INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRES (SCOTLAND) ACT INTO THE SUDDEN DEATH OF JOHN PATERSON CAMPBELL

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 JOSEPH PLATT, Esquire, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on the fourteenth and fifteenth August Two Thousand and Six into the death of JOHN PATERSON CAMPBELL

GLASGOW, 1st September 2006.

The Sheriff, having considered all of the evidence adduced,

DETERMINES, in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 section 6(1):

(a) That John Paterson Campbell who was born on 22 June 1971 and who resided principally at 9 Deepdene Road, Moodiesburn, Glasgow died in The Royal Infirmary, Glasgow at 1500 hours on 26 August 2005, aged 34 years;

(b) That the deceased died as a result of falling on 26 August 2005 from the fourth level of "A" Hall in Her Majesty's Prison, Barlinnie, 81 Lee Avenue, Glasgow to the floor of the said Hall;

(c) That the cause of the deceased's death was head and chest injuries due to the said fall from height; and

(d) That facts relevant to the circumstances of the deceased's death are as follows:-

(1) At the time of his death the deceased was in the custody of the Scottish Prison Service and had the status of both a convicted and a remand prisoner.

(2) In relation to his status as a convicted prisoner, the deceased was convicted of the crime of assault to severe injury and permanent disfigurement in the High Court of Justiciary on 27 August 2002 and was sentenced to a period of imprisonment of 8 years 6 months.

(3) In the time leading up to his death he was serving said sentence at Her Majesty's Prison, Castle Huntly.

(4) In relation to his status as a remand prisoner, the deceased was remanded to HMP Barlinnie aforesaid on 24 August 2005 by the Sheriff of Glasgow and Strathkelvin at Glasgow following his appearance on Petition in respect of Road Traffic offences alleged against him.

(5) On 19 August 2005 the deceased had commenced a period of home leave from Castle Huntly in terms of which he was due to return to prison on 22 August 2005. The deceased spent the period of weekend leave mainly at the home of his family at 9 Deepdene Road aforesaid. During his period of weekend leave the deceased consumed prescribed methadone as well as illicit cocaine and ecstasy.

(6) On 22 August 2005, the day on which the deceased was due to return to Castle Huntly, he left the family home stating that he was going to Airdrie for his methadone prescription.

(7) On 22 August 2005 the body of Catherine Thomson was found. She had been murdered. Catherine Thomson was the partner of the deceased's younger brother Craig Paterson Campbell, aged 29, unemployed and designed for the purposes of the Inquiry as care of London Road Police Office, Glasgow.

(8) On 23 August 2005, the deceased was arrested in connection with the charges referred to in the said Petition. He was detained in custody and appeared in Glasgow Sheriff Court on 24 August 2005 from where he was remanded in custody to H M Prison, Barlinnie as aforesaid.

(9) Between 22 and 25 August 2005 the deceased, who was believed to be the last person to have seen the said Catherine Thomson alive, was a person whom police officers investigating the murder wished to trace and question regarding the death of Catherine Thomson.

(10) By 26 August 2005 the deceased had become the principal suspect in the murder of the said Catherine Thomson. As a result of that status it was the intention of police officers conducting the investigation into the murder of the said Catherine Thomson to interview the deceased on 29 August 2005. The said police investigation was closed in due course; it concluded that the murder had been committed by the deceased.

(11) On his admission to Barlinnie following his remand the deceased was seen and assessed by both a prison officer and a nurse in accordance with the Scottish Prison Service's procedures for prisoners on admission. Nothing in his responses gave either the nurse or the prison officer grounds for concluding that the deceased was at risk of self-harm or suicide.

(12) In addition, as part of the Scottish Prison Service risk assessment carried out on the deceased, he was seen also by Dr J Kural who completed a doctor's risk assessment, questioned the deceased appropriately regarding his health and assessed the deceased in respect of his mood. Dr. Kural prescribed for the deceased 120 mg Dihydrocodeine twice per day to be taken orally as a detoxification dose to prevent withdrawal symptoms occurring in the deceased who had told Dr Kural that he had used heroin intravenously and had taken cannabis and cocaine in addition to prescribed methadone.

(13) Therefore, on admission to H M Prison, Barlinnie, the appropriate procedures were adopted by Prison Staff to examine and assess the deceased and to assess whether or not he was at risk of harm. These procedures and assessments indicated that the deceased was not at risk of harm or self-harm nor did he display any suicidal ideation. Accordingly, the deceased was appropriately assessed in accordance with the procedures in place for prisoners. There was no basis upon which the Scottish Prison Service might have concluded that the deceased was at risk of self-harm or suicide and the deceased was admitted to "A" Hall.

(14) Said "A" Hall does not have a safety net.

(15) Said dosage of Dihydrocodeine was prescribed by Dr Kural as a high dosage to prevent withdrawal symptoms. Dihydrocodeine in the said dose having been prescribed, the said doses were administered on the evening of 25 August 2005 and on the morning of 26 August 2005.

(16) Methadone was not prescribed for the deceased by Dr Kural as it is dangerous to provide such a prescription on the basis of unsubstantiated information provided by a patient.

(17) Dr Kural did not have the deceased's medical records. On the deceased's failure to return to H M Prison, Castle Huntly his records were, in accordance with the procedures then in place, forwarded to that prison's administrative headquarters at H M Prison, Perth.

(18) In his period on remand the deceased made the following phone calls from H M Prison, Barlinnie:-

(a) On Thursday, 25 August 2005 at 0911 the deceased telephoned 07790678659; said phone call lasted three seconds and was not answered. The said number is the telephone number of the deceased's brother the said Craig Paterson Campbell who was aware that the said call was from the deceased but who did not wish to speak with the deceased and who did not answer the call.

(b) On Thursday, 25 August 2005, at 1426 the deceased phoned 07981211745, the phone number of his mother Mary Campbell. In his conversation with his mother the deceased was lucid, did not appear to be suffering from drug withdrawal symptoms and did not give any indication of being anxious. The deceased's mother stated to him that Catherine Thomson was dead and that she had been murdered.

(c) On Friday, 26 August 2005, the deceased telephoned 07790678659. The call lasted nine seconds and was not answered by the holder of the telephone carrying the said number.

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(19) On 26 August 2005 at approximately 1335 hours the deceased was in his cell which was unlocked. He appeared to his cell mate to be anxious and agitated. Almost immediately thereafter the deceased crossed over the fourth floor balustrade and stood on a firebox overhanging the Hall floor four levels below. His cell-mate attempted to persuade the deceased to cross back over the rail but the deceased told his cell-mate that he had done something and could not come down.

(20) As a result of the actions taken by the deceased the other prisoners in "A" Hall were locked within their cells and prison staff including nurses and a trained negotiator attempted to persuade the deceased to cross back over the balustrade. The deceased was anxious, agitated and threatened to jump from the top level to the floor below. The deceased told the negotiator that he had done something terrible, that he was possessed by the devil and that he was going to jump. He said to the negotiator that he was going down for a long time. He requested medication but when told it was provided took no steps to take it. The deceased repeated to the negotiator that he had done something and stated that was why he had crossed over the rail. The said negotiator acted in accordance with his skills and his training and

did everything that he could to seek to deter the deceased from jumping from his position.

(21) At approximately 1425 hours the deceased jumped head-first from the position he had adopted and fell to the concrete floor, four levels below.

(22) The deceased received immediate professional medical assistance. Resuscitative measures were carried out and the deceased was conveyed by paramedics and the said Dr Kural to the Royal Infirmary, Glasgow where life was pronounced extinct at 1500 hours after further resuscitative efforts.

(23) The injuries which the deceased received in the fall were not survivable. The deceased jumped to his death. His actions were not the result of withdrawal from drugs or the misprescription of drugs within Barlinnie.

(24) There is no net in "A" Hall at Barlinnie Prison. There is a net only in "C" Hall. That net is located above ground level and at the base of the first floor level of the said Hall. The net is not a net although it is referred to as such but is a solid steel mesh constructed of steel mesh bars covered in plastic. The said net is rigid and is attached to the sides of "C" Hall by a sprung device.

(25) Falling from the fourth level of "C" Hall on to the net is likely to cause injury to the person falling. The net was installed not to prevent people falling to the ground but to prevent prisoners throwing objects over the rails of the first, second and third floors of the Hall thereby endangering staff and prisoners on the ground floor.

(26) When funds and plans permit nets such as that in "C" Hall are dismantled and removed by the Scottish Prison Service.

SHERIFF

NOTE:

I heard evidence in this case from 15 witnesses over two days on 14 and 15 August 2006.

The Inquiry was led by the Procurator Fiscal through his assistant and the Chief Constable of Strathclyde Police and the Scottish Ministers were represented; my Note of the Preliminary Hearing refers. I had been told at the preliminary hearing and at the start of the evidential hearing that the deceased's brother Mr Craig Paterson Campbell would attend the Inquiry and report to the the deceased's family. However,

shortly after giving his evidence - he was the first witness called - Mr Campbell left the court and did not return.

The deceased was John Paterson Campbell, aged 34, who was at the time of his death a remand prisoner within H M Prison, Barlinnie. He had been remanded to Barlinnie Prison, on 24 January 2006 from Glasgow Sheriff Court having appeared on Petition in that court that day in relation to alleged offences under the Road Traffic Acts. As well as being a remand prisoner the deceased had the status of a convicted prisoner having been sentenced on 27 August 2002 at the High Court in Glasgow to a total of eight years and six months imprisonment in relation to inter alia a charge of assault to severe injury and permanent disfigurement. Prior to his death the deceased had been serving his sentence in H M Prison, Castle Huntly from which he was granted weekend leave from 19 until 22 August 2005 inclusive.

I heard evidence from the deceased's brother that during the course of that weekend the deceased consumed illicit drugs.

On 22 August 2005, Craig Paterson Campbell's partner Miss Catherine Thomson was found murdered. The police investigation concluded that she had been murdered by the deceased. The deceased's brother clearly believed that the deceased had committed the murder of his partner and stated in his evidence that the deceased's family had no concerns about the circumstances which gave rise to the deceased's death. That sentiment had arisen because of the tragic circumstances of the murder of Catherine Thomson.

It was clear from the evidence which was given by police, prison and medical staff honestly, clearly and, in the case of Prison Officer Andrew Muir, poignantly, that the care and treatment of the deceased within H M Prison, Barlinnie was entirely appropriate.

On admission following remand the deceased was assessed by a prison officer, by a nurse and by a prison doctor, Dr Kural. Nothing in the deceased's responses - or indeed his observed demeanour - gave any person cause for thought that the deceased was likely to self-harm or commit suicide. It was clear that the deceased had abused drugs. His cell-mate who gave evidence, Mr Jason Ritchie, described the deceased as "rattling" and attributed this to withdrawal from drugs. However, he was clearly wrong in this. The source of the deceased's anxiety on the day of his death was not withdrawal from drugs.

When the deceased did not return to Castle Huntly on 22 August 2005 his medical records, in accordance with the then applying procedures, were forwarded to H M Prison, Perth. When he was admitted to Barlinnie Dr Kural did not have the benefit of his records and accordingly considered it unwise to prescribe in accordance with the unsubstantiated assertions of the prisoner. However, what he did do, standing the deceased's assertion that he had been taking heroin intravenously, was to prescribe

a relatively high level of Dihydrocodeine as an appropriate detoxification dose to prevent drug withdrawal symptoms. Dr Kural described how dangerous it could be to prescribe in accordance with what a practitioner might be told by a prisoner and accordingly it appeared to me that his course of action was entirely appropriate. Although the deceased's cell-mate believed that the deceased had been deprived of drugs, the deceased received the appropriate dosage of Dihydrocodeine on 25 August and 26 August, the day of his death. That was confirmed by the records and also corroborated by the findings of the post mortem report in which the pathologist, Dr Clark, referred to the high therapeutic level of Dihydrocodeine in the deceased's blood.

The reason that I raise these issues is that there appeared to be two principal points at issue in respect of this Inquiry.

The first of these was whether or not the deceased had jumped to his death because he was suffering from drug withdrawal symptoms. I did not find any credible or reliable evidence to substantiate that. Indeed, I heard a tape recording of the deceased's last telephone conversation with his mother and in it there was no indication that he was suffering from drug withdrawal symptoms. Furthermore, when he was over the balustrade and being spoken to by the negotiator he did ask for medication and that was arranged. He did not in fact cross back over the balustrade in order to take up the offer of medication. I was told that this reaction was unusual. That in itself gave the negotiator, Officer Muir, cause for concern because in his experience someone genuinely requiring medication would have taken steps to secure it and this the deceased did not do.

The only other explanation proffered for the deceased's agitation and his wish to commit suicide was his feeling of guilt or fear in respect of what it is believed he had done in murdering Catherine Thomson. It seemed clear from the terms of conversations which the deceased had with his cell-mate and with the negotiator at the time when he was threatening to jump that that in fact was what was foremost in his mind and what caused him to jump to his death.

The other issue which was raised was whether or not there should have been a safety net in "A" Hall. I heard evidence that there was a safety net in only one Hall in Barlinnie Prison and that was in "C" Hall. The net was described as solid metal meshing. It is not a net and certainly does not provide a trampoline effect and it is rigid. It is, however, connected to the balustrades above the first floor level by some form of sprung device. Evidence was given that falling onto such a net was likely to cause severe injury and indeed one official of the prison service stated that he had known of one person who had fallen on a net and who had broken his back. However, there was no evidence that anyone who had fallen on to such a net had actually died. Nonetheless, I was unable to conclude that the provision of a net - and that is probably not the appropriate term for what exists in "C" Hall - was something which on the evidence I could make a recommendation about. It appears clear that the prison service has considered the wisdom or otherwise of nets and has concluded that they do not contribute to safety and indeed it has a programme to

remove these. Amongst other effects which they have is that they can encourage people to jump because prisoners have the mistaken impression that the net will act as a form of trampoline and they will not be injured. In any case, the majority of prison suicides, I was told, were as a result of the use of ligatures and the prison authority concentrates its efforts on trying to ensure the cells are "ligature unfriendly". It is therefore clear that it would not be appropriate for me to make recommendations on the basis of the evidence I heard when these matters have been considered by those who have the duty to care for prisoners and who do consider from time to time whether or not the provision of nets is appropriate. Having said that, it was interesting to hear in evidence that the Home Office recommends (presumably for England) that in prisons such as Barlinnie "A" Hall there should be nets between the ground and first floors and between the third and fourth floors. In Scotland, however, the view has generally been that nets were provided to prevent materials falling on prison officers and prisoners on the ground floor. I heard evidence that it was common for prisoners to throw food from upper levels and that while the food itself might not harm prison officers or prisoners below, the crockery and cutlery which accompanied the food might well do so.

Finally, is it possible to say that the existence of a net in "C" Hall might have prevented the deceased's death? Is it possible to say that it might have; one prison officer who gave evidence confirmed that he was not aware of any case in which someone falling to a net had actually died so to that extent it might be said that the provision of a net might have prevented the deceased's death. However, for the reasons which I have given I do not consider that I had a sufficient basis upon which to recommend that nets such as that in "C" Hall should be provided in the other Halls in H M Prison, Barlinnie; a decision on whether or not such nets should be provided would have to be taken after extensive research and also consideration of alternatives.