

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2013 FAI 11

***INQUIRY HELD UNDER
FATAL ACCIDENTS AND
SUDDEN DEATHS
INQUIRY (SCOTLAND)
ACT 1976
SECTION 1(1)(a)
SECTION 1(1)(b)***

DETERMINATION by SHERIFF
MARTIN JONES, Esquire, Queens
Counsel, following an Inquiry held at
Glasgow on 7, 8, 9 and 10 May Two
Thousand and Thirteen into the death of
CHRISTIAN DOUGLAS MCINTOSH.

GLASGOW, 7 June 2013.

The Sheriff, having considered all the evidence adduced, DETERMINES:

- (1) In terms of section 6(1)(a) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 that Christian Douglas McIntosh, born on 24 July 1962 died between 2200 hours on 9 December 2009 and 0820 hours on 10 December 2009, while a prisoner within Cell 3/11, C Hall at Her Majesty's Prison, Barlinnie, 81 Lee Avenue, Glasgow.
- (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 there were no reasonable precautions whereby the death might have been avoided.
- (4) In terms of section 6(1)(d) of the 1976 Act that there were no defects in any system of working at H M Prison, Barlinnie, Glasgow which contributed to the death.

(5) In terms of section 6(1)(e) that any other facts which are relevant to the circumstances of the death are as follows:-

- (i) That there is no system within Barlinnie prison requiring a prison official who receives information that a prisoner has threatened to commit suicide to record that information or to record what action the official did, or did not, take in relation to that information unless the ACT 2 CARE procedure is invoked.
- (ii) That there is no formal requirement within Barlinnie Prison that such information should be recorded in the prisoner's health records where the ACT 2 CARE procedure is not invoked.
- (iii) That there is no system requiring communication of such information between prison officials responsible for the supervision and care of prisoner where a decision is taken by an individual prison officer not to invoke the ACT 2 CARE procedure.

Parties represented at the Inquiry

[1] Miss Jacqueline Spiers, Procurator Fiscal Depute, represented the Crown. Miss Catriona Watt, Solicitor, Messrs Anderson Strathern, Edinburgh, represented the Scottish Prison Service and Mr Michael Thompson, Solicitor, Thompson & Brown, Solicitors, Glasgow, represented the family of the deceased.

Legal Framework

[2] The Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act) Section 1(1)(a)(ii) provides that a Public Inquiry should be held into the death of any person held in legal custody. The purpose of the Inquiry is for the sheriff to make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction :-

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided;
- (d) the defect, if any, in the system of working which contributed to the death or any accident resulting in the death;
- (e) any other facts which are relevant to the circumstances of the death (all in terms of Section 6(1) of the Act).

[3] The court proceeds on the basis of the evidence placed before it and although described as an inquiry, the sheriff's powers do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the procurator fiscal and any other party if so advised.

Background information

[4] The Scottish Prison Service has a Suicide Risk Management Strategy known as the 'ACT 2 CARE' Strategy. This provides a framework for the care of those at risk of self-harm or suicide. According to the evidence, which I accepted, all prison staff including prison officers,

practitioner nurses and management are trained in and familiar with the ACT 2 CARE Strategy. All receive core training and an annual refresher course. The annual refresher course includes compulsory eLearning. The aim of the strategy is to identify prisoners who are more likely to harm themselves; to identify any trigger or event which might make self-harm or suicide more likely and to recognise the signs, referred to in the evidence as “cues and clues”, both verbal and non-verbal, which might indicate a risk of self-harm or suicide.

[5] Any individual member of staff can initiate the ACT 2 CARE strategy. Once the strategy is initiated, a case conference is then held to which the prisoner is invited. The ACT 2 CARE strategy booklet travels with the prisoner wherever that prisoner may go within the prison establishment. The prisoner’s position is reviewed at a case conference at which the hall manager, a prison officer from the flat where the prisoner is housed and the hall nurse are present. Family members may and sometimes do attend the case conference. The instigation of ACT 2 CARE provides for different levels of observation according to risk. The highest level of observation is where a prisoner is put in an observation cell and checked every 15 minutes. There may be restrictions imposed upon the prisoner requiring him to use anti-ligature clothing and bedding and there may be restrictions upon certain personal items the prisoner may have within his cell. The observation cells which are used are designed to avoid any potential for self-harm.

[6] A prisoner is taken off ACT 2 CARE only after a case conference is convened involving at least three members of staff, including a manager and a member of the medical staff (usually a nurse). The composition of the case conference means that there is access, if required, to the prisoner’s confidential medical notes. The case conference must reach a unanimous decision if

the prisoner is to be taken off ACT 2 CARE. If one member of the staff does not agree that the prisoner should be removed from ACT 2 CARE then for the protection of the prisoner the minority dissenting view will prevail.

[7] Once a prisoner is considered no longer to be at risk of self-harm or suicide he is removed from ACT 2 CARE. The prisoner is then in the same position as any other member of the general prison population and is not subject to any increased scrutiny or observation. Within the general prison population at Barlinnie Prison there are prisoners who suffer from mental illness but who are not subject to ACT 2 CARE. While ACT 2 CARE is designed to reduce instances of self-harm and prevent possible suicide, it was recognised that each prisoner who is on ACT 2 CARE is subject to a considerable degree of scrutiny, suffers additional loss of already restricted personal freedom, which could result in loss of self-respect, loss of community and exacerbation of the boredom and lack of stimulation that is part of normal prison life. For those suffering from mental illness it may, if not used appropriately, exacerbate symptoms of their illness resulting from isolation and loss of community.

Findings in fact

[8] The following facts were admitted or proved:

- (i) Christian Douglas McIntosh appeared at Falkirk Sheriff Court on 16 November 2009 in respect of a petition containing a number of charges. He was remanded in custody until liberated in due course of law and remained in custody until he died on 10 December 2009.

- (ii) On 16 November 2009, Mr McIntosh was admitted to H M Prison, Barlinnie, Glasgow. About 1820 hours that day while within the reception area of the prison, as part of the admission process, a prison officer conducted a Reception Risk Assessment and the relevant form was completed as part of the ACT 2 CARE strategy. The prison officer assessed that there was no apparent risk of suicide or self-harm. At approximately 21:40 hours that day the Health Care Risk Assessment in respect of Mr McIntosh was conducted. No apparent risk was identified.
- (iii) On 17 November 2009, Dr Vasanth Govindappa carried out a physical and mental health examination on Mr McIntosh. He completed the doctor risk assessment as part of the ACT 2 CARE strategy. He noted that this was not Mr McIntosh's first time in prison. On previous admissions there had been no concerns noted from previous ACT 2 CARE assessments. Mr McIntosh had not previously been subject to the ACT 2 CARE strategy. At the time of his admission he had admitted taking heroin and valium recreationally prior to his admission to prison. Dr Govindappa was told by Mr McIntosh that he suffered from depression and heartburn. Dr Govindappa prescribed Fluoxetine and Omeprazole for these conditions. He found Mr McIntosh's physical examination to be normal. Mr McIntosh denied any ongoing suicidal thoughts. Dr Govindappa prescribed Dihydrocodeine and Diazepam as part of a regime undertaken by Mr McIntosh to detoxify from his drug misuse.
- (iv) Following completion of the prison reception process Mr McIntosh was allocated Cell 3/11 in C Hall. On 16 November 2009 he commenced an 18 day detoxification programme, which concluded on 2 December 2009. During the course of that

programme Mr McIntosh was seen twice daily by a nurse when he was given his prescribed medication of Diazepam and Dihydrocodeine, the dosage of which reduced as the detoxification programme progressed.

- (v) At 1650 hours on 26 November 2009 Caroline Pauley, Mr McIntosh's partner telephoned Barlinnie Prison. She spoke to Martin Thomson a prison officer who was on duty at the prison gate lodge. Ms Pauley told Mr Thomson that she was concerned about a telephone conversation with Mr McIntosh, earlier that day when he said he was going to hang himself. Mr Thomson made a diary entry in the phone log in which such messages are recorded. Mr Thomson made that entry in the log for 26 November 2009. He recorded the time of the call and the information he had received from Ms Pauley. That log is contained in page 59 of Crown Production 6.
- (vi) Following receipt of the call Mr Thomson immediately telephoned C Hall and spoke to John Dowie a prison officer who was on duty there. He passed on the information provided by Ms Pauley. Mr Thomson then telephoned the prison health centre where he spoke to a practitioner nurse who was on duty there and passed the information to him. Although the name of the nurse noted in the phone log was Edward Deanie, Mr Deanie has no recollection of having received that call. The information was not recorded in Mr McIntosh's prison health records.
- (vii) Shortly after 5.00 pm that day Mr Dowie spoke to Mr McIntosh who was within his cell. Mr Dowie told him of the concerns which had been expressed about his threat to kill himself. Mr Dowie did not disclose the source of the information. Mr McIntosh in

response appeared surprised and denied that there was anything wrong with him. He said the information was rubbish and that it had been passed to the prison to make life difficult for him.

- (viii) At the time Mr Dowie spoke to Mr McIntosh he described his demeanour as fine. He was making eye contact with Mr Dowie and communicating well. Mr Dowie assessed Mr McIntosh over the next four hours. He observed that Mr McIntosh looked unshaven but did not look dishevelled. Normally a prisoner is allowed one telephone call per day. Mr Dowie allowed Mr McIntosh to make additional unscheduled telephone calls that evening to his family and arranged for those telephone calls to be monitored. Mr Dowie instructed that if the content of the calls raised any concerns then he was to be alerted. No such concerns were raised or communicated to Mr Dowie. Mr Dowie assessed that Mr McIntosh was not at risk and did not consider it necessary to commence the ACT 2 CARE procedure.
- (ix) Mr Dowie did not record any of the information he received. He did not record the assessment he undertook or the decision he made not to start the ACT 2 CARE procedure. There is no procedure in place at Barlinnie prison to formally record information of this nature (apart from the gatehouse phone log). Likewise there is no procedure to record, either, decisions taken by prison officers or other prison officials involved in the care of prisoners not to trigger the ACT 2 CARE procedure, or the reasons underpinning such a decision. Mr Dowie did not inform the night shift officers what had transpired with Mr McIntosh because he had not started ACT 2 CARE procedure and there was no requirement to do so.

- (x) Stuart McKay met Mr McIntosh when they were both remanded into custody at Barlinnie prison following each appearing at Falkirk Sheriff Court on 16 November 2009. Approximately one week after being remanded in custody Mr McKay and Mr McIntosh shared Cell 3/11 in C Hall. During the period of remand before his death Mr McIntosh had expressed feelings of loneliness and of missing his family. Mr McKay did not think this was unusual because he thought these feelings were common amongst fellow prisoners.
- (xi) During 9 December 2009 Mr McKay and Mr McIntosh spent the day together. Mr McKay observed that Mr McIntosh was acting normally. They were “having a laugh” together and Mr McIntosh was trying to “cheer up” Mr McKay. From 7:00 pm onwards both watched a football game on the television in their cell. The cell was locked around 9:00 pm when a check of the prisoners was made. Mr McKay stated that Mr McIntosh was fine and was laughing and “going on about the football game”. He described Mr McIntosh as being his usual self. Mr McKay had no “inclination” that Mr McIntosh was suicidal. At 10:30 pm Mr McKay went to bed and fell sleep. At that time Mr McIntosh had not yet gone to bed.
- (xii) At approximately 7:00 am on 10 December 2009 Mr McKay was wakened by a prison officer opening the cell door rousing prisoners for breakfast. At that point Mr McKay saw Mr McIntosh suspended from a ligature around his neck hanging from the window area of the cell. Mr McKay immediately left the cell and alerted the prison officers on the landing. Mr McKay was unaware of any of the concerns others may have had about Mr McIntosh.

- (xiii) On receipt of the information from Mr McKay, Prison Officers Alan Love and Donald Campbell along with Nurse Sunny Agbomeirele entered the cell, immediately cut the ligature and attempted to resuscitate Mr McIntosh by administering oxygen and cardio pulmonary resuscitation without success.
- (xiv) At 7:18 am Paramedics Crawford Nicholson and Joe McNaughton arrived and entered the cell. They found Mr McIntosh's eyes to be fixed and dilated. There were no respiratory signs. An airway was inserted and an air bag was attached. Shock pads were attached but Mr McIntosh's cardiac rhythm was asystole (meaning no cardiac output or blood flow). Dr Jai Rakesh Kural attended and pronounced life extinct at 8:20 am on 10 December 2009.
- (xv) At 7:50 am that day, following Mr McIntosh's death, police officers found letters written by him to his immediate family. These letters were in a sealed envelope within his cell. They are contained within Crown Production 4. The content of the letters confirmed Mr McIntosh's intention to commit suicide.
- (xvi) A post mortem examination was conducted on 15 December 2009 at the City Mortuary in Glasgow by Robert Ainsworth a Forensic Pathologist at the University of Glasgow. The cause of death was certified as hanging. Mr McIntosh committed suicide.

Note on the Evidence

[9] I heard evidence from Crown witnesses Martin Crawford (42), a prison officer with 16 years' experience and from Nurse John Kane (50) and Nurse Karen Reilly (48) both experienced health care professionals. Mr Crawford was the reception officer on duty on 16 November 2009 along with Nurse Kane and Nurse Reilly. These witnesses were responsible for

the admission procedure undertaken when Mr McIntosh arrived at Barlinnie prison that day. I am satisfied that all the appropriate procedures were carried out and that none of those witnesses had any concerns about Mr McIntosh at that time. Mr Crawford completed the ACT 2 CARE Reception Assessment form and Nurse Kane completed the Health Care Risk Assessment (pages 102 to 106 of Crown Production 7). Nurse Reilly completed the Health Care Record Nursing Assessment (page 69 of Crown Production 7). From the evidence I heard and accepted, Mr McIntosh's admission to Barlinnie Prison was routine and uneventful.

[10] I also heard evidence from Caroline Pauley (51), Mr McIntosh's partner, and from his daughter Kristie McIntosh (28). They both gave evidence about the telephone contact they had with Mr McIntosh during his period on remand until his death. Ms Pauley said that after Mr McIntosh had been remanded to Barlinnie prison she spoke to him on a number of occasions. She said she was not happy that he was back in prison. At first he seemed fine but that changed. She said that during one telephone call he said he was going to hang himself and that she would not see him again. Ms Pauley said she was angry at him for saying that but was concerned about his tone of voice. She said she was very worried about him so she decided to telephone Barlinnie prison. Her recollection was that she had phoned the reception area where someone gave her Mr McIntosh's prison number. She then spoke to someone in C Hall and passed on her concerns. Ms Pauley said she made that telephone call to Barlinnie Prison around six days before her partner's death although her evidence on that point was not entirely clear. She placed the call on either the 4 or 5 December 2009. Ms Pauley remembered a subsequent telephone conversation when she spoke to Mr McIntosh when he seemed a bit better. She arranged to visit him and did so around 8 December 2009. She said she got less than

10 minutes alone with him during that visit. She noted he was unshaven and was looking sad. He told her that he had been given a row for the telephone call and Ms Pauley told him not ever to phone and say that to her again. She said that she was not worried about him because she thought he was on suicide watch. That was the last time Ms Pauley saw Mr McIntosh and was later informed of his death by police officers on 10 December 2009.

[11] Kristie McIntosh also gave evidence about her telephone contact with her father during his time on remand. Miss McIntosh said she was in regular contact with him by telephone. Her father would telephone her most days. She described his moods as being up and down. She said he was depressed and angry at himself for being back in prison and for letting her and her mother down. She said that there were a couple of times when she was concerned about her father when he was really low and fed up. Miss McIntosh's mother had phoned her after the telephone call with her father when he had threatened to commit suicide. Miss McIntosh's mother telephoned Barlinnie Prison and passed on her concerns. She said her mother had done that six or seven days before her father's death. She said she was present when her mother made the telephone call to the prison. Miss McIntosh said she spoke to her father the day after her mother had telephoned the prison. On that occasion he had said he was all right but had got into trouble for the phone call. Miss McIntosh said the last time she had spoken to her father was in a telephone call on 9 December 2009, when she said he sounded fed up and was kind of sobbing. She said he sounded low. Miss McIntosh said she thought her father would be all right because her mother had telephoned the prison.

[12] Martin Thomson (35) a Prison Officer with 14 years' experience stated that on 26 November 2009 he was working within Barlinnie Prison. On that date he was working in the

gatehouse which involved, amongst other things, dealing with external telephone calls received at the prison. When asked if he remembered taking a telephone call that day from Ms Pauley, Mr Thomson said that he did not recall taking the call. He was then shown an extract from the gatehouse telephone log dated 26 November 2009 (Crown production 6). He confirmed that the entry was in his handwriting and that his name appeared below the entry, although what appeared was not his usual signature. He confirmed that the entry was noted as follows:-

“Phone call received at 1650 hrs from Caroline Pauley partner of 26267 Christian McIntosh, C3/11 saying that they had a bad phone call earlier and that McIntosh was threatening to kill himself. Info passed to John Dowie C Hall and Eddie Deanie H/C.”

Mr Thomson confirmed that following the call he looked up Mr McIntosh’s location within the prison and would then have taken the action detailed in the gatehouse log entry whereby he passed the information he received to prison officer John Dowie in C Hall where Mr McIntosh was housed and also passed the information to Eddie Deanie a nurse on duty in the prison health centre. He said telephone calls of such a nature were not uncommon but when they did occur he had been instructed to pass the information on to the residential unit where the prisoner was housed and to the health centre. Although Mr Thomson had no recollection of the telephone call he had no reason to doubt that he had noted the correct date and time of the call although he accepted it was possible he had made an error. When asked by the court about the gatehouse phone log he confirmed that it was primarily used to record information of this nature and said that he was confident that he had noted the correct date and time of the call.

[13] Edward Deanie (58) Practitioner Nurse at Barlinnie Prison then gave evidence and was asked if he remembered receiving a call from Mr Thomson about Mr McIntosh on 26 November

2009. Mr Deanie said he had no recollection of the call. He was shown the entry in the gatehouse phone log and accepted his name appeared there. Mr Deanie said that if he received such a call he would check whether the information had been passed to the Hall. If the information had been passed on he would not follow it up unless he was asked to go to the Hall to assess the prisoner or a case conference was initiated. He did not think that he would forget a call like that. One explanation could be that, as happened previously, his name had been confused with other staff members. He thought he may have been on holiday at the time of Mr McIntosh's death and had requested prison management staff for details of his holidays during 2009 but had been informed that the information was unavailable. Mr Deanie said that it was open to him to record the details of the information in the prisoner's health records and that was his usual practice. He said there was no formal rule requiring him to do so. As far as he was aware there was no record of the information in Mr McIntosh's health records. He said that the purpose in noting such information was to acknowledge that it had been received. He would have also recorded that the information had been passed to the Hall. Mr Deanie remembered that shortly after Mr McIntosh's death he was asked about the telephone call and said then that he had no recollection of receiving it.

[14] John Dowie (56) a Prison Officer with 21 years' experience gave evidence that he had worked in Barlinnie Prison for approximately eight years. He was trained in the ACT 2 CARE procedure having undergone his initial training in 2005/2006. He had undertaken the annual refresher training, which consisted of a two-hour session in the classroom and further computer-based eLearning. In particular, the training focused on core competencies which you must pass. The classroom session focuses on the ACT 2 CARE documentation and what to look

out for. Cues and clues are important, looking at demeanour, behaviour, verbal clues and non-verbal clues. He said he would check the prisoner was making eye contact, was communicating appropriately and whether he appeared depressed. One clue to watch for is where a prisoner has started to give away personal items. He said he would also use his general experience in the assessment exercise. In his view those who interact with prisoners are in a better position to identify risk. Mr Dowie confirmed that if he thought that a prisoner may be at risk or there was a doubt about that then he would trigger the ACT 2 CARE procedure. He had, on several occasions, triggered the procedure in respect of prisoners whose demeanour had raised concerns.

[15] Mr Dowie confirmed he was working in C Hall between 16 November 2009 and 10 December 2009. During that time he was working on the third landing. He was a general gallery residential officer in charge of one landing. He said that on average there were 65 prisoners in the landing with mainly two prisoners to a cell. There were three prison officers on duty at any one time between 06:30 hours and 21:30 hours. From 21:30 hours the prisoners were locked down overnight. His responsibility was to look after the prisoners under his care which included their welfare and safety.

[16] Mr Dowie said that he remembered Mr McIntosh from his remand period in 2009 but not before. His impression of Mr McIntosh was that he was a mature man who presented no problems for the staff. He described him as easy-going and friendly. He said he clearly remember receiving the telephone call when he was told about the content of the phone call from Mr McIntosh's partner but was dubious about it being on 26 November 2009. He said he

believed it to be on 9 December 2009. The reason he recollected that date was because when he returned to work on 10 December 2009 he heard about Mr McIntosh's death.

[17] When cross-examined Mr Dowie accepted that he might be wrong about the date because he had not been asked about it until the police took a statement from him 15 months after Mr McIntosh's death. Mr Dowie was shown the gatehouse phone log entry for 26 November 2009 (Crown Production 6) and accepted that his name appeared there. He also accepted that he was on duty at that time as was Mr Thomson. He was told that a telephone call had been received from Mr McIntosh's partner expressing concern that Mr McIntosh was going to harm himself. Mr Dowie said that when he received the telephone call other members of staff were on the break between 4.00 and 5.00 pm.

[18] When the staff returned Mr Dowie went to speak to Mr McIntosh around 5.15 pm. He was in his cell with Mr McKay. Mr Dowie called him out of the cell for privacy and told him about the phone call which had been received and the concern expressed that he was going to harm himself. Mr Dowie did not tell Mr McIntosh who had telephoned the prison because he had been told that the person did not want Mr McIntosh to know. Mr Dowie said that Mr McIntosh seemed to be somewhat surprised at the information and said it was a lot of rubbish. Mr McIntosh said there was nothing wrong with him and that the person who had made the phone call was just trying to 'Bam him up'. Mr Dowie took that to mean that someone was trying to make life in prison difficult for Mr McIntosh.

[19] Mr Dowie described Mr McIntosh's demeanour at that time as fine, making eye contact and interacting well with him. He was not dishevelled although he had a bit of stubble. Mr

McIntosh was responding verbally. He seemed his normal self. He did not seem down at all. He accepted that he had the option to trigger the ACT 2 CARE procedure in respect of Mr McIntosh but had to assess him first. Mr McIntosh asked to use the telephone immediately to speak to his family and was allowed to do that. Mr Dowie asked prison security to monitor the calls and instructed that if there was anything untoward then he should be informed. He received no subsequent information from any party. Mr Dowie explained that prisoners were normally only allowed one telephone call per day. Mr Dowie said he assessed Mr McIntosh over the next four hours and kept going back to the cell to check every hour to make sure he was fine. Mr McIntosh was given several opportunities to use the telephone to speak to his family during that time. Mr Dowie said he did not trigger the ACT 2 CARE procedure because taking account of all the information he had he did not consider that Mr McIntosh was at risk or vulnerable.

[20] During cross-examination it was suggested to Mr Dowie that Mr McIntosh may have made telephone calls using another prisoner's account. He did not accept that was likely. He explained that when prisoners come into prison they are given a PIN number, which is linked to the prisoner's prison number. The prisoner must list the telephone numbers they are going to telephone and can only use those numbers. In Mr Dowie's opinion it would be unlikely that Mr McIntosh would have been able to use another prisoner's PIN number to make telephone calls unless both prisoners had listed common telephone numbers and he said that would be quite rare.

[21] Again during cross examination Mr Dowie was played a recording of a telephone call made by Mr McIntosh to his daughter Kristie McIntosh at 15:21 hours on 9 December 2009

(Crown production 8). Mr Dowie accepted that during the call Mr McIntosh sounded a bit down and was crying. However, he maintained that when he spoke to Mr McIntosh he was not distressed and seemed to be his normal self.

[22] Mr Dowie accepted that he did not do anything further with the information he received although he said he told the other staff on duty with him about the telephone call. He could not recall who those staff members were. He said he did not make any notes about the call or the assessment he made of Mr McIntosh. There was no procedure for doing that. The only recording that would have been made was if the ACT 2 CARE procedure had been triggered and the document completed.

[23] Mr Dowie said that when he returned to work on 10 December 2009 he learned of the death of Mr McIntosh and said he was very surprised and shocked. Mr Dowie said that for each prisoner in the Hall there is a record card which has the prisoner's number, name, date of birth and location. Any information about the prisoner's health is contained within his health records kept in the health centre. Mr Dowie said that he would not be told if a prisoner was being treated for depression or whether he was undergoing drug detoxification. Mr Dowie confirmed that he knew Mr McIntosh was not subject to the ACT 2 CARE procedure when he spoke to him and as far as he was aware had not been subject to it during any part of his period on remand until his death.

[24] He said the system in Barlinnie Prison in 2013 remains as it was in 2009. No record is kept of such information. There is no communication with the health centre if an assessment is made not to trigger the ACT 2 CARE procedure nor is there any requirement in those circumstances to inform the Hall manager or other prison officials. Mr Dowie said that he had

no recollection of being asked about his involvement with Mr McIntosh during the prison internal enquiry into the circumstances of Mr McIntosh's death. He maintained that he was first asked about his involvement 15 months later. He did not have any knowledge of the Scottish Prison Service Self Inflicted Death in Custody: Audit, Analysis & Review procedure (SIDCAAR) nor was he asked to attend any meetings relative to that review. He denied that he had failed to mention his involvement with Mr McIntosh earlier because he may have been in trouble arising from his decision not to trigger the ACT 2 CARE procedure in respect of Mr McIntosh.

[25] Gerard Watt (47) Unit Manager at Barlinnie Prison joined the Scottish Prison Service in 1988. He has been working at Barlinnie Prison since December 2011. He is responsible for the two main residential halls within Barlinnie Prison. Mr Ward is a senior manager at Barlinnie prison and an officer with more than 25 years' experience. He was involved for many years in training both locally and nationally in the ACT 2 CARE procedure. His evidence provided some of the background information detailed at paragraphs [4] to [7] above.

[26] He confirmed that on receipt of information of the kind Mr Dowie was given he would expect the prison officer to go and speak to the prisoner. Sometimes malicious calls are made to the prison so he would expect a check to ensure the information was genuine. He would then check if the prisoner was in crisis, make an initial assessment and then come to a decision about whether to trigger the ACT 2 CARE procedure. In this case Mr Dowie went to see Mr McIntosh and spoke to him. He observed Mr McIntosh and was in a position to make an initial assessment of him. That is what Mr Dowie was trained to do. Mr Watt was of the view that those caring for a prisoner are best placed to make the initial assessment. He said the emphasis

is on assessment, contact and teamwork. Mr Dowie did what he was supposed to do and made a judgement call on the day based on Mr McIntosh's presentation and Mr Dowie's experience. He acknowledged that, in some cases, the decision can be a challenging one.

[27] In cross-examination, Mr Watt did not accept that Mr Dowie had brushed aside the ACT 2 CARE procedure in Mr McIntosh's case. He acknowledged that a prison officer could get the initial assessment completely wrong but the individual who carries out the assessment is trained to do so. He did not accept that the initial assessment might be better carried out by more than one individual. He explained that a prison is a busy volatile environment and that it would not be practicable to instigate the ACT 2 CARE procedure in every case without an initial assessment by a prison officer or official trained in the procedure.

[28] Mr Watt confirmed that there is no requirement within Barlinnie Prison to record information such as this or any decision taken by an individual officer not to trigger the ACT 2 CARE procedure. He accepted that these matters could be recorded and included in the handover book. Mr Watt stated that following the death of Mr McIntosh an internal incident report was completed, which contained statements from all of the prison personnel who were involved following the discovery of Mr McIntosh's body together with other associated documentation. A Scottish Prison Service Self Inflicted Death in Custody: Audit, Analysis & Review (SIDCAAR) document, was also completed.

[29] I then heard evidence from Professor Alec Spencer who is currently an honorary professor at the School of Applied Social Science at the University of Stirling. Professor Spencer prepared a report at the request of Mr Thomson on behalf of Mr McIntosh's family to provide an expert opinion surrounding the circumstances of Mr McIntosh's death while in custody. He

joined the Scottish Prison Service in 1972 and served in a number of prison establishments throughout the prison estate. His career in the Scottish Prison Service was a long and distinguished one as a career operational prison governor within the Scottish Prison Service. Reference is made to page one of his report for full details of his CV. That report is can be found in the First Inventory of Productions for the family.

[30] In summary it was his opinion that while the Scottish Prison Service ACT 2 CARE strategy for suicide prevention was fit for purpose the proper procedure was not followed in Mr McIntosh's case. While he accepted that the initial response by Mr Dowie was appropriate it was his opinion that it was not sufficient. He was of the view that the ACT 2 CARE document should have been initiated and discussions held with other staff, which would have triggered a case conference. He expressed the opinion that Mr Dowie had brushed aside the information he received about Mr McIntosh. He stressed that a fundamental principle of the strategy was that decisions about at risk prisoners should be made by teams not individuals.

[31] Professor Spencer was also critical of the absence of written notes of the information. He said they could be used to inform staff who were taking over duty or to enable the matter to be taken forward for further action the following day. There were other issues raised in his report which did not arise in the inquiry. I have referred here only to those parts of his opinion evidence which are relevant to the issues before me.

[32] His evidence was that the information received by Mr Thomson and passed to Mr Dowie was sufficient in itself to trigger the ACT 2 CARE procedure and he would not be swayed from that position. He did however accept that even if the procedure had been triggered the outcome may still have been the same. In his view it appeared that Mr McIntosh's

decision to commit suicide was not made on the spur of the moment. Mr McIntosh had already written suicide notes. He accepted the possibility that Mr McIntosh had decided to end his life and once reconciled to that decision he was able to convince others that he was well. Professor Spencer also said that even if Mr McIntosh had been placed on low risk observations he would have only been subjected to hourly observations.

[33] One area of conflict arose between the evidence of Professor Spencer and Gerard Watt. During his evidence Professor Spencer was critical of Mr Dowie and expressed the opinion that the ACT 2 CARE procedure should have been triggered upon receipt by Mr Dowie of the information concerning Mr Macintosh's threat to commit suicide. He accused Mr Dowie of brushing the information aside. Professor Spencer did not allow for a situation where a prison officer should, on his own, make an initial assessment whether to trigger the ACT 2 CARE procedure.

[34] Mr Watt an experienced senior manager in Barlinnie Prison with considerable experience which includes the training of prison officers in that ACT 2 CARE procedure was of the opposite view. He explained that all prison personnel who are responsible for the care of prisoners are trained to make these types of initial assessments and have been doing so for some considerable time. Prison officials must undergo initial training in the ACT 2 CARE procedure and undertake mandatory annual training thereafter.

[35] Whilst acknowledging Professor Spencer's expertise and knowledge in this field and the submission's made by Mr Thompson on behalf of the family in this regard I preferred the evidence of Mr Watt on this issue. As was submitted by Miss Watt, on behalf of the Scottish Prison Service, Mr Watt is a front line manager who has been involved in the ACT 2 CARE

strategy for many years and is involved in its implementation and the training of prison officers. I am satisfied by Mr Watt's evidence that properly trained prison officers with relevant experience who are directly responsible for the care of a prisoner are well placed to make these initial risk assessments. I am also satisfied that these initial assessments can be carried out by one trained officer. I do not accept Professor Spencer's view that it is necessary for a team of prison officials to be involved at that initial stage.

[36] The regime at Barlinnie Prison in Glasgow has a system well recognised by all staff which is effective in identifying and assisting vulnerable prisoners particularly those who may have ideas of self-harm or suicide. In my view the prison regime has to be effective but proportionate and be able to protect those who are vulnerable and require additional support without unnecessarily restricting further the already limited personal freedoms of each individual prisoner. Having heard all of the evidence in this case I have concluded that all of those who were involved with Mr McIntosh during his remand at Barlinnie Prison in Glasgow did their best to give him such assistance as they could and that his death and the circumstances which prevailed although tragic could not reasonably have been avoided.

[37] Another area of conflict which arose in the evidence surrounded the date of the telephone call made by Caroline Pauley to Barlinnie Prison and the subsequent telephone call from Mr Thomson to Mr Dowie to inform him that Mr McIntosh had threatened to hang himself during an earlier telephone call with Ms Pauley. Ms Pauley's evidence (and that of Miss McIntosh) was that she made the call to Barlinnie Prison approximately 6 days before Mr McIntosh died on 10 December 2009. She said she phoned the prison on either 4 or 5 December 2009. In his evidence Mr Thomson said he had no reason to doubt the accuracy of

the date entry on 26 November 2009 in the gatehouse phone log while Mr Dowie said he was almost certain that the call he received from Mr Thomson was on 9 December 2009.

[38] The date of the call is significant from the family's perspective. The principal criticism of Mr Dowie, which was advanced on behalf of the family, proceeds on the basis that if the telephone call made by Ms Pauley was made on 9 December 2009 and Mr Dowie had immediately triggered the ACT 2 CARE procedure then that would have been a reasonable precaution whereby Mr McIntosh's death might have been avoided. However, Mr Thompson accepted that his submission was predicated on the basis that 9 December 2009 was the date of the telephone call. He also accepted that if I decided that the date of the telephone call made by Mr McIntosh to Ms Pauley was at 16:50 hours on 26 November 2009 then that submission failed because Mr McIntosh's death occurred two weeks after the telephone call to the prison.

[39] In deciding this issue I considered carefully the evidence of each of the witnesses and the other available documentary evidence. The evidence of the entry in the gatehouse phone log on 26 November 2009 at 16:50 hours is a compelling piece of evidence. That entry is a contemporaneous note of what Ms Pauley said to Mr Thomson and details the action he took following the receipt of the information. While Mr Thomson, understandably, now has no recollection of the telephone call he was confident that he noted the correct date and time of the call. There was nothing in his evidence which caused me to doubt that he had done so.

[40] Ms Pauley and Miss McIntosh said that the call had been made on 4 or 5 December 2009. It appears to be accepted that the information given by Ms Pauley during that call was the same information, which was contained in the gatehouse log for 26 November 2009. There was no suggestion that there was more than one call of that nature made. Nor was it disputed that the

information had been passed to Mr Dowie immediately after the call from Ms Pauley. It followed then that the call must have been made while both Mr Thomson and Mr Dowie were on duty.

[41] As I understood Mr Dowie's evidence he was working from 6:45am until 12:45pm during the week, which included 4 and 5 December 2009. That meant he was not on duty on either of these dates, at the time when Ms Pauley and Miss McIntosh said the call was made. Mr Thompson, on behalf of the family in his submissions, rather unusually, suggested that I should reject the evidence of both Ms Pauley and Miss McIntosh about the date of the telephone call but that I should accept the evidence of Mr Dowie that he received the call from Mr Thomson on 9 December 2009. While I have no doubt that both Ms Pauley and Miss McIntosh were doing their best to remember the date the call was made to Barlinnie Prison, having regard to the evidence about Mr Dowie's shift pattern, which was not in dispute and which I accepted, I reject their evidence about that.

[42] I also reject the evidence of Mr Dowie that he received the telephone call on 9 December 2012. While Mr Dowie at times seemed confident about that date he did qualify his evidence on a number of occasions. In particular, he was clear that he had not been asked about the incident nor had he been involved in any Scottish Prison Service internal investigation following Mr McIntosh's death. He said he was first asked about the matter when the police took a statement from him 15 months after Mr McIntosh's death and accepted the possibility that he was wrong about the date. I have no doubt that Mr Dowie, in common with the other witnesses, was doing his best to try and recollect the details of the incident which had taken

place over three years ago. For these reasons, I have concluded that on the balance of probabilities Ms Pauley made the call to Barlinnie Prison on 26 November 2009.

[43] The Crown in their submissions urged me to make formal findings only with the exception of section 6(1)(e). I was invited to make findings about the circumstances where no written record was kept by Mr Dowie of the initial risk assessment he conducted of Mr Macintosh. While the Crown submitted that there was no evidence that had such a record been kept the outcome would have been any different the Crown nevertheless submitted that such a record should be kept in the future. It would ensure that all staff who dealt with the prisoner concerned would have a heightened awareness of the need to look for the cues and clues referred to in the ACT 2 CARE strategy. This was particularly so where concerns had been raised about the prisoner's wellbeing. The Crown referred me to the evidence of Professor Spencer and in particular to his opinion that where a prison officer does undertake an initial risk assessment but does not subsequently trigger the ACT 2 CARE procedure then that assessment should be recorded and the information made available to other members of staff. The Crown reminded me that Mr Watt, an experienced senior manager from Barlinnie Prison accepted that a record of such occurrences would possibly assist other staff members dealing with the prisoner and had conceded that the recording of this information would not present a serious problem and could be easily achieved. The Crown's position was that the noting of such information including the risk assessment would provide a more complete, long term record of concerns raised in respect of a prisoner.

[44] I was invited both by the Crown and by Miss Watt on behalf of the Scottish Prison Service not to make any formal findings in terms of section 6(1)(c) or (d) of the Act. Similarly, in

his submissions Mr Thompson, on behalf of the family, invited me to make no formal finding in respect of section 6(1)(d). He also accepted that if I decided that the date of the telephone call by Miss Pauley to Barlinnie Prison was 26 November 2009 then no finding should be made in respect section 6(1)(c). As I have decided that was the date of the phone call then that part of Mr Thompson's submission fails.

[45] While all of the parties invited me to make findings in terms of section 6(1)(e) of the Act, the Crown and Miss Watt submitted that I should restrict any finding to the issue of the recording of the information, which triggers a risk assessment and any decision made relative thereto. Miss Watt accepted that in Mr Macintosh's case the recording of that information would have identified and confirmed the date on which Mr Dowie carried out his assessment and would also have allowed for the information to be passed between shift personnel in the event that the situation were to change. She also accepted that the information should be recorded in the prisoner's health record.

[46] Mr Thompson in his submission in respect of section 6(1)(e) of the Act invited me to make similar findings in respect of recording the relevant information and the decision reached. But he went further and suggested that I should make findings about the preservation of evidence by the prison authorities following upon an incident of this nature. He was critical of the handling of the incident and in particular was concerned that a statement had not been taken from Mr Dowie shortly after Mr Macintosh's death. He was also concerned that all of Mr Macintosh's telephone records in the weeks leading up to his death had not been preserved. It was his submission that had these things happened then there would have been no confusion

about the date and may have given a clearer picture as to Mr Macintosh's apparent state of mind on the evening of 9 December 2009 and prior to 1 December 2009.

[47] Having considered the matter carefully I do not propose to make any formal findings concerning the preservation of evidence following upon an incident such as this. I am satisfied that the prison authorities understand the need to preserve evidence immediately following the death of a prisoner particularly where a Fatal Accident Inquiry is mandatory.

[48] In terms of section 6(1)(e) I am satisfied that there are facts which are relevant to the circumstances of the death of Mr Macintosh and I have made three findings about that. In view of those findings I have made the following recommendations which I trust the Scottish Prison Services will implement as soon as possible.

Recommendations

[49] Where credible information is received by a prison official that a prisoner has threatened to commit suicide the Scottish Prison Service should review their procedures to ensure that the information:-

- (i) is recorded in the prisoner's record together with the details of any action taken and the reasons for any decision not to invoke the ACT 2 CARE procedure;
- (ii) is communicated to all those involved in the supervision and care of the prisoner concerned;
- (iii) is recorded in the prisoner's medical records; and

- (iv) is reviewed in early course by a senior officer or hall manager and a prison health professional with a view to deciding whether any further action is necessary.

[50] I have no doubt that Ms Pauley and Miss McIntosh were being truthful when they described how Mr McIntosh presented in the days immediately preceding his death but their evidence about that was very different from the evidence of Mr Dowie and Mr McKay. In my opinion they also were truthful witnesses. Sadly it appears that once Mr McIntosh had resolved to commit suicide he wrote the letters to his family and did his best to convince others within the prison that he was well. He did that to prevent interference with the plan to kill himself and he succeeded. Mr McKay, who shared the cell with Mr McIntosh, gave evidence about the presentation and demeanour of Mr McIntosh and described him as, amongst other things, laughing and joking in the cell during the evening of 9 December 2009. Tragically it now appears that was a facade.

[51] Finally, I express my sympathy to Mr Macintosh's family and consider that they did their best to support him during his time in prison. I would also wish to thank the legal representative for their careful and sensitive presentation during the course of the Inquiry.

Glasgow 7 June 2013

Sheriff Martin Jones QC