

SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

**DETERMINATION BY SHERIFF THOMAS WARD, ESQUIRE
SHERIFF OF NORTH STRATHCLYDE AT GREENOCK**

**In
INQUIRY into the circumstances of the death of
DALE ANTHONY MULHOLLAND**

**Under the
FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT
1976**

Greenock February 2013

The Sheriff, having considered all of the evidence adduced, the submissions and the relevant statutory provisions:

DETERMINES

(1) in terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Dale Anthony Mulholland who was born on 22 May 1988 and who resided at 4 Suffolk Road, Greenock died on 19 March 2011 at approximately 19.20 hours within Her Majesty's Prison, Gateside, Greenock.

(2) in terms of Section 6(1)(b) of the 1976 Act that the cause of his death was hanging

(3) in terms of Section 6(1)(c) of the 1976 Act the reasonable precaution whereby the death might have been avoided would have been for either Morag Stirling or Raymond

Anderson to ensure the implementation of Rule 94(10) of the Prisoners and Young Offenders Institutions (Scotland) Rules 2006.

(4) in terms of Section 6(1)(d) of the 1976 Act that there were no defects in any system of working at HM Prison, Greenock which contributed to the death.

(5) in terms of Section 6(1)(e) of the 1976 Act that there are no other facts relevant to the circumstances of the death in respect of which any Determination falls to be made.

Sheriff

NOTE:

(1) This Fatal Accident Inquiry was held in terms of Section 1(1) (a)(ii) of the 1976 Act before me at Greenock Sheriff Court on 31 October, 01 November and 02 November 2012 concluding on 16 January 2013 with submissions on behalf of all the parties. This was a mandatory inquiry because the deceased was in legal custody at the time of his death.

(2) Miss Elizabeth Ross, Senior Procurator Fiscal Depute, represented the Crown. Mrs Patricia Mulholland, who was the mother of the deceased and who was unrepresented gave evidence at the outset of the inquiry and thereafter represented her son's interests in relation to the rest of the inquiry. Miss Sarah Phillips, Solicitor represented the Scottish Prison Service and the Scottish Ministers. Mr David Adams, Solicitor represented the Prison Officers Association of Scotland.

(3) Dale Anthony Mulholland appeared at Greenock Sheriff Court on 15 March 2011 charged with assault to severe injury and permanent disfigurement. He made no plea and no declaration and was remanded in custody for further examination to HM Prison, Gateside. As I understood all the submissions and the Joint Minute lodged a number of issues are not in dispute. These include the following.

(4) Dale Anthony Mulholland was remanded to Greenock Prison. A man called Brian Morrison was already serving a three year sentence at Greenock Prison. Morrison had been convicted of a serious assault on the deceased's sister Natalie. Although Morrison was a serving prisoner within the same prison he was located on a different floor of the prison to Dale Anthony Mulholland since Dale Anthony Mulholland was not a convicted prisoner.

(5) Dale Mulholland was initially assessed by prison officer Hugh Curry within the reception area of the prison at approximately 15:35 pm. A reception risk assessment was carried out by prison officer Curry. He asked Dale Anthony Mulholland if he felt suicidal or if he might hurt himself and Mr Mulholland responded in the negative. As a result prison officer Curry noted on the ACT 2 Care form that he had no concerns about Mr Mulholland.

(6) On or about 16:20 hours within one of the health centre rooms in HM Prison, Greenock prison nurse Yvonne Munro examined Dale Anthony Mulholland. She took a sample of his urine and it tested positive for Benzodiazapines. Dale Anthony Mulholland told Yvonne Munro that he had a history of psychiatric disorder and that he had had a previous psychiatric admission. He thereafter told her that he had no history of personal self-harm. In completing the ACT 2 Care assessment Yvonne Munro did not consider that Dale Anthony Mulholland was an apparent risk to himself. She did not consider that he showed any symptoms of being suicidal. She noted that he stated that he had no feelings of self-harm or suicide. ACT 2 Care is the Scottish Prison Services' suicide risk management policy. It is a multi-disciplinary approach to provide support for those who are at risk of self-harm or suicide.

(7) Prison officer Stephen Devlin carried out a cell sharing risk assessment on 15 March 2011. This form is completed with every new admission to the prison. Stephen Devlin noted that this was Dale Anthony Mulholland's first night in custody and that there was no requirement for him to have a single cell. He was not in need of protection. There were no concerns with regard to him sharing a cell. There were no behavioural concerns but Mr Mulholland was to be kept separate from Brian Morrison, a prisoner in HM Prison, Gateside, as they were known enemies.

(8) On the evening of 15 March 2011 Brian McKee, a prison officer of over 20 years service met Dale Anthony Mulholland as part of the induction process. Mr McKee knew Mr Mulholland well from Mr Mulholland's previous times in prison. Prison officer McKee asked Mr Mulholland if he felt vulnerable, suicidal or at risk of self-harm. Mr Mulholland replied in the negative. The first night of admission sheet was signed and dated by both Mr McKee and Mr Mulholland. Mr McKee in evidence stated that he had been trained in ACT 2 Care and that when he spoke to Mr Mulholland his demeanor was completely normal and that he did not exhibit any cues or clues that would cause him to place Mr Mulholland on ACT 2 Care.

(9) Mr Mulholland was thereafter placed in the induction hall on a ground floor flat of Ailsa Hall in Cell 1/15 on his own. On 16 March at 10:10 am within the health care centre Dale Anthony Mulholland was seen by Doctor Andrew Kirk, the prison doctor. All new admissions to the prison are seen initially by a nurse and then by a doctor within twenty four hours. The reason for the consultation is for the doctor to check the prisoner's physical and mental wellbeing. Doctor Andrew Kirk knew Dale Anthony Mulholland because of his previous admissions to prison. He was known to have been using Benzodiazapines and Doctor Andrew Kirk put him on a fifteen day detoxification programme. Doctor Kirk completed the ACT 2 Care assessment form. That form requires an assessment of a prisoner in relation to any emotional problems and whether the prisoner requires any observations particularly in relation to risk of self-harm or suicide. Doctor Kirk assessed him as being of no apparent risk to himself with no self-harm history or plans. As far as Doctor Kirk was concerned, the deceased, Dale Anthony Mulholland had a problem with alcohol and drugs. He had never been subject to ACT 2 Care during any previous admission to custody.

(10) Doctor Andrew Kirk was not aware of Dale Anthony Mulholland's suicide attempt in November 2009 nor was he aware that the deceased had self-harmed since the age of 15. There was information in his health records that he had been referred to a psychiatrist in 2009 but was not thought to be mentally unwell. He failed to attend for an out patient appointment on 20 January 2010. There was no action plan in place for him and he fell into the category of a person who should be treated on an out patient basis. Doctor Kirk's view was that even if he had known that information the only difference it would have made would be in terms of enquiring perhaps more deeply into how things were going.

His opinion was that people could change or change their ways of feelings about themselves. He thought it was how the person appeared at the time which dictated whether they were put on ACT 2 Care or not. Doctor Kirk's opinion was that Dale Anthony Mulholland did not exhibit any indications of someone who was at risk of self-harm or suicide from his observations.

(11) On 16 March Patricia Mulholland, Dale Anthony Mulholland's mother visited him. The deceased told his mother that when Brian Morrison had been in the exercise yard he had shouted details of what he had done to Natalie, Dale's sister. The deceased told his mother that he was worried that he would not be able to protect his family from Brian Morrison. He also made it clear that he wanted revenge on Brian Morrison and wanted to fight with him.

(12) On 16 March Raymond Anderson, the prison manager of Ailsa Hall in the prison spoke with Dale Anthony Mulholland. Dale Anthony Mulholland told Mr Anderson that there was still an issue between him and Brian Morrison and that if they met there would be violence between them. Prior to Dale Anthony Mulholland's admission to prison Greenock's Secure and Intelligence Unit received information that Mr Mullholland had written to another prisoner stating that he would be coming into HM Prison, Greenock and would stab Brian Morrison.

(13) In December 2010 the Intelligence Unit within HM Prison, Greenock issued a notice to all the halls that Dale Anthony Mulholland had written to another prisoner stating that he would be coming into Greenock Prison and would stab another prisoner. An order was thereafter issued that Dale Anthony Mulholland and another prisoner must be kept separate. It was known to the prison authorities that the other prisoner was Brian Morrison.

(14) On 16 March Raymond Anderson, the prison manager of Ailsa Hall spoke with Dale Anthony Mulholland. Dale Anthony Mulholland told Mr Anderson that there was still an issue between him and Brian Morrison. When Dale Anthony Mulholland was asked about his involvement with Morrison he stated "I will put an ounce of kit on his head". Mr Anderson explained that this meant that a bounty was being placed on the head of

Morrison which could be taken up by anyone within the hall. Once the prisoner had been assaulted he would be entitled to the “ounce of kit”.

(15) As a consequence of this information Dale Anthony Mulholland was placed on Rule 94 on the 17 March. Raymond Anderson, the prison manager of Ailsa Hall made the application and Morag Stirling, the Deputy Governor authorized it. The reason given in the form was “it has come to our attention that Mr Mulholland is at risk from a convicted prisoner within “A” hall, who is currently serving a sentence for assault on a member of Mr Mulholland’s immediate family”. It seems to me that form is slightly misleading in that it is clearly Mr Morrison who was at risk from Mr Mulholland and not the other way round. The person making the threat was Mr Mulholland and not Mr Morrison.

(16) Because of this threat and the imposition of the Rule, Dale Anthony Mulholland was removed from association with other prisoners. Dale Anthony Mulholland was not being placed in isolation. He was being segregated from other members for his own protection and the protection of others. Essentially he was being confined to his own cell as HM Prison, Greenock does not have an operational segregation unit. Albeit Mr Morrison was segregated, Mr Anderson confirmed that he continued to have the amenities of a television and kettle and was still permitted access to the exercise yard, physical training and education albeit he could not do so in the presence of other prisoners.

(17) On 19 March Dale Anthony Mulholland had a visit from his mother. Mrs Mulholland described him as being his usual self. She had no concerns about him. He was aware that because of the ongoing problem between himself and Morrison that he was to be transferred to Barlinnie Prison and was glad of the move.

(18) Prison officer Jamie Anderson escorted the deceased back to his cell. Dale Anthony Mulholland was confused as to why he was on the Rule when he thought that Brian Morrison was responsible for what had happened. The deceased thought that it should have been Brian Morrison who should be the subject of Rule 94. After that visit Dale Anthony Mulholland appeared to be angry. Prison officer Brian McKee spoke to him. Dale Anthony Mulholland was unhappy that he was on a Rule. The deceased was aggrieved that none of his friends were seeking revenge on Morrison and he stated that he had heard Morrison shouting comments to him from the exercise yard. It was suggested

that he could move cells to a cell opposite which was a suicide cell. Dale Anthony Mulholland responded that he was not suicidal and refused to move. He was allowed to telephone his mother from the hall telephone. However, he was unsuccessful in getting through.

(19) At about 18.05 pm there was a handover from day time staff to night time staff. The handover was conducted by Brian McKee to prison officers Jamie Anderson and Stuart McIntosh. Brian McKee told both officers that the deceased was on a Rule 94 and to keep an eye on him. Prisoners on Rule 94 are subject to hourly observations within Greenock prison. At 18.15 prison officer Jamie Anderson looked through the deceased's door spy hole to check on him. The deceased was watching television. This gave prison officer Anderson no cause for concern.

(20) At 18.35 pm the deceased pressed his buzzer and requested some toilet roll and some envelopes from Jamie Anderson. This was a not uncommon request. As it was lockdown the request was denied. The deceased did not complain about the refusal of his request. There was nothing that caused the prison officers to be concerned.

(21) At about 19.00 pm a further check was made on the deceased by prison officer Stuart McIntosh. The spy hole was covered with toilet paper and the deceased did not respond. As a result the prison officers opened the door and the deceased was seen hanging from the top bunk in the cell. He was thereafter laid on the floor and compressions started. Mouth to mouth resuscitation was also attempted. Other officers attended and aided in the resuscitation attempts. An ambulance was requested at 19.26 pm and arrived at 19.43 pm. Although the joint minute agrees a time of death of 19.45 on 19th March the parole evidence and the report of Dr Michael Johnston suggest a time of death of approx 19.20. I accept that when the prison officers entered the cell, Dale Anthony Mulholland was dead.

(22) The enquiry heard from a number of witnesses namely Mrs Patricia Mulholland, Dale Anthony Mulholland's mother; Brian McKee, prison officer; Doctor Andrew Kirk, prison doctor at HMP Greenock; Jamie Anderson, prison officer, HM Prison, Gateside; Raymond Anderson, prison officer, HM Prison, Gateside; Morag Stirling at the relevant time, Depute Governor, HM Prison, Gateside, Greenock; Doris Williamson, Clinical Manager, HM Prison, Greenock; William Marshall, prison officer, HM Prison, Greenock.

Section 6(1)(c) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 states that the sheriff shall make a determination setting out the following circumstances of the deaths so far as they have been established to his satisfaction : (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;”.

(23) In his book Sudden Deaths and Fatal Accident Inquiries, third edition, Ian H.B. Carmichael suggests that paragraph 5 – 75 on page 174 that the test to be applied is as follows: “the precise wording of S.6(1)(c) must be kept in mind. What is required is not a finding as to a reasonable precaution whereby the death or accident resulting in the death “would” have been avoided but whereby the death or accident resulting in the death “might” have been avoided..... Certainty that the accident or the death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a “probability” but a real or lively possibility that the death might have been avoided by the reasonable precaution”.

(24) Mr Adams on behalf of the Prison Officers Association (Scotland) in his submissions considered two potential precautions which were raised during the course of the inquiry and which it was suggested to me would have prevented Dale Anthony Mulholland’s death. The first precaution was whether if the deceased had been marked as “at risk” under the Scottish Prison Service ACT 2 Care suicide risk management strategy he might not have died and secondly whether if Mr Mulholland had been examined by a medical officer as soon as practicable after being removed from association with other prisoners under Rule 94(10) of the Prisons and Young Offenders Institutions (Scotland) Rules 2006/94 on 17 March 2011 at 12.05 he might not have died.

(25) I consider that I can deal with the first of these two potential precautions which were raised, relatively briefly. From the evidence which was led during the course of the enquiry it is evident that from the time he first entered Greenock prison until he was placed on Rule 94 Dale Anthony Mulholland was seen by a considerable number of responsible persons within the prison. He was initially assessed by a prison officer within the reception area of the prison. The ACT 2 Care form was completed. The deceased denied feeling suicidal or that he might hurt himself. No concerns were noted. He was then seen by the prison nurse. Again he was assessed as being of no apparent risk to himself. He had never previously been subject to ACT 2 Care during any previous

admission to custody. Cell sharing risk assessment was done and again no matters of concern were raised. Brian McKee a prison officer who knew the deceased well from his previous times in prison met the deceased as part of the induction process. Again the deceased was asked if he felt vulnerable suicidal or at risk. Again he replied in the negative.

(26) Ms Philips and Mr Adams canvassed other alternatives to placing Mr Mulholland on the Rule. These included transferring Mr Mulholland to another prison earlier; keeping Mr Mulholland and Brian Morrison apart in the same hall; or transferring Mr Mulholland or Morrison to another hall within the prison. Mr Mulholland was to be transferred on 22 March to Barlinnie. He was kept in Greenock because his family lived in Greenock and the risk of immediate violence had been lessened by his being placed on a Rule. It would have been almost impossible to keep Mr Mulholland and Morrison apart in Ailsa Hall because of the freedom of movement accorded to prisoners there. The other halls catered for different types of prisoners. I conclude that placing Mr Mulholland on the Rule and arranging for his transfer on 22 March was appropriate in the circumstances. The Rule would have required to be extended to allow for transfer on 22 March but again I do not consider that that would be unjust in the circumstances since it requires authorization from Scottish Ministers.

(27) On Wednesday 16 March 2011 the deceased was seen by Doctor Andrew Kirk the prison doctor. The deceased was known to Doctor Kirk from previous times in prison. The doctor was aware that the deceased had alcohol and drug problems and he was placed on a ten day benzodiazepine withdrawal programme and prescribed diazepam. He was not assessed as being at risk. Although the doctor was not aware of any prior psychiatric history he saw nothing in the deceased's presentation to him to suggest any major difficulties. All of the evidence pointed to a careful and proper assessment of the deceased on his admission to prison. I did not consider that there would have been any justification on his admission to marking him as "at risk" under the ACT 2 Care suicide risk management strategy.

(28) The second issue which all of the parties to the inquiry agreed was the important issue related to the non-implementation of Rule 94(10) of the Prisons and Young Offenders Institutions (Scotland) Rules 2006/94.

Rule 94(10) reads as follows: “where any prisoner has been removed from association under this Rule, a medical officer shall visit that prisoner as soon as practicable and thereafter as often as is necessary but at least once in every seven days”. It is not disputed in this case that Dale Anthony Mulholland was not assessed by a doctor following the imposition of Rule 94(1).

(29) The issue of whether the deceased should have been placed on Rule 94(1) was raised during the course of the inquiry. Prison officer Raymond Anderson had made the application for the Rule to be imposed and Morag Stirling, the Depute Governor had authorized it. The reason given for the imposition of the Rule was “it has come to our attention that Mr Mulholland is at risk from a convicted prisoner within “A” hall, who is currently serving a sentence for assault on a member of Mr Mulholland’s immediate family”. The deceased’s mother in her evidence to the inquiry was insistent that it was not reasonable for her son to be placed on Rule 94. She did not think that the imposition of the rule had been given proper consideration. However the evidence was that it was the deceased who made it clear that if he came into contact with Brian Morrison there would be trouble. The deceased had previously been the subject of a Rule 94 on 14 December 2010 because the prison had received intelligence that the deceased had threatened to stab Brian Morrison when he eventually came into Greenock Prison and had also threatened to “put an ounce of kit on his head”. The information with regard to likely violence all emanated from the deceased. The contents of the Rule 94 form suggest that it was the deceased who was likely to be assaulted by Brian Morrison. That does not accurately state the position. All of the evidence pointed to the deceased being the person who was bent on revenge and in all the circumstances as brought out in the evidence it was reasonable for the Governor to place the deceased on Rule 94. Rule 94 covers threats of violence to other prisoners and this is exactly what the circumstances were here.

(30) Brian Morrison was a convicted prisoner. I heard no evidence to suggest that he had made any threats to the deceased. Morrison was a different category prisoner from the deceased. The deceased was on the ground floor of Ailsa Hall and Morrison was on the top floor. They could have come into contact with each other during the course of the day. Because of the threats made by the deceased to Morrison it was felt that the risk was too great of the two of them coming into contact with each other. It was therefore decided that the deceased should be placed on Rule 94 as opposed to Morrison.

Morag Stirling confirmed that Dale Anthony Mulholland would be transferred to Barlinnie Prison on Tuesday 22 March 2011. That would allow him free association. That transfer was not conducted earlier as Mr Mulholland came from Greenock and his family resided there. In addition any risk of violence had been reduced by the imposition of the Rule 94.

(31) The immediate issue which was raised in terms of Section 6(1)(c) was the failure of Mr Mulholland to be seen by a doctor in terms of Rule 94(10) of the Prisoners and Young Offenders Institutions (Scotland) Rules 2006. That Rule is in the following terms: “where any prisoner has been removed from association under this Rule, a medical officer shall visit that prisoner as soon as practicable and thereafter as often as is necessary but at least once in every seven days”. Both Miss Phillips on behalf of the Scottish Prison Service and Mr Adams on behalf of the Prison Officers Association submitted that no evidence had been led that even if Mr Mulholland had been seen by a doctor between the 17 – 19 March 2011 that might have prevented his death. They both pointed out that it was a local Rule that any prisoner on Rule 94 was on hourly observations. All prison staff were trained in ACT. Prison officers knew Mr Mulholland and had a good rapport with him. Both Brian McKee and Jamie Anderson saw the deceased shortly before he took his own life. The deceased was on a detox programme which required medication administered by a nurse, once in the morning and once in the evening. Again a nurse saw the deceased two hours and forty five minutes before his death. No one raised any concerns. Any prison staff including nurses can put prisoners on ACT. Both Miss Phillips and Mr Adams submitted that Mr Mulholland did not exhibit any of the usual “cues and clues” that would cause them to think that he was at risk to himself or suicidal. There was also a prisoner listening scheme and a cell alarm but Mr Mulholland utilised neither. Furthermore it was pointed out that Rule 94(10) has now been superseded. There is no longer an obligation for a medical officer to visit a prisoner following removal from association.

(32) Doris Williamson was the Clinical Manager at Greenock Prison at the relevant time. She understood the purpose of Rule 94(10) “is to ensure that the person who has been removed from normal association is able to be detained in isolation ie. that their medical and physical health is appropriate since they could be there for a period of time”. She

confirmed that the very fact that a prisoner was on a Rule could have a detrimental effect on their mental health. The doctor would then carry out an assessment of the persons health at that time. Any additional supports would be put in place if that was deemed to be necessary. In addition the doctor could arrange to have the prisoner removed from Rule 94 if information provided to him justified such a course of action.

(33) The earliest Doctor Kirk could have seen the deceased was the Friday morning. That was because the doctor service was a part time service.

(34) Although it is perhaps difficult to see why the deceased was aggrieved since he was the person who was issuing the threats to Brian Morrison it is clear from the evidence of various witnesses that he was aggrieved that it was he who was being put on the Rule and not Brian Morrison. There is no doubt looking to the various notes and letters which were written by the deceased and left after his death that he felt that he had a genuine grievance at being placed on Rule 94. On the evidence led at the inquiry it is perhaps difficult to see any justification for that grievance but there is no doubt that the deceased felt that he was being unfairly treated and that this was obviously preying on his mind. The very fact that this was preying on his mind might well have led him to confide in the doctor if he had been seen on the Friday morning. I appreciate, of course, that he did not exhibit any obvious “cues and clues” and that did not confide in either the prison officers or the nurse. A doctor is in a different position from either prison officers or indeed a nurse. However the reason behind someone being seen by a doctor rather than any other professionals in the prison was, according to Doris Williamson, to ensure that a person is able to be detained in isolation and that their medical and physical health is appropriate since they could be there for at least a period of three days. The fact that the prisoner is on a Rule, in itself, according to Doris Williamson, might have a detrimental effect on his mental health. I agree with Ms Ross`s submission that the very fact that Mr Mullholland was on the Rule might have an adverse effect on his mental state which presumably is why there is ,or was at the time, a requirement for a visit by the doctor. In my opinion it is a “real or lively possibility” that an assessment by the doctor on the Friday morning may have alerted concerns from the deceased or even the doctor and as a result the doctor might well have taken appropriate steps to counteract those concerns.

(35) I am therefore satisfied that it would have been a reasonable precaution for Morag Stirling or Raymond Anderson to ensure that the terms of Rule 94(10) were implemented.

Raymond Anderson spoke in evidence to a guidance note regarding the implementation of Rule 94 which is made available to all Scottish Prison Service staff. He could not approve a Rule 94(1) order as this required to be done by a senior manager of unit manager level or above. The Deputy Governor confirmed that. The guidance given to Scottish Prison Service staff is admittedly unclear. That guidance states that not every admission to a segregation unit will be subject to a full mental health assessment. That could be achieved through either staff observation that is part of the decision making process or through nursing triage/medical officer assessment the next day. It also makes it clear that nursing assessment will be carried out where staff have concerns about the prisoner's mental health or addiction issues. Segregation staff should make initial contact with specialised resources where felt immediately required". The guidance does however, mention medical officer assessment although it is not entirely clear from the guidance whether that is in addition to staff observation or an alternative to it. The answer to this difficulty, of course, is contained within the rules which are clear and which provide that a doctor should see a person placed on the Rule as soon as practicable. Despite what is stated in the submissions it is clear that virtually no one seemed to be aware of the existence of the Rule and were certainly not used to implementing it. If the Rule had been known and had staff been aware of it there would have been no confusion. It seemed to me that the confusion arose because of an almost total ignorance of the Rule on the part of the prison staff including the doctor. I have no doubt that all of the prison staff who observed Mr Mulholland during the course of his incarceration at the relevant time picked up no indications that he might take his own life. However, the very fact that he was placed on the Rule made him angry and the notes which he wrote showed a festering resentment at a perceived injustice. The visit of the doctor on the Friday morning might well have alleviated these concerns.

(36) In terms of section 6(1)(d) of the Act the sheriff requires to set out "the defects, if any, and any system of working which contributed to the death or any accident resulting in the death;" Carmichael in his book on Sudden Deaths and Fatal Accident Inquiries at page 174 5-76 states: "the phrase" system of working" must be understood as including for the purposes of Section 1(1)(a)(ii) any system – or lack of system – of working such

as supervision where necessary, or routine in any custodial institution, where such has contributed positively to the death or accident resulting in the death”. I am not satisfied that the ignorance of the requirements of Rule 94(10) positively contributed to Dale Anthony Mulholland’s death. The guidance provided to prison staff in relation to Rule 94 was unclear and there did seem to be a total failure on the part of staff to appreciate the requirements of Rule 94(10). However, I cannot say that that positively contributed to Dale Anthony Mulholland’s death nor do I consider that Doctor Kirk’s lack of awareness of Dale Anthony Mulholland’s previous mental history positively contributed to his death either. Doctor Kirk made his assessment on the basis of what Dale Anthony Mulholland told him and from his own knowledge of Mr Mulholland. He also had available to him the prison medical notes and if the G pass system was working, notes from a prisoner’s GP. I do not consider that the lack of information available to Doctor Kirk would have made any difference to his assessment as it was clear from all other evidence before the doctor based on the observations of other professionals in the prison and the information given by Dale Anthony Mulholland himself, that no one felt that he was a suicide risk. I have no recommendation to make therefore in relation to Doctor Kirk’s lack of knowledge of the deceased’s previous history of self-harm.

(37) In terms of Section 6(1) (e) which relates to other facts which are relevant to the circumstances of the death I have no recommendation to make, since Rule 94 (10) has now been removed from the Rule book .

(38) Before concluding can I thank all the parties to the Enquiry for their assistance in agreeing much of the evidence prior to commencement and for providing helpful written submissions. Mrs Patricia Mulholland represented her son`s interests ably throughout, and conducted her case expeditiously and without rancour. For that, in difficult circumstances, she is to be commended.