SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2018] FAI 7

ED 2B 669/17

DETERMINATION

BY

SHERIFF T WELSH QC

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

ANTHONY McMAHON

At Edinburgh 7 March 2018; The sheriff having resumed consideration of the cause determines that in terms of section 6(1) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976:-

(a) Anthony McMahon (date of birth 16 February 1970) died within Cell 205, Level 2 of Glenesk Hall South, HMP Edinburgh, at between 9.07am and 12.10pm on 6 August 2016. His death was not accidental. He committed suicide.

(b) The cause of his death was external compression of the neck caused by hanging.

(c) There are no reasonable precautions I can suggest whereby his death might have been avoided;

(d) There are no observations I have to make about the system of working within Glenesk Hall South, HMP Edinburgh arising from the evidence or relevant to the death of Anthony McMahon;

(e) See para [16] below for other facts relevant to the circumstances of the death.

Note

[1] Ms K Rollo, Procurator Fiscal Depute, represented the Crown. Mr Hammond, Solicitor, represented the family of the deceased. Ms McCartney, Solicitor, represented the Scottish Prison Service. Mr Gillies, Solicitor, represented the Scottish Prison Officers Association. Mr Holmes, Solicitor, represented the NHS.

[2] The deceased, Anthony McMahon, was found dead in his cell on the morning of 6 August 2016. He had clearly taken his own life and hanged himself with his own belt. At that time he was housed in Glenesk South Hall which is a remand hall of the prison.

[3] An Inquiry of this nature does not determine any question of civil or criminal fault or liability. In *Black* v *Scott Lithgow Ltd* 1990 SLT 612, Lord President Hope at page 615 explained the purpose behind holding an Inquiry:-

> "The function of a sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the sub section refers, insofar as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required".

[4] Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") sets out the strictly limited statutory scope of the Inquiry and provides:

> "(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall 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 might have been avoided;
(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
(e) any other facts which are relevant to the circumstances of the death."

[5] I heard evidence from the following witnesses:

I. Michael McMahon, brother of the deceased.

II. Sally Anne Collis, Consultant Forensic Pathologist.

III. Kevin Clydesdale, Prison Officer.

IV. Gavin Murray Prison Officer.

V. Steven Robertson, Prison Officer.

VI. Leslie McDowall, Suicide Prevention Manager SPS.

VII. Caroline Johnston, Governor HMP Edinburgh.

VIII. Anthony Martin, Deputy Governor, HMP Edinburgh.

I also had access to the prison records relating to the management of Mr McMahon as a suicide risk in terms of the ACT 2 Care strategy. Parties agreed a Joint Minute of evidence.

The Evidence

[6] Michael McMahon gave evidence detailing the early family life of his brother Anthony who later in life lost his way and became a difficult and unpredictable person

at times. He got into trouble with the police and associated with the wrong kind of people. He was, however, a much loved family member. I was given a letter from his mother detailing the family's thoughts and concerns.

[7] The evidence disclosed that on 11 July 2016, Anthony McMahon appeared before Edinburgh Sheriff Court on a summary complaint libelling 2 charges under section 39(1) of the Criminal Justice and Licensing (Scotland) Act 2010. He was remanded in custody in Glenesk South Hall, HMP Edinburgh, pending trial on 11 August 2016. He had a 7 year history of bipolar disorder and on admission to the prison was prescribed Quetiapine, an antipsychotic drug, to treat his bipolar disorder. On 28 July 2016, after confessing to suicidal thoughts arising from depression caused by feelings of having let his family down again by being returned to custody, Mr McMahon, following assessment, was accommodated in a high risk anti-ligature cell on 15 minute observations in another hall of the prison until his transfer back to Glenesk South Hall on 4 August 2016 as a low suicide risk. His general management as a suicide risk was in accordance with the then Scottish Prison Service policy called "ACT 2 Care". In terms of that policy he was regularly assessed at a case conference. By 4 August, Mr McMahon was assessed a low suicide risk and transferred out of the high risk anti-ligature cell and accommodated, alone, in a double occupancy cell in Glenesk South Hall but subject to 60 minute observations by prison staff under the ACT 2 Care scheme. As a low risk inmate the deceased had access to his personal belongings and clothing including his leather belt. Mr McMahon was familiar with ACT 2 Care and known to the prison staff. He had been under the care of the ACT 2 Care regime before.

[8] On the morning of his death Mr McMahon was locked in his cell after breakfast, at 09.07, by Prison Officer Kevin Clydesdale. Mr Clydesdale then took over desk duties while two other two prison officers, Steven Robertson and Gavin Murray, took prisoners out for exercise in the prison yard for approximately one hour, during which time no observations were made on the deceased by Mr Clydesdale or the other officers on duty. It was a Saturday morning and prisoners were not taken to court that day. I heard evidence from Deputy Governor Tony Martin who visited the hall that morning on an inspection. In his opinion, which I accepted, there was adequate staffing to manage the number of prisoners within the regime that morning. There was one other prisoner on ACT 2 Care and there had been some incident during the night which involved the threat of a "dirty protest". Neither of these matters gave him cause for concern that the staff was overburdened and could not cope. In fact, on a Saturday, the regime was more relaxed than weekdays when prisoners have to be transported to court. I was informed by the prison officers who gave evidence that the system of working was that the officers when they came on shift were jointly responsible for making suicide observations. The task was not specifically assigned to a particular officer. An informal system of mutual trust operated. It broke down on this occasion. Each officer thought the others had made the observations.

[9] After morning exercise the evidence disclosed that the three officers in charge, PO Clydesdale, PO Robertson and PO Murray, were in the office, having locked all prisoners away until around 10.25. There was no suggestion in the evidence that the officers were struggling to cope with the workload or their duties in terms of the regime

which included making at least hourly checks on Mr McMahon. At approximately 11.00, Kevin Clydesdale was observed by Deputy Governor Tony Martin, walking back from the hall kitchen with food for himself, outwith his allocated tea-break time. At approximately 11.33, Prison Officer Steven Robertson discovered the deceased hanging by his belt from the top bunk in his cell. An emergency alarm was sounded. Prison staff attended immediately and administered first aid. Mr McMahon was pronounced dead at the scene by paramedic Kevin Brown at 12.10 on 6 August 2016. The police were called. Dr Sally Anne Collis, a forensic pathologist who gave evidence was unable to give any guidance as to the precise timing of death. She stated that death could have occurred any time after Mr McMahon was last seen alive at 09.07. She stated loss of consciousness would have been rapid and within seconds of constriction of the neck. She stated that death would have occurred following loss of consciousness and probably in a few minutes, although she could not be certain about this. Pieces of torn fabric were found in the cell by the police during a search, which may have indicated an intention to create a ligature.

[10] After the death an internal investigation and disciplinary process was initiated. The then Governor of the prison, Caroline Johnston, gave evidence that she viewed CCTV footage of the hall for the relevant period that morning and was able to identify three opportunities for observations on Mr McMahon, by the prison staff in charge, which were not taken. She found that certain officers failed in their duty to make minimum 60 minute observations in terms of the ACT 2 Care policy. Disciplinary action was taken against those officers considered to be in breach of their duty of care.

The SPS's Suicide Risk Management Strategy: ACT 2 Care

[11] The relevant policy guidance is contained in the SPS strategy document called ACT 2 Care. This has now been reviewed and updated. ACT 2 Care was introduced by the SPS in 2005, with a version of the strategy having been in place since 1998. ACT stands for Assessment Context Teamwork. This suicide prevention strategy has simple stated aims: "[t]o assure 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. To identify and offer assistance in advance, during and after a crisis."

[12] All prisoners entering, or re-entering, the prison go through a Reception Risk Assessment process. Prisoners are seen by a prison officer and a nurse immediately upon admission and by a doctor within 24 hours of admission. A series of questions is asked of the prisoner, the answers to which, together with the presentation of the prisoner, allow the assessor to mark the prisoner as being "at risk" or as being of "no apparent risk". If any of the three assessors marks the prisoner as being "at risk", an ACT document/booklet is raised immediately. Within 24 hours of being placed on ACT, a case conference is convened at which the prisoner together with a prison officer familiar with the prisoner and a member of healthcare staff are present. The case conference will decide how to continue to safeguard the prisoner. The case conference might decide to maintain the safeguards at the same level as when the ACT document was raised, to alter the safeguards, or to remove the prisoner from ACT altogether.

Isolation is always the last resort. Mr McMahon had been remanded for 17 days before he confessed to suicidal thoughts. At that stage he came under the protection of ACT 2 Care which is intended to create a person centred caring environment. I heard evidence from Lesley McDowall the SPS suicide prevention strategy manager who "owns" and manages the operation of the policy that the regime provides for different levels of observations depending upon level of risk. When assessed as high risk Anthony McMahon was subject to 15 minute observations for his own protection according to his ACT 2 Care records. However, as Ms McDowall explained, 60 minute observations is not a target, it is a minimum. The policy which all prison officers are trained in is intended to be interactive and not passive. The intention is that the officer engages with the vulnerable prisoner and tries through "clues and cues" to form an impression about the state of mind of the prisoner to assess if there is any change in mood which might give rise to change in assessment of risk and need further protective action. To that extent she was clear that any system which incorporated a tick box form that officers filled in would not, in her opinion, adequately deliver the objective of the policy. She mentioned a practice called "dead pegging" where officers on exterior perimeter patrols are expected to turn a key in a box or post to indicate they have covered that location on patrol. She stated Act 2 Care was more interactive and essential to the policy was the personal engagement by the prison officer with the vulnerable prisoner to assess his mood and state of mind. The ACT 2 Care policy is now, after review, restated as "TALK 2 me" which has the same objective. It was suggested to Ms McDowall that a form or tick box component to the policy would help officers remember to engage with their

duty of care to carry out periodic observations on vulnerable prisoners. She disputed this and thought, on the contrary, it would undermine one of the primary objectives of the policy and lead to a potentially dangerous mechanistic non-interactive result. The Governor of the prison rejected this idea for the same reasons. I accepted the evidence of Lesley McDowall and the Governor on this issue.

[13] The officers in charge of Mr McMahon's care were well aware he was subject to the anti-suicide regime and at risk. They knew that Mr McMahon was subject to observations. The ACT 2 Care booklet was held at the administration desk in the hall and available to them when they came on shift to familiarise themselves with the background to Mr McMahon's inclusion in Act 2 Care and for them to read all of the notes concerning his management, care plan and the observations made by the case managers and other officers about his mood and level of vulnerability to date. In addition a large whiteboard detailing the names of those on ACT 2 Care and the frequency of observations is prominently on display at the administration desk (positioned in such a way that only officers and not prisoners can see the details).

[14] From the evidence before me it is clear that ACT 2 Care and its successor TALK 2 Me, are sensible, humane and necessary policies. I do not consider it is appropriate for me in the course of a Fatal Accident Inquiry to make recommendations as to how the policy can or ought to be amended or improved.

Reasonable precautions and system of working, sections 6(1)(c) and (d) of the Act

[15] Representations were made by Ms Rollo for the Crown and Mr Gillies for the

SPOA that I should recommend that a system of working should be introduced to include a form which could act as a prompt to prison officers who have the responsibility to make observations on vulnerable prisoners at risk. Lesley McDowall gave evidence that such a proposal had been discussed during the review of ACT 2 Care. The idea was rejected because she said it would lead to a "tick box" approach/mentality to assessment of risk. She also gave evidence that a comprehensive process already existed with regard to policy development and change. If a suggestion is made by management or SPOA to change a prison policy it is considered first by a local prison level committee and then if endorsed and supported there it is advanced and considered at a national level committee. If the suggestion is considered sound the policy may be changed after widespread consultation and investigation if that is considered necessary. What was put to me in submissions was that a form would act as a reminder to the officers in charge of the need to make the observations in terms of ACT 2 Care. Ms McCartney for the SPS described this idea as a "red herring'. She said the officers were well aware of their responsibilities that morning. I have carefully considered this suggestion to make a recommendation along these lines but have come to the conclusion that the appropriate forum for the development of policy and practice in this regard is within the SPS. Accordingly, I have no recommendation of this sort considered either as reasonable precautions or to address what are suggested to be defects to the system of working to make under this section of the Act.

Other relevant factors sections 6(1)(e) of the Act

[16] There were two matters raised by the family which I shall mention. Firstly, in the

letter addressed to me amplified by Mr Hammond in his submission I was asked to question the wisdom of allowing Anthony McMahon access to his belt when he returned to Glenesk South Hall on 4 August 2016 as a low risk prisoner. Ms McCartney in her submission invited me to accept the evidence of the prison Governor and Lesley McDowall that part of the general prison regime is to make life in prison as normal as it can be, standing the obvious limitations and as part of that normalising process prisoners are allowed access to their own belongings. Mr McMahon even although he was assessed as a low risk prisoner had his belt returned to him which he used to take his own life. I was told during submissions that the Police take belts and shoe laces from all prisoners in custody for obvious reasons. I note also that in Anthony McMahon's cell, after a police search the day he died, were found pieces of knotted fabric which are shown in Production number 2 for the family. The professionals who assessed Mr McMahon as high risk denied him all clothing except anti-ligature clothing. When he was returned to Glenesk South Hall he was in terms of his care regime allowed clothing "as per Glenesk regime". Tony Martin indicated that even if prisoners were not allowed a belt they could borrow or obtain access to potential ligatures from other prisoners in the looser regime which operates in remand conditions in Glenesk South Hall. Be that as it may, I consider it, conscious as I am of the benefit of hindsight, unwise to allow any prisoner who is assessed as a suicide risk access to a belt. Such access is a fact relevant to this death which SPS may wish to consider.

[17] The second issue the family raised was the wisdom of keeping Anthony McMahon housed alone in his cell. The ACT 2 Care records disclose that Anthony

seemed to enjoy having a cell to himself in Glenesk South Hall but the family's concern was that the company of another prisoner may have prevented him taking the action he did. I have given careful consideration to this issue. On reflection, I have come to the view that those best placed to make decisions of this nature are the care management team and the prison authorities. The prison authorities have a duty of care to all prisoners including vulnerable prisoners and serious and delicate issues arise about the wisdom and possible consequences of housing potential suicide risks with other prisoners which I was not addressed on by Ms McCartney or Ms Rollo. I do not consider I am in a position to include any finding or make any conclusion on this matter in this determination.

[18] In conclusion I would like to express my thanks to the lawyers who presented the evidence to me. I also repeat to the family of Anthony McMahon, who attended with dignity in support of their son and brother, my profound condolences.