutherglen, Glasgow.

- (2) In the weeks prior to his admission to prison on 1 March 2010, Mr Millen had been abusing controlled drugs. Mr Millen had a long history of drug abuse. He was noted by his family to be anxious. He told them that people were after him. Mr Millen had made two attempts to take his own life in the past. He was not in prison when he made those attempts.
- (3) Mr Millen was convicted of theft by shoplifting and sentenced to three months imprisonment on the 1 March 2010. That conviction led to his recall to prison for a breach of licence. His sentence would have expired in July 2011.
- (4) Mr Millen was admitted into Barlinnie Prison on 1 March 2010. On 2 March 2010 a healthcare assessment was made of him by a prison officer, a nurse and a doctor. An ACT 2 Care Reception Risk Assessment on Mr Millen was completed. The ACT 2 Care Assessment is intended to assess whether or not a prisoner is at risk of self-harm.
- (5) In the course of the assessment Mr Millen reported that he was not feeling suicidal and that he did not feel that he might hurt himself. He reported that he had injured himself 15 years before by cutting his wrists. The prison records showed that Mr Millen had been assessed as high risk under the ACT 2 Care procedures in prison on three occasions in 2001, 2003 and 2006.
- (6) Mr Millen reported that he had been taking heroin, cocaine and benzodiazepine in the period before coming into prison and that he was addicted to controlled drugs. He described his drug abuse as chaotic. He had been prescribed methadone through a Community Addiction Team at a dose of 60 millilitres (mls) per day.

- (7) In terms of the ACT 2 Care assessment on 2 March 2010 Mr Millen was assessed as at no apparent risk of self-harm.
- (8) Mr Millen was prescribed 60 mls of methadone per day, which was in line with the prescription he had received when at liberty. Mr Millen was also prescribed diazepam.
- (9) On 2 March 2010 Mr Millen signed a Prisoner Treatment Agreement Form (Crown Production 7 at page 186 refers). Part of that agreement was that concealing methadone may have led to a review of his prescription.
- (10) On 12 March 2010 Mr Millen was found to have concealed diazepam. His prescription for diazepam was stopped.
- (11) On 23 April 2010 he reported to nursing staff that he was experiencing difficulties on the dose of 60 mls of methadone. Mr Millen had his prescription of methadone increased by 5 mls to 65 mls per day. The prescription was due to increase by an increase of 5 mls per week till it reached 80 mls.
- (12) On 23 April 2010 Mr Millen was transferred into the Segregation Unit following a fight with another prisoner. Mr Millen remained in that unit until his death. His methadone prescription was dispensed to him at the Segregation Unit by nursing staff.
- (13) On the 29 April 2010 Mr Millen was seen by a mental health nurse. He was noted as showing signs of anxiety. He stated that he was agitated, stressed and paranoid. The nurse saw no signs of mental illness and had no particular concerns about his mental health.

- (14) On the 4 May 2010 Mr Millen attended a meeting of the Risk Management Group. It was recommended that he work with the Mental Health Team on anxiety and paranoia issues.
- (15) On 7 May 2010 Mr Millen was found to have been concealing methadone. It was not known how often he had diverted his methadone or what he was doing or intended to do with the methadone. Mr Millen was referred to Dr Malik for a review of his prescription for methadone.
- (16) On 10 May 2010 he was seen by Dr Malik. Dr Malik was not bound by any guideline or protocol covering his prescribing of methadone within the prison.
- (17) Dr Malik decided to reduce the methadone prescribed to Mr Millen on safety grounds. The concealing of methadone by Mr Millen posed a risk to himself and fellow prisoners. The prescription was to be reduced at a rate of 10 mls per week and ultimately stopped. Dr Malik based his decision on his clinical judgement. The reduction and ultimate withdrawal of methadone was not a punishment. Dr Malik selected a rate of reduction appropriate for Mr Millen.
- (18) The concealment of methadone within a prison poses a risk to the health and safety of the whole prison population. There is a danger of overdose, which can be fatal and a risk of the transmission of infectious diseases.
- (19) After the 10 May 2010 Mr Millen received his methadone in the Segregation Unit from a nurse from the Addiction Team. He was seen on an individual basis by such a nurse each day. There were no other prisoners present. The nurse who dispensed the methadone would spend around five minutes with

Mr Millen. The nurses in the Addiction Team are trained in the treatment of mental health.

- (20) On 20 May 2010 Mr Millen submitted a CP3 Complaint form to complain about the reduction in his dose of methadone. He complained that he was suffering withdrawal symptoms. He asked for the rate of reduction to be slowed down and for detoxification treatment at the end of the process. He stated that he felt severely depressed and paranoid and referred to fall outs he had had with his family and his girlfriend.
- (21) His complaint was reviewed by Dr Raman who responded that it was not safe for Mr Millen to be prescribed methadone as he had been caught concealing methadone. Dr Raman indicated that there was symptomatic treatment available for Mr Millen. Mr Millen did not appeal that response.
- (22) A case conference was held on 25 May 2010. Mr Millen attended and complained about the rate of reduction in his methadone and said he would refuse to leave the Segregation Unit until his medication issues were resolved.
- (23) On 2 June 2010 Mr Millen attended another case conference. Mary Mitchell, a qualified mental health nurse, noted that Mr Millen participated fully in the conference. She did not have any concerns about his mental health. Mr Millen declined offers of treatment for withdrawal symptoms.
- (24) Other prisoners within the Segregation Unit noticed that Mr Millen was behaving erratically. On a number of occasions he was heard to shout in his cell and to be apparently speaking to himself. In the exercise yard on one occasion he was seen to be shaking and trembling.

- (25) The prison officers in the Segregation Unit did not have any concerns that Mr Millen was at risk of self-harm. Mr Millen told officers that he was discontented about the reduction in his methadone. Mr Millen reported that abuse was being shouted at him by prisoners in an adjacent wing. In light of that prison staff moved him to a cell further away where he would not be so exposed to the shouts.
- (26) Mr Millen spoke by telephone with his mother on the 2 June 2010. He complained about feeling unwell because of his reduced dose of methadone. He said that people within the prison were after him. His mother did not recognise any signs that he would harm himself.
- (27) On the 6 June 2010 Mr Millen caused damage to his cell. Prison officers called in a nurse to speak with Mr Millen. At around 12.40 he was seen in the Segregation Unit by nurse Lydia Witkiewiaz from the Addiction team who spent fifteen or twenty minutes with him. He was noted to be agitated and very anxious. He stated that he had been hearing voices and he that he had a crawling sensation on his skin. Nurse Witkiewiaz did not observe any behavioural responses to these sensations. He was given his methadone. Mr Millen calmed down as his feelings and behaviour were discussed. The nurse noted *"William benefits from giving time and attention to him"*.
- (28) At 10 pm on 6 June 2010, Mr Millen spoke to prison officer Steven Sharp who had no concerns about his condition.
- (29) Around 6.30am on 7 June 2010 Mr Millen was found hanging by a ligature from a roof light. Mr Millen had hanged himself. There were no signs of life and at 07.50 life was pronounced extinct.

- (30) Mr Millen left a note for his mother and a note for his partner. He apologised for the grief he had caused to them and made reference to having made enemies in the prison. He made no mention in these notes about any difficulties with methadone withdrawal.
- (31) A post mortem was conducted on 14 June 2010 at the Glasgow City Mortuary by Dr Marjorie Black. She concluded that the cause of death was hanging.

PART IV: SUBMISSIONS

Crown

- [1] The Crown invited me to make a determination under section 6(1) (c) that the death of Mr Millen might have been avoided had forcible detoxification not been imposed. I was invited to make a recommendation that the Prison Authorities be directed to ensure that in the event of the concealment of methadone that current guidelines are complied with and that forcible detoxification is therefore only imposed in very exceptional circumstances and not as a matter of course.
- [2] Under Section 6(1) (d) it was submitted that Mr Millen should not have been detoxified. It was further submitted that in the very exceptional cases where forcible detoxification is carried out there must be a robust system of monitoring the patient with clear lines of responsibility, recording and review.

Scottish Prison Service

- [3] On behalf of the Scottish Prison Service Mr Ross, Advocate, submitted that no recommendation could be made in terms of section 6(1) (c). There was no evidence to support the suggestion that the decision by Dr Malik to reduce the methadone prescribed to Mr Millen was an unreasonable decision. Secondly, it

was submitted that there was insufficient evidence to conclude that any such decision might have avoided the death of Mr Millen. Dr Roberts had accepted that the suggestion that detoxification from methadone was a contributory factor in Mr Millen's suicide was in the realm of speculation.

- [4] It was submitted that no recommendation should be made in terms of section 6(1) (d). There was no basis for any finding that there was a defective system of work in the form of an inflexible rule that a prescription will always be stopped in the event of a prisoner being caught concealing methadone.

Prison Officers' Association

- [5] It was submitted that there was no evidence critical of the members of the Prison Officer's Association of Scotland. I was invited to make no findings relevant to the members of the Prison Officer's Association of Scotland in relation to either in terms of Section 6 (1) (c) (d) or (e) of the Act.

Dr Malik

- [6] Mr Stewart submitted on behalf of Dr Malik that in terms of Section 6 (1) (c) that there were no reasonable precautions that could have been undertaken by Dr Malik whereby the death might have been avoided. Dr Malik's actions were reasonable in all the circumstances. The decision to reduce was a clinical one, based on the safety of Mr Millen and fellow prisoners.
- [7] It was further submitted in relation Section 6 (1) (d) that there was insufficient evidence in respect of causation to allow a finding under that section. It was submitted that the same causation arguments as submitted in relation to section 6(1) (c) applied equally to section 6 (1) (d) but with even greater force.

Mrs Linda Mullen - Next of kin

[8] Ms Toner, Advocate, submitted that in terms of Section 6(1) (c) there were reasonable precautions whereby the death and any accident resulting in the death might have been avoided. It was submitted that, had the question of Mr Millen's continuing methadone prescription been approached differently, in particular with regard to his forcible detoxification, then his death may have been avoided. In addition had his prescription been further reviewed in accordance with his medical needs that may in turn have rendered him better able to cope with his circumstances.

[9] In terms of section 6 (1) (d) it was submitted that the decision to reduce Mr Millen's methadone prescription, and the way in which this was done, was made, to some extent at least, as a punitive measure. It was submitted that this was a defect in the system of prescribing methadone to prisoners.

[10] It was submitted that it was not appropriate for Mr Millen to have his prescription cut to the extent that it was. The reduction of the prescription to this extent was punitive and, consequently, contrary to best medical practice.

[11] If the prescription was to be cut at all, it ought to have been done in the context of a full, robust and effective system of medical monitoring. Had the appropriate level of medical support been made available to Mr Millen, and had his methadone reduction been better managed, it may be that he would have felt better able to cope with his circumstances. It was submitted that whilst it can never be known for certain what caused Mr Millen to take his own life, the

methadone reduction program forced upon him was a contributory factor in his death.

[12] In terms of Section 6(1) (e), any other circumstances relevant to the death, it was submitted that the liaison between the Scottish Prison Service and the next of kin of Mr Millen in the immediate aftermath of his death was eloquent of grave failures in communication, resulting in increased distress to the family. It is submitted that such poor liaison is relevant to the circumstances of the death as a whole, from the perspective of the next of kin. It was accepted that this was not strictly within the scope of the Inquiry into the death of Mr Millen.

Helen Hutton & Stacey Morrison, Nurses

[13] Mr Fordyce made no submissions in terms of section 6 (1) (c) or (d).

[14] In terms of section 6 (1) (e), other facts relevant to the cause of death, the court was invited to make two recommendations:

- (i) There should be a re-consideration of the wording of the ‘Prisoner Treatment Agreement’ such as the one produced at page 186 in Crown Production 7. In particular, it should be made clear that any review of medication is not intended as a punitive sanction but one based on clinical need and in the interests of safety.
- (ii) Such an Agreement should be signed by a doctor and not a member of nursing staff.

PART V: NOTE ON EVIDENCE

Background of Mr Millen

[15] In March of 2010 Mr Millen was sentenced to a short period of imprisonment, which led to his recall to prison. He had been released on licence on the 10 July 2008 in respect of an extended sentence of seven years, which had a custodial term of six years and an extension period of twelve months. His release date would have been in July 2011.

[16] Mr Millen had a history of self-harm and attempts at suicide. He had been in prison before for custodial sentences. In 2001, 2003 and 2006 whilst a prisoner, he had been placed in the category of being at high risk of self-harm by the relevant prison authorities. His mother, Linda Millen, stated that she knew of two attempts at suicide by him when he was at liberty. She understood that he had not had any psychiatric treatment followings those attempts.

[17] Mr Millen had been addicted to drugs for a number of years. He had been taking methadone prior to his imprisonment as part of a treatment programme for his drug addiction. He reported that he had been abusing controlled drugs in the period immediately prior to his imprisonment.

[18] I heard evidence from his mother and Ashley McKay, his sister. Both spoke of Mr Millen being in a poor state just before he went in to custody. He was abusing drugs and was saying that people were after him. They described him as being paranoid.

The prescription of methadone to Mr Millen within Barlinnie Prison

- [19] Mr Millen was assessed on his admission to prison. He was assessed by nursing staff and a doctor. He was found to present no apparent risk of self-harm. There was no issue taken with this assessment in the course of the enquiry.
- [20] Mr Millen signed a Prisoner Treatment Agreement form. Part of the agreement was that in the event of any inappropriate behaviour such as concealing methadone, his prescription could be subject to review.
- [21] Mr Millen had his prescription increased on 23 April 2010 after he reported to nursing staff that he was experiencing difficulties and was not coping on a prescription of 65 mls per day.
- [22] Mr Millen was in the Segregation Unit from the 23 April 2010 until his death. His methadone prescription was dispensed to him at the Segregation Unit by nursing staff.
- [23] Within Barlinnie prison methadone is dispensed by nursing staff to prisoners in a liquid form and the prisoner swallows the liquid in the presence of the nurse. Prisoners queue up to receive their medication. Measures are in place to try to ensure that a prisoner cannot divert any of the liquid and keep it aside. The prisoner is asked to take a drink of water after the methadone has been swallowed and his mouth is examined.
- [24] In the Segregation Unit methadone is dispensed on an individual basis to a prisoner. The nurse meets with the prisoner and spends in the region of 5 minutes with him to ensure that the methadone is ingested.
- [25] It is recognised by the medical professionals in the prison that notwithstanding these measures, prisoners have on occasions been able to divert

methadone and evade detection. This has been done in a number of ways, which include swallowing the liquid and regurgitating it later.

The decision to reduce the methadone prescribed to Mr Millen

[26] On the 7 May 2010 Mr Millen was found to have been concealing methadone.

There was no evidence as to how Mr Millen had managed to conceal methadone.

There was no evidence of what Mr Millen intended to do with the methadone he had concealed or if he had done this before.

[27] Mr Millen was referred to Dr Malik as a result of having concealed methadone. He was seen on the 10 May 2010. Dr Malik decided that Mr Millen should be taken off methadone and that the reduction was to be at a rate of 10 mls per week.

[28] Dr Malik examined Mr Millen and had his records available to him. He based his decision on the way Mr Millen presented, his medical history and his history of drug abuse and methadone treatment. His decision was based solely on his clinical judgement. He made the decision on the grounds of safety. There was a risk that Mr Millen could accumulate methadone and take an overdose. It is of note that Mr Millen had asked for an increase in his methadone shortly before he was found to have concealed a quantity. There was also a risk that if Mr Millen passed on methadone to another prisoner that prisoner could overdose. The risk of the transmission of infectious disease was also present given that the methadone might be concealed internally before its transfer. Dr Malik took all these risks into account.

[29] Dr Malik as a doctor prescribing medication in the setting of a prison had a responsibility to all of the prisoners. In his opinion 20 mls of methadone could

prove fatal to a person who was unused to opiates. He considered that it was important for the system of prescribing methadone within the prison that prisoners realised that if they were caught concealing methadone they could have methadone withdrawn.

[30] The decision by Dr Malik to reduce the amount of methadone was not to punish Mr Millen for concealing methadone. The consultation on the 10 May 2012 was in line with the normal practice in the prison when a prisoner was in breach of the Prisoner Treatment Agreement. Dr Malik was not bound by any guideline or protocol covering his prescribing of methadone within the prison. He described his decision as not being set in stone and stated that he is always open to changing a prescription based on a clinical change of circumstances.

[31] The rate of reduction was chosen by Dr Malik based on his clinical examination of Mr Millen and his medical history. He could have prescribed an immediate reduction to 30 mls, which is recognised as a safe level even for a person who has been on a high dose. He considered that would have been harsh on Mr Millen. He decided that a slower rate was appropriate for Mr Millen in all the circumstances.

[32] Mr Millen displayed an unusual the response to the reduction in methadone. Mr Millen did not say anything and only nodded his head to indicate he accepted the reason for the reduction. In the experience of Dr Malik the usual reaction was for the prisoner to shout abuse at him.

[33] Dr Malik had no had contact with Mr Millen after the 10 May. The addiction nurses within the prison report back to the doctors and Dr Malik was confident that they would have reported any concerns about Mr Millen. There was

evidence from the witness, Mary Mitchell that the nurses in the Addiction team have training in mental health care.

[34] Dr Malik did not consider that he was qualified to state whether suicide could be a symptom of withdrawal from methadone. He considered that was an issue, which required the expertise of a psychiatrist.

[35] I accepted the evidence of Dr Malik. He gave his evidence in a careful and considered manner. I am satisfied that his decision to reduce the methadone prescribed to Mr Millen was an appropriate clinical judgement. He had the opportunity to examine Mr Millen and had access to his medical records and prison records. He took into account all the relevant factors and balanced the risks involved in leaving Mr Millen on his existing prescription against reducing his prescription with a view to his coming off methadone. Mr Millen went on to take his own life and one risk taken into account by Dr Malik was the risk of overdose by Mr Millen.

[36] I heard evidence from Doctor Kennedy Roberts. He has considerable experience in relation to drug treatment in the community and within prisons. He had prepared a report (Crown Production 9 refers). Parts of his report and his evidence related to the issue of the long term therapeutic benefits of drug treatment and the risks of relapse to drug use, namely the long term outcome for the patient. This was not relevant for Mr Millen given his untimely death.

[37] His report appears to have been prepared on the basis that the reduction of the methadone prescribed to Mr Millen was a form of punishment. The starting point in his report was that forcible detoxification should not be used as a sanction. In evidence, Dr Roberts gave careful and balanced consideration to

propositions put to him in cross-examination. When it was put to him that Dr Malik had stated that the reduction in methadone was a clinical decision and not a punishment, Dr Roberts, very properly, deferred to Dr Malik's clinical judgement. He did not criticise that clinical judgement.

[38] Dr Roberts acknowledged that an individual prescriber has to do what is right for the patient in light of all the circumstances. He accepted that in circumstances such as those within a prison, where there may be a danger to health, it may be appropriate to reduce the amount of methadone prescribed.

[39] Dr Roberts referred to guidelines issued by the Department of Health, *"Drug Use and Dependence – Guidelines on Clinical Management"*. The guidelines counsel against punitive measures and encourage clinicians to retain failing patients in treatment. Dr Roberts accepted that a doctor prescribing within a prison was entitled to take into account the health of the wider prison community. He gave evidence that in many prisons or similar institutions concealment of methadone would be likely to result in a review and a reduction programme. The approach taken by Dr Malik does not appear to run contrary to either the guidelines or practice. Dr Malik made a clinical decision not a punitive one and acted in line with practice in other institutions.

[40] In his report Dr Roberts concluded that Mr Millen's suicide was probably multi-factorial and that detoxification from methadone was a contributory factor. I note from his report in the final paragraph in the section headed *"Opinion"* that he states that rapid detoxification can have a deleterious effect on mental health. He then states that for Mr Millen, there may be some evidence of that in the

written statements he had received. This appears to have been the basis for his conclusion that the reduction was a contributory factor.

[41] In evidence he repeated this conclusion and then in cross-examination accepted that this was in the realm of speculation and that only Mr Millen knew why he had taken his own life. I am satisfied it was reasonable for that Dr Roberts on reflection to accept that in reaching his original conclusion, there was speculation. He did not have the opportunity to clinically examine Mr Millen and reach any view on his mental health. He had to proceed on the basis of untested information within witness statements. Further, as Dr Malik stated in evidence, this is an area in which a psychiatrist would have the necessary clinical expertise.

[42] In relation to the treatment and monitoring of Mr Millen during detoxification, Dr Roberts initially said that a person being detoxified should be reviewed by the prescriber, namely a doctor, on a weekly basis being the same basis as the rate of reduction. In cross-examination he accepted that this review would not need to be by the doctor, a trained addiction professional would be sufficient. Dr Roberts stated that he was pleased that Mr Millen had had supervision by an addiction nurse daily on an individual basis.

The behaviour of Mr Millen in the period from 10 May to 7 June 2010

[43] Mr Millen submitted a complaint about the reduction in his methadone on the 20 May 2010. He complained of suffering withdrawal symptoms. He also complained of feeling depressed and paranoid. His complaint was reviewed by Dr Raman who responded that it was not safe for Mr Millen to be prescribed methadone as he had been caught concealing methadone. Dr Raman stated that

Mr Millen could be given treatment to relieve his symptoms. Mr Millen did not appeal this review as was open to him in terms of prison regulations.

[44] At the case conference on 25 May 2010 Mr Millen was present when there was discussion about how much improvement he had made. He complained about the reduction in his methadone and stated that he could not cope with the rate and he was refusing to leave segregation until his medication was resolved.

[45] Mr Millen Case attended a further case conference on 2 June 2010. The witness Mary Mitchell was present at the meeting. She is a qualified mental health nurse. She described the behaviour of Mr Millen at the meeting. She had no concerns about him and she noted that he appeared to be fine. He did not display any signs of withdrawal. She referred to a written record of the meeting (Production 7 at page 203 refers) which accorded with her account. I accepted the evidence of Mrs Mitchell about the condition of Mr Millen. She had a clear recollection of the meeting and the written record of the meeting was consistent with her account.

[46] I heard evidence from Mr Ferris and Mr McGowan who were inmates in the Segregation Unit during the period that Mr Millen was there.

[47] Mr Ferris was there for the two weeks before Mr Millen died. He spoke to erratic behaviour by Mr Millen. He said that he had reported this to prison officers. He also said that he had written a letter to the family of Mr Millen after his death to tell them of what he had observed.

[48] I am not satisfied that I can wholly rely on the evidence of Mr Ferris. He stated that there was a change in Mr Millen when he had his methadone stopped. Mr Millen did not have his methadone stopped and by the time Mr Ferris was in

the unit Mr Millen had already been subject to reduction for a period of two weeks. I cannot draw from his evidence that the behaviour of Mr Millen was caused in whole or part by the reduced dose of methadone. I accepted his evidence that there was shouting and erratic behaviour by Mr Millen as that was spoken to by other witnesses. I did not accept that it was to the extent that Mr Ferris described. Mr McGowan was in the adjacent cell to Mr Millen and he spoke of shouting but to a much lesser extent.

[49] McGowan was there for five days and he was in the cell adjacent to Mr Millen. His contact with Mr Millen was after the methadone reduction had been put in place. He did hear Mr Millen shouting and heard him saying things that did not make sense. It is of note that Mr Millen reported to staff in the unit that abuse was being shouted at him by prisoners in an adjacent wing. Accordingly, there is an explanation for his being heard shouting.

[50] Mr McGowan did not speak to the level of disturbance referred to by Mr Ferris. He also said that he saw Mr Millen in the exercise yard and that he was shaking and trembling. Mr McGowan had limited contact with Mr Millen over a short period. I cannot draw from his evidence that Mr Millen's behaviour was as a result of the reduced dose of methadone.

[51] There was reference to a letter written by Mr Ferris to the family of Mr Millen. This letter was not produced and I heard little in evidence of its contents other than the evidence of Mr Ferris that he had written the letter.

[52] Mr Millen had a visit from his mother while he was within the Segregation Unit. She described him as looking "*alright*" and to chatting away to her as normal. She spoke with him on the telephone on later occasions. She described

him as sounding paranoid and he said that he was being terrorised by people. He also said that he was unwell because his methadone had been stopped. She last spoke to him on 2 June 2010. In the course of that phone call he complained about being “*mucked about*” by staff and not getting his methadone. She thought he sounded paranoid. She stated in evidence that she now is of the view that she should have recognised her son was having difficulties.

[53] There was evidence that Mr Millen was seen at around lunchtime on 6 June 2010 by a nurse from the Addiction Team. I did not hear evidence from that nurse as her present whereabouts are unknown. She made an entry in the records and that was led in evidence (Crown Production 7 at p243 refers). The nurse spent up to twenty minutes with Mr Millen and noted that he calmed down as she spoke to him. She did note that he was complaining of hearing voices and a crawling sensation on his skin. She noted that he did not show any response to these sensations. Mr Millen was given his methadone. It would have been open to the nurse to report back to a doctor about Mr Millen’s condition had she felt that was merited. There is no reference in her note of any intention to report to a doctor.

[54] Mr Millen was seen at 10pm that night by a prison officer. Mr Millen asked the officer if that was him on for the night shift and there was then some conversation between them. The officer had no concerns about Mr Millen.

PART VI: CONCLUSIONS

[55] The central issue in this Inquiry was the decision to reduce the methadone prescribed to Mr Millen and whether that reduction had a part to play in his taking his own life.

[56] I was satisfied that the decision by Dr Malik to reduce the methadone prescribed was an appropriate clinical judgement and was not taken to impose a punishment upon Mr Millen. Dr Roberts did not criticise his clinical decision. Dr Malik had the chance to examine Mr Millen and based his decision on that examination and the information in the records available to him. Dr Malik made his decision on the grounds of safety. There was a risk was that Mr Millen could take an overdose. There was evidence before me that he had made attempts at suicide in the past and sadly, in the event Mr Millen did end his own life.

[57] A clinician prescribing drugs within a prison holds a responsibility, which encompasses the individual patient and the wider community, which he treats. I do not consider that there was anything in the evidence before me to indicate that I should make a recommendation as to how appropriately qualified medical practitioners carry out their clinical responsibilities in these circumstances.

[58] I was not satisfied that on the evidence before me that there was a connection between the reduction of the methadone prescribed to Mr Millen and his decision to take his own life. His family had noted that he was very anxious and exhibited a fear of persons seeking reprisals before his admission into custody. On admission he reported a long history of drug abuse and stated that immediately before his incarceration his drug abuse had been chaotic. He had attempted suicide in the past.

[59] In the period he was in custody before his methadone was reduced he was also anxious and in fear of reprisals. There was evidence of his difficult behaviour within the prison. He was transferred into the Segregation Unit because he had been fighting with another prisoner. He had concealed diazepam and methadone. He apparently did not want to leave the Segregation Unit and return to the mainstream units. He complained to his mother at visits and on the phone that people were after him.

[60] It is significant that in the notes to his mother and partner, Mr Millen made no mention of the reduction in his methadone. He wrote of his fears of having made enemies in prison and about the grief he had caused to his family.

[61] Dr Roberts gave evidence that withdrawal from methadone can affect mental health. Mr Millen had no diagnosis of mental health problems during the period from his admission in March 2010 to his death. He was seen by nurses from the Addiction Team every day. The nurses who undertake that work are trained and experienced in drug addiction treatment and they also receive training in mental health care. They can report back to the prison doctors any concerns they have about a prisoner. There were no reports made by the nurses in respect of Mr Millen. His mother had spoken to him on the 2 June 2010 and did not recognise any sign of him being at risk of harming himself.

[62] Mr Millen attended two case conferences at which nursing staff had an opportunity to observe his behaviour. On the day before his death he spoke with a nurse from the addiction team. That evening he engaged in conversation with a prison officer. In all the contact that Mr Millen had with medical and prison staff no concerns arose as to his being at risk of self-harming.

[63] In light of all the evidence, I consider that Dr Roberts was correct to recognise that it would be to speculate to state that methadone reduction was a contributory factor in his death. Mr Millen appears to have been encountering problems some time before his methadone was reduced. He had sought an increase in his methadone and then concealed a quantity. An overdose of methadone can be fatal.

[64] I heard a considerable amount of evidence that Mr Millen was unhappy about the reduction in his methadone. He told his family about his frustrations. He made a formal complaint and raised the issue at each of the case conferences he attended in late May and early June. He was noted to be acting erratically by fellow prisoners and prison staff. I am satisfied that the amount of methadone he was prescribed was a matter that occupied much of his thoughts and troubled him. Mr Millen appears to have had other anxieties and worries and I cannot determine, in the evidence led before me, that the reduction of his methadone played a part in his decision to end his life. As was said by Dr Roberts in the course of the Inquiry, only Mr Millen knew why he took his own life.

[65] In relation to any monitoring of Mr Millen during the period of his detoxification, as I cannot be satisfied that there is a connection between the reduction in methadone and his death, it follows that I have not made any determination or recommendation as regards that issue. It is of note that Mr Millen was supervised by the Addiction Team in the prison. He was offered support and medical treatment on a number of occasions. Mr Millen also attended case conferences. Whilst in the Segregation Unit he met with a nurse every day in circumstances where there was the opportunity for the nurse to

observe his condition and for Mr Millen to report any problems. Dr Roberts indicated that he was pleased that Mr Millen had benefited from that type of supervision by a qualified addiction nurse.

[66] I heard evidence and submissions on behalf of the family about the lack of information they were given by the prison authorities immediately after the death of Mr Millen. As counsel acknowledged, this was not within the scope of this Inquiry. I consider that any prison authority must ensure that there is proper communication with bereaved families. To that end, I recommend that the Scottish Prison Service give consideration to the complaint by the Millen family and take such steps as they see fit.

[67] I wish to extend my condolences to the members of his family. Mr Millen was still a young man and it is tragic that he died in such sad circumstances and away from his family and loved ones.

Glasgow, 15 November 2013

Sheriff Johanna Johnston, Q.C.