SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

Ref: EDI-B403-18

DETERMINATION

BY

SHERIFF ROBERT DM FIFE

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

into the death of

MAXWELL TAYLOR

Edinburgh, 20 August 2018

The Sheriff, having considered the evidence, the productions, the terms of the joint minute of agreement and submissions presented at an Inquiry under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016,

Finds and Determines:

(1) in terms of section 26(2)(a) that Maxwell Taylor born on 16 March 1983 died in Her Majesty's Prison Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN on 16 February 2018, life being formerly pronounced extinct at 07:41 hours on that date; and

(2) in terms of section 26(2)(c) that the cause of death was hanging.

Note

Introduction

[1] On 8 August 2018 an Inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act") was held at Edinburgh

Sheriff Court into the death of Maxwell Taylor. The circumstances of the death had previously been investigated by the procurator fiscal who presented evidence to the court in the public interest.

[2] Mr Crosby, procurator fiscal depute, appeared for the Crown, Mr Fairweather represented the Scottish Prison Service ("SPS"), Ms Ross represented the Scottish Prison Officers Association and Mr Holmes represented NHS Lothian Health Board.

[3] The family were not represented at the Inquiry. Mr and Mrs Taylor, the parents, attended the Inquiry.

The legal framework

[4] The Inquiry was held under section 1 of the 2016 Act. The purpose of the Inquiry was to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. This was a mandatory Inquiry in terms of section 2(1) and (4) of the 2016 Act as Mr Taylor was in legal custody at the time of his death.

Circumstances

[5] At the time of his death Maxwell Taylor born 16 March 1983 ("the deceased") was a prisoner on remand in Her Majesty's Prison Edinburgh, 33 Stenhouse Road, Edinburgh.

[6] On 8 January 2016 the deceased appeared at Edinburgh Sheriff Court on a criminal petition on a charge of having an article with a blade or point in a public place without reasonable excuse when he was fully committed for trial and remanded in custody.

[7] The deceased was the sole occupant of cell 142, Glenesk Hall in HMP Edinburgh ("cell 142"). On the evening of Monday 15 February 2016 the deceased left cell 142 at 20:21 to speak to another prisoner at cell 132 in Glenesk Hall and then returned to cell 142. The door to cell 142 was secured for the night by staff at 20:34. At approximately 20:45 cell 142 was checked again. There were no concerns as to the deceased's wellbeing at that time.

[8] On the following morning Tuesday 16 February 2016 prison officers Campbell Salmond and Francis Stafford started their shift at 07:00 in Glenesk Hall. At 07:20 officers Salmond and Stafford were doing the morning check. On reaching cell 142 they found the deceased sitting on the floor in the cell. There was a ligature from his throat leading up to the top bunk. Officer Stafford put out an emergency "Code Blue" call and other officers attended. The ligature was removed. Nurse Jocelyn Higgins went to the treatment room nearby and retrieved a defibrillator, a bag containing resuscitation medications and general first aid equipment. CPR was carried out but there was no sign of recovery at all. Paramedics arrived, carried out an assessment and confirmed the deceased was dead. Paramedics pronounced life extinct at cell 142 at 07:41 on 16 February 2016.

[9] Officers from Police Scotland attended and carried out investigations. The circumstances of the deceased's death gave no cause for suspicion or concern.

[10] On 24 February 2016 a post-mortem examination was carried out at the City of Edinburgh Mortuary by Dr Ainsworth, consultant forensic pathologist. The medical cause of death was certified as: 1a Hanging. There were no signs of any specific natural disease. Toxicology was negative for all substances screened for.

[11] As at 16 February 2016 the SPS operated a Suicide Prevention Strategy known as Act 2 Care which was in place until December 2016. The current Suicide Prevention Strategy is known as Talk 2 Me. Act 2 Care represented a multi-disciplinary approach which involved putting together an appropriate care plan to keep a person considered to be at risk of suicide safe.

Evidence

[12] The court heard evidence from one witness, Allen Beatson, a practitioner nurse who worked at HMP Edinburgh. The evidence was otherwise presented to the Inquiry by a joint minute of agreement.

[13] Mr Beatson was a practitioner nurse at HMP Edinburgh. He had been a registered nurse for 41 years. He had worked at HMP Edinburgh for nearly 13 years. Mr Beatson described the admissions procedure for any new admission to HMP Edinburgh including the Act 2 Care reception risk assessment. The deceased Max (as he was known to Mr Beatson) was well known to Mr Beatson as recorded in his witness statement:

> "I had met Max before on numerous occasions because he had been in the prison on numerous occasions in the past. I had a reasonable relationship with him".

[14] Mr Beatson carried out the admission assessment with the deceased at the last period of incarceration starting 2 January 2016. Mr Beatson described the deceased as presenting bright and chatty at the time and that for the deceased it was one of his better days. Mr Beatson had no concerns about his welfare or mental state. Mr Beatson had recorded "Appears Settled". Mr Beatson recalled seeing Max on a regular basis during that last period of incarceration. Mr Beatson saw Max

socialising in the hall. Mr Beatson had no concerns about his welfare from his admission and prior to 16 February 2016.

Independent review

[15] An independent review of the psychiatric care given to the deceased prior to his death was carried out by Dr Duncan Alcock, a consultant forensic psychiatrist based at The State Hospital at Carstairs. Dr Alcock had access to the various records including the deceased's SPS medical records, Act 2 Care records and general practitioner ("GP") notes. Dr Alcock's report is dated 23 August 2017.

[16] In the opinion of Dr Alcock, in relation to the last period of incarceration, all relevant admission procedures were followed including completion of the Act 2 Care documentation. Dr Alcock recorded that since the deceased's death SPS had replaced Act 2 Care with the Talk to Me strategy. That had no impact on Dr Alcock's opinion. The deceased had several episodes of contact in the days preceding his death with members of the health team at HMP Edinburgh. There was no documented evidence of any concerns. Further, no concerns were raised by prison hall officers between the date of admission and the time of death. The deceased had been in prison on numerous previous occasions before January 2016. It was likely the deceased would have been known to a substantial number of prison officer staff. There were multiple previous occasions when concerns of self-harm or parasuicidal activities by the deceased had been brought to the attention of the health care team by prison hall officers. If there had been any concerns about the deceased in January and February 2016 it is likely prison hall officers would have acted on any concerns.

[17] The GP notes recorded various accounts over the years of the deceased self-harming and attempting suicide. The SPS notes recorded the frequent use of Act 2 Care in the deceased's management during various periods when he was in prison. The deceased had regular contact over the years with mental health nursing staff and visiting prison psychiatrists. On 26 October 2015 during contact with Dr Claire McLean, a clinical psychologist with NHS Lothian, the deceased had then described that he had suicidal thoughts on a daily basis and that he had a longstanding plan at the back of his mind. The deceased refused to discuss this further with Dr McLean. The deceased told Dr McLean that if his thoughts were to increase he would not talk to anyone as he did not want to be on Act 2 Care or be in a high risk cell.

[18] On a consideration of the SPS records Dr Alcock was of the opinion that over the years while in prison the deceased had been managed on multiple separate occasions through the Act 2 Care process and that the deceased appeared to have developed a good understanding of the Act 2 Care process.

[19] Because of his knowledge of the deceased's medical history including multiple previous attempts at self-harm and suicide, following the deceased's admission in January 2016 Mr Beatson made the mental health team within HMP Edinburgh aware that the deceased was again admitted to prison in January 2016 but that at the date of admission there were no issues.

[20] Subsequent to admission the deceased was seen regularly by members of the health team including 8 January 2016, 12, 13 and 15 February 2016. On none of these occasions was there any comment about the deceased's mental health.

[21] Commenting upon whether anything could have been done in order to prevent the death Dr Alcock concluded that all relevant processes aimed at reducing

the risk of self-harm and suicide were appropriately followed at the time of the deceased's last admission to prison. During previous periods of incarceration the deceased had had extensive assessment within a secure inpatient psychiatric facility and the end conclusion of that assessment was that the deceased did not suffer from an active mental illness and that the personality disorders from which he suffered were not amenable to inpatient treatment. Despite this the deceased was offered extensive treatments provided through the mental health team including extensive psychological work. Unfortunately the deceased declined to fully engage in that work. In the opinion of Dr Alcock he did not feel that anything different could have been done in order to prevent the death.

Mr and Mrs Taylor

[22] Mr and Mrs Taylor contributed to the Inquiry. They both agreed the deceased had had his "demons". They considered no one was to blame for the death. The deceased had always been in and out of prison. They recognised everything had been put in place by the authorities to deal with concerns of prisoners. Mr and Mrs Taylor were pleased that care procedures had been changed since the death, formerly Act 2 Care and now Talk 2 Me. Mrs Taylor in particular believed the only way out for the deceased was suicide and that he might now be at peace. Mrs Taylor believed the deceased may have planned his suicide for some time and that ultimately no one could prevent a person from committing suicide if they were determined to commit suicide.

Submissions

[23] The procurator fiscal invited the court to make formal findings in terms of section 26(2)(a) and (c) of the 2016 Act. No other submissions were made by the procurator fiscal. These submissions were adopted by all the representatives in court. In all the circumstances, having reviewed the evidence, the joint minute of agreement, the supporting productions and considered the submissions, I am satisfied formal findings should be made in this case.

[24] Finally, I expressed my thanks to Mr and Mrs Taylor for attending the Inquiry and their contribution which was greatly appreciated. Condolences were expressed to Mr and Mrs Taylor and the family by all the representatives and by me on behalf of the court.