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 SAMUEL CATHCART, Esquire, Advocate, Sheriff of the sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on the 15, 16, 17, 18 , 19 October and 7 November all Two Thousand and Seven into the death of ALEXANDER KERGAN

GLASGOW, 2007.

The Sheriff having considered all the evidence adduced, DETERMINES: in terms of the Fatal Accident & Sudden Deaths Inquiry (Scotland) Act 1976 Section 19(1):

(a) that Alexander Kergan, born 9.6.92, who resided at Kempsthorn Children's Unit, 40 Kempsthorn Crescent, Glasgow died at the Southern General Hospital, Glasgow at 1729 hours on 3 May 2006;

(b) that the cause of death was hanging;

(c) that there were no reasonable precautions whereby his death might have been avoided;

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

(e) that:-

(i) in September 2005 Alexander Kergan (Alex) was admitted to Yorkhill Hospital, Glasgow, having consumed 80 fluroxeline tablets, 30 diazepam tablets and a half bottle of Buckfast wine. The tablets had been prescribed for his mother. His consumption of these items was regarded as attempted suicide. At the time he complained of having been sexual abused at the age of six. Having been examined he was not regarded at risk to the extent that detention under Mental Health legislation was appropriate.

(ii) Alex was admitted to Kempsthorn Children's Unit, 40 Kempsthorn Crescent, Glasgow (Kempsthorn) on 16 March 2006 under a place of safety warrant under section 66 of the Children (Scotland) Act 1995.

(iii) Alex had a history of offending, behavioural problems at school, failure to attend school and was outwith parental control.

(iv) While in Kempsthorn he had difficulty accepting the rules and boundaries set. His offending continued as did his failure to attend school.

(v) On 28 April 2006, Alex's brother Sean was convicted of murder. Alex was informed of this on 30 April 2006. Alex and Sean had a close relationship.

(vi) At a Looked After and Accommodated Review held on 3 May 2006 it was decided, *inter alia*, that a placement for Alex be sought in a residential school.

(vii) Alex was unhappy at this decision.

(viii) At about 4.00 pm on 3 May 2006, Alex went to his room having argued with other residents in connection with their refusal to allow him to share a cigarette.

(ix) Between then and 4.30 pm approximately, he was spoken to by staff on at least one occasion. He was monitored whenever in his room as he had smoked in his bedroom in the past and was regarded as a fire risk.

(x) at about 4.30 pm Alex's body was discovered suspended by a lace from his trainer from the back of a door within his room.

(xi) The ligature was cut. He was lowered and unsuccessful attempts were made to resuscitate him.

(xii) He was removed to the Southern General Hospital, Glasgow where life was pronounced extinct at 1729.

(xiii) There were no suspicious circumstances surrounding Alex's death.

NOTE:

At this Inquiry the Crown was represented by Mr Hughes, Procurator Fiscal Depute; Mr Call, Advocate, represented Glasgow City Council; Mr Rinaldi, Solicitor, represented Greater Glasgow Health Board and Alex's family was represented by Mr Murphy, Solicitor. During the Inquiry the Crown led evidence from Rosemary Pavese, Social Worker, Glasgow City Council, Emma Connell, Student, c/o Pollok Police Office, Glasgow; John Kerr, Residential Worker, Kempsthorn Children's Unit, Glasgow, Chris Malcolm, Clinical Specialist FCANHS, Greater Glasgow Health Board, Glasgow, Joseph Gillen,

Social Worker, Glasgow City Council, Jason Kaushal; Child & Adult Psychotherapist, Anne Lamont, Unit Manager, Kempsthorn Children's Unit, Glasgow, Dr Eileen Blower, Consultant Psychiatrist FCANHS, Greater Glasgow Health Board, Glasgow, Constable B Martin, Detective Constable Lipsett and Sergeant Conway all of Strathclyde Police

No witness was called by the other parties.

Evidence

Ms Pavese was Alex's social worker. She gave evidence of him having a history of offending behaviour, poor school attendance and domestic difficulties. In December 2005 a Home Supervision Order was recalled as Alex was not co-operating. Ms Pavese continued to see him on a voluntary basis. Alex's family situation deteriorated and his offending increased. He was involved in substance misuse. His mother was unable to cope. His school attendance was not satisfactory and in March 2006 a place of safety order was made. As a result Alex was placed in Kempsthorn. In September 2005, Alex's brother Sean was charged with murder. At about the same time Alex attempted to commit suicide by taking an overdose of his mother's medication. When Alex's was asked about this incident he refused to discuss it. He alleged that he had been sexually abused when aged 6. In April or May Alex was told that Sean whom, according to Ms Pavese, he idolised had been convicted of murder. After his release from hospital Alex and his mother made it clear to Ms Pavese that the consumption of pills and alcohol had been an isolated incident. Alex told his social worker that he had no suicidal intention. He told her that the purpose of the overdose was not self-harm but to show off to friends. At a meeting at Kempsthorn on 3 May 2006 at which she attended, it was decided that Alex should be transferred to a residential school. She described Alex as being very disruptive during the meeting and it was clear that she did not want to go to a residential school. He told her that he was generally happy with his placement at Kempsthorn. In Kempsthorn he had contact with Includem and his involvement with FCAMH continued. Apart from the overdose in September 2005 this witness gave evidence that there was nothing else which made her believe that Alex was a suicide risk. FCAMH became involved at her request, not long after the overdose. As far as she was aware Alex had never been diagnosed as having mental illness. Her evidence was that Alex was not considered a suicide risk by her at the time of his death. She was

not aware that Alex was self-harming. She did not agree that no progress was made with Alex in Kempsthorn as he had developed a relationship with Includem and involvement with FCAMH.

Emma Cornwall gave evidence about being a member of staff who looked after Alex and others at Kempsthorn. She described Alex as having two sides to him. On the one hand he would talk away and laugh and in the other he would be abusive, destructive and really angry. He absconded more than once from Kempsthorn. He broke the lock on his bedroom window and climbed up and down the drainpipe outside the window. Other residents had accused Alex of theft. Alex was not allowed out without staff or an adult and he resented that. She described him having started a fire in his room when he set fire to papers in his bin and then threw it out of the window. He refused to go to school. In her experience she did not regard his mental state as out of the ordinary given what was going on in his life. It was her evidence that two days before his death Alex had told her that he had taken his mother's tablets but did not wish to discuss this matter further. He smoked in his bedroom and stubbed cigarettes out on his carpet. As a result of this monitoring was put in place whereby he if was in his room he would be checked every 15 to 20 minutes. Alex was aware of and agreed to this system. On the afternoon after the meeting when it was decided that Alex was going to a residential school Alex argued with other residents who refused to give him a share of a cigarette. He became agitated at this and stormed off to his room. When he was later offered part of the cigarette he refused. Miss Connell went to his room shortly after this when he seemed to be in a bad mood but more relaxed. He asked about the Includem worker who was due to take him to play football later that day and was told that he would be coming to collect him later. She attended Alex's room twice after that and her colleague Mr Kerr attended once. During this time she had no concerns for Alex's safety. On the last occasion she discovered Alex hanging from behind his door. She called for assistance. Mr Kerr attended and cut the lace around Alex's neck. Attempts were made by Mr Kerr to resuscitate Alex while an ambulance was called without success. According to this witness there was nothing which had occurred in the hours or days leading up this which gave her cause for concern that Alex might harm himself. She described an incident on 2 May? when Alex was playing about with the blind cord in the sitting room when he placed this around his neck. He then "played dead" on the floor. She said that she regard this as horseplay and gave her no concern about suicide. Prior to his death Alex appeared to happy, to go and play football with his Includem worker as he had done in the past. She had no recollection of reading about Alex's

previous suicide attempt in the paperwork available and nor had she been involved in any discussion about this. She first found out from Alex a day or so before his death. She described having had a lot of discussions with young people about suicide attempts. It was her position that it would not have made much difference if she had known about the previous suicide attempt as this would not have changed the way she worked with Alex. He was being monitored as closely as they could. She agreed that the type of monitoring would have been different. She gave evidence of Alex having broken a lock on the window in his room on two occasions and that the window had been screwed down. In response to this Alex had set fire to his bin.

Mr Kerr who was also responsible for the care of Alex and others at Kempsthorn described Alex as boisterous and "high" at times. He gave evidence of Alex having damaged the unit. Two days before his death Alex had gathered up newspapers, placed them in a plastic bin and set the bin on fire. He then threw the bin out of the window. Alex wanted to in and out of the window so it was screwed down for his safety. He was not aware that Alex had taken an overdose in September 2005. He did not think that this information was with the paperwork relative to Alex. He said that Alex was closely supervised in the unit because of his smoking habits. He was checked every 15 to 20 minutes. On the day of his death he described Alex as being annoyed with other residents because they would not give him a share of a cigarette. Mr Kerr spoke to the others and they then offered to share but Alex refused. He gave evidence of Miss Connell going upstairs to Alex's room to monitor him and on the last occasion she shouted him when it was discovered that Alex's had hanged himself. He cut the ligature and unsuccessful attempted to resuscitate Alex. Prior to this he had no concerns that Alex was about to commit suicide. Had he been considered a suicide risk while the monitoring period may have been the same it was Mr Kerr's view that the type of monitoring would have been different in that he would have insisted upon going into the room and making some effort to identify his mental state.

Chris Malcolm was a Clinical Specialist with Forensic Child and Adult Mental Health Services (FCAMHS) all Greater Glasgow Health Board. He met Alex at the end of 2005 with Jason Kaushal. He found Alex very difficult to engage and Alex was not keen to see them again. The case was allocated to Joe Gillen in the hope that he would persuade Alex to engage. When Alex was placed in Kempsthorn he was seen at least once a week by Mr Gillen. When Mr Gillen reported having seen scratch marks on Alex's arm it was decided to attempt to involve

Dr Blower a psychiatrist who had joined FCAMHS Team in April 2006. Alex refused to see her. When this witness visited Alex with Mr Gillen in the week before is death Alex was sitting on his window ledge. He was doing this to prevent the window being closed and secured. According to this witness there was no suggestion that Alex was at risk of jumping off nor that this was a suicide attempt. According to this witness it was Mr Gillen's task to assess the risk of Alex's offending in the future. It was not his job to assess mental health or suicide risk or self-harm. Alex was regarded as being at high risk of violent offending in the future. The marks on the arm were the principal reason for Dr Blower becoming involved. It was the evidence of Mr Malcolm that there are no studies on predication of suicide. There are no risk assessment tools that are predicative of this.

Joe Gillen gave evidence that it was his job to complete a structure risk assessment regarding the risk future offending and use of violence by Alex. He described Jason Kaushal as being more concerned with Alex's mental health. After the first few weeks Mr Gillen said that he develop a rapport with Alex. However, this changed when Sean was charged with murder as at that time Alex's offending behaviour escalated. He was referred to the Children's Hearing and a place of safety order made requiring Alex to attend at Kempsthorn. It was Mr Gillen's view that Alex and Sean had a strong relationship with Sean being very supportive. His imprisonment removed that support. Mr Gillen completed his report by 21 March 2006 but this was not the end of his involvement with Alex. While in Kempsthorn he saw no change in Alex's mood or demeanour. His involvement with Alex was estimated at 15 to 20 sessions. In February/March 2006 he saw superficial scoring on inside of Alex's arm. Alex claim to him that he had been scratched by a cat. In relation to the attempted suicide in September 2005 Alex told Mr Gillen that his intention was to get a high from the medication and that he had no intention of hurting himself. Although his family had concerns about Alex according to Mr Gillen none of these concerns related to self-harm or suicide. Mr Gillen reported the suspected self-harm to the Multi-disciplinary FCAMHS Team. Attempts to restart communication with Jason Kaushal were unsuccessful. Dr Blower agreed to become involved and when she attended with Mr Gillen at Kempsthorn on 27 April 2006 Alex refused to speak to either of them. Mr Gillen attended the meeting on 3 May when it was decided that a residential school be sought for Alex. He described Alex as being angry at the decision. Alex never reported to him about having been bullied by anyone while at Kempsthorn. Mr Gillen gave evidence that he did not feel that Alex

was at risk of suicide. Jason Kaushal kept Alex on his case load in the hope that he would engage sometime in the future.

Jason Kaushal received a report from the doctor who treated Alex as a result of his hospitalisation relating to the attempted suicide. He met with Alex and his mother. Alex would not engaged with Mr Kaushal. Mr Kaushal's impression at that time was that there was no obvious major mental health problem. He said that it was clear that when he met Alex, Alex made it clear that he did not want to be there and said so. Mr Kaushal did not regard Alex as actively suicidal nor did he regard him as detainable under Mental Health legislation. As Alex did not want to engage and as there was no overriding mental health problem the file was left open. He did not feel Alex required additional monitoring in view of his reported self-harm and attempted suicide. He did regard Alex as a suicide risk but could not quantify that risk. He regarded Alex statistically as at a greater risk of suicide in the future simply because he had tried it in the past but made it clear that he did not regard him as a major suicide risk. It was his evidence that suicide was unpredictable in any individual case. He had concerns for Alex's future life prospects generally.

Agnes Lamont was the Unit Manager at Kempsthorn. She was aware of Alex's previous suicide attempt. That information, according to her was contained within his chronological history provided roundabout the time of his admission to Kempsthorn. She had no particular concerns about the previous suicide attempt. Alex should have been seen by a LWAC nurse within a week of his arrival at Kempsthorn but this had not taken place. She described Alex as someone who found it very difficult at Kempsthorn at first. According to her he did not want to be there. She described his behaviour as "challenging". His aggression had to be dealt with. She did not see any change in his behaviour during his time at Kempsthorn. She had no concerns that he would take his own life and no other agency expressed such concerns to her. As Alex had set fire to a bin in his bedroom and as there were cigarette burns on his carpet he was regarded as a fire danger to himself and to others. A risk assessment was carried out and he was monitored every 15 minutes when he was in his room. Staff should have read Alex's history which would have disclosed the previous suicide attempt. This witness was also present at the meeting on 3 May 2006 when it was decided that Alex should be transferred to a residential school. Alex did not want to go. He was upset. It was planned that he would go to football that

evening with his Includem Worker. At about 4 o'clock in the afternoon of his death Alex did not seem different in any way. She explained that LWAC nurses are not mental health nurses.

Constable B Morton attended Alex's room on 3 May 2006 as about 4.36 pm. He checked for signs of life and found none.

Dr Blower was a Child and Adolescent Psychiatrist who was asked to meet Alex and carry out a mental state examination. She arranged to meet him at Kempsthorn on 27 April 2006 but he refused to speak with her. She was able to observe him and asked staff about his behaviour. She was informed there was no bazaar or unusual behaviour. She had no concerns that Alex was at immediate risk of committing suicide. She spoke to Jason Kaushal who told her that he did not think there was an immediate risk of suicide. It was her evidence that in assessing risk of suicide disturb mental state and expressed suicidal intent are important. Neither of these was present with Alex. It was her evidence that there was no way of protecting Alex's suicide, nor was there anything to indicate that he had acquired specific monitoring regarding suicide.

In general I regarded the evidence given by all the witnesses as credible and reliable.

Submissions

On behalf of the family, Mr Murphy expressed a number of concerns surrounding Alex's death and his submissions were as follows:- his first admission was that insufficient information was made available to staff at Kempsthorn in that only the Unit Manager was aware that Alex had attempted suicide in the past and no one at the unit was aware that Alex had a history of self-harming. His submission was that a proper monitoring system should have been put in place to check into consideration Alex's previous suicide attempt, his self-harming and what he described as his high level of risk taking behaviour. I was invited by Mr Murphy to determine that communicating to staff at Kempsthorn about the previous attempt to commit suicide by Alex and his self-harming constituted a reasonable precaution which could have been taken to avoid Alex's death. This submission was strongly opposed by Mr Call and Mr Rinaldi, in part, as I understand it, because there was no evidence led at the Inquiry in support of it. A similar joint criticism was made by Mr Call and Mr Rinaldi in relation to most of Mr Murphy's submissions. As far as the evidence is concerned Miss Lamont told the Inquiry that she was aware of a previous suicide attempt. Miss Connell told the Inquiry that Alex told her two days before his death that he had taken his mother's pills but would not discuss the matter further. Mr Kerr said

that he was not aware of any previous suicide attempt. I heard no evidence about the state of knowledge of other staff members with the exception of Ms Lamont according to whom the information was within Alex's records and should have been read by staff members. According to Miss Connell, if she had read of the previous suicide attempt it would have made no difference to her as Alex was being monitored every 15 minutes or so when he was in his bedroom as he was a fire risk due to his conduct when smoking in his room. According to Mr Kerr, had he known he would have monitored in a different way. The timing of 15 to 20 minutes would have been the same but he would have gone in and spoken to Alex to determine is state of mind. Mr Kaushal said that if advising the unit about suicide monitoring he would suggest that someone should always know where the person was and check on him. In a psychiatric unit Mr Kaushal would pop in every 15 minutes. He accepted the possibility that person being monitored might find this intrusive and of course Kempsthorn was not a psychiatric unit. Dr Blower gave evidence that there was nothing to indicate that Alex required special monitoring regarding suicide. It is of concern that at least one of the people responsible for the care of Alex at Kempsthorn was not aware of a suicide attempt approximately 7 or 8 months earlier. It may be that the monitoring was taking place in relation to Alex's smoking habits while in his room may have had more concern for his mental state had all staff members been aware of the prior suicide attempt but, on the evidence led before me I am not able to conclude that had all staff been aware and had a different type of monitoring been put in place Alex's death might have been avoided. There was no evidence that if such a system had been in place his death might have been avoided.

Mr Murphy submitted that there was no system in place at Kempsthorn to assess properly the risk Alex posed to himself and others and that staff were not made fully aware of his background. In considering this submission I had regard to the evidence of Miss Pavese, Miss Connell, Mr Kerr, Mr Malcolm, Mr Gillen, Mr Kaushal, Ms Lamont and Dr Blower from whose combined evidence I concluded that Alex's suicide could not be predicted. On the evidence before me at the Inquiry I am unable to conclude that there was a defect in a system of working which contributed to Alex's death.

Mr Murphy submitted that a more suitable place than Kempsthorn should have been found for Alex. There was not evidence led at the Inquiry in support of this. In particular the

availability and suitability of alternatives did not feature other than secure accommodation which was considered and rejected.

Mr Murphy submitted that it was not clear why another psychiatrist, preferably male could have been instructed prior to Dr Blower's involvement. Even if a male psychiatrist had been so instructed there is no evidence upon which I can conclude that this might have prevented Alex's death.

Mr Murphy made a number of criticisms. It was his submission that the instant with the blind cord seen by Miss Connell and others should have been looked upon more seriously. Miss Connell did not regard this as significant at the time. She described it as a carry on in front of others and saw it as nothing more than horseplay. In my view her interpretation of the event is not unreasonable.

Mr Murphy also suggested that sitting on his window ledge should have been viewed differently. It was the evidence of those who witnessed this incident that Alex was doing nothing more than trying to prevent his window being secured thus preventing him from climbing up and down the drainpipe. There was no suggested at the time even from those who were aware of the prior suicide attempt that this conduct gave cause for concern in relation to suicide. I accepted that evidence.

Mr Murphy criticised the fact that no LAAC nurse visited Alex while at Kempsthorn contrary to normal procedure. I am unable to say that this contributed to his death.

Mr Murphy submitted that no precautions were taken to ensure that Alex's indulging behaviour such as climbing out on to the roof were taken. This is contrary to the evidence which I accepted and which was to the effect that his window was nailed closed precisely to prevent such conduct. It was also his submission that it would have been a reasonable precaution while Alex was in Kempsthorn to put in place "measures of procedures which would cover all eventualities" until a report was carried out by health professionals. On the evidence led at the Inquiry I am unable to sustain that submission as it has no evidential basis.

The procurator fiscal depute, Mr Call and Mr Rinaldi made detailed submissions to me inviting me to make no findings under section 6(1)(c) and (d). As these submissions were to a large extent consistent and as they have been upheld by me I do not propose to rehearse the submissions here.

I would like to express my sympathy and condolences to Alex's family. I hope this Inquiry has assisted them in coming to terms with their tragic loss.