SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT PETERHEAD

[2019] FAI 23

PHD-B80-18

DETERMINATION

BY

SHERIFF CHRISTINE P MCCROSSAN

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

into the death of

WILLIAM RICHARD HUME

Peterhead, 31 May 2019

[1] The Sheriff, having considered the information 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 William Richard Hume, born on 21 December 1966 died in HMP Grampian, South Road, Peterhead on 2 May 2014, life being formally pronounced extinct at 0705 hours on that date;

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

(3) That in terms of section 26(2)(e) the precaution of his having been placed on the Scottish Prison Service Suicide Risk Management ACT 2 Care programme on his admission to HMP Grampian on 30 April 2014 might realistically have resulted in his death having been avoided.

HMP Grampian have in place a system of assessment which should have ensured that this reasonable precaution was taken. At the time of Mr Hume's admission there were certain defects in that system. Whilst not directly causing or contributing to Mr Hume's death the defects did to varying extents contribute to his not being placed on the ACT2 procedure. Those defects are detailed within this determination. Following the investigation carried out by SPS changes were made to rectify the defects. In such circumstances this inquiry does not consider there are any recommendations it can usefully make under section 26(1)(b).

(4) That in terms of section 26(2)(g) no facts in addition to those otherwise covered in this determination were relevant to the circumstances of Mr Hume's death.

Legal Framework

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

[3] The Crown in the public interest is represented by the procurator fiscal depute. A fatal accident enquiry is an inquisitorial process and it is not the purpose of an enquiry to establish civil or criminal liability.

[4] The Procurator Fiscal issued notice of the inquiry on 15 May 2018. A preliminary hearing took place at Peterhead sheriff court on 29 June 2018.

[5] Parties intimated that they proposed to enter into a Joint Minute setting out those matters that were capable of agreement between them; notwithstanding an evidential hearing would be required. Following incidental procedure a hearing commenced on 28 November 2018 and evidence was led over 3 days. Parties agreed to lodge their closing submissions in writing by 11 January 2019. Mr Hanton represented the Crown. The following parties were represented at the enquiry:

(i) the Scottish Prison Service (SPS) represented by Mr Scullion, Solicitor-Advocate

(ii) the Prison Officers' Association (Scotland), represented by Mr Cahill

(iii) NHS Grampian, represented by Ms Davie, Advocate

(iv) The family of the late Mr Hume, represented by Mr Sanders, Advocate

(v) Ms Rebecca Brownlie, wife of the late Mr Hume, represented by Mr David Penna

The documents listed in the Appendix to this determination were lodged as productions by the Crown and the Scottish Prison Service.

[6] The Joint Minute agreed between the parties is as follows:

> "1 William Richard Hume born 21st December 1966 was remanded in custody at HMP Grampian on 30th April 2014, following an appearance at Aberdeen Sheriff Court in relation to a charge of breaching bail conditions, being allocated Cell 8, Ellon Hall, B Wing. When apprehended by police, Mr Hume had covered his body in petrol, tied a rope around his neck and was found to be carrying a lighter.
>
> 2 Mr Hume was seen by a court social worker following his appearance in court when he was remanded, and although he refused to confirm or deny whether he was at risk of self-harm, he advised that the offence for which he had been remanded related to an attempt at self-harm, and that he planned to refuse

food and drink at the prison in order to be admitted to hospital. As such, a suicide risk identification court form was completed to that effect and accompanied Mr Hume from Aberdeen Sheriff Court to HMP Grampian. This form is Crown production number 7.

3 At about 19:30 hours on 1st May 2014 Mr Hume was locked in his cell for the night, with a check made on him about 20:30 hours, same day, at which time he responded to the checking prison officer.

4 At about 06:40 hours on 2nd May 2014, Mr Hume was found hanging from the door which leads from the main cell into the adjoining toilet, with a bed sheet and shoelaces having been used as a ligature.

5 At about 07:05 hours, same day, life was pronounced extinct by paramedics employed by the Scottish ambulance service.

6 Handwritten notes were recovered from within Mr Hume's cell and the contents are accepted as evidence. These form Crown production number 10.

7 The death of Mr Hume was reported to the procurator fiscal at Aberdeen on 5th May 2014.

8 The body of the deceased Mr Hume was subject to a post mortem examination by Professor James Henderson Kerr Grieve and Dr Matthew Stewart Lyle, on 6th May 2014 at Aberdeen mortuary and it was their considered opinion that he died as a consequence of hanging. The post-mortem report is Crown production number 2.

9 The 4th production for the Scottish prison service is a plan of the reception and health centre at HMP Grampian.

10 The 5th production for the Scottish prison service is a photograph of the corridor linking the reception and the health centre at HMP Grampian.

11 Crown production 16 is a Ministry of Justice publication which has no application to Scottish prisons.

12 HMP Grampian took its first prisoners on 3rd March 2014.

13 The Scottish Prison Service and National Health Service conducted a SIDCAAR (Apparent Self-Inflicted Death in Custody – Audit, Analysis and Review) report following the death. That report is that Crown production 19.

14 Prison officer Brian William Shand gave a police statement to DC Campbell on 2nd May 2014 in which he reported conversations with '*a few of [the] prisoners'* housed close to the deceased who were '*really surprised [about the death] because the prisoner seemed in good spirits [on 1st May 2014] and was playing pool and socialising with other prisoners.'*

15 Prison officer Graham William Buchan gave a statement to the health and safety executive on 13th January 2015 in which he advised that '*I knew she [Naomi Adams] had put someone on ACT, because I saw her with the ACT 2 care document. She was sitting by the desk on the female side, I was standing at the reception desk on the male side, and she said to me she was putting somebody on ACT.'*

16 The reception officer Marcin Klaudiusz Werniewicz gave a statement to the health and safety executive on 3rd March 2015 in which he advised that '*Naomi [Adams] carried out the risk assessment for Mr Hume. She didn't discuss it with me. I definitely saw Naomi with the ACT 2 care documents in her hand when she was dealing with him and I think she said that she was going to put him on ACT. I didn't see the content of the ACT book. I recall that Mr Hume was in a good mood when I searched him and the day after.'"*

[7] The following individuals were called by the Crown to give evidence:

1 Naomi Adams, prison officer, [SPS employee]

2 Lynn Mathewson, operations officer, [SPS employee]

3 Caroline Moir, Healthcare manager, [NHS Grampian employee]

4 Paul Smith, Residential manager, [SPS employee]

5 Mark Molloy, Unit manager, [SPS employee]

6 Affidavit evidence was produced from witness Rachel Isherwood, mental health nurse, [NHS Grampian employee].

[8] The Scottish Prison Service led the following witnesses: –

1 Leslie McDowall, Health Strategy and Suicide Prevention Manager, [SPS employee]

2 Ian MacGregor, Head of operations, HM Prison, Perth [SPS employee].

The ACT2 care procedure

[9] This is a mandatory enquiry under the relevant legislation as Mr Hume's death occurred while he was in legal custody within HMP Grampian, an establishment run by the Scottish Prison Service. Mr Hume's death was a result of suicide. This occurred less than 48 hours after his admission to prison. Therefore the main focus of the enquiry was on the procedure followed at the time of his admission to the establishment.

[10] At the time of Mr Hume's admission SPS operated a suicide risk management strategy known as ACT 2 care. A suicide risk management procedure had been in place since 1998 and revised into the one current at the time of Mr Hume's death in 2005. Its key aims were stated to be: –

> "to assume a shared responsibility for the care of those at risk of self-harm or suicide. To work together to provide a person centred caring environment based on individual assessed need where prisoners who are in distress can ask for help to avert a crisis. To identify and offer assistance in advance, during and after a crisis."

A copy of the strategy is produced as Document 11.

[11] Every prisoner coming into a SPS establishment must be assessed for risk of suicide or self-harm. This applies to prisoners on initial admission to prison on remand or on receiving a sentence, on transfer from another establishment or every time a prisoner is returned to the establishment having been out for a particular reason such as court appearance, home visit et cetera. The procedure is known as a reception risk assessment and is captured in the ACT 2 Care Reception Risk Assessment document (RRAD) (Document 12). The RRAD has: (i) a Front Page, (ii) guidance notes, (iii) the Reception Risk Assessment (RRA) form, (iv) the Healthcare Risk Assessment (HRA)

form and (v) a flowchart. Document 6 is the document that was completed for Mr Hume at the time of his admission.

[12] The front page is completed by the receiving officer. It contains the personal details of the prisoner. It also identifies the sort of documentation which may have accompanied him into prison. In particular in the box at the foot of the page the officer is required to confirm whether a "Personal Escort Record (PER)" has been received. She is also asked to confirm whether "Any additional information is received". If the officer replies YES to this she is required to specify the source and information received. Miss Adams who was the reception officer carrying out the assessment on Mr Hume confirmed that the PER had been received as had additional information. The further specification she provided in respect of that was as follows: "see attached sheet SPS risk identification court form".

[13] The PER form is the personal escort record which is completed by those escorting the prisoner from court. The PER identifies whether the prisoner poses any form of risk. There are categories of risk identified on the form. Mr Hume has been categorised as at "high risk" under the three categories on the form – medical, security and other. Under "other" he is identified as at risk of suicide / self-harm. In the section of the form headed risk – additional information the following is set down: "suicidal tendencies, self-harm, depression, conceals, violent". The SPS suicide risk identification court form contains the following information:-

> "Mr Hume advised he would not answer if he would place himself at risk of self-harm/suicide. However noted that the offence he has been accused of relates to

> him attempting to harm himself. Mr Hume disclosed that he is going to refuse to eat and drink and will 'end up in hospital'."

This form confirms that Mr Hume has appeared in court for a petition matter. The form has been completed by the court social worker. The top of the form states specifically that its purpose is; to notify receiving prisons of prisoners who may be at risk from self-harm or suicide. In bold capitals the following statement appears: "**This form must accompany the prisoner to the receiving prisons."**

[14] The guidance notes of the RRAD explain what a PER form is as follows:

> "This form is used by the escorting staff. PER should always be available. It is important that the information contained be scrutinised by the person carrying out the reception risk assessment and the health care assessment."

The notes give clear instructions to both the reception and healthcare professional on how to complete their section of the RRAD. The guidance advises that the individual completing the form is to familiarise themselves with the RRA flowchart at the back of the document.

[15] The procedure provides that the assessment is carried out in the reception area of the prison. The initial assessment – the Reception Risk Assessment (RRA) is carried out by a member of SPS staff. Thereafter a nurse carries out the Healthcare Risk Assessment (HRA). The nurse is not employed by SPS but, in this case, by NHS Grampian who are contracted to provide medical services to SPS within HMP Grampian. Finally if this is the prisoner's initial admission to the establishment the procedure includes his being assessed by a doctor. The guidance notes (part (ii) of the assessment form) provide that each person who completes the assessment must be trained in ACT2 care procedures.

The notes also provide that if any assessor considers the prisoner to be "at risk" of self-harm or suicide an ACT2 care document must be raised. This is also made clear on the flowchart on the back page of the RRAD. Additionally it is reiterated at the foot of both of the RRA and HCA forms.

[16] The raising of an ACT2 care form means that the individual has been identified as someone who is at risk of suicide or self-harm. In such circumstances a regime is put in place to support and endeavour to keep the prisoner safe. What the particular regime consists of depends on the individual prisoner and the information provided from the assessment. The matter is considered at a case conference. A minimum of three staff take part in any case conference, namely (i) the Hall manager who is the individual responsible for the day to day operation of the particular Hall the prisoner is allocated to (ii) a residential officer who works in the area where the prisoner is located and (iii) a nurse. It is best practice that the initiating person is also available at the case conference and any other person who has a contribution to make with regards to the prisoner's case; for example other staff members, prisoner's family, social worker et cetera. The prisoner himself is invited to attend the case conference. It is not always possible for a case conference to be held immediately on a prisoner being assessed as "at risk" but it must be held within 24 hours of that time. Until such time as a case conference can take place an immediate care plan must be drawn up for the individual at risk. The purpose of this is to consider and record what immediate steps are to be taken to support the prisoner until the case conference is convened. The minimum number of persons who must be involved in and agree an immediate care plan is two: the initiating person and

the manager of the area in which the person will be located. Again it is recognised as best practice for a nurse to be present and any other person who would have input to the care of the prisoner at that time. The prisoner is involved.

[17] Despite being marked "at risk" by the receiving officer and being identified as such by the PER and SPS suicide prevention form Mr Hume was not placed on the ACT2 care procedure. The focus of the enquiry was to try to ascertain why that was the case.

Summary of evidence and observations

[18] Mr Hume was identified by Miss Adams the SPS member of staff who carried out the RRA, as being "at risk" of self-harm or suicide. She advised the inquiry that having so assessed Mr Hume she proceeded to complete an ACT2 care document. No such document was lodged as a production in the enquiry. Indeed it was a matter of agreement that no such document has ever been located. Document 19 is a copy of the SIDCAAR report prepared following the SPS internal investigation into Mr Hume's death. The addendum to that Report confirms that an extensive search to locate this document was unsuccessful and the final conclusion reached was that there was no evidence to confirm that an ACT2 care form for Mr Hume existed.

[19] Miss Adams carried out a robust assessment of Mr Hume. She appears to have followed the guidelines closely. She spoke to the prison being busy with many prisoners coming through reception but she did not suggest that she felt pressured in any way by this. Document 6 is the document that was completed for Mr Hume.

Miss Adams completed the front page which contains Mr Hume's personal details and the date on which he was received into the establishment. It does not confirm the time but Miss Adams notes the time that she completed her assessment at the foot of the RRA form as 19:37 hours. On the front page of the form Miss Adams confirms that a personal escort record (PER) has been received for Mr Hume and that additional information in the form of an SPS suicide risk identification court form has also been provided. She notes on the front page that this suicide risk identification form is attached to the RRAD. She confirmed in evidence that she saw both of those documents. Those documents were lodged as productions 7 & 8.

[20] Miss Adams completed the RRA which is part (iii) 3 of the RRAD form. As set out above, at the very top of this form there appears the following statement: "the person completing this assessment must be trained in ACT 2 care procedures".

[21] There are 3 sections of the RRA form. In section 1 Miss Adams confirms she has checked the PR2 for the prisoner. The PR2 is an internal record held by SPS confirming whether individuals who have been in the prison on a previous occasion have been assessed as at risk of suicide or self harm. Miss Adams' response to this is to confirm that "yes" Mr Hume has previously been subject to ACT2 procedures. She is then prompted to check the PER and any additional information which has accompanied the prisoner. The question on the form is: "has there been any information received from PER or other source that has raised concerns with regards to at risk status". Miss Adams confirmed "yes" in Mr Hume's case.

[22] In evidence Miss Adams confirmed that she had sight of both of these forms at the time she was completing her assessment of Mr Hume. Miss Adams has identified Mr Hume as being at risk. Immediately under the section of the form where she confirms this assessment the following statement appears: "if risk has been identified raise an ACT2 care document and place this form within it". Miss Adams did raise an ACT2 document, she spoke to this and her evidence was credible. It was also corroborated by witness Lynn Mathewson and those witnesses' whose evidence has been set out in the Joint minute Mr Buchan and Mr Werniewicz. However the ACT2 form was not placed with the RRAD. Mr Hume was returned to the waiting area pending his healthcare assessment and the only form that appears to have accompanied him is the RRAD document. Miss Adams indicated that she had not completed the ACT2 care document by that time. The ACT2 booklet has never been located. Miss Adams also completed the First night of Custody form. This did accompany Mr Hume to Ellon Hall but has not been located since.

[23] The ACT2 care document is an integral part of the SPS suicide prevention strategy. If the system is followed properly then the ACT2 care document will be raised in circumstances where, as here, the prisoner is identified as being at risk by any individual involved in his assessment. Miss Adams' evidence was that she raised the document. However it is not clear to the enquiry the extent to which this document was completed or where it was placed once Miss Adams had raised it. There was no evidence to suggest that Miss Adams had told Mr Hume she was raising such a document. The impression given by Miss Adams' evidence was that she considered she

was carrying out the first step in the process and her involvement would be complete once she had passed the ACT2 care document over to the health adviser who was to carry out the subsequent assessment of Mr Hume. She did not appear to consider herself responsible for initiating any care plan for Mr Hume or for notifying the Hall Manager of Mr Hume's at risk status. Miss Adams believes that she placed the document on the reception desk within the reception area. Her evidence was that she completed it following her interview with Mr Hume. However the instructions at the foot of the RRA form are that the RRAD should be placed within the ACT2 care document. Therefore Miss Adams should have placed both documents together in a completed state at the end of her interview with Mr Hume, prior to his being assessed by the health professional. Subsequent evidence from SPS managers confirmed that this lapse was accounted for by a lack of sufficiently robust training about the roles and responsibilities of the reception staff. It is now made clear in their training that as soon as they identify a prisoner as "at risk" it is their responsibility to advise the relevant Hall Manager of this fact. Also the ACT2 care document must be placed with the RRAD form and passed to the healthcare assessor. If it cannot be placed directly into the hands of the healthcare assessor, instead of being placed on the reception desk, the paperwork is placed together and put in a specifically designed wall mounted bracket.

[24] As stated above it is not clear what happened to that document but it did not follow Mr Hume to the next part of his assessment which was the healthcare risk assessment. Mr Hume's healthcare assessment was carried out in the medical centre within the prison and not within the reception area itself. The medical centre is on the

same corridor as the reception area but in a separate area. Since this time a change has been introduced to the effect that all parts of the reception assessment will be carried out within the reception area. This with the intention of reducing the risk of any failure to pass vital information between the SPS staff and the NHS staff.

[25] The healthcare part of Mr Hume's assessment, that is the HCA, was carried out by Nurse Rachel Isherwood. Nurse Isherwood provided her evidence to the enquiry by way of affidavit evidence. She was employed by NHS Grampian as a mental health nurse. She obtained a BSc Honours degree in Mental Health Nursing in 2010 and has worked in secure units in hospitals in England and Scotland. She had moved to work at HMP Grampian when it opened on 3rd March 2014. She states that on the date that she assessed Mr Hume she had been trained by SPS in the ACT2 care procedure. This evidence was contradicted by that given by Miss Caroline Moir, which is referred to below. Miss Moir was the healthcare manager employed by NHS at the time and responsible for the provision of healthcare facilities at HMP Grampian. She stated that not all staff carrying out the assessments at that time had been trained in this procedure and Nurse Isherwood was one of those members of staff. Indeed during the internal SIDCAAR investigation Nurse Isherwood advised at interview that she had *not* been trained in the ACT2 procedure at the time of carrying out Mr Hume's assessment (page 2/3 of Production 19). This inconsistency in evidence was not reconciled at the Inquiry. No evidence of staff attendances at training courses was led. However I note the very firm and clear statement made by Nurse Isherwood in her sworn Affidavit:

> "When a prisoner was admitted a booklet would initially be filled in by the prison service staff and then passed to the health centre staff to complete their part. The booklet is called the ACCT booklet which is short for Assessment Care Context Teamwork. I had been trained by Scottish Prison Service in the ACCT procedure when I arrived to work at HMP Grampian and felt comfortable in how to use it".

[26] Nurse Isherwood also confirmed the following in her Affidavit:

> "At busy times we would have to work quickly but I felt I worked efficiently in processing prisoners without compromising on the quality of my assessments."

She therefore made no suggestion that she felt pressured to make assessments quickly due to the numbers being admitted to the prison at this time.

[27] Nurse Isherwood did not assess Mr Hume as at risk of suicide or self-harm. Her evidence was that this was based on the information available to her at the time of the assessment and on how he presented to her. Accordingly she did not raise an ACT2 care document. During the internal investigation into Mr Hume's death Nurse Isherwood indicated and indeed confirmed in her Affidavit to this court that in her view the communication between SPS and NHS Grampian was inconsistent at that time. She indicated that she had never seen productions 7 & 8 – these being the PER and the SPS Suicide Risk Identification Form. Further she stated that had she seen these forms she would have assessed Mr Hume differently and would have placed him on ACT2. She stated that the information contained on these forms would have raised concerns that he was not being honest in telling her that he did not have thoughts of self-harm in spite of how he was presenting. Nurse Isherwood did not appear at the inquiry so did not have the opportunity to provide clarity on matters, but it is not all clear how the HCA could be completed without the assessor having sight of these documents. The front page of

the RRAD makes it clear that a PER is available, together with additional information in the form of a SPS suicide prevention form. The guidance notes emphasise that it is imperative for both the reception and health care assessor to "scrutinise" these forms. The RRA form completed by Miss Adams shows she has had sight of these documents and that they indicate the prisoner to be "at risk". Indeed the healthcare assessor requires to complete a section in the HCA form confirming whether the PER and any additional information provided indicate the prisoner is at risk. Nurse Isherwood has entered NO in this section. Nurse Isherwood stated in her Affidavit that she did not know an ACT2 care document had been raised by reception staff. In her evidence before the internal SIDCAAR enquiry she said something different. She told that enquiry that she assumed one had been raised but she did not see it. Without Nurse Isherwood having the opportunity to provide clarity on these matters I do not feel able to come to any conclusion on what exactly was available to her when she completed this form; however the instructions on the form are so clear as are the entries made by Miss Adams that I am not persuaded that any lack of communication in the form of documentation not having been passed to have played any significant part in the outcome of this assessment. Nurse Isherwood is adamant in her Affidavit that she was trained. Likewise she is clear that she did not feel constrained by any external pressures to compromise in the quality of assessments; therefore I do not find a failure to provide general training or pressure of business to have contributed to any significant extent to Mr Hume not being place on ACT2.

[28] Following his reception risk assessment Mr Hume was admitted to Ellon Hall within HMP Grampian. Prison officer Paul Smith was the residential manager of that hall at the time of Mr Hume's admission. Mr Smith confirmed that he did not receive any information from the reception or from any other source to the effect that Mr Hume was at risk of suicide or self-harm. Accordingly no special measures were taken for his care.

[29] Miss Caroline Moir was employed as the Health Care Manager of HMP Grampian at the time of Mr Hume's admission. She advised that at the time she had not been aware that members of staff were carrying out reception risk assessments when not fully trained in the SPS ACT2 procedure, she is aware now that this was the case. She said Nurse Isherwood was one of the nurses who had not been trained. She acknowledged that it was the responsibility of NHS Grampian to provide fully qualified staff to carry out medical services at the prison; but explained that it was SPS who delivered the training. At the time leading up to the opening of the prison in March 2014 there was a high volume of staff needing trained and not a sufficient number of SPS courses. However Mr Molloy for SPS indicated that sufficient courses had been provided by SPS during this period. I did not consider the inquiry had to come to a view on who was responsible for any lack of training at this time. This because I was not persuaded that Nurse Isherwood was untrained. I also, for reasons set out below, was not persuaded that any failure to provide training courses, as opposed to certain shortcomings in the quality of training , had contributed to Mr Hume not being placed on ACT2.

[30] Miss Moir was not involved in the admission of Mr Hume. She had however when carrying out a clinical role carried out health care assessments. She advised the court that she would have had concerns for Mr Hume quite simply on the basis that the reception officer had concerns. She thought it likely she would have marked him as at risk of harm because the officer did. She herself would then have discussed his care with the Hall manager.

[31] Miss Moir was asked in the course of her evidence to describe the nature of the support which would have been put in place for Mr Hume had he been put on an initial care plan. In reflecting on what was known about Mr Hume at the time Miss Moir considered that he may have been placed in a general cell with observations, rather than the safer cells given to prisoners at the highest risk. However she confirmed that this would be a group and not an individual decision and would be closely followed by a case conference in which all matters would be considered. She confirmed that supports which were put in place for individuals identified as being at risk varied considerably. Those patients considered at very high risk of suicide would be placed in non-ligature cells in special clothing with observations being carried out as often as every 15 minutes. However these sort of measures were very much a last resort and the balance had to be reached between ensuring the dignity and privacy of the individual and protecting his or her safety. Proportionate and necessary supports were put in place and they were continually monitored through the ACT2 procedure.

[32] Mr Mark Molloy is employed by SPS as a unit manager. He was able to speak to the issues facing the admission staff at HMP Grampian at the time of Mr Hume's

reception. Mr Hume's admission took place only a short time after the prison started taking admissions from court. Those sorts of admissions are more challenging for prison staff as SPS have no control over the escort service and must take the prisoner in when they are transported from court. On the day of Mr Hume's admission it was a particularly busy day.

[33] Mr Molloy was concerned about the evidence that Nurse Isherwood was not trained. He was not aware that untrained healthcare staff were working in reception. In his opinion Nurse Isherwood, when assessing Mr Hume, should have asked to see the ACT2 book given the content of the RRA carried out by the officer or she should have herself sought the officer out to speak to her. He considered there was a breakdown in communication when it came to the transfer of documentation and was of the opinion that not all relevant information had been passed to healthcare.

[34] He told the enquiry that after this incident improvements to the paperwork system had been made. There is now an element of ownership on the member of staff who puts a prisoner on ACT, whether that member of staff be SPS or NHS. Immediately a prisoner is placed on ACT the Hall manager is told and paperwork should be physically handed over from one member of staff to another. It has also been enforced that the nurse must always get the personal escort record form. It was also the case that healthcare assessments when forming part of the reception risk assessment process now only take place in the reception.

[35] Miss Lesley McDowall gave evidence about the ACT2 procedure.

Miss McDowall is a registered nurse; before taking up her current role she was the

healthcare manager at HMP & YOI Cornton Vale. She had experience of carrying out reception risk assessments and had placed prisoners on ACT2. She said that at the time of Mr Hume's admission staff not trained on ACT could not carry out the reception assessments. It was her evidence that if an officer marks an individual as "at risk" the nurse cannot override that assessment. This is made clear in the training and is also set out in the flowchart on the RRAD. She stated that if it had been she carrying out the HCA she would have gone to reception to look for the ACT booklet.

[36] She told the court that prisoners can be removed from ACT2 at the first case conference. Over 30% of prisoners were removed within 24 hours of being marked as at risk. She had been present at HMP Grampian a week before it opened. There had been a programme of ACT2 care training sessions taking place then. It was her view that if the healthcare manager was aware that a member of her front-line staff was untrained in ACT2 she should have informed SPS. She was not surprised to find that Mr Hume's demeanour was noted to improve in the day after his admission; this was not uncommon.

[37] Mr Ian McGregor was the operations manager at HMP Grampian at the time of Mr Hume's death. He identified problems in relation to communication issues on the night of his admission. After Mr Hume's death it was emphasised to officers as part of the training that if they identified an individual to be "at risk" then they have ownership and responsibility for providing the relevant information to the nurse. New folders had now been provided to ensure that all relevant documentation was kept together and would be passed on to the Nurse following assessment by the officers. He also referred

to the fact that a log had now been started which recorded the forms which were available for each prisoner and where and to whom the forms had been passed.

[38] Three letters were found beside Mr Hume's body in his cell on the morning of 2 May. These have been lodged as production 10. One letter is addressed to Ian Woodward. This would appear to be Mr Hume's solicitor. The second is addressed to the police. The third is addressed to Mr Hume's wife whom he refers to as "Becky". In the letter addressed to Ian Woodward Mr Hume has written, *inter alia*:

> "dear Ian the police, hospital and prison service new I was suicidal and did nothing, I did ask for help, got no where."

Submissions

[39] All parties lodged written submissions.

Crown

[40] For the Crown Mr Hanton pointed out that it is a matter of fact that Mr Hume's death took place over four years ago. It took place at a time when HMP Grampian had been open for only a matter of weeks. Evidence had been led before the enquiry from a number of witnesses in relation to the procedures that were in place for the admission of prisoners at the time of Mr Hume's death. A number of witnesses spoke to changes that had been made as a direct result of this incident. He submitted that these changes may be considered to be precautions which had they been in place at the time, may have lessened the chance of the deceased passing into the custody hall without being identified to staff there as being potentially at risk of self-harm or suicide. This may have

resulted in the death being avoided by lessening the risks associated with prisoners who may self-harm or attempt suicide. However such precautions would not have removed the risk entirely. Mr Hanson went on to consider the changes in turn. These changes were as follows:

(1) how documentation is passed between staff. Since the incident the procedure is now that paperwork is placed in a wall mounted box rather than left loosely on a desk. This reduces the likelihood of paperwork going astray as appears to have happened in Mr Hume's situation.

(2) the location of nurses carrying out the RRA. The practice of carrying out nursing assessments separately from the reception area had been identified as contributing to a breakdown in communication between the member of staff carrying out the initial assessment and the healthcare professional. The change effected was that assessments be carried out completely in the reception area.

(3) Staff training. Members of staff had acknowledged a lack of training opportunities in place to ensure that all staff who are expected to undertake the RRA had been appropriately trained. The procurator fiscal identified this was a more serious breach of policy than the two previous issues of location and communication. Steps have now been taken to ensure all staff are trained in this procedure. Given the prison has now been operating for a number of years and has a more stable workforce training is provided in a more regulated fashion.

(4) Increased responsibility upon staff identifying prisoners at risk. Those who identify a prisoner at risk are responsible for ensuring that this fact is

communicated to those in the hall who will be responsible for the prisoner's care. Had this been the case at the time of Mr Hume's admission then Miss Adams would have been responsible for this and thus ensuring that all necessary paperwork followed Mr Hume through the assessment process. This change is likely to lessen the chance of someone in Mr Hume's position entering the prison without the support necessary under the ACT2 procedure.

[41] The procurator fiscal submitted that evidence led at the enquiry confirmed that there were issues that may be expected given it was a newly opened prison and was accepting ever greater numbers of prisoners from a number of different sources. Reference was made to the evidence of Mark Molloy, unit manager, who admitted that the project of opening a much bigger and more complex prison was challenging and much of that related to staff training and the pressure of business. Staff were under a lot of pressure and this would have affected their ability to process the increasing flow of prisoners into the prison from other establishments as well as courts. The Crown emphasised the lack of control that the prison had over the timings and numbers of prisoners arriving at any one time. This would have placed a level of pressure on both Miss Adams and Miss Isherwood to process incoming prisoners. Another factor was the inexperience of the staff at the prison at that time and a difficulty with recruitment and retention and accordingly appropriately trained staff being in position. It was the Crown's position however that notwithstanding these operational difficulties there was a proper procedure in place at the time of this test. While it may be considered that feelings and how that procedure was implemented might mean that Mr Hume entered

the hall as a normal prisoner with none of the available safeguards in place that may have lessened his risk to himself, that must be balanced with the evidence that he had appeared happier the day after his admission and it may be that he would have been reassessed at a case conference as being no longer at risk – that can never be known. Evidence was led from experienced witnesses about the general difficulties in identifying truly suicidal prisoners who may effectively hide from those around them their intentions.

[42] For all these reasons it is the Crown's submission that the additional precautions that have now been built into the systems that were already in place will have led to a reduction in the likelihood of prisoners who may be at risk not being identified as such. In such circumstances there is no requirement for this enquiry to make any further recommendations regarding further precautions. It should also be pointed out that it cannot be shown that the lack of these precautions at the time of Mr Hume's death amounted to a defect in a system that contributed to that death. It is the Crown's position that only formal findings should be made in this case.

Prison Officers' Association (Scotland)

[43] Mr Cahill represented the prison officers namely Miss Adams, Miss Mathewson and Mr Smith during the course of the enquiry. He invited the court to make formal findings. He submitted that there was no reasonable precaution that the prison officers, AES members could have taken that realistically might have resulted in the death being avoided. He proposed no defect in the system which contributed to the death nor that

there should be any finding of other facts which are relevant circumstances in Mr Hume's death.

[44] He restricted his submissions on evidence to dealing with that provided by those prison officers who had given evidence before the enquiry. He made the point that the evidence before the enquiry does not allow for a finding under section 26(2)(e)(ii). For such a finding to be made the court has to be satisfied that any precaution which could reasonably have been taken at the relevant time might *"realistically"* have resulted in the death being avoided. He stated that no evidence had been led as to whether, or the likelihood of, Mr Hume being continued to be subject of the ACT2 care regime beyond the 24 hour period. He submitted that it would be purely speculative to do so. Further it would involve speculation that any likely measure under the ACT2 care regime would have prevented the opportunity for Mr Hume to take his own life. In order to make such a finding it would have to be speculated that Mr Hume would have remained on ACT2 after a case conference within a 24-hour period and a highly restrictive measure – such as being placed in an anti-ligature cell – would have been imposed. This would be notwithstanding a positive change of the presentation of Mr Hume as identified by prison officers Mathewson and Adams from 30 April and 1 May; the assessment of an experienced mental health Nurse Isherwood that Mr Hume was not a risk of self-harm or suicide; and the comments of prison officer Brian Shand that he was "surprised" about Mr Hume "because the prisoner seemed in good spirits (on 1 May 2014) and was playing pool and socialising with other prisoners." It is submitted that this evidence if

one was to speculate would not allow for a finding that any reasonable precaution would have realistically prevented the death.

Scottish Prison Service

[45] Mr Scullion on behalf of the Scottish Prison Service identified in paragraph 5 of his submissions what evidence the enquiry had been focused on, namely:

(1) the admission of Mr Hume to HMP Grampian on 30 April 2014, specifically what information was known to SPS and NHS staff which shed light on Mr Hume's mental state

(2) how the SPS/NHS manage prisoners they deem to be at risk of suicide

(3) Mr Hume's demeanour on 1 May 2014, and

(4) the changes which have been implemented at HMP Grampian since Mr Hume's death.

[46] Mr Scullion invited the court to make formal findings in this case. He argued that a finding under (e) or (f) of section 26(2) requires a causal connection between the reasonable precaution of the defect in a system of working and the death. His submission is for that connection to be made there would need to be evidence that Mr Hume would have remained on ACT2 and that he would have been placed in an anti-ligature or safe cell. He stated there is no need for the court to make any recommendations as following Mr Hume's tragic death nearly 5 years ago, changes have been made at HMP Grampian which ensure so far as is practicable, that none of the issues which arose on 30 April 2014 will arise again.

[47] Mr Scullion set out a very helpful legal framework. He concluded by submitting that in order to make a finding under section 26(2)(e) I must be satisfied that the precaution is both reasonable and that it might – in the sense of there being a lively possibility that it might – have prevented the death. If I am to make any finding under section 26(2)(f) similar considerations apply, the difference being that the evidence must be sufficient on a balance of probabilities to justify the finding; I must be satisfied that the defect did in fact cause or contribute to the death. To make a finding under section 26(2)(g) this must be based upon evidence heard at the enquiry and critically must be evidence related to the death.

[48] Mr Scullion outlined the background to the introduction by the Scottish prison service of ACT2 care. He confirmed that it has been replaced by a new suicide prevention strategy known as Talk to Me. He outlined the process to be followed when a prisoner is admitted to prison, he then outlined the evidence of the various witnesses called to give evidence before the enquiry. In his discussion of the evidence Mr Scullion conceded that SPS accept that there was a breakdown in communication on the night of 30 April and it is accepted that Mr Hume should as a result of being assessed as "at risk" have been processed as a prisoner on ACT. However he went on to say that it is a considerable leap to suggest that had he been so assessed his death would or might realistically have been avoided. He made reference to the fact that Miss Adams and Miss Mathewson speak to seeing Mr Hume on 1 May and noting him to be in good spirits with a noticeable change in his demeanour. The joint minute agreed by parties refers to inmates referring to being surprised about Mr Hume's death because he

seemed to be in good spirits and was socialising with other prisoners. Mr Scullion suggested that this indicates that on 1 May there was no cause for concern for Mr Hume and thus it is impossible to conclude on the evidence that Mr Hume would have remained on a ACT2 care until the date of his death. In his view such a finding in fact would be an essential prerequisite to any reasonable precaution or defect in a system of working finding.

NHS Grampian/health board

[49] Miss Davie presented submissions on behalf of the NHS. She argued that the court should find make a formal finding in this case. She argued that there are no precautions so far as the health board are concerned which might realistically have resulted in the death being avoided. She submitted that there were no defects in any system of working operated by NHS which contributed to Mr Hume's death and that there are no other facts which are relevant to the circumstances of the death.

[50] Miss Davie also provided a useful analysis of the relevant legislation. She pointed out to the court that the reference to "reasonably" in the legislation refers to the reasonableness of the precautions not whether it was foreseeable that such precautions might avoid the death. She suggested the evidence identified a number of precautions which have been taken since the death of Mr Hume and it would be difficult to suggest that any of those precautions were not reasonable. However she stated that there are two subsections to this part of the act and section 26(2)(e) underlines the necessity of a causal connection between any reasonable precautions and the death being avoided; it

does so by importing two qualifications in respect of any reasonable precaution. Firstly any such precaution must be shown to be something which might realistically have avoided the death. This word realistically denotes something which is more than a remote chance. She states that it must be something which could practically have altered the outcome in the particular circumstances, it is not enough to show that such a reasonable precaution could have altered the outcome in theory. It is important that any conclusion reached is based solely upon the evidence heard. She made reference to Sheriff Principal Dunlop's helpful statement in the fatal accident inquiry into the death of Colin Marr (2011 FAI 20):

> "the task for the court is to consider the evidence which has been led and to reach a conclusion **if it can** as to what that evidence demonstrates so far as concerns the particular matters set out in section 61, recognising that the evidence may not be sufficient to satisfy the court that there is any clear conclusion that can be reached."

[51] She stated that the health board does not seek to demur from the fact that there are a number of relevant issues surrounding the involvement of Nurse Isherwood in the admission of Mr Hume to the prison which require to be addressed: her lack of training in ACT2 care at the relevant time, the health assessment had been carried out remotely from the reception area, and a lack of documentation had been passed from reception to the nurse. The evidence suggested that steps have been taken to address all of these issues as would be properly expected. However to accept that such issues existed is different from suggesting that they played a causal role in the tragic suicide of Mr Hume. It was respectfully submitted that none of the changes introduced to improve the communication between SPS staff and health board employees constitutes a

reasonable precaution which might realistically have avoided the death. In order for any concerns relating to Mr Hume and the risk he posed to himself to have any practical effect that would have required to be communicated to the hall, that being the point at which a case management conference would have been instigated. Paul Smith spoke to the fact that he would expect a radio message indicating a prisoner was being placed in ACT2 care and that would act as the trigger. Leslie McDowall was clear that at any training delivered on ACT2 care it was made clear that the person initiating the risk assessment was to contact the Hall manager to communicate that fact to them. Mark Molloy spoke to difficulties in this case arising as a result of that communication not having taken place with the Hall manager. Ian MacGregor spoke to that being one of the main issues which had been addressed following this incident. As stated above it was not the practice or certainly had not been communicated clearly in training to the officer at reception that it was incumbent on them to make that communication. That has now been rectified.

[52] It was clear from the evidence that once Mr Hume had been placed on ACT2 care at reception, prior to Nurse Isherwood's involvement there was nothing that she could have done which would have altered the fact that he was on that regime. The fact that she did not assess Mr Hume as being at risk could not have affected the process of putting him on ACT2 care. That process had already been commenced at reception. Nurse Isherwood's assessment was not the "prevailing" assessment. At its height the evidence suggests Nurse Isherwood may have provided a useful "second look" at

whether the relevant documentation was in place. It would never have been her responsibility to contact hall staff.

Mr Hume's family

[53] The submissions tendered on behalf of Rebecca Brownlee, Mr Hume's partner, are in the same terms as those submitted by Mr Hume's family. They state in general terms that the changes implemented since Mr Hume's death demonstrate the reasonable precautions that could have been taken at the time which would have realistically resulted in the death or accident being avoided. They speak to the failure in document transmission between SPS and the NHS, the failure in assessments been carried out over two locations and inadequacy of staff training and ownership of the ACT2 assessment. The defects in system referred to relate to the volume of admissions on the day, leading to pressure of business. There is criticism of the reliance on paper documents being transmitted from one location to another. Reference was made to the fact that there were inherent integrity issues when relying on paper documentation in this day of electronic technology. There is no detail of any specific recommendations which the family seek, nor whether they consider any findings should be made about whether any reasonable precautions would have realistically avoided Mr Hume's death or whether any of the defects referred to contributed to his death.

Determination

[54] The representatives in this case, apart from those acting for Mr Hume's family, have submitted that no recommendations should be made in this case and only formal

findings should be recorded. The procurator fiscal on the basis that it cannot be said that any defects in the system or that failure to take the precautions which could have been taken have contributed to Mr Hume's death. Those acting for SPS, POA and the NHS present the submissions with reference to the statutory wording, arguing that it has not been established that had Mr Hume been placed on ACT2 procedure this would "realistically" have resulted in his death being avoided.

[55] Certainly in determining whether any precautions could have resulted in a different outcome here a consideration is that Mr Hume took his own life in circumstances where he described himself as always being suicidal. But the SPS ACT2 procedure does not claim to eradicate the occurrence of suicide in custody. It is a risk management strategy and is focused towards providing care and support to those at risk of self-harm and suicide with the aim of reducing its occurrence. Mr Hume took his own life less than 36 hours after his admission into HMP Grampian. The evidence before the enquiry establishes that at the time he was admitted he was "at risk". The receiving SPS member of staff so assessed him, based on her own observations and the PER and additional information she had received from the court social worker. Nurse Isherwood confirmed that while she had not so assessed him, had the PER and additional information been available to her she would have done so. The internal investigation (SIDCAAR) confirmed that the correct assessment was that at admission Mr Hume was a prisoner at risk of committing suicide or harming himself. This Inquiry finds that as such he should have been placed on the ACT2 care programme. This would have been a reasonable precaution. It would have ensured that he would not

have been processed into the general prison population of Ellon Hall without the benefit of a support plan – an Initial care plan being put in place for him.

[56] Of course it cannot be said with certainty that this would have avoided Mr Hume taking his own life in the early hours of 2 May; but it must surely be the case that the effective implementation of a programme, specifically designed to reduce suicide among at risk prisoners, has a realistic possibility of achieving that aim. It has been suggested that for me to make such a finding I require to speculate about what would have happened in the hours after Mr Hume's having been placed on this programme. It has been argued that unless I am able to make findings from the evidence that he would have remained on the ACT2 care programme and been accommodated in a safe cell it cannot be established that his death could realistically have been avoided. This is not accepted. I do not consider I require to stray into the sphere of speculation at all. Neither do I require to make any such findings. The key aim of the ACT2 procedure has been set out *ad longum* above, but it is worth repeating here.

> "To assume a shared responsibility for the care of those at risk of self-harm or suicide. To work together to provide a person centred caring environment based on individual assessed need, where Prisoners who are in distress can ask for help to avert a crisis. To identify and offer assistance in advance, during and after a crisis".

The guidance notes on the RRAD contain the following:

> "We need to be sensitive to these "cues and clues" and the use of this document can help us to ask sensible questions, exploring with prisoners their needs and explaining the help available in your prison and how it can be obtained".

[57] It is not to the point that on 2 May Mr Hume had the means to take his own life; it is to the point that on his admission into prison he had not been placed on an initial care plan and thus had the support intended to be available for "at risk" prisoners. The evidence before the Inquiry was that it was unlikely that a step taken in Mr Hume's care was the placing of him in a safe ligature free cell. It is accepted by all that spoke to this factor that this can make matters worse for the prisoner. There are many ways to provide help, support and assistance, the purpose of which is to discourage the prisoner from feeling the only way out is to take his own life. Many prisoners on ACT2 are not in safe cells, but without the support available to them under the care plan they would remain at risk of taking their own life or harming themselves. A finding I am able to make on the evidence is that had Mr Hume been on an initial care plan he would have received support. It is clear from his letter to his solicitor found with his body that at the time he took his own life he felt he had asked for help and not been given it. What is clear from the ACT2 documentation is that the prisoner is advised of the fact that he is on an at risk status and is offered supports and encouraged to discuss what he considers important to keep himself safe. On a balance of probabilities I find that had he been provided with support under the ACT2 on his admission to HMP Grampian this might realistically have avoided his death. It was a precaution which could reasonably have been taken. It is realistic that had it been taken he would not have felt compelled to take his own life in the early hours of 1 May. His death may realistically have been avoided.

[58] Again it is not to the point that he may have been taken off ACT2 care at the first case conference which has to take place within 24 hours of an at risk assessment. This

would only have happened had the committee, consisting of the individual placing him on ACT2, the hall manager and a nurse, unanimously determined that he was no longer at risk. Mr Hume being taken off ACT2 because a unanimous decision has been made following a detailed assessment and meeting that he is no longer "at risk" is a completely different situation from his having never been on ACT2 at all. He himself has an input to that decision. A decision which in many cases would be taken because the initial care plan had by that time provided the help it was designed to.

[59] In any event from the evidence available I am of the view that it is more likely than not that Mr Hume would have remained on ACT2 at the time of his death. Miss McDowall's evidence was that it was not unusual for prisoners to be taken off "at risk" status at the first case conference; however the percentage she gave was 30%. That is less than half, therefore it is more likely than not that Mr Hume would have remained on this status at the initial case conference. I am asked to speculate on the basis of evidence that Mr Hume was giving no visible signs of being in any way in distress on 1 May. However this must be weighed with the evidence of Miss Moir that it can be very difficult to assess whether someone is at risk of taking their own life. Mr Hume's circumstances were that at the time of his arrest he had covered himself in petrol while holding a lighter; this was a very serious attempt at significant self harm. Thereafter the prison escort, social worker and SPS reception officer assessed him at risk of self harm on the day of his admission. He was noted to have been on ACT2 on a previous period in custody. Contrary to what Mr Scullion argues in his submission the evidence of Nurse Isherwood is that her assessment of him as not being at risk would not have been

maintained had she seen the PER and SPS suicide prevention form. I do not consider his appearing in better spirits the next day to be of any particular significance taken on its own. It was an observation made by fellow prisoners and prison staff, some of whom were not aware of Mr Hume having been on "at risk" status. Even for those who had been aware of his condition on admission and qualified to make assessments this was a superficial observation made in the absence of any proper assessment of how Mr Hume may actually have been feeling. This alone cannot be accepted as evidence tending to show that Mr Hume was no longer at risk.

[60] I have referred in my outline of the evidence led at the inquiry to the defects in the system at the time Mr Hume was admitted into custody. Mr Hanton in his submission itemises them succinctly. I have set down in paragraphs 27 & 29 why I do not consider these particular defects to have contributed to any material extent to Mr Hume not being placed on ACT2. The court does find that the shortcomings in the quality of the training provided to staff did contribute to Mr Hume not being placed on ACT2 care. This refers to the staff not being instructed that on their placing a prisoner on ACT2 it became their responsibility to ensure that fact was communicated to the Hall staff. This defect could also be categorised as a communication error, however the failure here was due to a lack of training. This shortcoming has been remedied.

[61] Miss Davie argued that by the time Nurse Isherwood became involved in the assessment process the failure to properly implement the ACT2 procedure had already occurred. The failure by reception staff to alert the hall to Mr Hume's status was the problem, there was nothing she could do to avert that. This was a carefully precise

argument but it was not correct. Had Nurse Isherwood adhered to the ACT2 procedure herself she would have been prompted to raise an ACT2 and the procedure would have been initiated at that point.

[62] Mr Sanders acting for the family of Mr Hume sought to question an SPS witness about the efficiency and reliability of relying on a paper-based system in this day and age, particularly relying on paperwork accompanying a prisoner around the establishment. This line of questioning was objected to by Mr Scullion acting for SPS on the basis that no notice had been given to the other representatives at the inquiry; accordingly those acting for SPS were not in a position to meaningfully respond or lead evidence on this matter. I did not allow Mr Sanders to pursue this line of questioning. He did not offer to lead any witnesses to speak to how the use of an electronic system would have improved the system in operation. The impression I got was that the argument was simply to suggest that it was self-evident that an electronic system must be a more efficient and reliable way to enter, communicate and store information. To this date on the evidence before the Inquiry it is not a system which has been adopted by the SPS in the ACT2 assessment process. It may well have advantages but an examination of that was not the purpose of this inquiry in the absence of any evidence that the present system being operated was not fit for purpose.

[63] I do not consider there are any other facts relevant to the circumstances of Mr Hume's death not covered so far in this determination.

Conclusion

[64] express my regret in taking such a number of months to issue my determination in this case. Alas this could not be avoided but I apologise to all involved. I would also comment that at the commencement of this Inquiry over 4½ years had passed since Mr Hume took his own life. The purpose of a fatal accident inquiry is to establish the circumstances of the death, to consider what steps (if any) might be taken to prevent other deaths in similar circumstances and to make appropriate recommendations. I have no doubt that all parties involved in this inquiry appreciate that this purpose is somewhat frustrated if the inquiry does not take place within a reasonable time of the death. No criticism is directed against any individual involved in this Inquiry but the effectiveness of holding such an inquiry after such a delay must be questioned, evidenced in this case where no recommendations are made, not because there were no defects or precautions that could have been taken, but because the necessary changes have already been made by those involved. This does not even begin to take into account the distress which in many cases will be occasioned to families in re-opening the circumstances around the painful loss of a loved one so long after the event. Finally I express my sincere condolences to the family of Mr Hume for their very sad loss.

Appendix

Documentary productions lodged by the Crown

1 Toxicology report

2 Autopsy report

3 Photo book

4 Fingerprint ID form

5 HMP Grampian statements

6 Reception risk assessment Part 1

7 Suicide risk ID court form

8 Personal escort record

9 Special risk prisoner form

10 Suicide note

11 Suicide risk management strategy

12 Reception risk assessment (Part 2)

13 ACT2 care document

14 Reception movement form

15 Safer cells

16 Safer custody

17 Audit and Assurance services report

18 Record of events

19 SIDCAAR guidance

Documentary productions lodged by the Scottish Prison Service

1 Talk to Me: strategy

2 Talk to Me: Guidance (Part 1)

3 Talk to Me: guidance (Part 2)

4 Reception and health centre plan

5 Photograph of reception/health centre link

6 National memorandum of understanding between the Scottish ministers and NHS Scotland 2011