

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2016] FAI 9

B416/15

DETERMINATION

BY

SHERIFF LINDA SMITH

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES
(SCOTLAND) ACT 1976**

Into the death of

JORDAN BARRON

Falkirk, 21st June 2016

This was a mandatory inquiry in terms of Section 1(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

The Sheriff, having considered the evidence adduced, Determines in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976:

- a. That the late Jordan Barron died within his cell, Cell 1/23, Munro Hall at Her Majesty's Young Offenders' Institution (HMYOI), Polmont at some point between 21.00 hours on 13th July 2014 and 05.20 hours on 14th July 2014 and was pronounced dead at 05.43 hours on 14th July 2014.
- b. That the cause of death of Jordan Barron was "1a hanging" and that was by suspension by his neck with a ligature formed from a piece of pillowcase secured to the frame of his bunk bed within his cell in Munro Hall, HMYOI, Polmont.

And made no determination in terms of Section 6(1) (c), (d), or (e)

Findings in fact

1. Jordan Barron (Date of Birth 13/9/94) was serving two consecutive sentences of four months detention, having been convicted of Culpable and Reckless Conduct whilst on Bail and Possession of Cannabis whilst on Bail. These sentences commenced on 1st May 2014 and he was due to be released from prison on 29th August 2014.

2. Staff found Jordan in his cell within HMYOI, Polmont at 05.20 on the 14th July 2014, suspended by a ligature (formed from a piece of pillowcase) around his neck, attached to the upper bunk in his cell. Attempts to revive him were unsuccessful and he was pronounced dead at 05.43 on that date by Emergency Services who had been called to assist.
3. A subsequent post mortem confirmed the cause of death to be due to “1a Hanging” with injuries recorded as consistent with the cause of death and suicide. The toxicology report confirmed a low level of Mirtazapine in keeping with the anti-depressant medication he had been prescribed by medical staff within the prison.
4. At the time of his death Jordan Barron had previously spent time in a custodial setting, including HMYOI, Polmont.
5. The Report of Dr Alex Quinn, Number 7 of Process, provides *inter alia* a detailed background to Jordan’s care until he was sentenced to a term of imprisonment in HMYOI, Polmont. Before Jordan was born there was concern that he was not thriving in the womb and he had failed to meet normal developmental milestones after his birth. Jordan was taken into local authority care shortly before his first birthday but it was not until 2001, when Jordan was approximately six years old, that a decision was made to pursue an adoptive placement. He was described by Dr Susan Dewar, the Medical advisor to the Adoption and Fostering Panel, as “having behavioural difficulties and to be somewhat obsessional”. He had a catalogue of failed foster and prospective adoptive placements and concerns were raised by his Safeguarder that he had been placed at times inappropriately with foster carers who were ill-suited or ill-equipped to care for his needs. Behavioural difficulties escalated. Referrals to psychiatric and psychological services identified Jordan’s attachment difficulties but continuing changes of placements and schools or limited resources thwarted any attempt to address these issues for him. At some point when he was about fifteen years old he was allowed to live with his mother. On-going behavioural and offending led to frequent appearances before Children’s Hearings and before the adult courts.
6. Jordan had a tempestuous relationship with his mother characterised by numerous aggressive and heated arguments wherein both parties said hurtful and nasty things to each other. Crown Production 5 is the transcript of a recorded telephone call at approximately 19.40 hours on 10th July 2014 between Jordan and his mother. Crown Production 6 is a transcript of a further recorded telephone call on that date at approximately 19.51 hours between Jordan and his mother. These transcripts are indicative of the conversations between Jordan and his mother, which had taken place over the years of their relationship. There is no evidence to suggest that these particular telephone calls contributed to or had any relevance to his decision to take his own life on 14th July 2014.
7. Crown Productions 7, 8, 9, 10 and 11 are undated notes written by and found in Jordan Barron’s cell after his death. Crown Production 10 is a letter to his mother and makes reference to suicidal thoughts “.... And everyday am getting thoughts off

Just ending it am never going to do that in hear its when I get out I worrie Ive already planned it and wrote a letter to you and hollie but I don't want to do this but if it keeps getting worse I don't know what am going to do I would at least like to end good witch You." The letter also explains that Jordan had had some discussion with a psychologist within the prison, and shows some insight into his difficulties and the problems he had trying to talk about his feelings.

8. ACT2Care is the name of a programme designed by the Scottish Prison Service to assist staff to consider whether a prisoner is at risk of self-harming or attempting suicide. It is accepted that it is not possible to predict if anyone is likely to attempt suicide but this programme attempts to identify those who may or may not intend to self-harm. It is not a programme designed to build relationships with prisoners. All prison staff and medical staff that gave evidence were familiar with ACT2Care and the documentation associated with it. ACT2Care documentation is completed as a matter of course in relation to any new admission to HMYOI, Polmont or on transfer to Polmont or on return to Polmont from Court.
9. Jordan Barron had ACT2Care assessments during the period from April 2011 to June 2014 whilst passing through prison reception as an admission, transfer or on return from Court. He was noted on his most recent admission to have a history of anxiety and depression and to have been prescribed Mirtazapine by his General Practitioner, whose contact details were noted.
10. From his admission to HMYOI, Polmont on 1st May until his death on 14th July 2014 Mr Barron was able to self-refer for medical attention in relation to a number of physical, dental and mental health issues. Neither his mother nor prison staff had any indication or thought that Jordan Barron presented any risk of self-harm or suicide.
11. On the day following his admission (2nd May 2014) Jordan Barron was seen by Angela Malarky, Mental Health Nurse, to discuss Jordan's concerns about his anxiety, for which he had sought assistance from admission staff the previous day. He was offered and agreed to treatment for anxiety management and was seen on the 8th May for his first consultation with Ms. Malarky. He was given a workbook to do in preparation for their next scheduled meeting on 13th May. It was envisaged that Angela Malarky would see Jordan weekly and that this would be a low-level therapy treatment, providing opportunity to talk and learn self-help and relaxation techniques. Jordan Barron did not attend appointments on 13th or 20th May but did attend on 4th June, when anxiety management commenced with Ms Malarky and he appeared keen to engage. He had a further appointment with Ms Malarky on 11th June where he continued to be "keen to engage". Despite an expectation of further appointments to continue weekly therapy after the 11th June, Jordan Barron had no further meeting with Ms Malarky due to her absence on urgent annual leave, attending courses and staffing shortages. She sent a "slip" out saying she could not attend and "if concerned contact the mental health team". It is not known if Jordan Barron received this information, if an explanation was given to him or if he was informed about each cancelled meeting. Angela Malarky had no concerns about

Jordan Barron. Drs McGregor and Quinn thought it better to “miss therapy appointments” rather than to introduce another therapist to continue sessions. Continuity of therapy from the same health care professional is preferred and more beneficial to the patient.

12. The decision to engage in an anxiety management programme was mentioned in Jordan Barron’s undated letter to his mother (Crown Production 10). If such meetings had taken place they may not, in themselves, have prevented his death but may have provided an opportunity for ACT2Care observation and assessment by a mental health care professional. It may also have provided an opportunity for Jordan Barron to understand coping mechanisms for his feelings. There was no evidence that the breakdown in Jordan Barron’s therapy sessions contributed to or had any relevancy to his death.
13. Following Jordan Barron’s death the Scottish Prison Service and the National Health Board carried out an Operational and Learning Review (Crown Production 13) and drafted a Joint Learning Plan (Crown Production 13 Appendix 2). These initiatives were implemented towards the end of 2014 and as a result there are now weekly clinical review meetings, a shared diary system, provision for staff absences, caseload reviews and staffing increased from three full-time mental health nurses to four full-time mental health nurses plus a part-time mental health nurse.
14. While at liberty Jordan Barron had been prescribed Mirtazapine at 15mgs by his General Practitioner. Mirtazapine is an anti-depressant drug generally prescribed to treat anxiety disorders. It is normally prescribed in 3 doses per day at 15mgs, 30mgs or 45mgs. Jordan Barron’s dosage was increased to 30mgs 3 times a day after meeting with Dr Rosa Serrano, clinical psychologist at HMYOI, Polmont on 20th June 2014. The increase in dosage did not reflect any particular concern held by Dr Serrano but was viewed as a normal increase for a patient who had been on a lower dosage for some months and was still suffering from anxiety symptoms. Dr Serrano was aware that Angela Malarky had assessed Mr Barron as having an anxiety disorder; Dr Serrano confirmed this diagnosis at her examination of Mr Barron on 20th June 2014, found no evidence of any depressive disorder and had no concern of suicide risk at that time. She anticipated arranging a follow-up appointment with Mr Barron in 4-6 weeks’ time to review the dosage and to let the increased dosage take effect.
15. Mirtazapine has a “currency” within a prison environment as it helps induce sleep and can reduce restlessness. On 3rd July 2014 a medication spot-check was carried out by Care Assistant Jackie Anthony on Jordan Barron, expecting to find him in possession of 7 Mirtazapine tablets; he was found to have 3 less than was expected. In accordance with procedures at that time the remaining Mirtazapine tablets were removed from him and his explanation for the discrepancy was noted on the Medication Spot-check Form, which she signed (Crown Production 2 page 40). The form was then passed to Brian Leitch, Mental Health Nurse at Polmont. Mr Leitch had no recollection of dealing with this discrepancy and could not provide an explanation as to how this had been dealt with. Mr Leitch could not say whether

Jordan Barron had had his medication reinstated or whether this was authorised by a doctor but confirmed that Mr Barron's Mirtazapine was issued to him again on 9th July 2014. Following Jordan Barron's death staffing levels of mental health nurses within the prison have increased, particularly on busier shifts; two nurse prescribers have been appointed and are authorised to prescribe medication. New Medication Spot-check Forms (Crown Production 17) have been introduced requiring a counter-signature by a mental health nurse. A revised system of work in relation to spot-check of prisoners in possession of medication has been issued and is now operating within HMYOI, Polmont (Crown Production 16).

16. Overdosing on Mirtazapine does not create toxic consequences but can create physical sedation. Medication spot-check of prisoners in possession of prescribed medication provides an opportunity for ACT2Care observation by prison and healthcare staff.
17. Jordan Barron's decision to take his own life was a deliberate act, evidenced by letters to his mother and girlfriend with wishes for his funeral arrangements. His cell was relatively tidy and there was a piece of paper noting a planned visit and a self-drawn calendar with the date of his liberation marked. The undated letter to his mother (Crown Production 10) mentions thoughts of ending his life in the days prior to the event but also indicated that he would not do so in prison. There was no evidence that this "thinking" was marked by any change in his demeanour, mood or presentation.

Procedure and Personae:

The Inquiry heard evidence over three days, 4th, 7th and 8th April 2016 and legal submissions on 23rd May 2016. Permission was granted on 30th March 2016 to enable Dr Chris McGregor (Crown Witness) to give evidence by live TV link from Bristol Crown Court.

The parties were represented at the Inquiry as follows:

1. Mr O'Reilly, Procurator Fiscal Depute for the Crown
2. Ms McCartney, Solicitor for Scottish Ministers on behalf of the Scottish Prison Service
3. Mr Burnet, Advocate, on behalf of NHS Forth Valley Health Board with Mr Gormley, Solicitor
4. Mr Aitken, Advocate, on behalf of Susan Barron, with Mr Myles, Solicitor

Witnesses who gave evidence:

For the Crown:

1. Jennifer Urquhart, Prison Operations Officer
2. Thomas Meikle, Prison Operations Manager
3. Susan Barron, mother of Jordan Barron

4. Jackie Anthony, Care Assistant NHS, HMYOI, Polmont
5. Brian Leitch, Mental Health Nurse, HMYOI, Polmont
6. Angela Malarky, Mental Health Nurse, HMYOI, Polmont
7. Dr Chris McGregor, Consultant Psychiatrist
8. Darline Reekie, Health Care Manager in Prison Health Care
9. Dr Rosa Serrano, Consultant Psychiatrist for HMYOI, Polmont

For NHS, Forth Valley:

10. Dr Alex Quinn, Consultant Psychiatrist

For Scottish Ministers on behalf of Scottish Prison Service:

11. Lesley Dowell, Health Strategy and Suicide Prevention Strategy, HMYOI, Polmont

The Crown lodged an Inventory of Productions numbering 1-17.

Mr Burnet lodged an Inventory of Productions comprising a report from Dr Quinn and a Supplementary Inventory of Productions comprising a signed statement of Angela Malarky, dated 31st July 2014.

Mr Aitken lodged an Inventory of Productions comprising five documents relating to prison bunk beds.

In addition a Joint Minute of Admissions was lodged on 7th April 2016.

I appreciated the assistance of the Crown and the representatives of the other parties to this Inquiry and for their expeditious and considered manner throughout.

NOTE:

1. The deceased's family was represented by Mr Aitken, Counsel, who led no evidence but by arrangement with the Crown, Susan Barron, the Deceased's mother, gave evidence at an early stage, enabling her to hear the evidence of the remaining witnesses.
2. The first chapter of evidence focused on the factual discovery of Jordan Barron on the morning of his death, attempts by prison staff and emergency services to revive him and the time of death. The post-mortem examination established the cause of death was "1a hanging" and that was by suspension by his neck with a ligature formed from a piece of pillowcase secured to the frame of his bunk bed within his cell. This evidence was not controversial and all parties agreed that formal findings in relation to Section 6(1) (a) and (b) of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976 should be returned.
3. Jordan Barron had had a troubled life. He had been in numerous foster and potential adoption placements from the age of four months to twelve years, to such an extent that a Safeguarder to a Children's Hearing was critical of the care Jordan

had received through Social Work Services. By the age of fifteen years he had begun to be dealt with through the adult courts. This was not Jordan Barron's first experience of HMYOI, Polmont or of adult prison although it appears to have been the first time he was admitted to Polmont as a convicted prisoner. It was clear to me from this background and from the prison staff who gave evidence, that Jordan "knew the ropes" and had not created any particular impression on the staff – good or bad. He had a history of relationship problems and attachment issues which, both psychiatrists agreed, would require prolonged help and support if he were to co-operate and go on to lead a less anxious and more settled life. Both psychiatrists agreed that this could not be achieved during the terms of sentence imposed on Jordan Barron.

4. The evidence centred on two main aspects of Jordan Barron's care in HMYOI, Polmont that gave rise to concern to NHS and SPS staff. The first related to the breakdown of anxiety therapy counselling sessions that he had agreed to participate in, and the second was in relation to a breakdown in normal procedures following a spot-check on prisoners in possession of medication.
5. Jordan Barron sought help for anxiety and depression and agreed to engage in anxiety therapy counselling with Angela Malarky, Mental Health Nurse. He missed two appointments with her but re-engaged and was expecting to go for weekly therapy meetings with her. In an undated letter found in his cell after his death (Crown Production 10) he shows some insight into his anxiety issues, how they may have come about and the difficulty he had in expressing his feelings. It is not clear what he thought or felt about the therapy sessions being repeatedly cancelled or if he had been told the reasons for this. No criticism was made of Ms. Malarky; she regarded these sessions as a low-level intervention to provide coping strategies to a young man thought to be anxious about his custodial sentence. He told her that he had had a troubled and chaotic home life but, as Dr McGregor pointed out, that is not unusual for most of the young men in an institution such as HMYOI, Polmont.
6. Criticism was directed at the NHS and SPS for the lack of continuity of treatment. Following Jordan's death, a Joint Operational Review (Crown Production 13) was held and a draft Joint Learning Plan (Crown Production 13 Appendix 2) was proposed. Two significant learning points were identified: (1), that there should be clear cross cover arrangements in place for staff absence in terms of mental health caseloads and continuity of care and, (2), that there should be weekly clinical review meetings held where mental health caseloads are reviewed, including cross cover arrangements for staff absence. These were implemented by the end of 2014 and provided opportunity for mental health staff to discuss and evaluate the treatment of inmates in their care and provided a continuity of care and tasks in the event of staff absence. An increase in qualified staffing levels particularly over busy shifts and delegated authority to mental health nurses to prescribe medication in certain circumstances also improved the service within the prison.
7. Prescribed medication within a prison setting has to be monitored to prevent abuse. Most prisons have a system to spot-check that the correct amount of medication is

in the possession of the correct individual. In HMYOI, Polmont the system provided that medication could only be authorised by a person medically registered to do so i.e. a doctor. Tablets were issued on that person's instruction at a set amount and dosage. On 3rd July 2014 a spot-check was carried out on Jordan Barron's medication by Care Assistant Jackie Anthony. She had a form which stated what tablets he should have, when they had been given to him and how many he should have at the time of the spot-check. When she checked Jordan Barron's medication on 3rd July 2014 she found him to have three tablets of Mirtazapine fewer than he was meant to have. It was not her job to enquire into the circumstances but only to note on her form any explanation proffered by the inmate to her. She did this and said that she had brought this matter to the attention of Brian Leitch, Mental Health Nurse, who was on duty that day. He couldn't remember her doing so, although the form had been completed and signed by her and noted that she had spoken to him. Mr Leitch gave evidence of his normal way of dealing with this situation, expecting to speak personally to the inmate involved or if not able to do so that day to make an entry in the diary to ensure it was dealt with the following day. He would usually withdraw the medication and speak to a doctor or psychiatrist for instructions on how to deal with the discrepancy and for instructions as to how or if the drug was to be re-issued to the inmate concerned. He was at a loss to explain what he had in fact done. Mr Leitch appeared genuinely concerned by his inability to explain or remember how he had dealt with the spot-check of Mr Barron and explained that the new procedures are much more robust.

8. A new spot-check form (Crown Production 17) requires both the person carrying out the spot-check and the mental health nurse who receives the form detailing the outcome of the spot-check to sign it. The mental health nurse receiving the form must also state on it the outcome of the spot-check and the date it was listed in the mental health diary for review if required. There are now two nurse prescribers either of whom can review the case and can decide on the prescription. This is now logged in the Healthcare record and on the in-possession medication check form; the form itself is photocopied and copies provided to the inmate and to Admin to be lodged in the Health Care record and the Spot-check Folder in pharmacy. Training had been provided for these changes and additional staff employed to assist with the caseload of the department. If a similar event were to occur in future there would be a copy of the paperwork on computer on the Healthcare record for the inmate, a paper copy with the inmate and in the prison pharmacy, the paperwork would be signed by the assistant who carried out the spot-check and receipt of this signed for by the mental health nurse. A mental health nurse could now assess the situation and, if qualified to do so, could reinstate or instruct how the prescribed medication could be administered without consulting a doctor or psychiatrist (although if the nurse felt medication should be stopped this could only be done by a doctor or psychiatrist). Increases in staffing, weekly review meetings and a communal diary had enabled staff to feel better informed about each inmate and had reduced the pressure on their workload.
9. There was no evidence that if the therapy sessions had continued as planned and/or if the muddle in relation to the spot-check procedure had not occurred Jordan

Barron's death by suicide might have been avoided. These "failures" in the workplace systems did not contribute to his death. It is true that both denied Jordan Barron the opportunity of meetings with members of the mental health team who, as a matter of course, and in common with other members of the prison staff, would have considered the ACT2Care policy in the course of their interaction with him. However, he was still very much involved with prison life and its routines, which brought him into contact *inter alia* with other members of the health care team, including consultant psychiatrist Dr Rosa Serrano and prison officers involved in his daily routines. On one view it may be said that the more personal interaction an inmate has with any member of staff the more likely it is that any change in mood, demeanour or presentation may be detected under the ACT2Care programme. However, it is also likely that a young man with significant attachment difficulties who has spent a considerable proportion of his life in institutional care may have learned to mask his feelings. Notwithstanding the lapse in his therapy sessions with Angela Malarky and despite the spot-check procedures not being carried out properly, he remained on Mirtazapine, referred himself to the dentist, to medical staff to complain about limb and joint pains, he was attending classes to give up smoking and sought advice on sexually transmitted diseases. In addition, there were no complaints about his behaviour or participation in prison routine.

10. I was invited by the Crown to consider making two findings in terms of Section 6(1)(e) of the 1976 Act. (i) where an inmate is taking prescribed medication a system should be in place to ensure this is investigated and drawn to the attention of appropriate medical staff in order that they may have an opportunity to advise and assess inmates who may be vulnerable or at risk of confusion about their medication. (ii) where a clinical need for mental health intervention is identified steps should be taken to ensure that the programme of any treatment is followed to ensure that the inmate receives the benefit of the treatment and to build a rapport between medical staff and inmates.
11. Mr Aitken submitted that a finding in terms of Section 6(1)(c) should be returned on the basis of the combined failures of the system in relation to (a) the poor staffing levels, (b) the breakdown of therapy sessions and (c) the lack of proper procedure in relation to the spot-checking of Mr Barron's Mirtazapine medication. In his submission he accepted that such failures could not satisfy the standard expected under Section 6(1)(d) that on the balance of probability such failures contributed to Jordan Barron's death. His submission was that they might have done – it was a possibility not a probability. Mr Aitken maintained that it was the possibility of those missed opportunities occasioned by these failures which deprived Mr Barron of the opportunity of engaging with mental health staff, which in turn supported a Section 6(1)(c) finding. He stressed that the changes of policy and procedures introduced following the internal enquiry since Jordan Barron's death have made the systems more robust but this did not preclude the Court from making a formal finding in terms of Section 6(1)(e) if the Court felt a Section 6(1) (c) finding was not necessary.

12. For the reasons mentioned in paragraph 9 of my Note I am not satisfied that if any of the procedures or meetings with Jordan Barron had taken place his death might have been prevented and accordingly I have made no determination in terms of Section 6(1)(c). I was also not satisfied that a Section 6(1)(e) determination to ensure that discrepancies in an inmate's medication, as submitted by the Crown, was relevant in this case. Whilst it was regrettable that the system in place at the time was lax and staff over-stretched, the discrepancy in Jordan Barron's medication was not relevant to his death. He could not have overdosed on Mirtazapine; his prescription continued to be administered to him as noted on 9th July 2014 and prison staff noted no changes in his mood or presentation in the days before his death. Likewise, I was not persuaded that a Section 6(1)(e) determination to ensure that a programme of treatment is adhered to was practicable (no matter the good intentions for it) where that course of treatment was in reality a course of therapy requiring commitment and co-operation on the part of an inmate. The facts arising in relation to the discrepancy in Mr Barron's medication at the spot-check and from the evidence of the discontinued anxiety management sessions revealed inadequacies in procedures and staffing within HMYOI, Polmont, particularly in relation to the mental health team. These inadequacies did reduce the opportunity for staff to meet with Jordan Barron and to assess him in terms of the ACT2Care policy. However, I did not find that these inadequacies individually or cumulatively were relevant to his death as he continued to meet with prison and medical staff with no noticeable change to his demeanour, mood or presentation.
13. Dr McGregor stated in her evidence that HMYOI, Polmont has to deal with a number of very vulnerable young men; on admission prison staff have little background information about them and rely on what they are told by the inmate. Many come from economically and educationally poor backgrounds and have complex psychological disorders, which may fall short of recognisable mental illness. Ideally they require treatment and considerable time spent with them to enable them to cope from day to day and to have some understanding of their condition. They may not wish to co-operate, they may not see the point in co-operating and may not have the time or the life-experiences to enable them to do so. Jordan Barron was still regarded as an adolescent and, like many young men of his age, he demonstrated a wish to change aspects of his life and sought help in doing so as he indicated to Dr Serrano when he met with her on 20th June 2014. He told her that he had been "trying to cope throughout his life". She diagnosed him with "anxiety disorder with panic attacks which was long-term and likely caused by trauma through his life." He had "good insight" and "no risk of suicide".
14. Dr McGregor observed that prison and mental health staff had to deal with inmates "as they find them". Previous records on medical disorders or psychiatric assessments are not available to provide background information but can be requested. Her evidence and that of Lesley McDowall (witness with responsibility for Health and Suicide Prevention Strategy) demonstrated to me that the main aim of NHS and the SPS is to protect inmates from harming themselves and others and this is what they aim to do, particularly for inmates serving relatively short sentences such as Jordan Barron. Given that HMYOI, Polmont has a high intake of

disturbed young men from socially and economically deprived backgrounds, perhaps further thought should be given by NHS and SPS to their future aims towards mental health and behavioural issues of such inmates whilst within the prison setting and to supported care from other agencies on their release.

Finally I wish to extend my sincere condolences to Jordan Barron's mother and friends.