INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRY (SCOTLAND) ACT INTO THE SUDDEN DEATH OF WAYNE ALAN ADIE

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

INQUIRY HELD UNDER FATAL ACCIDENTS AND

SUDDEN DEATHS

INQUIRY (SCOTLAND)

ACT 1976

SECTION 1(1)(a)

SECTION 1(1)(b)

DETERMINATION by

MICHAEL GERARD O'GRADY, Esquire, Queen's Counsel, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow between the Sixteenth day of October and Twenty Third day of October Two Thousand and Six into the death of WAYNE ALAN ADIE, aged 26 years.

GLASGOW, November 2006.

The Sheriff, having considered all the evidence adduced, DETERMINES; in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Section 6(1) -

(a) Wayne Alan Adie, date of birth 5 September 1979, formerly residing at HMP Barlinnie, 81 Lee Avenue, Glasgow died at around 9.00 pm on 25 November 2005 within Cell 1/24, B Hall at said HMP Barlinnie, Glasgow.

(b) The cause of Wayne Adie's death was suicide by hanging. There was no accident which contributed to the death.

(c) There were no reasonable precautions whereby the death of Wayne Adie might have been avoided.

(d) There were no defects in either the social work or Scottish Prison Service system of working which contributed to the death of Wayne Adie.

(e) There are no other facts which are relevant to the circumstances of Wayne Adie's death.

(1) Wayne Alan Adie was at the time of his death 26 years of age. In July 2005 he was sentenced to 12 months' imprisonment at Kirkcaldy Sheriff Court. His earliest

date of release would have been 9 January 2006. He was originally confined in HMP Perth. In or about October 2005 he was transferred to HMP Barlinnie, Glasgow.

(2) Mr John Adie, father of the deceased, visited him on at least a weekly basis. In or around October 2005, Mr Adie senior became concerned for his son's wellbeing. In the course of conversation Wayne appeared to be harbouring certain delusional beliefs. These related to variously to him believing that he had important information about scandalous behaviour by a member of the judiciary; that the police wished to recruit him to sell drugs for them; that he intended to reveal these facts; and that because of his knowledge and intentions he expected to be murdered by the authorities on his release from prison.

(3) Mr Adie senior became greatly concerned about the content of his conversations with his son. He regarded his son's beliefs as fantasy. He considered that they bore no relation to reality. He felt that such behaviour was entirely out of character for Wayne and was convinced that his son's mental health required some investigation.

(4) On the afternoon of 9 November 2005, Mr Adie senior telephoned the Social Work Department at HMP Barlinnie. He spoke to social worker Stuart Campbell. He broadly explained to Mr Campbell that he concerns for his son's mental health although he did not go into great detail about the content of his conversations with Wayne. Mr Campbell specifically asked Mr Adie senior if there might be any issues of self-harm arising from the situation. Mr Adie senior said that there were not. Mr Campbell agreed that he would go to the hall where Wayne Adie was housed to investigate the matter. He promised to telephone Mr Adie to report. He explained that he would be unable to do so that day.

(5) The following morning Mr Campbell returned to his duties. He completed a referral form which he was required to do to open up a record of his involvement with Wayne Adie. This would allow a computer file to be opened up and notes to be added to that file. Mr Campbell attempted to see Wayne Adie that morning but for reasons which were not clear he was advised by staff that he would be unable to see Wayne. For a variety of operational reasons such refusal is not unusual. Mr Campbell was obliged to attend at a training session that afternoon and was therefore unable to see Wayne or report back to Mr Adie senior.

(6) That same day, 10 November 2005, in the late afternoon Mr Adie senior again telephoned the Social Work Department and on this occasion spoke to the duty worker Sheila Smith. He explained that he had spoken to Mr Campbell on the previous day, gave some details of his concerns and advised Miss Smith that he had not heard from Mr Campbell. In the course of the conversation again Miss Smith enquired of Mr Adie senior whether there were any issues of self-harm in relation to his son. Again Mr Adie senior advised her that there were not. Miss Smith telephoned the gallery prison officer Mr Wright, advised him of the nature of her enquiry and was told that there were no current concerns regarding Wayne's behaviour or demeanour. Furnished with this information, Miss Smith telephoned Mr Adie senior to update him on the situation. Nonetheless, Mr Adie senior still considered that his son might benefit from some mental health input. Miss Smith advised she would raise the matter with the Mental Health Team.

(7) Miss Smith, knowing that she was about to go on holiday, completed the appropriate paperwork. She also spoke to the practice team leader Helena Bryce and it was agreed that the topic of Wayne's mental health should be raised at the next meeting of the Mental Health Team. With this in mind, Miss Smith left a note for the senior social worker Brian Tolmie requesting that he raise the matter at the next Mental Health Team meeting. Mr Tolmie was not available to be spoken to personally.

(8) There exists within HMP Barlinnie, and indeed the Scottish Prison Service as a whole, a procedure known as ACT. This procedure, which involves various precautions and investigations, is put in place in relation to any prisoner in respect of whom there is an issue of self-harm or suicide. Had any of the parties considered on the available information that such risk existed in relation to Wayne then this procedure would have been invoked. No such fear existed or could have been anticipated at the time.

(9) The Mental Health Team is a multi-disciplinary group which meets each Friday afternoon. It is chaired at deputy governor level and its composition varies but includes, for example, the health care manager, psychologists, addictions worker, senior social worker, chaplain and psychiatrist. Anyone within the prison, and indeed outwith it, can refer concerns in relation to an individual prisoner to the Team who will consider the position and decide what action is appropriate. The next meeting of the Mental Health Team following upon the referral to Brian Tolmie was on 25 November 2005.

(10) On 18 November 2005, practice team leader Helena Bryce received another telephone call from Mr Adie senior. He was again expressing his concerns regarding his son's mental health and regarded his son as paranoid. In view of these continuing concerns Miss Bryce attended that afternoon at B Hall where she interviewed Wayne Adie. She explained to Wayne the reason for the interview and conveyed to him his father's concerns. Wayne assured Miss Bryce that he was now receiving anti-depressant medication and was feeling much better and that his father had no reason to be concerned. Miss Bryce, a professional of many years experience, could detect no obvious mental health issues. Nonetheless, she chose to err on the side of caution and decided to refer the matter to the Mental Health Team. She did so by that day completing and processing a referral form.

(11) On 22 November 2005 the mental health referral was passed to Carol Allan, a practitioner nurse with responsibility for mental health. Miss Allan was armed with the referral form which contained *inter alia* information on the background leading to the referral. That afternoon Miss Allan attended at the hall to interview Wayne. Her purpose was to assess his state of mental health. She too, also a professional of considerable experience, had no concern for Wayne's mental health arising from the interview. Although Wayne did not consent to his case being discussed with the Mental Health Team nonetheless his case was referred to a meeting of that team on 25 November 2005.

(12) In the meantime on 24 November 2005, Stuart Bennett, a prison officer, had been on duty in B Hall. He had been approached by Wayne Adie who wished to speak to him. They had a private conversation during which Wayne told Mr Bennett

that he felt that staff were speaking to other prisoners about him, were telling other prisoners incorrectly that he was a sex offender and that staff were informing police on him. Mr Bennett was concerned by the content of the conversation and also by the presentation of Wayne Adie. His body language and expressions seemed inappropriate to the conversation and Mr Bennett was concerned that he might be disturbed and paranoid. Following the conversation Mr Bennett made a call to the Mental Health Team and spoke to Nurse Carol Allan, expressing his concerns. He followed up this conversation with an email. Nurse Allan had agreed to interview Wayne Adie, and did so as previously narrated.

(13) Dr John Baird is a consultant psychiatrist of considerable experience who is based at Leverndale Hospital. His practice also embraces assessment and treatment of prisoners at HMP Barlinnie. He often makes recommendations to and attends at meetings of the Mental Health Team. On 25 November 2005 he met with Wayne Adie at the request of the Mental Health Team. He had a full and detailed discussion with Wayne. Following that interview Dr Baird was satisfied that Wayne Adie was depressed and that he had paranoid beliefs. Dr Baird was of the view that Wayne's principal problem was not his depression (for which he was already receiving medication) but lay in his paranoia. In the circumstances he agreed with Wayne that he would be prescribed Olanzapine on a daily basis. Olanzapine is an anti-psychotic drug. After the meeting Dr Baird spoke with a member of the Mental Health Team and in due course followed up with a detailed letter containing his findings to the team. In the course of his interview with and examination of Wayne Adie, Dr Baird had regard for the question of self-harm. There was nothing in Wayne's presentation or the content of the conversation which suggested that self-harm was an issue at that stage. Dr Baird was not present at the Mental Health Team meeting but his assessment and views were passed on to the meeting and considered by it.

(14) On the afternoon of Friday, 25 November 2005 prisoners including Wayne Adie were returned to their cells following recreation. Wayne was returned by Officer Stuart Campbell. At that stage Wayne gave no cause for concern. At around 10.00 pm Prison Officer Colin Barclay in the normal course of his duties checked Cell 1/24 in which Wayne was housed. He looked through the spy hole on the cell door. He was unable to see into the cell. He switched on the cell light using the switch on the outside. He was still unable to see and was of the view that the toilet door was open and blocking the spy hole. He continued checking the rest of the prisoners and returned to Wayne's cell at around 10.10 pm. Again he was unable to see into the cell. He shouted and there was no response. He kicked the door and there was again no response. He immediately contacted the night shift supervisor, asking him to come to B Hall. This was the standard procedure for opening a cell. Mr Barclay had with him a sealed pack containing a key for the cell door. He was authorised by the supervisor to open the door. As he did so he could see that the toilet door was still against the cell door. There was a chair behind it. As he pushed past these he could see Wayne Adie hanging from the window. There appeared to be a ligature, one end of which was tied to the window, the other to Wayne's neck. Wayne was immediately cut down and placed in the recovery position. A nurse was sent for by radio. It became quickly apparent that Wayne was already dead.

(15) A multi-disciplinary meeting of the Mental Health Team took place on Friday, 25 November 2005. Wayne Adie's case was discussed. It was agreed that he was

unwell. He had been seen by Dr Baird when he was guarded regarding information. He had been commenced on anti-psychotic medication. A decision was made that he would be kept under review by the Mental Health Team and psychiatrist and in the interim he had moved to the bottom flat of B Hall for closer supervision.

(16) On 1 December 2005 at the City Mortuary, Glasgow, Dr Marjorie Black, Forensic Pathologist, University of Glasgow carried out a post-mortem examination of Wayne Adie. Her conclusion was that the deceased was seen to have features entirely consistent with death from hanging, that there were no asphyxia signs of other significant injuries to the body, and that no natural disease was identified. She was satisfied that the cause of death was hanging.

NOTE:-

I have set out above the findings-in-fact which I have made based on the evidence adduced in the Inquiry into the death of Wayne Alan Adie. It was clear that Wayne Adie was a young man who in consequence of a long-standing drug addiction had come into conflict with the authorities on many occasions, had been incarcerated as a result and was latterly troubled, anxious and clearly ill. The full extent and nature of that illness was not and could not be explored but it is reasonable to infer that it was at least in part due to his involvement with drugs and consequent troubled history.

However that may be, Wayne's tragic death was in my view entirely unforeseeable. There is no doubt on the evidence available that neither his closest family nor professionals of considerable experience and skill could, notwithstanding their concerns, detect any likelihood of Wayne harming himself as a result of his anxiety. Sadly, I am of the view that no-one - family or professionals - did, could, or should have foreseen such an eventuality. I am satisfied that prison authorities and professional staff employed by them quite properly and carefully addressed the issue of self-harm and were entitled on the facts before them to reach the conclusions which they did. Tragically (and it is perhaps symptomatic of Wayne's condition) he hid his true feelings and intentions from even those closest to him. This made his eventual suicide, in my view, wholly unpredictable and unpreventable.

The court had the benefit of hearing in evidence from Mr John Adie, Wayne's father. In what must have been a painful and difficult exercise for him, he assisted the court by detailing his own involvement with and concern for Wayne at around this time. Understandably, standing his dreadful loss, Mr Adie senior felt somehow that something should have been done to prevent Wayne's death. While I understand that view entirely it is one which I cannot in the circumstances share and I accordingly have made the formal findings which I have.

I should add that in addition to his evidence the court had the opportunity of hearing from Mr Adie senior in a moving statement which he read. In it he made it plain that whatever difficulties Wayne had brought to his door in the course of his short life, he was a young man who was popular in his community and even within the prison system. It was clear that Wayne, despite his problems, was much loved by his family and equally clear that as and when he was able to do so Wayne reciprocated that love and affection. It is to be hoped that it is that part of Wayne's life which will be

remembered by his family. Mr Adie, despite Wayne's difficulties, was nonetheless clearly proud of the positive aspects of Wayne's life, and no doubt justifiably so.