SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

2010 FAI 9

FATAL ACCIDENT INQUIRY

Under

Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976

Determination by Sheriff Mhari S Mactaggart

Following an Inquiry at Livingston into the death of

RICHARD CROMPTON

Livingston, 21st December 2009

The Sheriff, having resumed consideration of the cause, Determines in terms of section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976:-

(a) That Richard Crompton (born 3rd October 1967) and ordinarily resident at 49 Kenmore Avenue, Deans, Livingston died on 19th January 2009 at an indeterminate time after 13.00 hours but before 17.50 hours. The place of death was HMP Addiwell, West Lothian;

(b) That the cause of death was suspension by ligature;

(c) That no reasonable precautions could have been taken whereby his death might have been avoided;

(d) That there were no defects in any system of working which contributed to his death;

(e) That there were and are no other facts which are relevant to the circumstances of his death.

FACTS

1. Richard Crompton, born 3rd October 1967, was a prisoner within HMP Addiwell, West Lothian serving a sentence of five years in respect of a conviction for Road Traffic and Misuse of Drugs offences. His earliest date of release was 19th January 2012. He was transferred from HMP Barlinnie, Glasgow to HMP Addiwell on 9th January 2009. HMP Addiwell opened on 12th December 2008 and Mr Crompton was among the first group of prisoners transferred there from other HMP establishments.

2. HMP Addiwell is run by the firm of Kalyx.

3. Mr Crompton was serving his first custodial sentence.

4. On initial admission to HMP Barlinnie on remand on 25 October 2007 Mr Crompton was assessed as "at risk" by admission staff and similarly assessed on 26 October by a nurse and on 27 October by a GP. ACT 2 Care procedures were accordingly commenced.

5. ACT 2 Care is a procedure widely used within HM Prisons for the assessment of and continuing care of those at risk of self harm or suicide.

6. On 1st November 2007 a case conference at HMP Barlinnie assessed Mr Crompton as being no apparent risk and the ACT 2 Care procedures closed.

7. On 19th September 2008 Mr Crompton was sentenced to five years imprisonment with an earliest release date of 19th January 2012.

8. On 19th September 2008 a further ACT 2 Care assessment was carried out at HMP Barlinnie and Mr Crompton was assessed as "no apparent risk".

9. On 23rd October 2008 a further ACT 2 Care assessment was carried out at HMP Barlinnie and Mr Crompton was assessed as "no apparent risk".

10. Whilst at HMP Barlinnie Mr Crompton was prescribed Mirtazipine, an anti-depressant drug previously prescribed by his GP.

11. On 26th December 2008 whilst at HMP Barlinnie, Mr Crompton refused his Mirtazipine.

12. On 12 December 2008 HMP Addiwell opened. It was staffed mainly by persons with no previous experience of prison service.

13. New recruits at HMP Addiwell underwent a nine week training programme prior to the prison opening. This training mainly took the form of power point presentation and included a mental health training module.

14. On 9th January 2009 Mr Crompton was transferred from HMP Barlinnie to HMP Addiwell.

15. On arrival at HMP Addiwell on 9th January 2009 reception procedures were carried out in relation to Mr Crompton including an ACT 2 Care assessment by PCO Emma Dyet and Mental Health Nurse Jamie McDonald. Neither had prior experience of the ACT 2 Care procedures.

16. The ACT 2 Care assessment form in respect of Mr Crompton was incomplete.

17. On arrival at HMP Addiwell on 9th January 2009 Mr Crompton presented to PCO Emma Dyet as being jokey, polite and chatty. Although she did not complete the risk assessment part of the ACT 2 care form, her assessment was that he presented as no apparent risk.

18. On arrival at HMP Addiwell on 9th January 2009 Mr Crompton was assessed by Mental Health Nurse Jamie McDonald. He presented as in a good mood, smartly dresses, relaxed and did not appear anxious. He was assessed as no apparent risk.

19. Neither PCO Emma Dyet nor Mental Health Nurse Jamie McDonald noted whether Mr Crompton was taking any form of medication.

20. On 9th January 2009 Mr Crompton was examined by Dr Mohammed Khan, locum GP. Mr Crompton told Dr Khan that he has stopped using Mirtazipine before Christmas 2008. Mr Crompton denied any suicidal notions. Dr Khan considered it appropriate to re-prescribe Mr Crompton Mirtazipine and prescribed 15mg as a starting dose.

21. Dr Khan did not assess Mr Crompton as being at risk.

22. Mr Crompton was allocated room 58 on Tay B wing at HMP Addiwell. This was a single occupancy room with shower/toilet area. As part of the standard equipment issued to prisoners, it was equipped with an electric kettle.

23. Prisoners on Tay B wing had easy access to brushes for cleaning out their rooms. The brushes in use in January 2009 had hollow metal handles or shafts.

24. On 15th January 2009 Mr Crompton refused his Mirtazipine medication from Nurse Lynsey Feeney. It is likely this was his first dose since prescription by Dr Khan. No reason for the refusal was noted.

25. On 16th January 2009 Mr Crompton had a visit with his partner Ms Tracy Forbes. He described this to a fellow prisoner, Peter Millar, as being a good visit and he seemed in good spirits.

26. On the evening of 18th January 2009 Mr Crompton played cards with fellow prisoner Peter Millar and did not appear to be in low spirits.

27. Some time between 0800 hours and 0900 hours on 19th January 2009 Mr Crompton was observed in his room by Peter Millar to be sitting on his bed watching television. They did not converse at that time. Mr Crompton was scheduled to start an educational class that day but did not attend.

28. In the course of the morning of 19th January 2009 Peter Millar and two other prisoners independently approached the door of Mr Crompton's room but elicited no response from him.

29. On 19th January 2009 PCO Laura Govan was on duty on Tay B wing from 0715 hours until 1315 hours. For some of that time she was the only PCO on Tay B wing.

30. Accommodation Fabric checks are carried out daily at HMP Addiwell. The purpose is to check rooms are clean, that the facilities within them are working and that only those items which should be within the room are there. It is not a room search.

31. Four headcounts are carried out daily at HMP Addiwell, two formal and two informal. The formal head counts are carried out in the morning and in the evening. Informal headcounts are carried out in between. During formal headcounts prison staff are expected to engage directly with prisoners and elicit some form of response from them. This is not necessarily expected during informal headcounts. Formal head counts are recorded.

32. At some time in the late morning of 19th January 2009 PCO Laura Govan was joined by PCO Alina Kruszyna from an adjoining wing and they commenced an Accommodation Fabric Check of Tay B wing. They concluded this check before reaching Mr Crompton's room and instead commenced an informal lunchtime head count.

33. At some time shortly before 1300 hours PCO Alina Kruszyna observed Mr Crompton within his room during the informal head count. He was observed to be sitting on his bed, either reading or watching television. There was nothing untoward noted in his demeanour at that time.

34. Mr Crompton missed lunch on 19th January 2009.

35. At 1700 hours on 19th January 2009 PCO Margaret Purdie carried out a formal head count on Tay B wing. On eliciting no response from Mr Crompton she entered his room. She observed his body in the shower area of the room.

36. Mr Crompton's body was in a seated position within the shower area of his room. It was slumped forward. The handle of a brush was wedged across the shower and suspended from it was the flex of a kettle. The flex was tied around Mr Crompton's neck.

37. Mr Crompton's body was removed from the shower area to the main area of his room by PCOs.

38. By 1700 hours rigor mortis had set in suggesting death had occurred some time before then.

39. No attempt was made to commence CPR.

40. Mr Crompton was pronounced dead at 1750 hours.

41. A post-mortem examination was carried out on 21st January 2009 by Dr Ralph BouHaider. The toxicology report showed no significant findings. The cause of death was suspension by ligature.

42. Subsequent to Mr Crompton's death, further mental health training has been given to PCOs at HMP Addiwell.

NOTE

This was an Inquiry into the tragic death of Mr Richard Crompton whilst serving a custodial sentence at HMP Addiwell, West Lothian. Mr Crompton's partner, Miss Tracy Forbes was represented at the Inquiry and she and members of her family were present throughout the Inquiry.

The purpose of a Fatal Accident Inquiry is to establish the facts surrounding a death. It is not to apportion blame.

Evidence and submissions were heard over four days. The Crown was represented by Miss MacLaren, Procurator Fiscal Depute, Miss Forbes by Mr Addison, Solicitor, Scottish Prison Service by Mr Chaffey, Solicitor and Kaylex by Mrs Anwar, Solicitor. I am extremely grateful to all of them for their sensitive and thorough examination of witnesses and exploration of the facts.

The Inquiry heard evidence from:-

- Mr Richard Anthony Simpson, Deputy Director of HMP Addiwell;
- Ms Margaret Purdie, PCO, HMP Addiwell;
- Mr Gary Chambers, Residential Unit Manager, HMP Addiwell;
- Mr Scott Stewart, PCO, HMP Addiwell;
- Ms Laura Govan, PCO, HMP Addiwell;
- Ms Alina Kruszyna, PCO, HMP Addiwell;

- Mr Peter Millar. c/o HMP Addiwell;
- Mr Thomas Sutherland, c/o Lothian and Borders Police;
- Mr Russell Gordon, Head of Security, HMP Addiwell;
- Ms Emma Dyet, PCO, HMP Addiwell;
- Mr Jamie Macdonald, Mental Health Nurse, HMP Addiwell;
- Mr Dennis Langton, DC, Lothian and Borders Police
- Dr Mohammed Khan, GP, HMP Addiwell; and
- Ms Lynsey Feeney, Nurse, HMP Addiwell.

An Affidavit by Dr Ralph Bouhaidar, Forensic Pathologist was lodged as was an Affidavit providing supplementary evidence by Mr Anthony Richard Simpson. A Joint Minute of Admissions was lodged in respect of the statements of Ms Marie Guest, Staff Nurse and Ms Tracy Forbes, partner of Mr Crompton.

The History

Mr Crompton was a long term prisoner serving a sentence of five years. His earliest date of release was 19th January 2012. He spent his period on remand and the initial part of his sentence at HMP Barlinnie, where he met fellow prisoner Peter Millar. Mr Crompton was serving his first custodial sentence. HMP Addiwell opened on 12th December 2008 and Mr Crompton was among the first prisoners transferred there from other prison establishments. It is unclear from the evidence how much notice Mr Crompton was given of the transfer but it seems very little notice was given. From the statement provided by his partner it seems he had mixed emotions about the transfer. He was housed in Room 58 in Tay B wing within HMP Addiwell. This was a single occupancy room. Peter Millar was housed on the same block. Upon arrival at HMP Addiwell Mr Crompton was assessed (as all prisoners are) by reception staff, by a nurse and by a GP. The assessments carried out by PCO Emma Dyet, Mental Health Nurse Jamie McDonald and Dr Khan were at one. Each assessed him as being at no apparent risk of self-harm or

suicide. He told Dr Khan that he had previously been prescribed Mirtazipine (an anti-depressant) but had stopped taking this voluntarily around Christmas 2008. Dr Khan re-prescribed 15mg of Mirtazipine (a tritation dose) to assist him in getting a good night's sleep and to help him generally whilst he was settling in to a new prison environment. It is unclear from the evidence whether this drug was in stock or had to be ordered in. During his time at HMP Addiwell Mr Crompton does not appear to have come to the attention of the prison authorities in any adverse way at all, and in general he seems to have presented as a pleasant, well mannered individual. On 11th January 2009 Mr Crompton was seen by a doctor in relation to chest pains, on 12th January 2009 by a nurse in relation to a mouth abscess and on 13th January 2009 by a medical officer in relation to a prescription for the abscess. On 15th January 2009 Mr Crompton refused to take the Mirtazipine being dispensed to him by Nurse Lynsey Feeney. From the evidence led it is likely that this was the first dose of Mirtrazipine dispensed to Mr Crompton at HMP Addiwell. Ms Feeney did not record any reason for the refusal nor could she recall any reason being given to her. This refusal appears to have been a completely voluntary decision on the part of Mr Crompton.

On 16th January 2009 Mr Crompton had a visit with his partner Ms Tracy Forbes. This appears to have been a successful visit and Ms Forbes account of it in her statement indicates that Mr Crompton was in reasonably good spirits at the end of the visit. This is borne out by the account of the visit he gave to fellow prisoner Peter Miller. Mr Miller also spoke to Mr Crompton expressing disquiet at the authorities for "changing his medication" and that he seemed "down" in the days prior to 19th January. I did find that evidence to sit easily with the other evidence suggesting Mr Crompton to have been generally in good spirits and does not sit easily with the clear evidence that Mr Crompton refused to take the medication prescribed to him. On 18th January he attempted to call his partner, Ms Forbes, but was unable to reach her. In his message he sounded down but Ms Forbes did not read anything of significance into that, putting it down to the fact that he had simply missed speaking to her. In any event Mr Millar played cards with Mr Crompton on the evening of 18th January 2009 and described him as being "OK".

On 19th January 2009 Mr Crompton was seen some time between 0800 hours and 0900 hours by Peter Miller. He was in his room watching TV. Mr Miller did not attempt to speak to him at that time. There was evidence that Mr Crompton was due to start a class that day but did not attend it. He appears to have remained within his room. At that time, prisoners who did not attend for work or classes were pretty much left to their own devices, however that has now changed and they require to remain in their rooms. During the course of the morning of 19th January Peter Miller and two other prisoners tried to engage with Mr Crompton. Individually they approached his room door but got no response from him.

PCO Laura Govan gave evidence of starting her shift on Tay B wing at around 0715 hours on 19th January 2009. Normally there are three members of staff on duty, one of whom escorts the prisoners to their classes/work. The other two remain on the wing. However, on 19th January 2009 she recalled the other PCO leaving the wing for a period of time, and this meant she was the only PCO on duty on Tay B wing for some time during the course of her morning shift. In the course of her shift she attempted to carry out an Accommodation Fabric check on the prisoner's rooms but admitted that, as it approached lunchtime, her priority was to carry out a head count of prisoners. At some point in the course of the morning she was joined by PCO Alina Kruzsyna, who had been working on an adjoining wing. Together they carried out accommodation fabric checks on the ground floor of the wing but stopped before reaching Mr Crompton's room. They then commenced an informal head count together. Ms Kruzsyna recalled seeing Mr Crompton during the headcount. He was within his cell, lying on the bed and either watching television or reading. She could not recall any conversation with him but did not note anything untoward in his demeanour.

Mr Crompton did not leave his cell for lunch. During lunch Peter Miller recalls asking a PCO if they knew where Mr Crompton was and it was surmised that he had not yet returned from his class. No particular procedure was or is followed if prisoners do not attend for lunch. This could be for a variety of reasons: they may have purchased their own food; they may not like what is on offer; or they may simply not be hungry. There

was no evidence to suggest that Mr Crompton had previously missed lunch and on this occasion his non-attendance did not cause any particular concern nor give rise to any particular investigation.

At around 1700 hours on 19th January 2009, PCO Margaret Purdie carried out a formal head count on Tay B wing along with PCO Katherine McNulty. The procedure for a formal head count is to announce lock up. The prisoners then return to their rooms, the doors are locked and the formal head count is then carried out. During this formal head count the PCO expects to either see the prisoner or have some vocal recognition from him. On attending at Mr Crompton's room, PCO Purdie called out for a response from him but did not receive one. On entering the room she noted that the toilet/shower area door was closed. On entering the shower area she found Mr Crompton on the shower floor. She could only see him from the waist down but knew that there was something seriously wrong. She summoned assistance from other PCOs. PCOs Gary Chambers and Scott Stewart arrived quickly thereafter. Mr Crompton was in a seated position on the shower floor. His body was slumped forward and he had the flex of a kettle around his neck. The other end of the flex was tied around the handle of a brush which was wedged across the shower. The flex was accordingly suspended from the brush handle. PCO Chambers cut the flex and he and PCO Stewart attempted to move the body from the shower area into the room. Both described the body as being very stiff and they had difficulty moving it from the shower area. Both immediately formed the view that Mr Crompton was dead and this view was shared by the nursing staff at the scene. The decision was taken not to commence CPR due to the condition of the body. Paramedics arrived at 17.50 hours and pronounced Mr Crompton dead. Two suicide notes were found with Mr Crompton's room and a photograph of his children was found within the shower area. A post-mortem examination was carried out on 21st January 2009 by Dr Ralph BouHaider. The toxicology report showed no significant findings and the cause of death was suspension by ligature.

ACT 2 Care Procedures:

ACT 2 Care is a widely used procedure within HM Prisons for the assessment of and ongoing care of those who may be at risk of self harm or suicide. An assessment is made of all prisoners upon initial reception into custody when ACT 2 Care Reception Risk Assessment document is completed. This is a six page document which includes one page of guidance notes. Page 3 of the document is the Reception Risk Assessment and specifically states that the person completing the assessment must be trained in ACT 2 Care procedures. Section 1 requires to be completed with details of whether prisoner is at admission stage, transfer stage or return stage. It requires confirmation as to whether the prisoner is or has previously been the subject of ACT 2 care procedures. This part of Mr Crompton's form on admission to HMP Addiwell was not completed. Section 2 of the document requires the assessing officer to carry out an assessment of behaviour, attitude and risk. Part 1 requires a set of questions to be answered by the prisoner, Part 2 requires the assessing officer to provide details of their assessment of behaviour and demeanour. Both parts were completed by PCO Dyet. Part 3 is a Summary and Risk assessment, and requires the assessing officer to summarise how the prisoner presented in parts 1 and 2 and to assess the level of risk in their own words. PCO Dyet did not complete this part of the form. Thereafter the assessing officer is required to tick a box indicating At Risk or a box indicating No Apparent risk. PCO Dyet did not tick either box.

Page 4 of the document is the Health Care Risk Assessment and this was completed in relation to Mr Crompton by Nurse Jamie McDonald. All of this part of the form was completed by Nurse McDonald although in answer to the question whether the prisoner is currently on ACT the word NO is ringed and then scored out. Nurse McDonald gave evidence to the effect that he was not responsible for scoring that answer out and could give no explanation as to how that had come about. He ticked the box confirming Mr Crompton as being at no apparent risk.

The final part of the Health Care Risk Assessment was completed by Dr Khan. Although he did not tick either assessment box he put and entry on the form confirming that, in his opinion, Mr Crompton presented as no apparent risk.

A previous ACT 2 Care assessment was carried out on Mr Crompton on his initial remand at HMP Barlinnie. At that time he was assessed as being at risk and therefore the next stage of the ACT 2 Care procedure was carried out namely a case conference and immediate care plan actioned. Although Mr Crompton only remained on ACT 2 Care for a few days at Barlinnie, the fact that he had been on ACT continued in his records and in particular was highlighted on his Personal Escort Record which accompanied him from HMP Barlinnie to HMP Addiwell. Further there was evidence that such information would have been and indeed was available to reception staff at HMP Addiwell on the PR2 computer system. It is clear therefore from the evidence that his history of ACT 2 Care involvement was well recorded by HMP Barlinnie and passed to HMP Addiwell.

PCO Emma Dyet gave evidence that there were no ACT 2 Care forms at the Reception area of HMP Addiwell in the days immediately prior to the prison opening and that these had to be uplifted from HMP Barlinnie. She spoke to being unfamiliar with the forms, unaware of the guidance notes and uncomfortable completing the assessment part of the form. She gave evidence that she did not feel qualified to carry out a risk assessment on prisoners and that she had received only one hour of training on mental health issues prior to the prison opening which she considered to be inadequate. PCO Emma Dyet clearly did not complete her part of the form fully or correctly. However, she was clear in her evidence that her assessment of Mr Crompton would have been no different even if she had received fuller training and had been more familiar with the form. He had presented to her as jokey and chatty and she would not have assessed him as presenting any form of risk. Mental Health Nurse Jamie McDonald had received no formal training on the ACT 2 Care procedures or forms but had familiarised himself with the form prior to using it. He was aware of the guidance notes. He was clear in his evidence that his assessment of Mr Crompton was that he presented as no apparent risk of suicide.

Dr Khan was equally clear that Mr Crompton presented to him as at no apparent risk. The prescription of Mirtrazipine was a precautionary measure only to allow him to settle into a new prison regime and environment.

PCOs Margaret Purdie, Laura Govan and Alina Kruszyna all confirmed that they were aware of the ACT 2 Care procedure and aware of the necessity to keep an eye out for any potential problems with prisoners which may give rise to implementing the ACT 2 Care procedures. Of concern however, was the fact that Nurse Lynsey Feeney had received no training on ACT 2 Care and was unaware that she may be required to open an ACT 2 Care document. However, the inquiry heard no evidence that Mr Crompton's behaviour during his time at HMP Addiwell had given cause for concern and had at no stage prompted any member of staff to consider implementing the ACT 2 care procedures in relation to him.

The completion of the ACT 2 Care documents in relation to Mr Crompton seems to have been somewhat haphazard. They are certainly incomplete. However, there is nothing to suggest that the assessments of him carried out by PCO Emma Dyet, Mental Health Nurse Jamie McDonald and Dr Khan were incorrect. There was no evidence to suggest that, at any point during his time at HMP Addiwell, Mr Crompton should have been the subject of ACT 2 Care measures.

Further mental health and ACT 2 Care training has been given to PCOs at HMP Addiwell since Mr Crompton's death.

There is nothing in the way the ACT 2 Care procedures were carried out at HMP Addiwell which contributed to Mr Crompton's death.

Transfer documents:-

On transfer from HMP Barlinnie a Personal Escort Record Form was completed and sent to HMP Addiwell as was a SPS Medical transfer form. Both provided a summary of information in relation to Mr Crompton. His medical records did not accompany him but were sent directly to the medical team. There was some evidence that the SPC Medical transfer form was incomplete but there was no evidence to suggest that this in any way affected the assessment of Mr Crompton on his arrival at HMP Addiwell.

Provision of kettles and brushes:

There was evidence that the provision of kettles within individual prisoner rooms was now common practice throughout HMP Prison service and in particular evidence that such provision was made at HMP Barlinnie. There was some cross-examination of witnesses as to the length of flex attached to these kettles, but there was no evidence led to suggest that the length of flex was anything other than normal. There was no reason why Mr Crompton should not have had a kettle and flex in his room. At no time was he the subject of ACT 2 Care procedures which may have required the provision of items within his room to be monitored. I was satisfied that there was no indication in advance that the kettle flex, being an ordinary item in everyday use, would have been used for the purpose of suicide.

Peter Miller gave evidence to the effect that both he and Mr Crompton had brushes in their rooms all the time for the moment they arrived at HMP Addiwell. That evidence was not supported by the evidence of PCOs that brushes were kept in cupboards on the wings. However, it was clear that brushes were readily available to prisoners to clean out their cells. There was no evidence that Mr Crompton's room had been checked in the days leading up to his death and a brush removed. There was clear evidence that the Accommodation Fabric check was not carried out on his room during the morning of 19th January. It was unclear whether the brush was always in his room or whether he had acquired it immediately prior to 19th January. Again there was nothing to indicate in

advance that this ordinary object would be used for the purpose of suicide. There was nothing to suggest that Mr Crompton should not have had these items within his room.

Training of Staff at HMP Addiwell:-

There was clear evidence at the inquiry that the majority of staff recruited by Kaylix were inexperienced within the prison service. A nine week training programme was undertaken by all of them prior to the prison opening. There were a few opportunities to gain some limited experience in other Kaylix prisons in England but almost none of the PCOs who gave evidence had any prior experience in dealing with prisoners prior to the prison opening in December 2008. Mr Crompton had himself described the staff as "green" to his partner, meaning they were inexperienced. Nurse Lynn Feeney had no training in ACT 2 Care procedures prior to taking up her appointment and Emma Dyet expressed concern that she had only received one hour of mental health training as part of the training programme. The need for greater training in this area appears to have been recognised by Kaylix who have rolled out further training in the months since Mr Crompton's death. There was also evidence that the recruitment of inexperienced staff may have been part of the ethos of Kaylix, in an attempt to move away from the old style of prisoner management. The provision of adequate training to staff in identifying and assessing prisoners at risk must be a priority within our prison system. This is particularly when assessing a prisoner upon reception into the prison. The fact that PCO Emma Dyet did not feel sufficiently qualified to complete the ACT 2 Care documentation is a cause of some concern as is the fact that she had no line manager to whom she could turn in January 2009 for assistance. A manager was not recruited to reception until later in 2009. There is however nothing to suggest that the level of training given to Kaylix staff in any way contributed to the death of Mr Crompton.

Provision of medication to prisoners:-

Mr Crompton was prescribed a tritation dose of Mirtrazipine by Dr Khan on admission to HMP Addiwell. The dose was 15mg and he prescribed this to help settle Mr Crompton into the new prison regime and to help him sleep. Mr Crompton had previously been prescribed this drug at home by his GP and thereafter at HMP Barlinnie. He had voluntarily refused to take it on 26th December 2008 at Barlinnie. There was some suggestion that he may have been trying to come off the medication. This is borne out by his refusal to take the medication offered to him. At HMP Addiwell he told Dr Khan of his previous refusal. His physical care records show that on 12th January 2009 whilst seeing RGN M Guest in relation to his mouth abscess he stated that he did not want the Mirtrazipine that had been prescribed to him. Thereafter he refused this medication on 15th January 2009. There was some dubiety as to whether this drug would have been in stock at HMP Addiwell when it was prescribed by Dr Khan on 9th January or whether it would have to have been ordered in. Given that there is no record of any prescription being dispensed to him prior to 15th January it seems likely this was the first time the drug would have been made available to him. There was evidence from Nurse Jamie McDonald and from Dr Kahn that it can take about 3 -4 weeks for the full effect of this drug to be felt. Even if Mr Crompton had been given the drug on 9th January, by 19th January the full effect of it would not yet have been felt by him. There was evidence that without the drug in his system he may have experienced a loss of appetite, feelings of isolation and depression. Other than his failure to leave his room on 19th January and his failure to attend lunch on the same day, there was no evidence that Mr Crompton was displaying these symptoms. In any event, even if the drug had been instantly available to Mr Crompton there was clear evidence that he would have been likely to refuse to take it. Mr Crompton could not have been forced to take this medication and it was entirely his right to refuse it. If there was a delay between prescription of Mirtrazipine by Dr Khan on 9th January 2009 and dispensing same on 15th January 2009, this did not contribute to Mr Crompton's death.

Checking of prisoners not at day time activities:-

It is clear that the activities timetable for prisoners in January 2009 was haphazard with no clear record kept as to who was scheduled to be at activities and who was not. Those not at classes or activities in January 2009 were left very much to their own devices. That system has since been improved and tightened up and there are now clearer checks and records in place as to which prisoners are on the wing and which are at activities. Those not at activities are now required to remain within their rooms. On 19th January 2009 Mr Crompton elected to remain within his room. He was checked at lunchtime during an informal head count. There was no reason for staff to check on him with any greater frequency given that he was not on ACT 2 Care. It was his own decision not to leave his room that day. He was entitled to exercise his right to privacy. There was no evidence that he was left for any longer than any other prisoner that day and there was nothing to indicate that he should have checked more frequently. I am satisfied that there was nothing deficient in this system of checking on prisoners that contributed to Mr Crompton's death.

Conclusion:-

I have made findings under section 6(1)(a) and (b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 in light of the evidence presented at the inquiry. I have made no findings under subsections (c) and (d) and there are no circumstances which would justify any further findings. Unfortunately Mr Crompton seems to have been determined to take his own life in circumstances which were unforeseeable.

The Court has already expressed sympathy to Mr Crompton's partner on her loss but do so again now. She sat stoically and with dignity through what must have been extremely difficult evidence for them to hear and they are commended for that.