SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2018] FAI 17

B2903/17

DETERMINATION

BY

SHERIFF LINDSAY WOOD

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

ANDREW LORNE MACDOUGALL

GLASGOW, 16 February 2018

The Sheriff, having considered the information presented at the Inquiry determines in terms of Section 26 of the said Act that:

(1) Andrew Lorne MacDougall, born 4 August 1967 and residing latterly at Her Majesty's Prison, Barlinnie, 51 Lee Avenue, Glasgow died there at 12.05 pm on 2 July 2017.

(2) In terms of section 26(2)(a), death occurred at Her Majesty's Prison, Barlinnie when Mr MacDougall was in custody.

(3) In terms of section 26(2)(c) the cause of death was:

1a Hanging

(4) No findings were sought or are made in respect of section 26(2)(b), (d), (e), (f) and (g).

NOTE:

Introduction

[1] This is a Fatal Accident Inquiry in terms of section 2(4)(a) of the 2016 Act as Mr MacDougall was in legal custody at the time of his death.

[2] Mr MacDougall's death was reported to the Crown Office and Procurator Fiscal Service on 3 July 2017.

[3] A preliminary hearing was held on 25 January 2018.

[4] The representatives of the participants were Ms McRobert, Procurator Fiscal Depute for the Crown; Ms Anne-Marie Chalmers, Solicitor for the Scottish Prison Service; Ms Betheny Ross, Solicitor for the Prison Officers Association Scotland; Ms Eleanor Paton, Solicitor for NHS Greater Glasgow and Clyde and Mr Simon Collins, Solicitor for Karen McLeod, sister of Mr MacDougall.

[5] No witnesses were called and the facts relating to the circumstances of death were presented to the Inquiry in a joint minute agreed by all parties.

Legal framework

[6] A Fatal Accident Inquiry was held under section 1 of the 2016 Act.

[7] The Inquiry is governed by the Fatal Accident Inquiry Rules 2017.

[8] In terms of section 1(3) of the 2016 Act, the purpose of an Inquiry is to:

(a) establish the circumstances of the death, and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[9] The matters to be covered in the Determination under section 26 are when and where the death occurred and the cause or causes of the death.

[10] The Crown in the public interest was represented by the Procurator Fiscal Depute. A Fatal Accident Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Summary

[11] The following facts summarise the evidence before the Inquiry:

1 On 8 June 2017 at Stornoway Sheriff Court, Andrew Lorne MacDougall, date of birth 4 August 1967, (hereinafter referred to as "the deceased"), appeared from custody charged with a contravention of section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. He pled not guilty and was remanded in custody. An intermediate diet was fixed for 20 June 2017 and a trial was fixed for 18 July 2017, both at Lochmaddy Sheriff Court. The deceased was remanded in custody to HMP Inverness or any other lawful establishment.

2 At an intermediate diet on 20 June 2017 at Lochmaddy Sheriff Court, the deceased pled guilty to said charge. Sentence was deferred until 18 July 2017 for preparation of a Psychiatric Report, a Criminal Justice Social Work Report and a Drug Assessment. The deceased was remanded in custody to HMP Inverness or any other lawful establishment.

3 From 8 June 2017 until date of his death on 2 July 2017 the deceased was incarcerated at HMP Barlinnie (hereinafter referred to as "Barlinnie" or "the prison"). He was accordingly in legal custody as at the date of his death.

4 The deceased was placed in cell 52 (a single occupant cell) within C Hall, HMP Barlinnie during his period of remand.

5 Throughout his time on remand there had been no issues with the deceased.

6 As at 1 July 2017, lockdown in C Hall was between 4.30 pm and 8.30 am. Hall C consists of 162 cells which hold a capacity of 320 prisoners. There are three levels each with 54 cells.

7 The deceased was within cell 52 which is on the top level on the right hand side of the hall as you enter the main reception point. This is a double occupancy cell however the deceased was the sole occupant.

Events of 1-2 July 2017

8 At approximately 4.40 pm on Saturday 1 July 2017 Prison Officer Ally Tait checked on the deceased within cell 52 prior to lockdown and closed his cell door. All was in order at this time.

9 At approximately 8.25 am on Sunday, 2 July 2017, Joseph Cairns, Prison Officer, attended at the deceased's cell. He observed the deceased alone, hanging within the cell by a shoelace used as a ligature secured around his neck and secured to the metal window grille. He thereafter contacted two prison officers, namely John Stokes and James McArthur to assist him.

10 Mr McArthur and Mr Cairns held the deceased whilst Mr Stokes cut the ligature and they placed the deceased on the floor.

11 The emergency services were contacted and uniformed police officers attended. The police casualty surgeon Dr Bruce Henderson attended and life was pronounced extinct at 12.05 pm on 2 July 2017.

12 Detective Sergeant Clark and Detective Constable Lawrie attended the prison along with Scenes of Crime Officer Colin Powell.

13 The deceased was observed lying on his back on the floor of cell 52, he was wearing blue striped boxers and black socks and there was a ligature around his neck. Near to his body was a pair of red jogging bottoms and a pair of black Nike trainers which had their laces removed.

14 There was a part of the ligature tied to the metal window grille (where it had been cut). To the left hand side of the cell was the toilet, a sink, a TV unit with a TV and on the TV unit was a hand written note which read: "So sorry to take the easy way out but I'm not well regards everyone." It was signed *A McDougall*. Said note was seized by DC Lawrie.

15 General view photographs were taken by Scenes of Crimes Officer Colin Powell along with photos of the deceased in situ.

Medication

16 The deceased was prescribed the following medication at the time of his death: Lactulose Syrup 3.1-3.7 g/5ml – 10-30 ml at night (used to treat constipation)

Mirtazapine 30mg – at night (antidepressant used to treat major depressive disorder)

Alginte Raft-forming Oral Suspension – one 5ml as required (for heartburn)

Fluphenazine Decanoate Injection 25mg/1 ml ampoule – 2 x 25mg to be injected every two weeks (used to treat symptoms of schizophrenia)

Ventiollin Accuhaler 200 micrograms – one puff every four hours as required (for Chronic Obstructive Pulmonary Disease)

Serevent Accuhaler 50 micrograms – one puff twice daily (for Chronic Obstructive Pulmonary Disease)

Omephrazole 20mg – daily (to treat excess stomach acid)

Lisinopriol 10mg – daily (to treat high blood pressure)

Simvastatin 40mg – to be taken at night (to lower cholesterol)

Medical Treatment

17 The deceased was assessed by Consultant Forensic Psychiatrist Dr Alistair Hay on 3 April 2017 whilst he was on remand at HMP Porterfield in respect of another matter.

18 On assessment, Dr Hay noted that the deceased was a very pleasant individual who engaged well and remained relaxed throughout the interview. There was no evidence of underlying disturbance of mood and no signs of any underlying major depressive disorder. He was not suicidal. His thought processes were rational, structured and well organised. He did not appear perplexed, preoccupied or distracted. Dr Hay was satisfied that the deceased should remain on his prescribed medication with no change to his management plan. The

content of this assessment was provided to the prison service by letter from Dr Hay and is contained in his prison healthcare notes.

19 Upon admission to Barlinnie on 8 June 2017, the deceased was assessed in terms of Talk to Me – Prevention of Suicide in Prison Strategy by Helen Frew. He was assessed as "no apparent risk". It was noted that he had "decent mood, good eye contact, spoke well". He denied feeling suicidal.

20 Following that initial assessment, he was thereafter assessed by a healthcare professional. It was noted that he had previously been on ACT twice. He was "diagnosed alcohol induced psychosis. Numerous admissions to IPCU over last 12 years. Currently on depot injection. Prev self harm attempt 2005 – nil since. No thoughts of self-harm or suicide at this time". It was further noted that the deceased was "conversing well. Good eye contact maintained. Feels mood well currently. Denies any thoughts of self harm or suicide at this time." He was again assessed as "no apparent risk".

21 On 9 June 2017 the deceased participated in the prison induction scheme. He advised Prison Officer Sneddon that he had no thoughts of suicide or self-harm. It was noted that he had long standing mental health issues due to alcohol abuse therefore a Mental Health Team (MHT) referral was submitted.

22 On 9 June 2017 the deceased completed a form stating that he had no thoughts of self-harm or suicide.

23 Following the referral to the MHT, the MHT contacted the deceased's General Practitioner and confirmed that the deceased was known to Mental Health

services. They confirmed his depot medication and it was administered that day on 9 June 2017.

24 A mental health assessment was carried out with the deceased on 13 June 2017. He was noted as mentally well with no psychotic symptomatology. He reported he was coping well with prison and his appetite and sleep was good. He was clean and well kempt. He was pleasant and conversed freely. He denied any thoughts of suicide or self-harm. He was participating in hall activities and stated he had been mentally well for some time. He declined a referral to the alcohol support service as he was not expecting a sentence. His management plan was to continue with his fortnightly depot injection and the MHT would monitor his mental state. He agreed to comply with his medication and alert staff should his mood deteriorate.

25 On 19 June 2017 the MHT discussed the deceased at the MDMHT meeting. Hall staff reported he was quiet and polite with no issues or concerns being raised.

Telephone calls

26 Crown Label number 2 are recordings of the telephone calls made by the deceased to his family and friends whilst he was in HMP Barlinnie. He made no mention of any suicidal thoughts or any deterioration of his mental health. He appeared to be making plans for the future and his release from custody.

Post Mortem

27 A post mortem examination was carried out on 11 July 2017 at the Queen Elizabeth University Hospital by Consultant Forensic Pathologist, Dr Marjorie Turner and the cause of death was recorded as:

1a Hanging

Submissions and conclusions

[12] The procurator fiscal depute invited the court to make a formal determination in respect of Mr MacDougall's death which submission was adopted by all parties. Having considered the terms of the joint minute and the productions, I am satisfied that such a formal determination is appropriate in the circumstances of Mr MacDougall's death. He had hung himself in his prison cell and there were no indications beforehand that he intended to take his own life. Accordingly, nothing could have been done to save his life and he was treated, cared for and handled appropriately throughout his time in Barlinnie.

[13] I wish to commend Ms McRobert, the Procurator Fiscal Depute and all of the other solicitors for their helpful and professional contributions to this Inquiry. I am particularly grateful to Mr Simon Collins for the way he looked after the interests of the family and was able to satisfy them that there were no indicators of concern which might have led to preventative action being taken. This in turn led to an agreed position, witnesses not having to attend to give evidence and a considerably shortened Inquiry hearing.

[14] I wish to record my sincere condolences to Mr MacDougall's sister, Karen McLeod for her sad loss.