

B1954/14

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

SHERIFF JAMES KENNETH
MITCHELL, Esquire, Advocate
following an Inquiry held at Glasgow
on the TWENTIETH AND TWENTY
FIRST days of OCTOBER TWO
THOUSAND AND FOURTEEN into the
death of **DAVID ROBB THOMSON**,
aged 45 years, who formerly resided at
Flat 2/2, 36 Lora Drive, Glasgow.

GLASGOW, 10 November 2014.

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

(1) In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry
(Scotland) Act 1976, that **DAVID ROBB THOMSON**, born 9 August 1967, who formerly
resided at Flat 2/2, 36 Lora Drive, Glasgow, died at a time not precisely established
between 21.15 hours on Thursday 13 June 2013 and 06.00 hours on Friday 14 June 2013
whilst detained in legal custody as an untried prisoner alone in Cell 1/25, E Hall, H M
Prison Barlinnie, 81 Lee Avenue, Glasgow. Mr Thomson was pronounced dead on
Friday 14 June 2013 at 06.21 hours.

(2) In terms of section 6(1)(b) of the Act that the cause of death was hanging, Mr Thomson having suspended himself from the window fitting of the cell by means of a ligature, namely, a strip torn from his bed sheet, around his neck.

SHERIFF

NOTE:

[1] This Fatal Accident Inquiry was held on 20 and 21 October 2014 in terms of section 1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of David Robb Thomson, who was pronounced dead at 06.21 hours on Friday 14 June 2013 within Cell 1/25, E Hall, H M Prison Barlinnie, Glasgow.

[2] The procurator fiscal was represented by Ms Spiers, procurator fiscal depute. Ms Waugh, advocate, appeared for the National Health Service and Miss Phillips, solicitor, Edinburgh appeared for the Scottish Ministers. There was no other representation at this Inquiry.

[3] The parties' legal representatives were able to agree a substantial amount of evidence, which was encompassed in a joint minute of agreement. I am indebted to Ms Spiers, Ms Waugh and Miss Phillips for the considerable work which they undertook to agree the undisputed evidence in this Inquiry.

Closing submissions of the parties' representatives

[4] In her closing submission, the procurator fiscal depute submitted that only formal findings in terms of section 6(1)(a) and (b) of the 1976 Act were appropriate. She submitted that on the evidence led there were no reasonable precautions whereby the act of hanging or Mr Thomson's death might have been avoided. She submitted that no evidence was led of any defect in any system of working that caused or contributed to the act of hanging or to Mr Thomson's death. She submitted that there were no other facts relevant to the circumstances of his death. She sought that the court made no findings in terms of paragraphs (c), (d) or (e). The procurator fiscal depute's submissions were adopted by Ms Waugh and Miss Phillips. Miss Phillips added a brief submission dealing with an apparent failure to process the requests made to have Mr Thomson placed on protection from the time of his arrival at H M Prison Barlinnie, Glasgow. I shall return to this submission later at paragraph [57].

Joint Minute and evidence led

[5] As appears from the joint minute, Mr Thomson appeared at Glasgow Sheriff Court on 24 May 2013 on a petition containing charges of a contravention of section 49(1) of the Criminal Law (Consolidation) (Scotland) Act 1995 and theft by shoplifting. He made no plea or declaration before the sheriff and was committed to HM Prison Barlinnie pending further examination. On 31 May 2013, he again appeared in Glasgow Sheriff Court when the sheriff granted warrant to detain him in the prison until liberated in due course of law on the section 49(1) charge. At this Inquiry, Mr Thomson's solicitor advocate, Mr Gerard Sweeney, Glasgow stated in evidence that on 31 May 2013 Mr

Thomson instructed him not to apply for bail. Mr Thomson remained in custody at HM Prison Barlinnie until his death.

24 May 2013

[6] In his evidence, Mr Sweeney stated that he had been Mr Thomson's legal representative for the better part of 10 years and had represented him on a number of occasions. He explained that he knew Mr Thomson's difficulties, his involvement with alcohol and drug abuse and his mental health difficulties. Mr Sweeney stated that when he saw Mr Thomson in the cell area within Glasgow Sheriff Court on 24 May 2013 he was "considerably concerned" because Mr Thomson was "presenting differently". Mr Sweeney stated that he felt that there was "something far wrong". Mr Thomson asked to be placed on protection. Mr Sweeney stated that he went to the custody suite within Glasgow Sheriff Court, where the current custodial contractor operates, and made application for Mr Thomson to be placed on protection. Mr Sweeney stated that it was normal procedure to make such a request in the custody suite.

[7] After Mr Thomson appeared before the sheriff on 24 May 2013, he passed through the custody suite and was taken to HM Prison Barlinnie, Glasgow. He was not placed on protection when he was first admitted to the prison.

[8] Mr Sweeney's evidence was that on 24 May 2013, Mr Thomson presented in a "a very paranoid way". He was "fearful of being in custody". He spoke of his fear that persons in the Govan area were looking for him because it was thought that he might have been involved in the death of a young lady whom he knew. Mr Sweeney stated that, at that time, Mr Thomson "thought his life was under threat". Mr Sweeney considered that self-harm was the issue.

The period prior to 24 May 2013

[9] It is appropriate to consider what the available evidence discloses as regards how Mr Thomson came to be in the condition he was when seen by Mr Sweeney. Dr Balbir Singh Chita, a general medical practitioner with some 25 years of experience gave evidence. He confirmed that on 19 December 2012 Mr Thomson had registered as a patient at his practice, namely, the Ibroxholm Medical Centre. Dr Chita thought that the initial registration was probably carried out by the practice nurse. He referred to a note dated 19 December 2012, which stated that Mr Thomson had recently been at the Southern General Hospital as he had put his arm through a window. The note records that “in hospital Mr Thomson suffered from alcohol withdrawal”. The note also records that:

“His cousin is arranging for him to go to Addictions Centre. (He) would also like a referral to Mental Health Services, says he has been hearing voices since coming out of hospital. (He) signed himself out of hospital.”

[10] On 19 December 2012 at the Ibroxholm Medical Centre Mr Thomson gave a history that he had been drinking heavily since he was 12 years of age. He had been hearing voices and could not sleep since he had stopped drinking. The note records:

“Hearing voices ‘that’s David Thomson. Going to kill you’. ‘He is going to get killed’. Thinks able to see shadows in hallways etc. Voices in head when walking past people. That’s David Thomson we’re going to kill him.

Behavioural problems as child. Refusing school attendance. Afraid all time. Not suicidal. Voices to not instruct any actions. Hads score”.

Dr Chita explained that Mr Thomson’s Hads score was very high. He was referred for urgent assessment to Brand Street Resource Centre. On 20 December 2012 this referral

request was faxed from the practice. In the referral letter it is noted that Mr Thomson had described hearing auditory hallucinations after giving up drinking approximately a month previously.

[11] On 7 January 2013 Mr Thomson was admitted to Brand Street Resource Centre, Govan, Glasgow. He remained there until 25 January 2013. Dr Chita spoke to the terms of the discharge summary, which comprised a letter dated 6 February 2013 sent to the Ibroxholm Medical Centre (Crown production 4 at pages 390/2). It was noted that Mr Thomson's mother had died some six months previously and that he admitted to having been drinking heavily thereafter. He had a longstanding history of several years of hearing voices. That tended to be of a male telling him to hurt people. He also believed that people on buses talked about him as he got on. In the day of his assessment he admitted he felt worried that people were out to harm him in some way and that this had resulted in him smashing windows in his house. He described hearing ongoing auditory hallucinations telling him that he would be killed. He described his mood as anxious but denied having any suicidal thoughts or plans. He stated that he had lost about five stone in weight since the death of his mother.

[12] Mr Thomson had been admitted to the Brand Street Resource Centre for monitoring of his mental state and an alcohol detox. It was considered that his presentation was in keeping with alcoholic hallucinosis. He found the initial part of the detox process quite difficult and had some breakthrough withdrawal symptoms. His regime had to be adjusted and then Mr Thomson had no further problems. At page 391 the letter records "He settled well into the ward and interacted with both his fellow peers and staff. He continued his detox, his voices did appear to settle". When he was discharged he was given medication, namely, zopiclone, a sleeping pill.

[13] On 4 February 2013 Mr Thomson was seen at the Ibroxholm Medical Centre by Dr Chita when he was prescribed the medication recommended by the Branch Street Resource Centre. Mr Thomson did not return for further consultation. I accepted the unchallenged evidence given by Dr Chita, who presented as a careful and competent medical practitioner.

[14] On 2 April 2013 Mr Thomson had been admitted to HM Prison Barlinnie. Nicole Morrison, a mental health nurse at HM Prison Barlinnie confirmed this when referred to Crown production number 4, which comprised the prison health care records relating to Mr Thomson. It is recorded that Mr Thomson admitted to alcohol dependence and misuse of drugs. It is recorded that he had no thoughts of deliberate self-harm or suicide. On 2 April 2013 he was seen by mental health nurse Ms S Welsh (non-witness). Mr Thomson denied any thoughts or plans of suicide or self-harm. He confirmed his history of drug and alcohol abuse. He stated that he had had an alcohol related seizure the day before. He felt paranoid and heard voices. On 4 April 2013, Mr Thomson attended at a case conference and appeared brighter. He again denied any thoughts of suicide or self-harm and stated that he would inform staff if his mood changed. He was kept on low risk regime within the D Hall. There is no note in the prison health care records of when Mr Thomson was released from prison. Nurse Morrison confirmed that health care staff were not told when prisoners were discharged or transferred.

[15] There was no evidence before this Inquiry as to when Mr Thomson was released from prison. There was no evidence before this Inquiry regarding where Mr Thomson was or how he was fairing during the period between 4 April 2013 and 24 May 2013. As noted above, Mr Thomson's presentation on 24 May 2013 caused Mr Sweeney

considerable concern. It is now necessary to have regard to the evidence led in relation to the period from 24 May 2013 until Mr Thomson's death.

The period from 24 May 2013 until 31 May 2013

[16] On 24 May 2013, at about 1830 hours, Mr Thomson arrived at HM Prison Barlinnie. It is noted on the ACT 2 Care Reception Risk Assessment document that a personal escort record was received. Iain Templeton, a prison officer with nine years' service, stated that on 24 May 2013 he was working in the reception area within the prison. Before he saw Mr Thomson the proper procedure was completed. He checked the PER form received from the private security contractor responsible for the transfer of prisoners from the court to the prison. He noted that no concerns had been raised. Mr Templeton then interviewed Mr Thomson and assessed him as he asked the questions contained in section 2 of the form. Mr Templeton had only a vague recollection of this meeting. He had noted that Mr Thomson "states he feels suicidal and may harm himself". In the light of this, and his own observations, Mr Templeton considered that Mr Thomson was "at risk" and ticked the appropriate box. The effect of this decision was that Mr Thomson was placed on a level of support appropriate to the "at risk" assessment. This involved observations every 15 minutes, 24 hours a day and Mr Thomson being permitted only to wear anti-ligature clothing. Mr Templeton also noted that the underlying issues leading up to him feeling suicidal were several close family bereavements and also a hate campaign on social networking. Mr Templeton was clear that Mr Thomson did not want to go into the mainstream prison population.

[17] Practitioner nurse Mrs Mary Quarshie stated in evidence that she saw Mr Thomson and completed her ACT 2 Care assessment at 19.50 hours on the same date.

She stated that she went through the form (contained in Crown production 4 at page 31) with Mr Thomson. She asked him the questions on the form and noted his responses. Amongst other things, he told her that he was schizophrenic and was hearing voices. He said that he had a history of psychiatric disorder: see page 41. Mrs Quarshie noted that she “couldn’t tell whether he was suicidal or not but told reception officers of his suicidal ideation. She placed him on “at risk”.

[18] Mr Thomson remained on the “at risk” regime of checks every 15 minutes throughout the day and night and anti-ligature clothing only.

[19] On 24 May 2013, at 18.38 hours prison manager Stephen Doherty, then the residential manager in A Hall, was involved in agreeing an immediate care plan for Mr Thomson. Mr Thomson was admitted into A Hall at approximately 19.15 hours. He was told how the care plan worked. At that stage, Mr Thomson requested protection. Overnight, it was considered that Mr Thomson was settled but when he awoke he expressed his fears of being attacked by other prisoners.

[20] A case conference was convened on 25 May 2013 within A Hall at 9.20 am. Mr Thomson attended, as did Mr Doherty. Another nurse and prison officer, both non-witnesses, also attended. At that meeting Mr Thomson denied any thoughts or intentions of suicide or self-harm. It was decided to reduce him to low risk category which meant that his daytime regime would be the normal hall routine but that he would have to be observed every 60 minutes. In answer to me, Mr Doherty stated that everyone including Mr Thomson agreed that he should come off high risk and at risk. The effect of this was that there was no restriction on the clothing he would wear. Mr Doherty was unable to remember whether Mr Thomson asked for protection. He stated that such request was

“not that important to the case conference *per se*”. He also explained that it was not always possible for all the relevant documentation to be seen before the case conference.

[21] Dr Kahoda Buksh saw Mr Thomson on 25 May 2013 and concluded his assessment at 10.42: see Crown production 4 at page 53. Chronologically, this meeting came after the case management conference. Dr Buksh was an experienced general medical practitioner with over 40 years’ experience. Without any of the paperwork, Dr Buksh saw Mr Thomson in A Hall. The assessment was part of the statutory admission procedure. Dr Buksh’s noted, at page 53, that Mr Thomson told him that he was feeling “okay”. Mr Thomson denied feeling suicidal or inclined to self-harm. Dr Buksh stated that Mr Thomson was quite sober. There was nothing in his presentation that caused Dr Buksh concern. Dr Buksh noted that Mr Thomson had been commenced on alcohol detoxification. Dr Buksh stated that because Mr Thomson had a history of mental illness he required to be seen by the mental health team without Dr Buksh having to make a referral. Dr Buksh impressed as a competent and careful medical practitioner of experience. I had no difficulty in accepting his unchallenged evidence as credible and reliable.

[22] Mr Thomson was detained in C Hall. On 28 May 2013 he attended at a case conference, which was also attended by practitioner nurse Quarshie. The manager of C Hall was also present. It was determined that Mr Thomson should remain assessed at “low risk”. As indicated above, he had commenced alcohol detoxification. He was assessed as being “still moody and rattling”. Accordingly, remained subject to hourly investigations but was allowed to wear normal clothing and remain in a normal cell.

[23] On 30 May 2013, Mr Thomson’s position was reviewed at a further case conference again attended by the floor manager, practitioner nurse Quarshie and Mr

Thomson. The note of the conference states that Mr Thomson “looks moody, low mood, shabby looking, awaiting to go to court”. The decision taken was to retain him on the regime appropriate to his current low level of risk.

[24] On 31 May 2013, Mr Thomson returned to Glasgow Sheriff Court, where he had a further consultation with Mr Sweeney. Mr Sweeney advised that Mr Thomson instructed him not to apply for bail. Mr Thomson still wanted to be placed on protection. Mr Sweeney followed up this instruction and the same day both faxed and wrote to the prison making that request: Crown production 5, page 242. As at 31 May 2013, Mr Sweeney was still very concerned about how Mr Thomson was presenting. Mr Sweeney did not have face to face contact with Mr Thomson after 31 May 2013.

[25] Prison officer Alistair Coyle gave evidence that whilst acting as first line manager in E Hall he received a telephone call from the manager of C Hall regarding a prisoner who had been receiving threats from unnamed prisoners. This call related to Mr Thomson. On 31 May 2013 Mr Coyle saw Mr Thomson in the Manager’s Office in E Hall and found him to be “hunched over” and “unshaven”. He was considered to be a meek and vulnerable individual who would easily be a target for bullying and that it would be beneficial for him to remain on protection within E Hall. Mr Thomson said to Mr Coyle that he had been stealing from people in the community and felt that because of these crimes he had been threatened by several prisoners in C Hall. He also stated that he was threatened at his home, prior to being remanded, by the same individuals. Mr Coyle stated that Mr Sweeney’s letter had been received and he was aware of it when he made the decision to place Mr Thomson on protection within E Hall. Thereafter, Mr Thomson remained on protection within E Hall until his death.

The period after 31 May 2013

[26] On 3 June 2013, at 07.55 hours, a further case conference was held at which Mr Thomson attended. He was still subject to an ACT 2 Care plan and was being managed on the basis of being at “low risk”. Mr Coyle recalled that at this meeting Mr Thomson presented in a completely different way from that in which he had on 31 May 2013. Mr Thomson’s mood appeared to be “a lot better”. He had been effectively managed as “low risk” and no issues had come to light. He presented as clean shaven. He had showered and was wearing clean clothing. He participated in the meeting and denied any thoughts of suicide or self-harm. He was noted to be “conversing freely”. It was noted that “feeling settled now that he is in E Hall states he would speak to staff if struggling”. Mr Coyle stated that he was not worried about Mr Thomson at that time and that it was agreed he was now at “no apparent risk”.

[27] Accordingly, on 3 June 2013 the regime of “low risk” whereby Mr Thomson was checked every hour was discontinued.

[28] It was a matter of admission that on 9 June 2013, Prison Officer Paul Matthews (non-witness) conversed with Mr Thomson to enquire after his welfare as Mr Thomson was failing to leave his cell and interact with other persons in E Hall. Mr Thomson said that he was concerned about “the government putting him in jail and that the government intended him harm”. Mr Matthews offered reassurance and made several enquiries as to whether Mr Thomson had suicidal thoughts. It is admitted that “Mr Thomson was very reassuring in confirming that he had no such thoughts”. Mr Matthews told Mr Thomson not to hesitate to seek further assistance. Mr Matthews was concerned about Mr Thomson’s demeanour and made a referral to the mental health nurse.

[29] Ms Nicole Morrison, aged 40 years, who has been a mental health nurse since 1996 and has over 10 years' experience working in HM Prison Barlinnie, gave evidence. Ms Morrison is an employee of Greater Glasgow and Clyde NHS. She is not employed by the Scottish Prison Service. She works as part of the mental health team at the prison. She was referred to an entry dated 12 June 2013 in the prison health records at Crown production 4, page 18. She was able to confirm that the note had been made by her but was unable to recollect this consultation with Mr Thomson. She confirmed that she saw Mr Thomson following a referral from a Hall Officer. She had recorded that Mr Thomson was due at court on 24 June 2013. She recorded that he was settled throughout the interview:

"No signs of distress or distraction, orientated to t/p/p, had to think before answering but no problems noted. Denied (sic) all thoughts suicide or self-harm and gave no cause for concern during the interview. states no problems being located in E Hall, appetite and sleep all normal, occasionally attends exercise and rec. long standing alcohol problems in community, will refer on to alcohol liaison team. No further input from mental health team required"

[30] Ms Morrison stated that if she had had concerns that there was a risk of self-harm, she would have placed Mr Thomson back on ACT 2 Care. This was an easy thing to do. If she had concluded that psychiatric referral was necessary then she would have referred Mr Thomson to that and he would have been seen within a couple of days. She had noted no such concerns.

[31] Alan Gilmour, an experienced prison officer, aged 48 years with 27 years' service stated in evidence that insofar as he was able to recollect Mr Thomson, he regarded him as "a very nervous character". Mr Gilmour stated that on Tuesday, 11 June 2013, Mr Paul Matthews (non-witness) was working on early shift and he was on back shift. As part of

the handover between them, there was information sharing relevant to the welfare of the prisoners. Mr Matthews spoke with him regarding Mr Thomson, who Mr Matthews had referred to the mental health team. Mr Gilmour learned that Mr Thomson had come out for lunch on Tuesday but on Wednesday never appeared for any meals. There was a further conversation between Mr Matthews and Mr Gilmour and it was decided that a meal would be put in to Mr Thomson's cell at lunchtime on Thursday (13 June 2013) if he did not appear. Mr Gilmour was aware that Mr Thomson had taken a meal in and had eaten it. He was also aware that Mr Thomson had become a bit dishevelled and had not been showering. His cell was a bit untidy.

[32] On 13 June 2013, Mr Gilmour entered Mr Thomson's cell to give him a legal letter. This is depicted in Crown production number 8, photograph 6. It is stated to be "Legal correspondence" and, I note, bears the same telephone numbers as on Crown production 5, page 242, namely G Sweeney, Solicitors Limited. The content of that correspondence was not disclosed at this Inquiry. Mr Gilmour was able to advise that the correspondence was not an indictment containing any charge: it was privileged mail.

[33] Mr Gilmour stated that he took the opportunity to engage Mr Thomson in conversation because he was not coming out of his cell, was a bit dishevelled and had not washed. Mr Thomson told Mr Gilmour that other prisoners were out to get him and that "the government had put prisoners in the establishment to take him out". He told Mr Gilmour that he had had a conversation with Mr Matthews to the same effect. Mr Gilmour stated that he tried to reassure Mr Thomson that the government had not put prisoners in the establishment to take him out. He offered him a shower, which Mr Thomson declined. Mr Gilmour stated that throughout the conversation Mr Thomson

continued to keep good eye contact with him. Mr Gilmour assessed that Mr Thomson was not at risk of self-harm or suicide.

[34] Mr Gilmour stated that he personally had put an evening meal into Mr Thomson's cell. Mr Gilmour stated that Mr Thomson had been happy to take the meal and had consumed all of it. At that stage he was talkative. Mr Gilmour stated that he had no cause for concern that he was going to harm himself. He had concerns that Mr Thomson may be paranoid.

[35] Mr Gilmour stated that Mr Thomson preferred to spend most of his time in his own cell. In his experience, this was not unusual for prisoners on protection because some of the other prisoners on protection were sex offenders and some prisoners were reluctant to mix with sex offenders, preferring to remain in their own cell. Mr Gilmour confirmed that if he had serious concerns regarding Mr Thomson he would have initiated ACT 2 Care.

[36] Ms Evelyn Watters, a 43 year old prison officer, with over eight years' experience, is an operations officer. On 13/14 June 2013 she was on nightshift in E Hall. She did not know Mr Thomson personally. She was sure that she had never had any information about him at handover. Once she commenced her duties on the evening of Thursday 13 June 2013, Ms Watters had to check upon the welfare of each prisoner in the hall. This she started to do about 9.15 pm and she did so by looking through the glass in the cell door. She checked the cell door of every prisoner, including Mr Thomson. She had no concerns about him. Ms Watters was satisfied that each prisoner in his cell had responded to her, including Mr Thomson. There was a bell within Mr Thomson's cell, which, if he needed to do so, he could have used to attract attention at any time whilst he was confined there.

[37] The next morning, just after 6.00 am, Ms Watters' duty required her to carry out a further check upon the welfare of each prisoner in the hall. This involved her going round each of the cells, putting the light on in the cell and obtaining a response from the prisoner(s) inside. Ms Watters stated that, before commencing the cell check, she required to use the lavatory which was situated in the vicinity of Cell 1/25, where Mr Thomson was detained.

[38] Once she had used the lavatory, Ms Watters decided to commence the cell check at Mr Thomson's cell instead of where she would normally have done. At this point in her evidence, Ms Watters became very distressed. She explained that when she looked through the viewing glass on the cell door, she saw Mr Thomson hanging. She said that he was under the window. She looked again. At that time she was alone. She tried to use her radio to summon assistance but her radio did not work.

[39] She had to go her desk some minutes' walk away to summon assistance. She did so as quickly as she could and summoned urgent assistance. There was a very quick response from other officers. A first line manager gave permission for the seal pack to be opened. This meant that access to the cell could be gained.

[40] It is admitted that at approximately 06.00 hours on 14 June 2013, prison officer Alan Kilpatrick was on duty within the segregation unit at the prison when he was alerted to a "Code Blue" within E Hall. He attended immediately at Cell 1/25 in E Hall where he saw Mr Thomson, with a ligature made from a bed sheet around his neck, hanging from the window fitting. Mr Kilpatrick entered the cell, cut the ligature thereby releasing Mr Thomson's body. At all material times, Mr Thomson was the only prisoner detained in Cell 1/25.

[41] At approximately 0600 hours on 14 June 2013, practitioner nurse Sherine Lawson was on duty within the Health Centre at HM Prison Barlinnie, when she received a “Code Blue” from E Hall. Sherine Lawson attended immediately at Cell 1/25. On examination she found Mr Thomson to be cold to the touch with fixed and dilated pupils. Sherine Lawson commenced and continued chest compressions on Mr Thomson until the arrival of an ambulance crew.

[42] On 14 June 2013, at about 06.15 hours, Peter Smith, ambulance technician and Lindsay McCall, paramedic attended at Cell 1/25, E Hall, Barlinnie, to examine Mr Thomson. They found no signs of life and Lindsay McCall pronounced Mr Thomson’s life extinct at 06.21 hours

[43] At approximately 07.15 hours on 14 June 2013, police constables Naveed Hussain and Lesley Rhymer attended at Cell 1/25, E Hall, H M Prison Barlinnie and seized a handwritten note, which forms Crown production 7.

[44] At approximately 10.00 hours on 14 June 2013, Andrew Kirkaldie, Scene Examiner, Easterhouse Police Office attended at Cell 1/25, E Hall, HM Prison Barlinnie and took photographs of Mr Thomson’s cell showing:-

Photograph 1 – view of cell door
Photographs 2-3 – general views of Mr Thomson
Photograph 4 – view of a section bed sheet knotted to the window bars
Photographs 5-6 – views of paperwork on a table
Photograph 7 – view of a bag to the left of Mr Thomson
Photograph 8 – general view of Mr Thomson
Photograph 9 – facial view of Mr Thomson
Photograph 10 – view of ligature around Mr Thomson’s neck
Photographs 11-12 – views of the bed sheet
Photographs 13-15 – general views of items on a worktop
Photographs 16-19 – views of medication blister packs on a worktop
Photograph 20 – view of medication on a shelf
Photograph 21 – view of plastic bags on a shelf
Photograph 22 – view of the sink area within the cell

These photographs form Crown production 8 and are true and accurate reproductions of what they depict.

[45] At approximately 11.00 hours on 14 June 2013, Dr Simon Osbourne, police casualty surgeon attended at Cell 1/25, E Block, HM Prison Barlinnie, where he examined the body of the Mr Thomson. On examination, Dr Osbourne found a ligature around Mr Thomson's neck but no other trauma evident. His report forms Crown production 6.

[46] On 21 June 2013 a post mortem examination was carried out on the body of Mr Thomson at the Southern General Hospital, Glasgow by Dr Julie McAdam, Forensic Pathologist. The post mortem report forms Crown production 2. The cause of Mr Thomson's death was ascertained to be:-

1a Hanging

[47] Samples of blood and urine collected at post mortem were analysed for alcohol, acidic and basic drugs, benzodiazepines, paracetamol and drugs of abuse by Hazel Torrance, Forensic Toxicologist at the University of Glasgow. Analysis revealed low concentrations of Chlordiazepoxide and Desmethyldiazepam. The Toxicology Report forms Crown production 3.

[48] Intimation of the death of Mr Thomson was provided to the procurator fiscal at Glasgow by the Registrar of Deaths for Glasgow on 21 June 2013. The Intimation forms Crown production 1.

[49] On 10 July 2013, a self-inflicted death in custody audit, analysis and review was carried out by the Scottish Prison Service. No issues were identified that would have prevented the death of Mr Thomson.

Discussion and Determination

[50] I have considered all the undisputed evidence put before me. In my judgment, it is established that Mr Thomson deliberately tore his bed sheet and suspended himself from the window fitting of the cell. In my judgment, it is established that the cause of Mr Thomson's death was hanging whilst he was alone in his cell, he having suspended himself from the window fitting of the cell by means of a ligature, namely, a strip torn from his bed sheet around his neck. As he was alone in his cell, there is no question of involvement by anyone else. The post mortem report records that when found Mr Thomson "appeared to be dead but was cut down and resuscitation attempted. Paramedics arrived but were of the opinion that he had been dead for some time". The precise time of Mr Thomson's death is not established.

[51] All of the witnesses who interviewed Mr Thomson during the time he was on remand in HM Prison Barlinnie after 24 May 2013 were trained in the ACT 2 Care assessment process, the key aims of which are "to assume a shared responsibility for the care of those 'at risk' of self-harm or suicide; to work together to provide a person centred caring environment based on individual assessed need where prisoners who are in distress can ask for help to avert a crisis; and to identify and offer assistance in advance, during and after a crisis.": Crown production 4 at page 20.

[52] Each of the witnesses spoke to being aware that prisoners sometimes gave "clues" that they were worried and that sometimes there were "cues" in their personal histories which could lead to the view that they were especially vulnerable. The witnesses all confirmed that they were trained to look for signs and symptoms during the assessment process and had done so when interviewing Mr Thomson.

[53] Mrs Quarshie impressed me as an honest witness doing her very best to recollect the matters about which she was asked. I accept her unchallenged evidence. Mr Coyle was an experienced prison officer with 16 years' service. He impressed me as a caring and concerned man. Along with the others present at the meeting on 3 June 2013, including a practice nurse and Mr Thomson, Mr Coyle formed the view that it was no longer necessary to maintain Mr Thomson on hourly checks as his presentation and assertions were to the effect that he now felt settled and presented no apparent risk of self-harm or suicide. I considered Mr Coyle to be an impressive witness, who gave evidence clearly and in an open and straightforward manner. I accept his unchallenged evidence. Ms Morrison gave evidence in an open and straightforward way. Her evidence was not challenged in any respect. She impressed as a caring, concerned and conscientious mental health nurse. I accept her evidence as being credible and reliable. I am satisfied that if she had had any concerns regarding Mr Thomson she would have taken appropriate action to place him back on the ACT 2 Care regime. Mr Gilmour was an experienced officer. He gave evidence in an open and straightforward way. He impressed me as a concerned and conscientious officer who discharged his welfare responsibilities towards Mr Thomson in an entirely proper and compassionate manner. I was satisfied that had he had concerns that Mr Thomson might harm himself in any way, he would have taken steps to initiate the ACT 2 Care regime. Ms Watters' evidence was unchallenged and clearly given. I accept her account as credible and reliable. I accept the undisputed evidence of each of the witnesses who were adduced at this Inquiry as being credible and reliable.

[54] In my judgment, Mr Thomson's death was sudden and unexpected. He had given no indication to anyone to arouse any reasonable suspicion that he was at risk of

self-harm or suicide. Mr Thomson was seen by Ms Morrison, an experienced member of the mental health team on 12 June 2013 and had a lengthy conversation with Mr Gilmour, an experienced prison officer on 13 June 2013. Neither of these witnesses considered that Mr Thomson was at risk of self-harm or suicide. He gave no cause for concern when Ms Watters checked upon the prisoners in E Hall about 9.15 pm on Thursday 13 June 2013.

[55] Within Mr Thomson's cell a note was found which stated "Please contactt Sheen Isawood Kinning Park, Plantasin SQ Glasgow" (sic). It was agreed that she was Mr Thomson's aunt. In my judgment, it is not established as probable that Mr Thomson suspended himself with suicidal intention. I accept that it is possible that he did so. It is established that he knew he was going to court on 24 June 2013 but the content of the letter from his lawyer is not known. On the evidence led, it is not open to this court to conclude that Mr Thomson could not face another sentence of the court. It would be improper speculation to do so. There is no evidence before this Inquiry that he intended to plead guilty to the charge, in respect of which he enjoyed the presumption of innocence. The evidence led does not establish that Mr Thomson was suffering from any mental illness at the time of his death. It does not establish that he was paranoid.

Although some of the things Mr Thomson said appeared bizarre to those who heard them, neither Ms Morrison nor Dr Buksh were concerned that he was likely to self-harm or attempt suicide. That was also the view of Mr Gilmour. That view is entirely consistent and fits with the decision taken on 3 June 2013 that Mr Thomson was at no apparent risk of self-harm or suicide. The available evidence is not sufficient to justify a finding of suicide. It is possible that Mr Thomson did not intend to kill himself but, whilst in low mood perhaps in the hope that his lot might improve, suspended himself to draw attention to his situation, but events went sadly wrong.

[56] For these reasons, in my judgment, the procurator fiscal depute was correct to seek only formal findings. I agree that there is no evidence of any reasonable precaution which might have been taken to avoid the death or any defects in any system of working which caused or contributed to Mr Thomson's death. There are no other facts which are relevant to the circumstances of the death.

[57] In her closing submission, Miss Phillips raised the matter of Mr Thomson not being placed on protection before 31 May 2013. She accepted that Mr Thomson had not been placed on protection between 24 and 30 May 2013. She submitted that there was no evidence that these five days without protection contributed in any way to his death. During that time, Mr Thomson was still subject to ACT 2 Care procedures and was checked every hour on a 24 hour per day basis. When he was transferred to E Hall he was placed on protection.

[58] I accept the evidence given by Mr Sweeney as credible and reliable. He is an experienced solicitor advocate, who was clearly concerned regarding the welfare of his client Mr Thomson. It is a matter of concern that the request which Mr Sweeney made on 24 May 2013 to the staff employed by the private security contractor in the custody suite at Glasgow Sheriff Court was not conveyed to the prison. I accept as credible and reliable the undisputed evidence of prison officer Iain Templeton to the effect that when he checked Mr Thomson's PER on 24 May 2013, no comments had been raised. This is confirmed by sight of the form: Crown production 4, page 30.

[59] Mr Templeton gave evidence that Mr Thomson requested protection and did not want to go into the mainstream prison population. At Crown production 4, page 37 in the night report, there is a further note of Mr Thomson requesting protection. It appears that this note was counter signed by the manager. Although I do not consider it relevant

to the circumstances of Mr Thomson's subsequent death, nevertheless, it goes too far to hold that the failure to consider his requests had no effect upon him. It is of concern that none of these requests for protection was considered, particularly having regard to Mr Coyle's evidence about how Mr Thomson presented on 31 May 2013. I hope that early consideration will be given in the appropriate quarters to the operation of the present systems in place (1) for conveying requests to the appropriate prison for prisoners to be placed on protection in prison made by solicitors to the staff of the private security contractor in the custody suite at this court; and (2) for arranging consideration of requests made in the prison by prisoners to be placed on protection, in order that these requests might be considered and determined without delay.

[60] Although it commenced more than a year after Mr Thomson's death, I hope that this Inquiry and its determination has served some purpose and may assist in bringing closure to all those who are affected by the manner and circumstances of Mr Thomson's death. On behalf of the court, I again extend my sympathy and condolences to his family, friends and to all those who cared about him.