SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2021] FAI 9

FAL-B378/20

DETERMINATION

BY

SHERIFF C M SHEAD

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

into the death of

GARRY MUNRO

1 December 2020

The sheriff, having considered the information presented at an inquiry on 17 November 2020 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, finds and determines:

(1) Mr Garry Munro was born on 5 March 1982. He died sometime between the evening of 27 and the morning of 28 January 2019 at HMP Glenochil. He was pronounced dead at 07: 52 hours on 28 January.[1] He committed suicide.

(2) The cause of death was suspension by the neck by means of a ligature made from his belt (hanging).[2]

[1] Section 26(2)(a)
[2] Section 26(2)(c)

(3) I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26(2) of the Act.

(4) I have no recommendations to make under section 26(1)(b) of the Act.

NOTE

Introduction

[1] This is a mandatory inquiry into the death of Mr Garry Munro in terms of section 4(a) of the 2016 Act.

The proceedings and the parties

[2] Preliminary hearings took place at Falkirk Sheriff Court on three occasions before the inquiry itself which was held on 17 November. Ms Rollo, procurator fiscal depute, appeared for the Crown. Mr McConnell, counsel, appeared for Forth Valley Health Board and Mr Smith for the Scottish Prison Service ("SPS").

The sources of evidence

[3] A joint minute of agreement was agreed by the parties. I heard evidence from four witnesses one by video link. A number of other statements and documents had been submitted in advance of the hearing. The result was that both the evidence and the submissions were completed in one day. I am grateful to parties for their assistance in the preparation and conduct of the inquiry.

The legal framework

[4] The inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the 2016 Act). The purpose of such an inquiry is set out in section 1(3) of the 2016 Act and 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."

Section 26 of the 2016 Act states, among other things, that:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out –
> (a) in relation to the death to which the Inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2) and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers as appropriate.
> (2) The circumstances referred to in subsection 1(a) are –
> (a) when and where the death occurred;
> (b) when and where any accident resulting on 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;
> (g) any other facts, which are relevant to the circumstances of the death.
> (3) For the purposes of subsection 2(e) and (f) it does not matter whether it was foreseeable before the death or accident that the death or accident might occur –
> (a) if the precautions were not taken, or;
> (b) as the case may be, as a result of the defects.
> (4) The matters referred to in subsection 1(b) are –
> (a) the taking of reasonable precautions;
> (b) the making of improvements to any system of working;
> (c) the introduction of a system of working

(d) the taking of any other steps which might realistically prevent other deaths in similar circumstances."

A summary of the parties' positions

[5] The procurator fiscal depute's primary submission was that the court should make findings in terms of section 26(2)(a) and (c). In that connection she submitted that Mr Munro had hanged himself at HMP Glenochil sometime between the evening of 27 January and the morning of the 28. He had used a belt belonging to him as a ligature. Having been discovered in his cell he was pronounced dead at 07:52 although it was clear that he had been dead for some time when that pronouncement was made. The other parties to the inquiry were content that I should make findings which reflected that submission. It was common ground that the deceased had committed suicide.

[6] None of the parties made any criticism of the care which had been provided to the deceased by the mental health nurses from whom the deceased had sought assistance. No independent medical evidence was presented which would have entitled the court to conclude that there had been any failings in the care provided by the mental health nurses. Seeking to put the matter into context both Mr McConnell for Forth Valley Health Board and Mr Smith for the Scottish Prison Service invited me to conclude that the evidence showed that Mr Munro had not exhibited any indication that he intended to kill himself in January 2019. In light of the evidence and those submissions I am prepared to accept that Mr Munro gave no indication to Mr Fitzgerald the mental health nurse who saw him on 25 January, the prisoner officer who locked him into his cell that might and his grandmother to whom he had spoken on the phone that day that

he intended to harm himself or that he was suicidal. He was not regarded by the prison authorities as being a suicide risk.

[7] The main issue which divided parties was whether the court should find under section 26(2)(e)(i) and (ii) that depriving the deceased of his belt was a precaution which could reasonably have been taken and, if it had been taken, might realistically have resulted in his death being avoided. I consider that issue later in my determination.

The circumstances of the deceased and his death

[8] At the time of his death Mr Munro was serving a life sentence for murder. He was convicted at the High Court of Justiciary sitting at Edinburgh on 5 February 2015. The punishment part of his sentence was fixed at 16 years.

[9] He had a history of drug and alcohol abuse but no history of having reported thoughts of self-harm or suicide. The deceased had been diagnosed with Huntington's disease which is a progressive genetic brain disorder.

[10] On 18 January 2019 he referred himself to the prison mental health team. He was seen by Mr Craig Fitzgerald a mental health nurse on 25 January.

[11] On the afternoon of 27 January he spoke to his grandmother on the phone. At that time he had seemed normal.

[12] The deceased and the other prisoners on the hall were locked into their cells about 17:00 that day. At that time he spoke to Mr Donaldson one of the prison officers and he seemed fine. He was last seen watching television in his cell which he occupied on his own.

[13] The following morning Mr Munro was found dead in his cell at 07:20. Paramedics were called and he was pronounced dead at 07:52. It was obvious that he has been dead for some time. Subsequently another prisoner reported having heard a bang at about 1.00 or 2.00am but he did not alert the staff at the time.

[14] A post-mortem was carried out which concluded that the cause of death was hanging.

[15] The deceased had written a letter which was found in his cell which appeared to be a suicide note.[3]

[16] At the time of Mr Munro's death the SPS operated a suicide prevention policy known as "Talk to Me" in respect of which all members of staff who have contact with prisoners are trained. Any member of staff can intimate a concern about a prisoner in writing. If that step is taken a case conference is organised and an assessment of the risk the prisoner poses to himself is undertaken.

A summary of the main points of the oral evidence

Craig Fitzgerald

[17] Mr Fitzgerald adopted his statement. He had worked as a mental health nurse and had interviewed the deceased on 25 January. This had been in response to Mr Munro referring himself to the mental health services in the prison. That referral had been in writing. Mr Fitzgerald was allocated the referral and he first looked at it on

[3] Crown production 11

25 January. He was about to go on leave for a few days and decided he would speak to Mr Munro before he did so.

[18] He met the deceased that day. His purpose in doing so was to carry out "a form of triage" rather than a full assessment. He agreed with Mr Munro that he would see him again when he returned from leave a few days later. He had asked him whether he was having thoughts of self-harm or suicide and received a negative response. He was looking to see whether Mr Munro was showing any signs of agitation, distress, distraction or hesitation but he was not. He was left with the impression that there was nothing to be worried about. Mr Munro seemed calm and settled. If he had been concerned he would have initiated the "Talk to Me" process.

[19] He did not make any note of the reason or reasons that had prompted Mr Munro to refer himself to the service nor did he have any recollection of the reason or reasons. His only recollection was some discussion about the prisoner's prospects of parole and his family. He accepted that it was difficult to predict suicide.

[20] In re-examination he explained that the meeting on 25 January was not intended to be an in depth assessment of Mr Munro's state of mind.

Doreen Doull

[21] This witness also adopted her statement. She had been employed as a mental health nurse at the prison since 2012. She explained the procedure in the event of a self-referral. Her practice was to carry out an initial assessment which she described as

"a triage" the purpose of which was to ascertain the nature of the problem. In addition an initial assessment of the patient's state of mind would be undertaken.

[22] She had worked with Mr Munro since 2016. She was aware that he had Huntingdon's disease. She considered that such a diagnosis can lead to mental health problems especially if the condition is advanced. In her dealings with Mr Munro she did not have any concerns that he was exhibiting suicidal ideation. He did have a history of drug abuse and low mood and anxiety.

[23] According to the records she had seen the deceased on 5 September 2018. It was noted that he did not have a mental health diagnosis and that he had no thoughts of self-harm or suicide. At that time he was not prescribed medication. This consultation coincided with the anniversary of Mr Munro's mother's death. Ms Doull thought that event might have provoked anxiety in the deceased.

[24] She last saw him on 3 October 2018 which had been a planned review. At that time it is recorded that Mr Munro wondered if his mood swings were related to having Huntingdon's. She said that she would have noted if he had exhibited any symptoms and confirmed that there was no such note. She said that he was not aware of how severe his symptoms would become.

[25] She was shocked when she was told that Mr Munro had killed himself. She had thought he was resilient. His suicide "came out of the blue". His health had never been such that she felt she had needed to invoke the "Talk to Me" process.

Euan Donaldson

[26] Mr Donaldson explained that he had been a prison officer at Glenochil for approximately 10 years. He had been working on 27 January. Together with his colleagues he supervised the lock up of the prisoners. That took place at about 5.00pm.

[27] He knew the deceased. As far as he was concerned Mr Munro had never caused any problems in the hall. He was housed in a single cell that night. He recalled having said goodnight to him and that the deceased responded. He had no concerns for Mr Munro's wellbeing. He last saw him sitting on his bed watching television.

[28] If he had been concerned about a prisoner's state of mind he would have reported it to his manager. He was aware that he could initiate the "Talk to Me" process if he thought it was appropriate to do so.

[29] Prison officers would not have access to a prisoner's medical records but there were occasions when an officer might be asked by a mental health nurse to keep an eye on a particular prisoner without being told the specific grounds for concern.

Lesley McDowell

[30] Ms McDowell is the head of health strategy in the Scottish Prison Service and a qualified nurse. In 2015 she was made manager with various responsibilities including suicide prevention. In her current role she is responsible for the production of various policies and procedures which include suicide prevention. She adopted her witness statement.

[31] She had participated in the Death in Prison Learning Audit and Review (DIPLAR)[4] into the death of Mr Munro. This is a joint review which involves both the SPS and the NHS and takes place in respect of all deaths in custody. She drew attention to the conclusion of the review.[5]

[32] She went on to explain the main points of the suicide prevention strategy that is presently in use and is referred to as "Talk to Me"[6]. Mr Munro had no history of having been made subject to this process or having reported thoughts of self-harm or suicide.

[33] She explained that if a prisoner wants to have a belt he has to request one. His request will then be considered by the prison authorities. Such a request would be considered according to a policy called "Items in use" which lists the items a prisoner may have access to.

[34] The majority of suicides involve the use of a ligature. In more than 70% of those cases bedding is used to make a ligature. The second most commonly used ligature is clothing. Mr Munro's death is only the third occasion in over 10 years when a belt has been used as a ligature.

[35] She explained that the prison service aims to make prison a comfortable and therapeutic environment. This is achieved in part by allowing prisoners to choose the clothing they wear and the items they have access to. The aim is to build a constructive and trusting relationship between prison staff and the prisoners. If items such as belts were removed that would indicate a lack of trust.

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[4] Crown production 9
[5] Statement para [6]
[6] [7]-[8]

[36] Around 60-70% of the prison population have mental health problems. That does not mean that the same percentage is at risk of suicide. If belts or other personal items were removed merely because a prisoner was recognised as having mental health problems this would make prisoners less likely to come forward with their health concerns. One of the most effective ways of preventing suicides is to create an environment where prisoners feel able to speak about their concerns.

[37] The witness is a member of the National Suicide Prevention Management Group (NSPMG) which is a group of experts on the matter of suicide prevention. Following the suicide of Anthony McMahon where a belt was used as a ligature the Group considered whether prisoners should be denied access to belts and decided that they should not. The Group had taken into account the determination of Sheriff Welsh QC in considering whether the approach of the prison service required to be modified. Ms McDowall confirmed that she had given evidence at that Fatal Accident Inquiry including in relation to the provision of belts to prisoners.

[38] In cross-examination by the procurator fiscal she expressed the view that it would be too extreme a position to deny any prisoner with mental health difficulties access to a belt. As she pointed out not every prisoner who suffers poor mental health is a suicide risk. The policy of the SPS was to try, within limits, to normalise the life of prisoners by allowing access to clothing and personal effects. She rejected the suggestion that a belt was a dangerous item.

[39] She did not accept that there was any lack of independence in the Group itself. On the contrary the members of the Group are independent and free to express their

views. She confirmed that following Mr McMahon's death the Group had considered both the findings of the internal review and the sheriff's determination. The decision had been taken that it was not necessary to remove belts from prisoners.

[40] It was not necessary to remove a belt from a prisoner unless he or she presented as at risk of suicide. Encouraging prisoners to talk about their problems and anxieties is one of the most effective ways of preventing suicide. Removing personal items such as belts would undermine the relationship of trust between prisoners and officers. That relationship of trust was crucial to encouraging frank discussion and thus preventing suicide.

The submissions in relation to the use of the belt as a ligature

[41] The Crown invited the court to make findings in relation to section 26(2)(e) and (f). It was submitted that the fact that a belt had been used more than once in recent years as a means of committing suicide pointed to the existence of a defect in the system of working which contributed to the death. In particular it was argued that to allow a prisoner with a history of mental health difficulties access to a belt represented such a defect. A belt could readily be transformed into a ligature and notwithstanding the desire of the prison service to create an environment of comparative normality it was a misjudgement to allow such prisoners access to such belts. Put shortly it was submitted that the danger of doing so significantly outweighed the perceived benefit.

[42] In addition the Crown submitted that the policy under question had not been determined by "fair and open means". I understood this is to be a reference to the

NSPMG and its composition. It was submitted that the Group lacked the necessary degree of independence from the SPS.

[43] Mr McConnell's primary focus was on the care which the prisoner had received from the mental health team and he contended that there was no basis in the evidence for criticism of that care.

[44] Mr Smith also made a submission on that point which I need not rehearse. He went on to address the question of Mr Munro's access to a belt and why the court should not accept the submission of the Crown on this issue.

[45] To put his submission in context he reminded the court that there was in place a suicide prevention policy referred to as "Talk to Me" in respect of which the relevant members of staff had received training. Any member of staff could initiate the process which would lead to the organising of a case conference to allow for a thorough assessment of risk to be undertaken.

[46] He also drew attention to the determination of Sheriff Welsh QC in the case of Anthony McMahon. In that case the deceased had been deemed to be a risk of suicide and he was subject to a supervision regime. Notwithstanding those circumstances Sheriff Welsh had declined to make a recommendation of the kind sought by the Crown in this case.

[47] He relied on the evidence that the vast majority of prison suicides did not involve the use of a belt. Other methods were much more commonly employed and could not always be guarded against. For those recognised to be at risk of suicide preventative steps could be taken including the removal of items of clothing which

might be used as a ligature. The advantages of trying to provide a more normalised environment for prisoners had been explained by Ms McDowell and were cogent. As was clear there was a balance to be struck between keeping prisoners safe and allowing them access to their own clothing and possessions.

[48] In the wake of Mr McMahon's death there had been an appropriate review by the NSPMG and the Group had decided that belts should not be removed from prisoners as a matter of course. That decision had been reached by taking into account the internal review and the determination of the sheriff in that case.

[49] He submitted that there was no evidence before the court to justify the view that somehow the Group lacked the necessary independence. Its membership involved those whose expertise lay in suicide prevention who were free to express their views on the policies that should be adopted by the SPS.

[50] He submitted that the rule of practice proposed by the Crown i.e. that those with mental health problems should be denied access to a belt was likely to be unworkable. The SPS would require to be provided with information from other bodies such as the NHS. On the basis that some 60-70% of the prison population had some mental health problems the resources involved would be very considerable and should be measured against the demonstrably small risk of a prisoner committing suicide.

[51] In any event there would be problems of definition. What would constitute a mental health problem for these purposes? It was submitted that the Crown's proposal was unrealistic.

[52] In summary he submitted that the matter of access to belts had been considered recently and would be kept under review. The balance struck by the SPS was an appropriate one. Against that background he invited the court to refrain from making the findings proposed by the Crown.

Conclusions

[53] It was common ground that Mr Munro committed suicide and that he had used his belt to do so. There was no dispute about where and when he died and I am satisfied that there is a proper basis for the findings recorded at the beginning of this determination.

[54] There was no criticism of the care given to the deceased by the mental health nurses. For my part I can see no reason to make any criticism of that care.

[55] One issue raised in the evidence was whether Mr Munro's diagnosis of Huntingdon's disease had played a part in his decision to kill himself. With the benefit of hindsight it might have helped if the reason for Mr Munro's self-referral in January 2019 had been recorded. However that may be there is no clear evidence to suggest what might have prompted his decision. There is nothing in the letter he left which throws light on the question. Intelligence received after his death suggests he may have been in debt to another prisoner. There may have been a number of other considerations which were weighing on his mind. He appears to have given no sign to those with whom he was last in contact that he intended to end his life. That being so I

cannot come to a conclusion as to whether anxieties over his physical illness played a part in his decision.

[56] I now turn to consider the Crown's submission in relation to the issue of whether the removal of the belt was a reasonable precaution and whether the failure to do so could be characterised as a defect in the system of working in terms of sections 26(2)(e) and (f) of the Act. I am not persuaded that those submissions were well founded having regard to the evidence before the inquiry.

[57] Belts are not commonly used by prisoners to commit suicide. Following the last recorded death by this means the matter was reviewed by the NSPMG and no change in policy was recommended. That group included experts in the field of suicide prevention and there was no evidence before me which suggested that they were not entitled to come to the conclusion which they did. It seems to me that I should proceed on the basis that the issue was given proper consideration and that a rational conclusion arrived at.

[58] The conclusion arrived at by the NSPMG does not remove the duty of the court to consider whether a different view on the same issue should be reached. However as I have said I am not persuaded that a different view is warranted. The policy adopted by the SPS appeared to me to reflect all the appropriate considerations.

[59] In this case Mr Munro was not regarded as a suicide risk. There was nothing to suggest he should have been treated as such. Thus the question of whether to deprive him of some of his possessions including his belt simply did not arise.

[60] In any event as is clear from the records kept by the SPS suicide by means of a belt is uncommon. Other methods are often resorted to with ligatures being made from clothing or bedding. That being so even if the deceased had not had access to a belt at the material time he had access to both bedding and clothing which could have been employed to the same end.

[61] There are systems in place to manage the risk of suicide posed by prisoners. These include the removal of ordinary clothing including belts and the transfer of the prisoner to a designated cell where regular observations can be kept on him or her.

[62] In his determination following the inquiry into the death of Anthony McMahon Sheriff Welsh expressed the view that it would be unwise to allow any prisoner who is assessed as a suicide risk access to a belt.[7] As noted that expression of opinion was taken into account by the SPS in determining whether to alter its policies and procedures. Clearly there is a material difference between a prisoner who is at demonstrable risk of suicide and one who is suffering from mental health difficulties when there is no indication that those difficulties are severe and in any event indicative of a desire to commit suicide. Unfortunately Mr Munro did not give any sign of his intention and there was no basis on which the SPS should have treated him as if he posed a risk of suicide.

[63] I have noted that the procurator fiscal made a submission that the NSPMG lacked independence but the point was not developed in any detail. In any event I do

[7] [16] of the determination of 7 March 2018

not consider that there was any evidence to suggest a lack of independence. Accordingly I reject that submission as irrelevant to the determination I have to make.

[64] The parties extended their condolences to Mr Munro's family and friends and I would like to join them in expressing my condolences.