IN THE COURT OF SESSION

A152/2024

MINUTE OF ADMISSIONS

FOR THE FIRST DEFENDERS

in the cause

SHARON MacFADYEN, residing at 12 Muirbank Avenue, Rutherglen, South Lanarkshire G73

Pursuer

against

(FIRST) THE SCOTTISH MINISTERS, Solicitor's Office, Victoria Quay, Edinburgh EH6 6QQ; **(SECOND) THE RT. HON. DOROTHY BAIN K.C., THE LORD ADVOCATE**, Lord Advocate's Chambers, 25 Chambers Street, Edinburgh EH1 1LA; **(THIRD) JO FARRELL, CHIEF CONSTABLE OF POLICE SCOTLAND**, having its headquarters at Tulliallan Castle, Kincardine FK10 4BE

Defenders

- - - - - - -

REID, K.C. and SCULLION for the first defenders state to the court that, without prejudice to their rights and pleas with regard to just satisfaction, the first defenders admit the following:

1 On 2 March 2015, Allan Marshall was remanded into custody prior to his trial. He was held at HMP Edinburgh. On 19 March 2015, Mr Marshall began to show signs of his mental health deteriorating. On 22 March 2015, his cellmate expressed concern about Mr Marshall's abnormal behaviour, which was consistent with a severe mental health episode. No referral was made to NHS, as should have been done, given Mr Marshall's symptoms. Mr Marshall's cellmate was moved to another cell. On 24 March 2015 Mr Marshall repeatedly pressed the call button for

assistance.

2 In the early hours of the morning of 24 March 2015, Mr Marshall became agitated in his cell. Prison officers decided to leave him in his cell until more staff were available when the day staff came on duty. No referral was made to NHS.

3 On the morning of 24 March 2015, Mr Marshall exhibited signs of severe mental health episode. He was acting in what appeared to be a paranoid and fearful manner. He was moved to the Separation and Reintegration Unit ("**SRU**") within HMP Edinburgh. At around 7.30 am, Mr Marshall was moved to the shower area within the SRU. He was compliant during the removal. No referral was made to NHS either before or after his transfer to the SRU, as should have been done, given Mr Marshall's symptoms.

4 Mr Marshall did not take a shower. After Mr Marshall had been in the shower area for around ten minutes, four prison officers entered the shower area. Prison officers attempted to move Mr Marshall back to his cell. He was not, as he had been during transfer to the SRU, compliant. He evidenced symptoms consistent with a severe mental health episode Those symptoms were not recognised as being consistent with a severe mental health episode by the prison officers attending upon Mr Marshall. They should have been recognised as such. The officers did not withdraw from the shower area and seek NHS assistance. Mr Marshall struggled with officers, in response to the restraint. Some officers sustained injuries.

5 Between around 07:48 and 08:28 a number of prison officers restrained Mr Marshall in and immediately outside the shower area as they sought to remove him to a cell within the SRU. Prison officers from elsewhere in the prison were called to assist in the restraint. A total of seventeen prison officers were involved at various points during the restraint. During the course of the restraint, unauthorised and dangerous restraint techniques and excessive force were used by some of the prison officers who were involved. More than one prison officer used their feet during the restraint . Plasti-cuffs were applied to Mr Marshall when they should not have been and when he was in a prone position.

6 At around 08:28, Mr Marshall became limp and stopped breathing. There were at least twelve prison officers at the scene. None of the officers commenced CPR compressions. A 'code blue' was called. Medical staff arrived on the scene at about 08:29. They commenced chest compressions, which SPS staff continued. Paramedics arrived at around 08:57 and took Mr Marshall to Edinburgh Royal Infirmary.

7 Mr Marshall never regained consciousness and died in hospital on 28 March 2015. The cause of death was certified as "*hypoxic-ischaemic brain injury due to out-of-hospital cardiac arrest during physical restraint in a man with coronary artery atheroma*". Mr Marshall had a number

of injuries on his body caused by the restraint.

8 Prior to and during the course of the restraint, Mr Marshall was evidencing symptoms of a mental health crisis. They were not, but should have been, recognised as such. Prison officers did not seek appropriate medical attention. Prison officers did not implement de-escalation techniques. Had they sought medical attention and/or implemented de-escalation techniques there may have been no need to use force on Mr Marshall. The use of force was unnecessary and was in any event excessive.

9 There were defects in the SPS systems of work in terms of (i) identification of behaviour associated with mental illness; (ii) identification of medical emergencies; (iii) relevant training; and (iv) recording and sharing of relevant incidents.

10 In all those circumstances:

(a) forceful restraint was not necessary ;

(b) the force used during the restraint went beyond that which was proportionate in the circumstances;

(c) the forceful restraint caused Mr Marshall's death;

(d) Mr Marshall's death could and should have been prevented;

(e) Causing Mr Marshall's death through the use of unnecessary and excessive force breached Mr Marshall's right to life under Article 2 of the European Convention on Human Rights; and

(f) accordingly, Mr Marshall's death was unlawful.

11 In those circumstances, the pursuer is entitled to a declarator in the following terms:

> *"That on 24 March 2015, the Scottish Prison Service, through the acts of its employees, used force on Allan Marshall while he was in custody on remand in H.M.P. Edinburgh and that force was not necessary and went beyond that which was proportionate and thereby caused the death of Mr Marshall, that being incompatible with Mr Marshall's rights under Article 2 of the European Convention on Human Rights and thus unlawful in terms of section 6 of the Human Rights Act 1998."*

IN RESPECT WHEREOF