SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2020] FAI 36

LIV-B197-20

DETERMINATION

BY

SUMMARY SHERIFF JOHN A MACRITCHIE SSC

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

into the death of

MICHAEL REID

Livingston, 21 October 2020

DETERMINATION

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 that:-

(1) In terms of section 26(2)(a) of the Act, Michael Reid, born on 2 November 1981 (aged 34), died at Her Majesty's Prison Addiewell, on 19 October 2016, at or about 18:39.

(2) In terms of section 26(2)(b) of the Act, no accident had occurred.

(3) In terms of section 26(2)(c) of the Act, the cause of death was hanging.

(4) In terms of section 26(2)(d) of the Act, no accident had occurred.

(5) In terms of section 26(2)(e) of the Act, there were no precautions which could reasonably have been taken, which might realistically have resulted in the death being avoided.

(6) In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death.

(7) In terms of section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

RECOMMENDATIONS

(1) In terms of section 26(1)(b) of the Act, I do not consider it appropriate to make any recommendations as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, or (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] The inquiry was held under the said Act into the death of Michael Reid.

[2] On 20 October 2016, the death was reported to the Crown Office and Procurator Fiscal Service.

[3] On 29 September and 21 October 2020, respectively, a preliminary hearing and hearing were held.

[4] The representatives of the participants of the inquiry were (1) Rebecca Swansey, Procurator Fiscal Depute for the Crown, (2) Liam Smith, Solicitor for the Scottish Prison Service, (3) Stuart Holmes, Solicitor for NHS Lothian and (4) Stephanie Canda, Solicitor for Sodexo.

[5] A joint minute of agreement and the productions referred to therein, constituted the entire evidence before the inquiry.

The legal framework

[6] An inquiry was held under section 1 of the said Act.

[7] The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[8] The purpose of the inquiry was 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 which require to be covered in this determination under section 26 of the Act in relation to the death to which the inquiry relates, are my findings as to:

(1) (a) when and where the death occurred, (b) when and where any accident resulting in the death occurred, (c) the cause or causes of the death, (d) the cause or causes of any accident resulting in the death, (e) any precautions which - (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided, (f) any defects in any system of working which contributed to the death or any accident resulting in the death, and (g) any other facts which are relevant to the circumstances of the death; and

(2) such recommendations (if any), as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

[10] This determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

[11] The procurator fiscal represents the public interest, an inquiry is an inquisitional process and it is not the purpose of an inquiry to establish civil or criminal liability.

Summary

[12] On 13 May 2013, Mr Reid was remanded in custody for the offence of assault and robbery.

[13] Between 13 and 18 June 2013, Mr Reid had initially cut his wrists and arm and was immediately thereafter placed on an Act 2 Care plan. His mental health then appeared to improve and latterly he was assessed as no longer posing an immediate risk to himself.

[14] On 27 August 2013, Mr Reid was sentenced to 83 days imprisonment in respect of an unexpired sentence for contravening Section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010 and a consecutive 6 years and 3 months imprisonment for said assault and robbery.

[15] Between 30 September and 4 October 2013, Mr Reid initially "smashed up" his cell and explained that such was a choice he had made, as opposed to hanging himself. He was immediately thereafter again placed on an Act 2 Care plan, during which he initially refused sustenance. However, his mental health again then appeared to improve and latterly he was assessed as no longer posing an immediate risk to himself.

[16] Between 17 and 26 November 2013, Mr Reid was initially found unconscious within his cell with a sheet attached to the door, tied around his neck. He had however managed to press a buzzer to alert staff. Mr Reid was again immediately thereafter placed on an Act 2 Care plan, during which he expressed suicidal ideations. However, his mental health then again appeared to improve and latterly he was assessed as no longer posing an immediate risk to himself.

[17] From 5 December 2013 until 6 February 2014, Mr Reid had been prescribed the anti-depressant Fluoxetine.

[18] Between 5 and 17 February 2014, Mr Reid initially again expressed to prison staff suicidal ideations, was again immediately thereafter placed on an Act 2 Care plan, but his mental health then again appeared to improve and latterly he was assessed as no longer posing an immediate risk to himself.

[19] From 1 April 2014 until 22 June 2014, having been seen by a psychiatrist, Mr Reid was prescribed the anti-depressant Citalopram and until 1 July 2014, the anti-psychotic Quetiapine.

[20] Between 8 and 13 September 2014, Mr Reid had initially been keeping himself locked up, again expressing suicidal ideations and refusing sustenance. He was again immediately thereafter placed on an Act 2 Care plan. However, his mental health then again appeared to improve and latterly he was assessed as no longer posing an immediate risk to himself.

[21] From 20 November 2014 he was prescribed the anti-depressant Mirtazapine.

[22] On or about 15 February 2015, Mr Reid chose to cease to take the prescribed medication Mirtazapine. His mental health however remained stable and he did not appear to require any further contact with mental health services.

[23] Since on or about 18 February 2015, Mr Reid has had no contact with mental health services and from this point his mental health appeared stable.

[24] On the 24 December 2015, Mr Reid chose to stop receiving family visits as, he stated, he wanted his family to get on with their own lives.

[25] Between 27 July 2015 and 27 September 2016, Mr Reid saw the prison healthcare team for physical ailments only.

[26] On 17 May 2016, Mr Reid indicated that he did not wish his case to be considered by the Parole Board for Scotland, despite being eligible for parole on 21 November 2016, with an otherwise earliest date of liberation of 21 December 2017.

[27] In July 2016, Mr Reid then chose to stop telephone contact with his family.

[28] On 2 August 2016, a Review Board recommended that Social Work and Psychology personnel should undertake 2:1 work with Mr Reid, to try and motivate him to take part in a programme of offending behaviour work, designed to reduce Mr Reid's risk of serious violence to others.

[29] Between 15 August 2016 and 20 September 2016, Mr Reid took part in four such sessions with Social Worker Anne Baxter and Forensic Clinical Psychologist Dr Ewan Lundie. Dr Lundie noted that Mr Reid's mental health was stable and his presentation and comments during these sessions, did not raise any concerns about his mental health or indicate a risk of suicide. During these 2:1 sessions Mr Reid advised he was finding the prospect of being released from custody daunting. Mr Reid was reassured that the social work department would attempt to make this transition as smooth as possible.

[30] On 19 October 2016, PCO Joanna Raczka contacted Anne Baxter to advise that Mr Reid did not want to attend his appointment on the following day. Mr Reid gave no reason for wanting to cancel this appointment. Anne Baxter discussed this cancellation with her Social Work Team Manager, who agreed that social work would not approach

Mr Reid at that time, as it was felt that he may have needed some space and time to consider how to proceed. Anne Baxter noted this was not unusual for Mr Reid, as he had previously cancelled appointments with healthcare.

[31] Of even date, at approximately 15:20 hours, Mr Reid returned from his passman job in the Selkirk Unit and claimed to PCO Raczka "that's me sacked from Selkirk".

[32] At approximately 15:30 hours, Mr Reid asked to be locked up until the morning. This was not unusual for Mr Reid, who stated on this occasion, that he needed time behind his cell door to calm down. Staff within HMP Addiewell were aware that Mr Reid sometimes requested "timeout", to calm down. He would usually always tell staff when he needed this time and he used this as a way of coping.

[33] On further investigation, it was found that there were no issues regarding Mr Reid working in the Selkirk Unit as a passman and that he had not in fact been "sacked" from his job. PCO's Steven Little, Elton Prince and Ian McGee were with Mr Reid during his shift on the Selkirk Unit and at no point did they feel Mr Reid was acting out of character. Mr Reid was described as being in good spirits during his passman shift.

[34] At approximately 15:50 hours PCO Robbie Pennie opened Mr Reid's cell door to see if he wanted to exercise. Mr Reid was asleep on his bed at that time with the lights off. At approximately 17:00 hours PCO Pennie was carrying out a numbers check, when he opened Mr Reid's cell door and saw that Mr Reid was still asleep.

[35] At approximately 18:10 hours unlock time was commenced, PCO Raczka was carrying out this duty and when she got to Mr Reid's cell, she decided to double check

whether Mr Reid wanted to stay locked until the morning. Upon opening Mr Reid's cell, PCO Raczka observed Mr Reid hanging from a tied piece of bedding from the toilet door.

[36] At 18:13 hours, PCO Raczka alerted staff members that Mr Reid was not breathing. First responders immediately attended at Mr Reid's cell and commenced CPR while an ambulance was called. At 18:33 hours an ambulance arrived and paramedics were led directly to the scene where they took over CPR on Mr Reid. At 18:39 hours the paramedics in attendance pronounced Mr Reid's life extinct.

[37] On 24 October 2016, Mr Reid's body was taken to Edinburgh City Mortuary, Cowgate, Edinburgh, and examined by Dr Gillian Wilson, who certified the cause of death as hanging.

[38] On 25 February 2020, Dr Duncan Alcock, MB, ChB, MRCPsych, an independent Consultant Forensic Psychiatrist, having previously considered all relevant prison records, provided a report regarding the care and treatment of Mr Reid whilst he was within HMP Addiewell.

[39] Dr Alcock opined that that on each of the said earlier occasions when Mr Reid displayed poor mental health, the staff working within HMP Addiewell had responded appropriately, to both the risks that Mr Reid presented and to his mental health needs. Following Mr Reid's discontinuation of his prescribed medication, there was nothing to suggest that Mr Reid's mental health had declined thereafter.

[40] Dr Alcock indicated that there were no apparent grounds for requiring Mr Reid to be transferred to an inpatient psychiatric setting through the Mental Health Act. The

medical treatment that Mr Reid was receiving within the custodial setting was sufficient to manage the risks that were then apparent. The mental health care provided to Mr Reid during this period of custody was in his opinion reasonable and there did not appear to have been any errors or omissions in relation to Mr Reid's care and treatment.

[41] Dr Alcock indicated that there were no signs that Mr Reid would act to take his own life during the course of his work with Dr Lundie and that there was no recent significant changes in Mr Reid's presentation towards custody prison officers. Dr Alcock opined that it was highly likely that Mr Reid's longstanding personality trait, of acting in an impulsive fashion was likely present and therefore Mr Reid may not have considered the full impact of his actions upon both himself and others, notably his family. Given that he could act in such an impulsive fashion, it appeared to Dr Alcock that there were no specific signs that would have indicated to others that he was shortly going to take his own life.

[42] All interested parties invited me to make but formal findings.

Discussions and conclusions

[43] I concluded on the foregoing evidence that on each of these said earlier occasions when Mr Reid displayed poor mental health, the staff working within HMP Addiewell had indeed responded appropriately to both the risks that Mr Reid presented and to his mental health needs. Mr Reid's mental health seemed to improve after each intervention, such as to not require any continued intensive supervision and treatment.

[44] Following Mr Reid's refusal to take his prescribed medication, there was nothing to suggest that Mr Reid's mental health had declined thereafter such that would have given grounds for his being placed in an inpatient psychiatric setting, through the Mental Health Act.

[45] On the foregoing evidence, I concluded that the medical treatment that Mr Reid had received within HMP Addiewell was sufficient to manage the risks that were then apparent. The mental health care provided to Mr Reid during his period in custody was reasonable and there was no evidence of their being any errors or omissions in relation to his care and treatment.

[46] I concluded that there were no sufficiently significant recent signs that Mr Reid would act to take his own life and that, as concluded by Dr Alcock, that it was highly likely that Mr Reid's longstanding personality trait of acting in an impulsive fashion, was likely present. Given that Mr Reid was someone who would regularly act in such an impulsive fashion, there were no specific signs that would have indicated to others that Mr Reid was shortly going to take his own life and accordingly that further steps should have been taken, by those concerned with his care.

[47] In the foregoing circumstances there was nothing more which prison or medical staff could be expected to have done to assist Mr Reid; and particularly no precautions which could reasonably have been taken, which might realistically have resulted in the death being avoided, nor were there any defects in any system of working which contributed to the death.

[48] I conclude by taking a further opportunity to record that my thoughts are with the family of, and all those affected, by the untimely death of Mr Reid.