SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2019] FAI 24

B1019-18

DETERMINATION

BY

SHERIFF LINDA MARGARET RUXTON

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

into the death of

ROBERT WILLIAM NOBBS

GLASGOW, 5 June 2019.

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

(1) in terms of subsection (2)(a) that Robert William Nobbs, born 21 October 1966, formerly of Inverkip, Paisley, died in Her Majesty's Prison, Low Moss, 190 Crosshill Road, Bishopbriggs, G64 2QB on 3 November 2017, life being formally pronounced extinct at 0801 hours on that date;

(2) in terms of subsection (2)(c) of the said Act that the cause of death was hanging; and

(3) in terms of subsection (2)(f) of the said Act that the lack of a suitable regime for the support and accommodation of offence-protected prisoners over a prolonged period and the associated failure to implement local measures to mitigate the restrictive conditions under which they were incarcerated were failures in the system of working at Her Majesty's Prison, Low Moss. These defects contributed to the death of the said Robert William Nobbs who was a vulnerable prisoner at high risk of suicide.

NOTE:

Introduction

[1] An Inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act") into the death of Robert William Nobbs, born 21 October 1966, formerly of Inverkip, Paisley, was held at Glasgow Sheriff Court. The Inquiry commenced on 16 October 2018 and, after several continuations, concluded on 7 March 2019. Ms Margaret Dunipace, Procurator Fiscal Depute, appeared for the Crown in the public interest. The Health Board of Greater Glasgow and Clyde was represented by Ms Ann MacNeill, Advocate. Mr Ross Fairweather, solicitor, appeared on behalf of the Scottish Prison Service. The Scottish Prison Officers' Association was represented by Mr Andrew Phillips, solicitor.

[2] The court heard evidence from five witnesses to fact. Three witnesses gave evidence by affidavit. Otherwise uncontroversial facts were agreed by joint minute. Two

expert witnesses gave evidence: Mr Philip Wheatley CB, former Director General of Prisons in England and Wales and Dr Khuram Khan, Consultant Psychiatrist at the State Hospital, Carstairs and Her Majesty's Prison Cornton Vale. Details of the witnesses are contained in the annex to this Determination.

[3] This Inquiry was held under section 1 of the 2016 Act. The inquiry was mandatory in terms of section 2(1) and (4) of that Act as Mr Nobbs was in legal custody at the time of his death. He had appeared at Greenock Sheriff Court on a petition containing charges under the Civic Government (Scotland) Act 1982 sections 51A and 52A (possession of indecent images) and a contravention of the Firearms Act 1968 (possession of a prohibited weapon). His first court appearance on these matters was on 18 August 2018 when he was committed for further examination and remanded to Her Majesty's Prison, Low Moss ("Low Moss"). He appeared in court again on 25 August when he was fully committed for trial and again remanded to Low Moss.

The legal framework

[4] The primary purpose of a fatal accident inquiry ("FAI") is to give a public airing of the facts surrounding a death or fatal accident. This affords those with a direct interest, such as the family of the deceased, the chance to hear first-hand from witnesses and learn the full circumstances of the death as they are known.

[5] An FAI is not the place for matters of legal culpability to be explored and determined: the sheriff has no power to make a finding of fault or to apportion blame amongst persons or organisations that might have contributed to the accident. Questions

of civil or criminal liability for a death are properly matters to be pursued elsewhere. Concepts such as duty of care, foreseeability and negligence have no place in an FAI. Significantly, section 26(6) of the Act sets out that the determination of the sheriff shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. Such a prohibition is designed, in part, to encourage a full and open examination of the circumstances of a death in a setting where witness should feel free to give frank evidence in the spirit of the Inquiry, untroubled by concerns about it being used in any other proceedings. Thus an FAI is not an adversarial procedure but an inquisitorial one.

[6] The scope of an FAI extends beyond mere fact-finding. It aims to restore public confidence and allay public anxiety where the circumstances of the fatal accident have given rise to serious public concern. To that end, its focus is towards the future. Where possible, such an inquiry seeks to prevent future accidents and deaths occurring in similar circumstances.

[7] While the evidence led at an FAI may be fairly comprehensive in an effort fully to inform relevant parties, it does not follow that every matter explored should be included in the sheriff's determination. Like an FAI, the sheriff's determination must be finite. Only those matters which properly fall under the provisions of sub-section 26(2) of the Act are relevant.

[8] In an Inquiry such as this, in terms of section 26(2) the sheriff must determine

- where and when the death occurred - section 26(2)(a);
- the cause of death – section 26(2)(c);

- any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in the death being avoided – section 26(2)(e);
- the defects, if any, in any system of working which contributed to the death – section 26(2)(f); and
- any other facts which are relevant to the circumstances of the death – section 26(2)(g).

It is important to appreciate that findings under subsections (e) and (f) are entirely separate. The tests applicable to each should not be conflated.

The sheriff may also make recommendations if considered appropriate in the public interest.

[9] The standard of proof that has to be met before material facts can be established in an FAI is the civil standard of proof on the balance of probabilities. Rules of evidence in civil proceedings apply: indirect evidence of hearsay may be admitted.

Background

[10] It became clear in the course of the Inquiry that, from the outset, Mr Nobbs was a very vulnerable prisoner who was at high risk within the prison setting. Several features contributed to this assessment.

(1) Mr Nobbs had no experience of custody. This was his first time in prison. It is well-recognised that such prisoners are at greater risk and are therefore more vulnerable than others with more experience of the custodial setting. This

enhanced risk was recognised by the prison staff who highlighted his first-time status in capital letters on his prison record. Moreover, Mr Nobbs was a remand prisoner. This category of prisoner is also recognised to be at higher risk than those convicted and serving their sentence. His naivety was evident from the beginning. Mr Malcolm McKay, one of the hall prison officers, carried out Mr Nobbs' assessment on his first night in jail. It was obvious that Mr Nobbs had no experience of custody and little idea of what to expect. Mr McKay described Mr Nobbs as a very humble and gentle person, quite unlike most prisoners. It was clear that Mr Nobbs was frightened of his environment. As will be seen, he was afforded protected prisoner status which segregated and protected him from other prisoners. Mr McKay commented that "he would not have lasted a minute in the mainstream prison".

(2) Mr Nobbs fully accepted responsibility for his offences and was deeply ashamed of what he had done. He had profound and overwhelming feelings of guilt, particularly about the effect that his conviction would have on his family. He was worried about the impact any publicity might have on his partner and young son with whom he had lost contact since his arrest and that he had brought shame upon them.

(3) Mr Nobbs was someone who had suffered from depression and anxiety for much of his life although he had not sought help in relation to his mental health, despite having been encouraged to do so by his partner. He had

received no formal mental health diagnosis. However, his sister Julia explained that he was the type of person who always saw the black side of things – she described him as an "Eeyore" character. She had supported him for many years, providing him with coping strategies as a means of climbing out of his black moods. His tendency to look on the dark side of things was recognised by Mr McKay and also by Mr Martin Forrest, the Prison Chaplain.

(4) Mr Nobbs had disclosed incidents from his childhood when he had suffered sexual abuse. These issues were unresolved and had affected him profoundly. He spoke of the resultant "turmoil in his head".

(5) Mr Nobbs had previously considered suicide on at least three occasions that the court heard about. First, he had bought a Taser (this was the weapon referred to in the Firearms Act contravention) and had adapted it so that it would deliver a lethal charge. He had decided against killing himself when he realised the effect it would have on his family having witnessed the devastating impact of a friend's suicide.

Secondly, when he was arrested, Mr Nobbs had attempted to harm himself with a screwdriver. This had been brought to the attention of the prosecutor and he had been seen by a community psychiatric nurses. Warnings of suicide risk accompanied him from court.

Finally, and of most concern, he disclosed in a letter to his sister dated 21 September that he had attempted to hang himself in his cell three times on 19 September. These attempts on his life was made while he was sharing his

cell but occurred when his cell mate was out at court. He had just had a distressing meeting with a social worker and was concerned that he was not going to be allowed to see his son. These were serious suicide attempts. Apparently he had told his cell mate what he had done. His friend had counselled him against making any formal disclosure because he would end up in "the Digger".

(6) Mr Nobbs was afraid of two aspects of prison life in particular: he feared being put into the Digger and he was terrified of Barlinnie prison. He harboured the myth that the Digger was "a place for nutters and killers". He had been told that the nastiest people went in there, that people could be heard screaming through walls and that if you went in there you never came out. This was a reference to the nearby Segregation Unit where hostile and disruptive prisoners are sent. Prisoners deemed at risk of suicide and who are subject to the Talk to Me procedures are not sent there. While this was clearly a myth, perhaps designed to put the wind up novice inmates, nevertheless it was clear that Mr Nobbs lived in genuine fear of being put in the Digger. These myths were never dispelled and so he had good reason, as he saw it, to hide any suicidal feelings from the authorities. As for Barlinnie, he had convinced himself that he would receive a lengthy prison sentence and he was terrified of going to Barlinnie. He was aware of its reputation as a hard and austere prison.

(7) The charges on which he had been remanded included some of a sexual nature. Prisoners remanded or convicted of sex offences are also considered to be at higher risk within the custodial setting. Because he was charged with offences of this nature, Mr Nobbs was placed under protection. As an offence-protected prisoner, for his own protection he was not allowed to mix with the general prison population. As a consequence he was subject to a very strict prison regime. He was allowed little in the way of social interaction with anyone and spent up to 23 hours a day locked in his cell. He had very limited access to exercise and was not allowed to participate in any of the educational activities, work parties or recreation. His ability to contact family members by phone depended on the movement of other prisoners within the unit and was not guaranteed. He was not allowed access to the library or any other facilities located within the mainstream prison. His whole regime was unpredictable. Unfortunately, as Low Moss did not have the facilities to cater for prisoners on protection he was kept in solitary confinement for much of his remand, between 18 August and 27 August and between 2 October and his death.

[11] There were, however, several safeguards or protective features which mitigated the extent of Mr Nobbs' vulnerability.

(1) The first and most important was the support he had from his family, in particular his sister Julia Wheatley. He received support from his parents and letters from his partner Shirley McPhee and from their son. Mrs

Wheatley gave him consistent and unstinting support – which she had done all her life – and, in particular, continued to provide sound advice and strategies to Mr Nobbs to help him cope with his situation. He called her "my rock". Mrs Wheatley travelled from England to visit him on 3 occasions around his birthday in October and throughout his remand there was a regular exchange of e-mails and letters. Telephone calls to his sister and parents were frequent and often lengthy although these were sometimes curtailed because of prison movement and the need to confine Mr Nobbs to his cell.

(2) A second and important source of support came from one of the prison officers, the said Malcolm McKay. From the outset it was obvious that Mr McKay had been very impressed by Mr Nobbs and had taken an immediate liking to him. They developed a special rapport and Mr McKay spent a lot of time talking to Mr Nobbs, particularly in the earlier part of his remand.

(3) Mr Nobbs also benefitted from ongoing contact with the prison chaplains and, in particular, with the full-time chaplain, Mr Martin Forrest. Mr Forrest first met Mr Nobbs soon after he was remanded. One of the officers asked him if he would go and see him because he was concerned as it was Mr Nobbs' first time in prison. Mr Forrest saw Mr Nobbs frequently – at least once per week, sometimes more often. Sometimes there were lengthy visits to give Mr Nobbs space to talk. Two other colleagues from the

chaplaincy also saw him. Mr Forrest made it his business to go and see him as he needed someone to talk to. He clearly enjoyed talking to the chaplain.

(4) From 27 August until 2 October, Mr Nobbs shared a cell with a prisoner "Craig". At that time, Craig was also on remand for charges which included a sexual offence and so both were offence-protected prisoners subject to the same regime. Craig was an experienced and seasoned prisoner, described by Mr McKay as "the typical revolving door", in and out of prison. According to Mr McKay, the two were absolute opposites but "in an unconscious stroke of genius" the pairing was a huge success and they got on like a house on fire. Mr McKay described it as something akin to "the Odd Couple". However, on 2 October Craig pleaded guilty to some charges and his plea of not guilty to the sexual offence was accepted. Unfortunately for Mr Nobbs, that meant that his cell mate returned to Low Moss as a convicted prisoner and was no longer subject to protected status. The result was that he could no longer share a cell with Mr Nobbs. From that day until his death, Mr Nobbs was in a cell on his own.

Events leading up to Mr Nobbs' death

[12] Shortly before his death, Mr Nobbs had been expressing to his sister his belief that he was going to receive a lengthy prison sentence and how afraid he was of going to Barlinnie. He was terrified at the prospect. On the evening before he died, in the course of a telephone call, Mr Nobbs had encouraged his parents to watch a television

documentary due to be aired that night about Barlinnie. This was the Ross Kemp documentary about the Barlinnie prison depicting its reputation as one of the country's most notorious jails.

[13] During the evening Mr Nobbs watched the documentary in his cell. At one point during it the subject of the incarceration of sex offenders was examined in the course of which Ross Kemp apparently made derogatory remarks, asking prison officers how they looked after such prisoners whom he implied were "the lowest of the low". At this point Mr Nobbs would have been able to hear the reaction from the mainstream prison from others watching the programme. There was a noisy response with jeering and name-calling – Mr McKay described it as "a torrent of abuse" – in the course of which his former cell mate's name was shouted. (There was no suggestion that Robert Nobbs' name was mentioned.)

[14] At about 0700 hours on 3 November during the morning check, officer McKay found Mr Nobbs dead in his cell. He had hung himself by his shoe laces. He had been dead for some time. He left notes for his family from which it was clear that he suffered overwhelming feelings of guilt and shame with feelings of failure and remorse. He also stated that he "could not handle Barlinnie". Everyone was shocked by his death. No-one had seen it coming. No-one had any concerns that he would have taken his own life and no protective measures had been put in place at any stage. Accordingly, the fundamental issues explored during the Inquiry were whether there were any reasonable precautions which might realistically have prevented his death and whether there were any defects in the system of working that contributed it.

The prevention of suicide in prison

[15] Suicide in prison, as in the wider community will never be eradicated. A person determined to take their own life will generally succeed – a universal view shared by Dr Khan and Mr Wheatley. According to Dr Khan, the suicide rate in prisons is about nine times that in the community. Mr Wheatley observed that persons with significant social and health problems (physical, mental and psychological) are disproportionately represented in the prison population. However, the Scottish Prison Service operates a robust and comprehensive strategy designed to prevent or at least reduce the numbers of suicides in prison.

[16] The strategy is contained in the document "Talk To Me: The Prevention of Suicide in Prison Strategy". In December 2016 this strategy replaced and built on the previous strategy "Act 2 Care". The strategy, as outlined in an affidavit from Ms Lesley McDowall, Health Strategy and Suicide Prevention Manager for the Scottish Prison Service, is primarily focussed on ensuring that appropriate person-centred care is provided where a person is identified as being "At Risk" of suicide. The strategy embraces a holistic, multi-disciplinary approach to ensure a supportive environment. All staff are trained in the Talk To Me procedures. They are trained to listen and observe and look for cues and clues that would suggest that a prisoner is at risk of suicide. Should that be the case, the Talk To Me procedures are readily and quickly activated. The procedures can be activated by anyone who has concerns. The strategy is supplemented by several less formal arrangements designed to provide support to

prisoners. These include "Listeners" who are prisoners themselves who have volunteered to take on such a role and who are trained by the Samaritans Organisation and "Open Secrets", an outside counselling service for survivors of childhood abuse. Mr Wheatley commented that at the time of its introduction the Scottish Prison Service strategy was the best and most sophisticated suicide prevention policy in the UK. In his opinion, it was second to none.

[17] In terms of the strategy, Ms McDowall explained the reception risk assessment procedure when a prisoner is admitted. The initial assessment covers any issues the prisoner may have, for example, any mental health or self-harming issues that may require Talk to Me procedures to be activated. In assessing whether a person is deemed to be at risk of suicide staff are trained to take account of a number of features including a person's body language, tone of voice, whether the person makes eye contact and whether they appear tense or anxious. All these are indicators that a person may be struggling to cope and in need of support. The assessor should also consider any external information including information that comes from court or via the escort officers. Within the guidance it is emphasised that assessment is a dynamic process where levels of risk can change, sometimes very quickly. These principles apply at every stage of assessment.

Mr Nobbs' mental health (a) Assessment and contact with mental health team

[18] Mr Nobbs was admitted to Low Moss 18 August 2017 and went through the reception risk assessment process. The first step in that process is an interview with the

reception officer. His task is to carry out an initial assessment before the prisoner meets with a member of the nursing staff. Within 24 hours, the prisoner is then seen by a doctor.

[19] As part of the assessment, the reception officer was made aware of alerts that had accompanied Mr Nobbs to prison. A letter from a community psychiatric nurse who had seen Mr Nobbs in custody highlighted that this was his first time in custody and that he was anxious although he had not expressed any suicidal thoughts. A letter from the procurator fiscal depute warned that he was a suicide risk. The reception officer had been informed that Mr Nobbs had attempted to injure himself with a screwdriver but had not suffered any injuries as a result of this. Mr Nobbs was described as openly chatty. He was making good eye contact and appeared relaxed. He stated he was not suicidal and he was assessed as presenting no apparent risk.

[20] Mr Nobbs was then seen by a nurse in reception. She recorded that he had previously self-harmed and that he had previously received input for mental health problems (although this seems not to have been further explored). No issues or concerns were raised and it was noted that he was fully compliant. The previous assessment that he was not at risk of suicide was confirmed.

[21] All prisoners newly admitted to Low Moss are accommodated in the "first night centre" in Kelvin Hall "A" Block where they are further assessed and are introduced to the prison regime in an attempt to settle them. They are provided with information as to what to expect while incarcerated and what is expected of them. Mr Malcolm McKay was on duty in the first night centre when Mr Nobbs was admitted.

[22] Mr McKay was to be a source of steady support to Mr Nobbs during his time on remand. From the outset, Mr McKay developed a special rapport with Mr Nobbs. It was clear to him that Mr Nobbs had no jail experience. Mr Nobbs was very open about his offences and Mr McKay gauged a sense of relief from Mr Nobbs that he had been finally brought to account for his behaviour. Mr McKay spent some time with Mr Nobbs for the first night assessment. He explained about the prison routine. As a protected prisoner, it was explained to Mr Nobbs that he would not spend long in Low Moss but would soon be transferred to Barlinnie. It was further explained that this was because Low Moss did not have the facilities to look after protected prisoners and for that reason Mr Nobbs was warned that he would be subject to a very limited regime until he moved on to Barlinnie. Mr McKay advised that there was a much better regime in place at Barlinnie where he would get much more in the way of recreation and socialising. Finally, Mr Nobbs was asked whether he felt suicidal to which he replied, "no". Mr McKay had no concerns on that account. Rather, the opposite was the case because of Mr Nobbs' sense of relief at having been caught. (This was confirmed by his sister – Mr Nobbs had told her that he had to stop his behaviour by being arrested.)

[23] In accordance with normal practice, Mr Nobbs was seen by the prison general medical practitioner on the following day. As mentioned, the relevant record highlighted that it was his first time in prison. It was noted that he had no previous or current suicidal ideation under explanation that when he was arrested Mr Nobbs got upset and self-harmed with a screwdriver as a "cry for help". During the consultation Mr Nobbs maintained good eye contact. He was calm and again denied any active

suicidal ideation. He gave a history of suffering from stress for over 40 years and he was advised to speak to his personal officer. Again he was assessed as not being at risk of suicide.

[24] On 23 August it was noted in the prison records that Mr Nobbs had been remanded on a charge that he was ashamed of. He participated in the immediate support plan and it was noted that he required help through the chaplain as he had lost family support because of his offence.

[25] Mr Nobbs was next seen on 24 August when he attended a core screen interview carried out by Miss Lorraine Hunter, the Behavioural Change Officer at Low Moss. Miss Hunter gave evidence and explained that this was a procedure designed to assess a prisoner's initial risks, to establish how they are feeling, how they are settling in and if any referrals require to be made, including those in the community, for example, housing, job centre applications and generally to try to fix other problems in the community. It is a one-to-one interview under the auspices of a multiple-agency approach designed to ensure that information is shared with other agencies.

[26] Miss Hunter remembered the interview with Mr Nobbs well because she spent longer than usual with him – about an hour and a half. She made a full record of the interview where she noted that he presented as a person with a number of issues. In particular he felt guilt in bringing shame upon his family with whom he had lost contact as a result of crime. Despite feeling low he had no thoughts of suicide or self-harm; he explained that he felt that he had put his family through enough and would not want to put them through any more. Various pieces of information were given to him and he

was advised that he could be given additional support which would include being checked on more often and given the opportunity to speak to people. He was encouraged to put in a referral to the mental health team and to make an application to Open Secrets. This was because he spoke briefly about childhood trauma and she thought he would benefit from speaking to someone. He was given his admission letter which is an information pack for new prisoners. He was also given a referral form and information about visiting. In addition, he was given information about the Family Contact Officer who deals with any issues regarding visits and can also contact family members. She spoke to him briefly about this officer because he said he had lost contact with his family, however, he declined the service because he said that his family did not want to speak to him at that point. Mr Nobbs agreed to refer himself to the mental health team and to the Open Secrets programme although he decided to delay the latter until after his next court appearance as he thought he would be taken to a different establishment.

[27] In the course of the interview, Miss Hunter also explained to Mr Nobbs that as a protection prisoner his movements would be restricted. He would be allowed out of his cell for exercise for one hour each day and also at meal times. At these times he would be able to mix with other protection prisoners but not with any other prisoners in the Hall. As a result of the restrictions on his movement, Mr Nobbs was not able to participate in the induction process which was held over a five day period as this was held in the Link Centre which was located in the mainstream part of the prison.

[28] On 25 August Mr Nobbs made a second court appearance when he was committed to prison until trial. He returned to Low Moss and was again screened through the reception risk assessment process. Again, the notes of these interviews recorded no specific concerns. Mr Nobbs was talkative and compliant and assessed as presenting no apparent risk.

[29] Mr Nobbs' next contact with the prison mental health team followed a self-referral which he submitted on 30 August. On his referral form he noted the reasons for his request concerned the nature of the charges he faced, the problems it would have on his family and himself. He felt that a meeting with the team would be of great benefit to him. The referral was considered and treated as a routine matter. An appointment for 11 September was noted on the referral form but mistakenly was not entered into the team diary. Accordingly, it did not take place. A further appointment was given for 25 September but before then on 14 September Mr Nobbs submitted a second referral form to Mental Health Team stating that he needed to speak to someone about his problems "ASAP", that he was having problems sleeping and was anxious. Again, this was assessed as routine. It was noted that Mr Nobbs already had an appointment for 25 September.

[30] On 25 September he was seen by Mr Andrew Lockhart, a registered mental health nurse and team leader of the team of four mental health nurses, including himself. These nurses were on site every day between 8.00 am and 4.00 pm Monday to Friday but were not on site at the weekends.

[31] Mr Lockhart could vaguely remember the meeting with Mr Nobbs although his recollection was not clear. He carried out a mental health assessment. He noted that there had been no previous contact with the mental health services. In the course of the interview Mr Nobbs spoke of stress at work and at home and of having had a plan at one point to commit suicide using a Taser device. There was a frank and open discussion during which he denied any current suicidal ideas. He did not appear to be distressed. He was asking for help in relation to a childhood trauma. Mr Lockhart concluded that Mr Nobbs was not clinically depressed (so medication was not appropriate) but that psychological support was the way forward. It was left that Mr Lockhart would come back to Mr Nobbs although no timescale was given. Mr Lockhart was able to re-assure Mr Nobbs that he was not suffering from any mental illness and that he could get help. He needed support to deal with his issues.

[32] Unfortunately, this support did not materialise. Mr Nobbs was discussed at a multi-disciplinary feedback session at the beginning of October when it was decided that he should be referred to psychology for low intensity interventions to manage anxiety symptoms. A follow-up appointment was made for 31 October, although this was not communicated to Mr Nobbs (apparently for security reasons). In the event, that appointment did not take place either as Mr Lockhart was called away to deal with an urgent matter. Mr Nobbs remained unaware of the decision to provide psychological support. No steps were taken to re-schedule the cancelled appointment. This was an "administrative oversight" – Mr Lockhart admitted that he completely forgot to re-schedule.

[33] In the meantime, on 23 August an entry in the prison records was made by a social worker highlighting that Mr Nobbs was on remand for charges he was ashamed of and that he needed support through the Chaplaincy service, again flagging up his vulnerability. A further entry recorded that on 11 September a referral to the mental health team had been made by a social worker but this did not appear to have provoked any further action.

(b) Others' impressions of Mr Nobbs' mental health

[34] Mr McKay was anxious to dispel the view that Mr Nobbs was left languishing in his cell. From the start when he had carried out the first night interview with Mr Nobbs, he had been impressed by him. He had taken an immediate liking to him. Mr McKay spoke of Mr Nobbs' humility: he was open about his charges and fully admitted them. He described Mr Nobbs as a "decent human being". He explained that "Rob liked to talk". They would have long conversations about anything and everything. Mr McKay clearly had a special relationship with Mr Nobbs. He spent more time with him than any other prisoner. He saw him every day. There was a lot of humour in their conversations and "light ribbing". According to him, there was something in Rob that was not like a normal prisoner. He never complained. He appreciated the time Mr McKay spent with him and always thanked him. However, due to circumstances beyond his control, Mr McKay was not able to spend as much time with Mr Nobbs once he was back in a cell on his own. This was due to other work commitments. He had little time to talk to

him any more – he "wasn't touching base with Rob" and was conscious of that. He was therefore keen to ensure the chaplains saw him more.

[35] At no time did Mr McKay have any concerns about Mr Nobbs' mental state. He saw no change or deterioration. Had he done so, if necessary, he would have implemented the Talk To Me strategy without hesitation. During their discussions Mr Nobbs opened up and spoke about various issues. If he was "going down a black road" Mr McKay was always able to turn him round and bring him out of it. Far from appearing suicidal, Mr Nobbs talked positively about his future. He seemed to have a plan for the future. He had every reason to be optimistic and hopeful. While most prisoners have a pretty bleak outlook, Mr McKay never saw that with Mr Nobbs. His whole focus was on trying to sort out issues with his partner and son and on getting his life back together. Mr McKay saw someone who wanted to turn his life around.

[36] Similarly, the Chaplain, Mr Forrest, spent a lot of time with Mr Nobbs and gave him on-going support. He was concerned about Mr Nobbs and made it his business to visit him on a regular basis. If Mr Forrest was not available he would ensure that one of his colleagues went in to see Mr Nobbs. Mr Forrest found him very subdued and very low every time he saw him. Mr Nobbs continued to be distressed about his circumstances and worried about his family. That was a constant worry and he was particularly concerned about the effect of publicity on his family in a small community. Mr Forrest considered that the situation he was in was consuming him – he was overwhelmed by being in prison.

[37] The chaplain had lengthy discussions with Mr Nobbs almost always about his problems. It was clear that Mr Nobbs needed someone to talk to and that he enjoyed talking to Mr Forrest. Mr Forrest, too, enjoyed their conversations. Mr Nobbs opened up fairly quickly and became more and more frank and transparent in these discussions. Suicide was mentioned a couple of times but always in the context that this was not what Mr Nobbs was going to do because of the effect it would have on his family. There was a lot of conversation about his future and much about which prison he would go to. Mr Forrest recognised this tendency to look on the black side and endeavoured to deflect Mr Nobbs to a more positive outlook. His mood was better when he was in a shared cell. He got on well with his cell mate Craig and they opened up to each other and enjoyed the company. Mr Nobbs never tried to minimise what he had done but was full of remorse. He was clearly under a great deal of emotional strain. After his cell mate was re-located, Mr Nobbs clearly missed the company.

[38] His sister, Julia, had intermittent concerns about Mr Nobbs' mental stability but on the whole had no real concerns that he would take his own life. She monitored his demeanour because she knew how easily he could "slip". She knew how to get him back out of his dark moods and in e-mails to him she would repeat the strategies they had used all his life. He phoned her and their parents regularly, most days. In his early calls he was anxious and desperate to start the long journey to recovery.

[39] On 19 September she received a phone call from him in which he sounded panicked and under pressure. This followed an upsetting child protection interview with a social worker which he had terminated. He was afraid that he would never see

his son again. She reassured him and by the end of the phone call she was satisfied he was calmer and that all was well. However, in a letter written on 21 September he explained following that interview he had spent "two hours climbing up the wall with guilt and anguish" and how he had written his letters of goodbye to the family and tried to hang himself three times. On each occasion he tried to hang himself, he described how he had passed out and had come to after the laces broke. He was dribbling and shaking uncontrollably. He told his sister that this experience made him realise that it was not his time to go and said that he would keep the shoe laces for the rest of his life as a reminder. He explained that he had to keep his neck covered lest officers would notice that he was sporting some large bruises from the ligatures. Mr Nobbs pleaded with his sister not to tell anyone about this because of his fear of being put in the Digger. She reluctantly went along with his request for fear of losing his trust, but she was "incredibly anxious as to what he might do". However in the days that followed he appeared a lot more normal and was more positive about the future.

[40] Julia Wheatley travelled from England to visit her brother on 20, 21 and 23 October for his birthday. They had discussions about the future and he talked about what he had done and why. From his description of his routine, she was concerned that he was very much alone in his cell 23 hours a day with no stimulation at all. He did not have a personal officer and his cell mate with whom he had really gelled and who listened and talked to him about his behaviour had moved out. Both she and Mr Nobbs spoke to one of the prison officers in the visiting area who took them through the process of accessing hobby materials and the like. She expressed concern that he was on

his own for 23 hours a day and was told that she would need to speak to "family contact". There was some discussion with a prison officer about how he could get another cell mate. At one point they spoke to Craig, his former cell mate, who was also keen to share a cell again. No evidence was heard as to whether that was acted upon.

[41] During this time Mr Nobbs expressed his frustration that he had not been able to access counselling and that he had heard nothing back from the mental health team. He had also been told about Open Secrets by the Chaplain in relation to traumatic experiences in childhood and was following these things through himself.

[42] On 23 October Mrs Wheatley saw her brother for the last time. He behaved bizarrely. When she arrived he had his head in his hands and was sobbing, with tears streaming down his face. He changed instantly on seeing his sister and immediately appeared "upbeat and normal". She thought he had tipped over the edge as a result of the isolation. They spoke about the future. She was not concerned that he was suicidal but "just that he had lost his way". She felt that following years of not being able to seek help, he was finally ready to talk to people about what had happened to him as a child but help – at a critical time – was not forthcoming. Mrs Wheatley raised her concerns about the on-going isolation with Mr Nobbs' solicitor who arranged to go to see him but unfortunately did not manage to do so before he died.

[43] Subsequent e-mails and telephone calls were relatively positive and gave no cause for concern. However during their last two telephone conversations Mr Nobbs was convinced that he was going to prison for a long time and spoke of how terrified he

was about going to Barlinnie. Mrs Wheatley was concerned about his mental state. She thought that he was deeply depressed but did not believe that he was suicidal.

[44] On the evening before his death he spoke to Mrs Wheatley's husband. They had a light-hearted conversation. He also spoke to his parents that evening when he told them to watch the television documentary about Barlinnie that was due to be aired that night.

[45] Throughout his time on remand the isolation he was experiencing was a constant issue. He expressed the difficulty he was having coping with this on many occasions in his conversations with his sister. This was confirmed by Mr Wheatley who had listened to recordings of some of the telephone calls. It was clear that he had little to distract him from ruminating on his problems and was becoming overwhelmed by the circumstances he found himself in. The strict regime and lack of facilities were features that had a significant negative impact on Mr Nobbs' mental health. The Inquiry heard evidence from Mr Kenneth McCaskill, Deputy Governor of Low Moss as to the arrangements for such prisoners. His evidence was augmented by testimony from Mrs Siobhan Taylor, Unit Manager with responsibility for the day to day management of Kelvin Hall and from Mr Malcolm McKay.

Prison regime for protected prisoners at Low Moss

[46] Prisoners are categorised as "protection prisoners" for various reasons – one is that they are being tried for, or have been convicted of, committing a sexual offence. This type of prisoner is categorised as an "offence-protection prisoner". Mr Nobbs was such a

prisoner having been changed with an offence involving the downloading of indecent images. Such persons are considered in need of protection as they would be at risk of assault by other prisoners.

[47] Mr McCaskill explained that there are four other prisons across the SPS estate that are designated to hold protection prisoners, including prisoners on remand for, or convicted of, a sex offence: Barlinnie, Glenochil, Dumfries and Edinburgh. These prisons have a regime in place for protection prisoners.

[48] E-Hall is the area within Barlinnie where offence-protection prisoners are housed. Between 250-260 protection prisoners are located in E-Hall. These prisoners have a regime which is similar to non-protection prisoners. The regime includes access to the library, access to education and recreation and the opportunity to be part of a work party.

[49] There was nothing like that in Low Moss. When the prison opened in March 2012, it was never envisaged that the prison would hold offence-protection prisoners for any length of time. Therefore it did not have a regime in place for them. The practice was to receive offence-protection prisoners from the local courts and then arrange for these prisoners to be transferred to Barlinnie as soon as possible. There were two designated transfer days each week and it was anticipated that prisoners would be transferred on the next transfer day following their admission. Protection prisoners were therefore routinely transferred to Barlinnie within a couple of days of their admission to Low Moss. However, by the time Mr Nobbs was admitted this arrangement had broken down. Barlinnie was full to capacity and transfers were not occurring.

[50] Mr McCaskill explained that the increase in numbers of persons remanded for or convicted of sex offences has increased significantly and steadily over the last decade and continues to rise. In part this is due to the sharp increase of those being tried for and convicted of historical sex offences. In 2006, the number of prisoners being held in connection to a sexual offence was around 700. In 2018, that number was around 1,370. There are a further 470 non-offence-protection prisoners.

[51] Shortly after commencing her post as unit manager, Mrs Taylor became aware that transfers to Barlinnie were not taking place as quickly as they should have done. Increasingly Barlinnie was running at full capacity with no spaces for additional offence-protected prisoners. There was no opportunity for transfer. That meant that, instead of spending a couple of nights in Low Moss prior to transfer, prisoners like Mr Nobbs were staying in Low Moss for weeks and months at a time without access to any proper regime. She confirmed that the SPS management were made aware of the problem which was being considered at a national level. They were aware of both the space inadequacy and the lack of a suitable regime for such prisoners.

[52] In the meantime, she averred that it was not possible to introduce any changes to resolve the problem. Kelvin Hall 1A was supposed to be a first night centre to which all new prisoners were initially admitted, regardless of their status. While Barlinnie was full, there were not sufficient numbers of "overspill" offence-protected prisoners to justify housing them in a dedicated unit in Low Moss. To have done so would have left spaces unoccupied so that Kelvin Hall would have been running under capacity and therefore inefficiently. It would also have put pressure on other parts of the prison.

Furthermore, any suggestion of moving some of the offence-protection prisoners from Barlinnie to fill the spaces was not possible because Low Moss was not designated to hold such prisoners so that other agencies were not contracted to or able to provide the necessary support. Accordingly, nothing was done to try to ameliorate the restricted circumstances in which the offence-protection prisoners found themselves and the situation was allowed to continue.

[53] Mr McKay also expressed concern about the situation to his superiors. The prisoners were locked up "24/7". There was no regime in place or facilities for offence-protected prisoners. Prison officers, he said, did not know how to look after such prisoners other than through basic training. The section in which Mr Nobbs was housed accommodated a maximum of 38 prisoners. It was used as a "dumping ground" for all sorts of other prisoners, particularly the disruptive ones. There were six different categories of prisoner in 1A and all had to be kept apart from each other and managed separately. Mr McKay saw staffing levels at that time as another problem as staff were regularly taken from the area to work elsewhere – "we were robbed of staff significantly". He said that he had found this period particularly difficult. The lack of staff meant they were working "really, really hard" and this impacted on the time that could be spent with prisoners. The workload, he said, was manageable if you did the bare minimum according to the rule book. He described how he felt he was just "treading water" and providing prisoners with "the absolute basics". He was critical of managers who appeared "okay with that as long as we were ticking the boxes". This

was a very frank but telling account of working conditions at that time. Mr McKay had been vocal about it to managers.

[54] Given the strict and isolated conditions and with the knowledge of his predisposition to suicide given his high risk and vulnerability, at no time did anyone consider Mr Nobbs to be at active risk of suicide. The question was whether his suicide should have been anticipated and if so whether it was avoidable.

Could Mr Nobbs' suicide have been anticipated and could it have been prevented?

[55] The various assessments of Mr Nobbs to determine his mental state were reviewed by Dr Khan and Mr Wheatley. Neither had any concerns about the way in which the various reception risk assessments were carried out and recorded or of the conclusions reached. Although Mr Wheatley commented that these initial assessments were fairly superficial – in that they simply asked "Do you feel suicidal?" – they were adequate. They took account of mood, demeanour and responsiveness. The reception staff were aware of and took into account the warnings that had accompanied him from court and he was immediately identified as a first-time remand prisoner. There was some inconsistency about previous suicidal ideation but, of course, much depends on whether the prisoner chooses to disclose such history. It was not until the more in-depth assessment by the prison GP on the day after his admission that such detail was disclosed and recorded.

[56] The doctor took this into consideration when assessing Mr Nobbs' risk and having listened to his account, together with his body language, reasonably concluded

that he had no active thoughts of self-harm. The self-harming episode when Mr Nobbs was arrested was considered by the doctor (and by Mr Nobbs himself) to have been a "cry for help" rather than an attempt at something more serious. This was a reasonable assessment in Dr Khan's opinion. In psychological parlance, such behaviour constitutes a "mal-adaptive coping strategy" designed to numb psychological pain. He explained that although a cry for help does not indicate that there is no risk of actual suicide, it does not indicate an immediate risk – as he put it "no red light". This type of behaviour is generally dealt with through less intensive measures such as supportive counselling. In connection with the Taser episode where Mr Nobbs had decided against following his plan through because of the potential impact on his family, Dr Khan explained that it is a good indicator of future prognosis for a person to demonstrate good insight into mental and behavioural issues. Dr Khan considered that being a family man was a good protective factor for Mr Nobbs. That said, any previous attempt at self-harm is a major risk factor in any assessment. However, in the circumstances Dr Khan was satisfied that there was no immediate risk of suicide and that the doctor's conclusion was justified.

[57] Likewise, there was no suggestion that there was any immediate risk that should have been identified during the first night assessment by Mr McKay. No evidence of immediate risk was apparent. On the contrary, although naturally anxious about being in prison for the first time, Mr Nobbs appeared generally relieved. Mr McKay was careful to explain to Mr Nobbs what he could expect of prison and tried to alleviate some of his concerns, including his anxiety about Barlinnie.

[58] Dr Khan explained that judging whether a person is at risk of suicide can be difficult. For a psychiatrist it is based on subjective assessment together with objective assessment of demeanour, taking account of past history and any protective factors. Many persons who have suicidal thoughts keep these to themselves and remain guarded about their mental state. Mr Nobbs appeared to be one of those. Mr Wheatley agreed and felt that Mr Nobbs had been guarded from the outset, a view shared by his sister. Moreover, as Mr Wheatley was keen to point out, what is being assessed is the *immediate* risk of suicide: these assessments are only valid for the time at which they are made. Circumstances can and do change very rapidly. This together with the guarding characteristic makes it notoriously difficult to predict whether an individual will commit suicide at some future time.

[59] A further early opportunity to identify any suicidal concerns arose at the core screen interview conducted by Miss Hunter. This was a much more comprehensive interview. Mr Nobbs' session took longer than usual and it was evident that a wide-ranging discussion took place. He was open and co-operative throughout. Various issues were identified including childhood trauma. The Open Secrets programme was mentioned as Miss Hunter realised that Mr Nobbs needed to seek to someone and felt that the counselling service would assist. He was also encouraged to refer himself to the mental health team, which he did. Miss Hunter was satisfied that although Mr Nobbs was clearly feeling low and anxious, he had no thoughts of self-harm and she had no concerns on that front.

[60] Mr Wheatley was complimentary about the core screen interview which he considered was well done. Furthermore, a full report of the meeting was placed on the prison system so that everyone interacting with Mr Nobbs could see it. Good advice was given and, again, there was nothing to suggest that Mr Nobbs was actively at risk of suicide. Dr Khan shared that view.

[61] The next interview – with Mr Lockhart on the 25 September – followed what Mr Wheatley described as a very sensible self-referral. In his referral request form, Mr Nobbs had disclosed that he needed help and why. It should have indicated that he was struggling. Mr Wheatley considered that the referral was dealt with fairly slowly although there was evidence that, notwithstanding the failure to set up the 11 September appointment, the referral was processed within the target time of 28 days. In the course of the interview, Mr Nobbs disclosed many things that were stress factors. These demonstrated that there was a lot going on in his head and that he was anxious and depressed. In Mr Wheatley's opinion, while not indicating that he was suffering from mental illness as such, there were clear warnings that he was experiencing real problems in coping with what had happened to him in the past and his current situation.

[62] Therefore it was not acceptable, according to Mr Wheatley, that there was no follow-up appointment made. Nor was it acceptable that no further feedback was given to Mr Nobbs to advise him that a referral to psychology would, indeed, be made. The decision of the multi-agency meeting itself was not properly followed up.

[63] Dr Khan agreed. The delayed and then cancelled appointment with no follow-up was unacceptable. He regarded these as failures in the system. Psychological support in

the form of counselling or anxiety management should be offered and initiated as early as possible in high risk prisoners such as Mr Nobbs. Mr Nobbs was appropriately assessed at the meeting with Mr Lockhart during which issues requiring psychological support were identified but this support was neither communicated to him nor followed up.

[64] It was acknowledged that at the time there were shortcomings in the provision of mental health services. These were outlined in affidavit evidence presented from Rhoda MacLeod, Head of Adult Services for Sexual Health , Police Custody and Prison Healthcare across National Health Service Greater Glasgow and Clyde ("NHSGGC"). Her responsibilities include health care services in Low Moss. She explained how health care staffing levels generally have an impact on the standard of mental health care that can be offered in prisons. Where there are shortages of primary health care staff, members of the mental health team are required to assist with the core nursing duties rather than concentrate on their mental health specialism. It was also acknowledged that there were shortcomings in staffing at the time of Mr Nobbs' remand. She explained that because of the specific challenges of health care within the prison environment, it was difficult to recruit and retain staff.

[65] Neither Dr Khan nor Mr Wheatley considered that the shortcomings in the support offered and received by Mr Nobbs by the prison mental health team, though unacceptable, materially contributed to his death. Likewise they did not conclude that had appointments been offered more quickly that his death would have been prevented.

Submissions

[66] In respect of the identified shortcomings in the care provided by the mental health team, neither the procurator fiscal in the public interest nor any of the other represented parties asked me to make any positive findings in terms of section 26(2)(d) or (e). On behalf of her client, Ms MacNeill submitted in so far as relating to the involvement of NHS Greater Glasgow and Clyde that the evidence did not support a finding that there were any reasonable precautions that the Board could have taken which would realistically have resulted in Robert Nobbs' death being avoided. Nor were there any defects in the system of working which contributed to his death.

Conclusion

[67] On the evidence before me, I was satisfied that Mr Nobbs had been properly and professionally assessed at all stages. The support that he required was identified and steps were taken to progress that albeit that no further appointments took place and that he was never advised of the decision to refer him for the psychological support he clearly needed. That was unfortunate. While there were identified and acknowledged shortcomings in the support given to him by the mental health team, I saw no evidence to suggest that these were systemic failures. For example, the failure to re-schedule Mr Nobbs' appointment with Mr Lockhart was an unfortunate error. Mr Lockhart was frank enough to say that he simply forgot to do it. Although there was another "mix-up" over the 11 September appointment which never materialised, I did not consider that the evidence disclosed demonstrable systemic failure.

[68] In any event, there was no evidence to support a finding that these individual failings causally contributed to Mr Nobbs' death in any meaningful way. The apparent lack of progress and absence of communication undoubtedly caused him frustration and anger but it would be a leap too far to suggest that they affected his mental health to such a degree that they were causally linked to his death.

[69] I was equally satisfied that his suicide could not reasonably have been anticipated. It came as a severe shock to everyone. His sister had no inkling of it. Mr McKay and Mr Forrest likewise had no concern that Mr Nobbs was at risk of suicide – Mr McKay's response was one of "utter disbelief". Significantly, the prison authorities were unaware of his previous attempts to hang himself in his cell. When Mrs Wheatley became aware of this, some time had passed and her brother had given her firm reassurances that he realised that it was not his time and had kept the shoelaces as a reminder of that. This was an indication, as was the Taser incident, that he had thought things through and had good insight into his situation. As Dr Khan said, such insight suggested a good prognosis. Mr Nobbs had been talking positively about the future and Mr McKay saw no change in his mental state. Although he had a tendency to look on the black side, he was able to be brought out of these moods. Both Mr McKay and Mr Forrest commented to the same effect. The profound shock felt by Mr McKay when he discovered Mr Nobbs' body that morning on 3 November was a powerful indicator that his suicide was completely unexpected. That he did not see it coming haunts Mr McKay to this day.

[70] I was entirely satisfied that staff were well trained and fully aware of the Talk To Me procedures. The prevailing ethos in the prison is such that, if necessary, these procedures are readily activated. Had any of those who had dealings with Mr Nobbs in the prison had any concerns that he was at active risk of suicide, I have no doubt that they would have invoked the correct procedures under the strategy, without hesitation. As Mr Forrest said, he would have "immediately opened the paperwork".

[71] I therefore conclude that Mr Nobbs' death could not reasonably have been anticipated. Accordingly, there were no reasonable precautions whereby his death might realistically have been avoided such as would justify a finding in terms of section 26(2)(e) of the 2016 Act.

Expert opinion on the restricted regime operated for protected prisoners

[72] Both Mr Wheatley and Dr Khan were critical of the regime operated at Low Moss – or the lack of it – for protected prisoners such as Mr Nobbs. Both were of the view that it contributed significantly to his situational anxiety and depression.

[73] Mr Wheatley was highly critical of the regime under which Mr Nobbs was incarcerated at Low Moss. As a former Director General of Prisons in England and Wales his experience within the prison sector, at operational, managerial and the highest policy levels together with his advisory work at national and international governmental levels demonstrated an expertise second to none. He was a hugely impressive witness and I found his evidence logical, pragmatic and reasonable. He demonstrated a comprehensive understanding of the complexity of managing competing and often

conflicting demands within the prison setting where resources were finite. He appreciated the position of prison staff, managers, prisoners and their families and so was able to take a rounded view of things. Thus his opinions were most persuasive. I did take into account, however, that Mr Wheatley was unaware of the support provided to Mr Nobbs by Mr McKay. He was not provided with such information. In fact, Mr McKay's evidence to the Inquiry came late on the instruction of the court because it was important to hear directly from one of the hall officers. Undoubtedly Mr Wheatley would have approved of Mr McKay's approach and been impressed by the encouragement and support Mr McKay offered, as was I. Notwithstanding that Mr McKay's contact with Mr Nobbs did not form part of Mr Wheatley's opinions, I am satisfied that they remained essentially valid. Mr McKay's interactions with Mr Nobbs did not reflect any formal measure designed to address the absence of a reasonable regime.

[74] The number of prisoners who are either on remand for or convicted of a sex offence has continued to rise over the last decade. Mr Wheatley observed that this was due in part to the increased numbers of reports of historical sexual abuse and the consequent rise in the number of prosecutions and convictions. This has been a long-term trend since about 2006. Numbers continue to rise. Accordingly, this is nothing sudden or new but has been going on for decades. In such circumstances it is the job of the prison authorities to take account of this rise and to appreciate its impact on the prison population. They should be planning for it. The prison population keeps on changing. It is fluid and dynamic and the SPS must keep an eye on things so that they

can match the right number of places to the right number of prisoners. It is the responsibility of the prison authorities to ensure that there is the right accommodation for the population they are receiving. Although the headline levels may remain quite steady, the make-up of prison population changes. Put bluntly, the job of the prison authorities at national and local level is to keep ahead of the game and not wait until they are overwhelmed by it.

[75] Mr Wheatley accepted that Low Moss was under a duty to accept any prisoner sent there. That included those charged with sex offences even though Barlinnie was at full capacity and unable to take such prisoners on transfer. He acknowledged the difficult position for managers at Low Moss but it is the job of the prison services to keep ahead of the game to ensure that there is suitable accommodation available. This has always been the case and often necessitates changing the role of the accommodation – "re-role-ing".

[76] Mr Wheatley acknowledged that Low Moss had limited options to re-role. (It was his understanding that Mr Nobbs was the sole offence-protected prisoner on remand but there was no clear evidence before the court about that so there may have been others.) Mr Wheatley's concern about the situation in Barlinnie and the knock-on effect on Low Moss was that someone had not been watching what was happening so that accommodation ran out. He acknowledged that resources for running prisons are finite and there are therefore limits to the degree to which the regime can be enhanced meaning that increased use of re-sources in one area of operation has to be met by a reduction elsewhere. Likewise the fabric of any prison once built is relatively inflexible.

In practice the buildings place limits on the way the prison can be run. These and the dynamic nature of the prison population are everyday challenges for the authorities and for Governors. Their duty is to look after the prisoners who arrive, not a previous population. It is the job of prison managers to ensure that they have the appropriate accommodation for the population they are receiving. To re-role involves changing existing facilities and therefore should not require additional resources.

[77] If Mr Nobbs were the only prisoner affected by the delay in transfer to Barlinnie (or there were only a few such prisoners) Mr Wheatley accepted that it would not have been appropriate to re-role the facilities. In such circumstances, what was required was a local fix. It was inappropriate and unreasonable to keep a prisoner on such a limited regime for more than a few days. Where the necessary changes cannot be made quickly, then local fixes must be put in place for those establishments who do not have appropriate regimes.

[78] Such local fixes can be fairly simple. They might include ensuring that the prisoner has access to a gym or to exercise in his cell; ensuring there are materials available for hobbies to keep the person occupied. Hall staff should be told to speak to the prisoners regularly, to maintain on-going contact.

[79] Cell sharing was another potential local fix. It was clear that Mr Nobbs had benefitted from his cell sharing experience with Craig. The arrangement provided both with a mutual source of support and companionship. Unfortunately that came to an end when Craig no longer required offence-protected status and changed from being a remand prisoner to a convicted one. Mr Wheatley explained that there is no legal reason

why those accused or convicted of sex offences cannot share a cell with a non-protected prisoner. Provided a proper risk assessment is carried out and it is carefully managed, that should be possible. However, he was aware that this is a sensitive matter in Scottish prisons following the murder by a non-sex offender of a cell mate who was offence-protected. After that the rule was strictly applied and such a practice of sharing was discontinued. It happens in England and Wales where there is no bar to cell sharing on that basis provided there is consent by both prisoners. However, it remains the case that being charged with a sexual offence makes it more difficult to share a cell and such a prisoner is at a disadvantage if he wishes to share a cell.

[80] In the circumstances in which Mr Nobbs was being kept, that fix should have been considered as it would have relieved his isolation. Careful management of cell sharing which included risk assessment and consent of the prisoners in such circumstances should have been possible in Mr Nobbs' case.

[81] Mr Wheatley was scathing of the fact that there was no evidence of local fixes having been introduced in Low Moss. He considered that it would be dangerous to keep a prisoner in such circumstances for weeks at a time in a single cell without access to social interaction and ordinary regime activities. He judged Mr Nobbs to be "near the edge", struggling to cope and deprived of the things that would make prison bearable. In his circumstances such fixes were very important.

[82] Mr Wheatley identified the various issues already referred to that contributed to Mr Nobbs' increased vulnerability within the prison. While that did not mean that he was at immediate risk of suicide, it did mean that he possessed a number of re-disposing

factors that made him *more likely* to commit suicide. In that case, steps should have been taken to try to address these. It was the responsibility of the Governor through the hall manager to ensure that measures were taken to ameliorate the situation. Hall staff also have a key role to play in such circumstances. There was no suggestion that this was done in any formal way. Much of the little time he had outwith his cell was taken up with making phone calls to his family but even that was unpredictable. Additional access to phones might have helped. Basically anything to help distract him from ruminating on his problems should have been considered. Mr Wheatley had never known a situation where a lone sex offender like Mr Nobbs had been stranded in a place with no regime for a length of time. The prison management failed to provide a regime which gave him a reasonable life in prison.

[83] Efforts should have been made to ensure that hall staff understood his position and staff should have been instructed to keep a close eye on Mr Nobbs and interact with him on a regular basis. He should have been given access to facilities – even simple things like materials for hobbies or things to keep him occupied in his cell. Access to further exercise or to enable him to exercise in his cell were other possibilities.

[84] As it was, Mr Nobbs had little to break the monotony of his solitary confinement and loneliness. He had little to deflect him from his obsessive thoughts except day-time TV.

[85] Dr Khan also confirmed that the restricted regime would have impacted negatively on Mr Nobbs' mental health and increased his vulnerability. He was obviously distressed and anxious and struggling with social isolation and feelings of

hopelessness. Greater opportunities for social interaction and recreation would have provided him with some distraction. He lacked sufficient social support and structure. His social isolation was compounded with feelings of powerlessness and uncertainty. In the circumstances in which Mr Nobbs found himself, Dr Khan agreed with Mr Wheatley that routine is beneficial and that predictability in an unpredictable environment is generally good. Conversely, unpredictability and uncertainty adds to stress.

Submissions on the lack of a regime for offence-protected prisoners at Low Moss.

[86] I received detailed written submissions and have considered these. Put shortly, the representatives of the individual interested parties to this Inquiry urged me to return formal findings only and specifically not to make any findings under sections 26(2)(e) and (f) in respect of the regime criticisms. However, Mrs Dunipace, in the public interest, invited me to make a finding in terms of section 26(2)(f) that the limited regime operating for protected prisoners at the time was indeed a defect in the system of working at Low Moss which contributed to Mr Nobbs' death. She submitted that I would be entitled to make such a finding based on the expert evidence, particular the opinions of Mr Wheatley.

[87] In contrast, others sought to persuade me that the evidence provided no basis for such a finding. On behalf of the Scottish Prison Service, Mr Fairweather argued that the ideal to provide all prisoners with a varied, stimulating and predictable regime had to be tempered with reality. The situation at Low Moss around the time of Mr Nobbs' death reflected the constant conflict that many prisons face in trying to manage (i) the

complex needs of different categories of prisoners; (ii) the requirement to keep prisoners safe; and (iii) the unpredictable demand for prison spaces. In terms of the local fixes proposed by Mr Wheatley, he submitted that Mr Nobbs did benefit from meaningful social interaction so far as could be accommodated in light of his protection status: the positive relationship he had with Mr McKay; his regular family contact; his contact with the chaplains; sharing a cell for some of the time; and contact with the mental health services. It was not possible to re-shuffle the various categories of prisoners within the prison population as suggested by Mr Wheatley for the reasons outlined by Ms Taylor. He suggested that there was no evidence to support a finding that the regime constituted a defective system of working which, on the balance of probabilities, contributed to Mr Nobbs' death.

[88] On behalf of the Prison Officers' Association of Scotland, Mr Phillips likewise invited me to return formal findings only and, in particular, to make no finding under section 6(2)(f). The problem lay further down the line at Barlinnie. The officers in Low Moss did the best they could in difficult circumstances. Mr McKay, in particular, did everything he could to alleviate the effects that the limited regime would have had on Mr Nobbs. The regime available between August and November 2017 did not operate as it should have. He submitted that the reasons for this were unavoidable due to increased numbers of offence-protected prisoners at Barlinnie. Low Moss had no option but to keep them once Barlinnie was at capacity. It would be speculative to conclude that Mr Nobbs death was related in any way to periods of isolation.

Conclusion

[89] I have concluded that the system which allowed Mr Nobbs to remain the subject of such a restricted regime was indeed defective**.** He was imprisoned in circumstances which would have been tolerable for no more than a few days – I agreed with Mr Wheatley that to have kept him without a proper regime was poor prison practice and unacceptable. In these circumstances measures to address and mitigate the situation – local fixes – required to be found. Ignoring the situation and allowing it to continue was not an option.

[90] I was not convinced that local fixes were given adequate consideration. There was certainly no evidence that they were considered for Mr Nobbs as an individual. That they should have been is obvious. He was a first-time prisoner on remand. He was struggling with profound feelings of shame. The nature of his offences were such that he required to be protected from others and was subject to vilification and stigmatization from other prisoners, as was evident from the reaction to the documentary. That would have been frightening. He was having to deal with demons from his childhood and had recently disclosed having been sexually abused as a child. He had lost contact with his partner and young son and was deeply anxious about the effect on them of publicity about his offending. He feared he might not ever see his son again. He was suffering from reactive depression to his circumstances and was struggling to cope. He had contrived to harm himself in the past. Although the prison authorities had no knowledge of his previous attempt to hang himself in his cell, the elaborate plan to kill himself with a Taser device was well documented. I agree with Mr Wheatley that all

these pre-disposing factors meant that Mr Nobbs was a highly vulnerable prisoner who, if not at immediate risk of suicide, was at high risk and therefore required to be watched carefully. Depriving him of any sort of reasonable regime was therefore unacceptable and amounted to a defect in the system whereby he was incarcerated in terms of the 2016 Act.

[91] Some possible local fixes would have been simple – for example to have provided him with some hobby or library materials. Others required slightly more thought such as additional access to recreation or exercise or more telephone access. Cell sharing would have addressed the isolation and lack of socialisation. Although there were policy reasons in Scotland against the sharing of cells between protected and non-protected prisoner and remand and convicted prisoners, this was a case where Mr Nobbs and Craig had already very successfully shared a cell and where both had expressed a desire to do so again. In light of Mr Nobbs' high risk and vulnerable status, cell sharing should have been considered as an exception to the policy. There was no evidence that it was actively thought about beyond simply to exclude it, if it was given any thought at all.

[92] As it was, no local fixes were put in place for Mr Nobbs. The support and companionship provided by Mr McKay was an example of what should have happened across the board. He spent additional time with Mr Nobbs and ensured that he was, as he put it, not left languishing in his cell. Even then, work pressures made it impossible for Mr McKay to sustain his contact with Mr Nobbs. Likewise the support given by Mr Forrest and the other chaplains was considerable. But these were supports given by

individuals. They were not part of any specific care plan for Mr Nobbs. There was no evidence (and nothing in the records) to suggest that Mr Nobbs' vulnerability had been formally highlighted so that the need to take additional measures to ensure his wellbeing were identified and put into place. Rather it was concluded that there was nothing that could be done and that the situation was allowed to persist.

[93] Far from being speculative, it is entirely reasonable to conclude that the isolation and the deprived conditions in which he was kept for several months had a detrimental impact on his mental health and contributed to his overwhelming sense of hopelessness and despair. Accordingly, it is likely that they had a direct bearing on his death. I am satisfied that the evidence supports the conclusion that it is probable that the lack of an appropriate regime for offence-protected prisoners and consequently the highly restrictive conditions in which Mr Nobbs was held had a direct causal connection with Mr Nobbs' death in terms of section 26(2)(f).

[94] It is equally likely that the documentary on Barlinnie acted as the trigger for his suicide. Mr Nobbs was terrified of being sent there and the documentary itself together with the response from the mainstream prisoners in Low Moss would have compounded those fears. He wrote in his letter that he could not handle Barlinnie. The programme, I suspect, was simply the last straw for Mr Nobbs.

The position since 2017

[95] In connection with the shortcomings identified in the provision of care by the mental health team, Ms MacLeod gave assurances that efforts have been and continue to

be made to address these staff shortages through increased recruitment and enhanced working conditions to encourage retention of staff.

[96] Staffing levels – specifically within the Low Moss mental health team – have since increased. In November 2017 there were 2.6 whole-time-equivalent ("WTE") Band 5 mental health nurses and one full time Band 6. Of that number, a WTE Band 5 Mental Health Nurse was on maternity leave. Currently there is 1 full time Band 6 Mental Health Nurse and 3 WTE Band 5. In addition, there is also now a WTE Band 7 mental health nurse on secondment to manage and supervise the mental health team. As a result of this increase in staff numbers, routine mental health referrals – like that of Mr Nobbs – can now be dealt with more quickly than in 2017.

[97] Ms MacLeod advised that budget levels have inevitably had an impact on the standard of mental health care that can be offered in prisons. With regard to psychological services, there had for some time only ever been one permanent WTE consultant clinical psychologist across all three prisons. However, since 2017 funding from the Scottish Government have enabled an additional 0.8 WTE principal clinical psychologist and one WTE nurse therapist across all three prisons. At the point of Mr Nobbs' referral to psychology this additional psychologist was on maternity leave. NHSGGC have now secured an additional two WTE principal psychologists, two WTE nurse therapists and one WTE assistant psychologist. This service will be available across all three prison sites. It is expected that, as a result of these additional resources, patients like Mr Nobbs who are referred to psychology following on from a mental health assessment, should be seen by a psychologist more quickly than was the case in

2017, depending on individual need. These staffing improvements were welcomed by Dr Khan.

[98] Further resources have been pledged from the Scottish Government to provide joint training to Scottish Prison Service and non-mental health NHS prison staff on identifying low level mental health issues. This will assist staff in identifying prisoners who may require some additional mental health support and will promote a more psychology and trauma aware environment within Low Moss.

[99] As a direct result of the administrative oversights in relation to Mr Nobbs' appointments, the Health Board implemented additional staff training to ensure that in the event of a cancelled appointment, a new appointment will be made with corresponding entries in the patient's records detailing why they were not seen and the noting the date of the re-listed appointment.

[100] I was not invited to make any formal recommendations in respect of the mental health facilities at Low Moss. In light of the significant improvements made, there is no need for me to do so.

[101 Mr McCaskill and Ms Taylor provided an update about the facilities available to offence-protected prisoners at Low Moss. Barlinnie continues to be working at full capacity and the number of prisoners accused or convicted of sex offences continues to rise. They remain accommodated in Low Moss. However, the numbers have increased to the point at which there are now enough offence-protection prisoners to be accommodated in their own dedicated section – Kelvin Hall 1B. Staggered unlocks are no longer required as prisoners are allowed out of their cells and can socialise with

fellow protected prisoners at mealtimes. They can also enjoy some recreation in the evening. The regime now allows "slightly improved access to outside exercise and recreation" according to Ms Taylor. However, there was no evidence that the protection prisoners are given access to the library, education, or that they are able to participate in work parties. Mr McKay remains concerned about the regime afforded to these prisoners. They cannot even access simple things like a haircut. Furthermore, numbers are such that there is now an overspill from Kelvin Hall 1B so that offence-protected prisoners are being held under staggered locking conditions elsewhere in Low Moss although they can access some of the facilities in 1B.

[102] Mr McCaskill advised the court that the SPS is aware that there is a need to examine and reconfigure prison capacity in order to manage the increasing sex offender population. This is currently being looked at. The SPS Strategy and Innovation Directorate are preparing a report for the Executive Management Group of the SPS which sets out the various prisoner population issues facing the organisation now and going forward. The report contains a chapter which focuses on the increasing sex offender population, and identifies certain factors that might be contributing to this increase. It is expected that the report will include proposals for the management of this population group in the future. Once complete, the report will be considered by the Executive Management Group of the SPS, who will then consider the next steps.

[103] I was not asked to and do not make any formal recommendation in respect of the treatment of protected prisoners at Low Moss. I am satisfied that as the matter is being considered at high level and that a report can be expected imminently.

Concluding remarks

[104] Having considered all the evidence, I am satisfied that there are no other issues relevant to the circumstances of Mr Nobbs' death that fall to be included in this Determination.

[105] Finally, I wish to pay tribute to Julia Wheatley and to Shirley McKee for listening to the evidence with dignity and fortitude. One of the purposes of a fatal accident inquiry is to allow relatives of the deceased to hear evidence for themselves directly from those who have direct knowledge about the circumstances of the person's death. A striking feature of this Inquiry was that prison staff remembered Mr Nobbs very well – sadly not always the case in such inquiries. It was equally striking that he was held in high regard, particularly by Mr McKay who had things in common with Mr Nobbs and who developed a special rapport with him. Many positive and complimentary things were said about Mr Nobbs and those who had most to do with him enjoyed their conversations and were impressed by him. All were shocked and saddened by his death. That much was clear from the Chaplain's evidence when he spoke of finding several prison officers in tears when he attended at Mr Nobbs' cell on the morning of his death. Thus I hope that Mrs Wheatley and Ms McPhee have derived some comfort from what they heard in the course of the Inquiry.

[106] It remains for me, on behalf of the Court, to extend sincere condolences to Mr Nobbs' family.

ANNEX

List of Witnesses

Witnesses to fact

1. Andrew Lockhart, Team Leader Mental Health Nurses, HMP Low Moss
2. Julia Amanda Wheatley, Mr Nobbs' sister
3. Lorraine Hunter, Behavioral Change Officer, HMP Low Moss
4. Malcolm McKay, Prison Officer, HMP Low Moss
5. Martin Forrest, Chaplain, HMP Low Moss

Witnesses of skill

6. Philip Martin Wheatley CB, formerly Director General of Prisons for England and Wales
7. Khuram H Khan, Consultant Forensic Psychiatrist , State Hospital, Carstairs

Witnesses by affidavit

8. Kenneth McCaskill, Deputy Governor, HMP Low Moss
9. Rhoda MacLeod, Head of Adult Services for Sexual Health, Police Custody and Prison Healthcare, NHS Greater Glasgow and Clyde.
10. Lesley McDowall, Health Strategy and Suicide Prevention Manager, Scottish Prison Service