SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE IN FALKIRK

[2020] FAI 3

FAL-B172-19

DETERMINATION

BY

SUMMARY SHERIFF DEREK D LIVINGSTON

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

into the death of

LIAM KERR

Falkirk, 24 January 2020

Determination

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

1. In terms of section 26(2)(a) Liam Kerr's death occurred in the intensive care unit at Forth Valley Hospital, Falkirk, Larbert at 1430 hours on 19 January 2017.

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

   (a) ischaemic brain injury

   (b) out of hospital cardiac arrest

   (c) external compression of the neck with clothing

3. In terms of section 26(2)(e) there are no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.
4. In terms of section 26(2)(f) there were no defects in any system of working which contributed to the death.
5. In terms of section 26(2)(g) there are no other facts relevant to the death.

Recommendations

None under the Act but see addendum to this opinion.

NOTE

Introduction

[1] This is a fatal accident inquiry held into the death of Liam Kerr ("Liam"). Following a notice of inquiry being lodged by the procurator fiscal on 13 June 2019 this court ordered the inquiry. After a preliminary hearing took place on 8 August 2019 the inquiry was assigned to take place on 16 September 2019. Evidence was led on that date and 17 September, 28 October and 1 November 2019 with a hearing on submissions taking place on 13 January 2020. I made avizandum on that date. At the inquiry the procurator fiscal was represented by Ms Degaetano. Also represented were the following parties who had interest in the matter: the Scottish Prison Service (SPS) represented by Ms Phillips (solicitor), the Prison Officers Association represented by Mr Gillies (solicitor), and NHS Forth Valley represented by Ms Watts (advocate). At

submissions Mr Fairweather, solicitor, represented the SPS and Mr Dawson, advocate, the NHS.

[2] During the inquiry oral evidence was led by the procurator fiscal from the following:

1. Sean Kerr, brother of the deceased
2. Brian Leitch, mental health nurse
3. Brenda Fleming, mental health nurse
4. Brian Ward, prison officer
5. Neil Pirrie, prison officer
6. Robert Dudgeon, prison officer
7. Joanne Brogan, mental health nurse
8. Catherine Warner, clinical forensic nurse (also known as Kate)
9. Denise Allan, clinical manager, HMP Cornton Vale
10. Charles Kelly, head of psychology, HMYOI Polmont
11. Natalie Walker, social worker
12. Kenneth Mackenzie, through care outreach worker
13. Dr Rosa Serrano, consultant psychiatrist
14. Susan Brooks, former governor of HMYOI Polmont
15. Callum McCarthy
16. Dr Nick Hughes

In addition Lesley McDowall was led as a witness on behalf of the Scottish Prison Service.

The Evidence

[3] There was little dispute regarding the evidence. I have summarised my findings as follows.

[4] Liam was born in February 1997. He was the third youngest of six siblings. He came from a difficult background and had spent a large amount of his life in care. His father had been imprisoned and although it was stated in evidence he had killed himself whilst in custody in 2011 I have subsequently discovered findings made by a FAI at Glasgow determining he died of natural causes. His parents had a history of misuse of drugs and alcohol and periodically cooperated with social work intervention but frequently did not. They had regular separations and reconciliations. He was received in foster care in 1997. Rehabilitation was unsuccessful and he went to live with his paternal grandparent and three older brothers some two years later. She died in 2004 and after a short period in a children's home he went back to live with his parents. This broke down about a year later due to the volatility of the parents' relationship, them misusing alcohol and drugs and poor care of the children. He then went into foster care and stayed with the same carers along with his brothers for nearly two years. Problems arose mainly involving a sibling and in April 2008 he was accommodated in a children's home. He then moved to another home following the closure of that one and was still there in 2015 but was from time to time abusing alcohol and drugs.

[5] Liam had previously had mental health problems. In 2011, under the influence of cannabis, he had described suicidal thoughts. He was given psychiatric help and a

year later his presentation had greatly improved. There was an episode of depression in 2014 but he was not considered to have any significant mood or psychotic disorder. He failed to attend referral appointments. In 2015 he was detained under the Mental Health Act and spent about six months in hospital. He was diagnosed as having a drug induced psychosis and prescribed antipsychotic drugs at the time. He took an overdose in December of that year months after his release from hospital and was unclear as to whether he intended to end his life. The psychiatrist who saw him felt this was an impulsive act. He had stopped taking his antipsychotic medication. He had several further hospital admissions that year under the influence of drugs and alcohol and had poor engagement with psychiatric services.

[6] At the time of his death Liam was lawfully detained in custody at HMP Polmont awaiting trial and sentence in respect of a number of matters. He had been in Polmont since 14 November 2016. He was assessed on 14 November 2016 as displaying no risk of committing suicide and having no thoughts of deliberate self-harm. Following upon an incident on 3 January 2017 he was made subject to rule 95 of the Prison Rules meaning he was removed from the main part of the prison and transferred to the Separation and Reintegration Unit (SRU) in Dunedin Hall.

[7] Following upon his move he displayed erratic behaviour which gave cause for concern that his mental health was deteriorating. He was assessed several times by members of the mental health team at HMP Polmont. At no time was he considered to be at risk of self-harm or suicide. He was referred to a psychiatrist on 12 December 2016 due to his odd behaviour and possible psychosis. Shortly before then he had disclosed

to his social worker that he had been sexually abused in the past and this information was passed to prison staff and Liam was spoken to by Brenda Fleming of the prison Mental Health Team (MHT).

[8] On 3 January Liam was involved in a fight with another prisoner in which he used a weapon which resulted in his transfer to the SRU. He was assessed by the MHT on 5 January following concerns about a deterioration in his presentation and mood. A full assessment was carried out. Current and previous trauma were identified and it was decided to refer him for trauma work once sentenced. In the interim he was to be monitored by both prison and mental health staff and referred to a psychiatrist if necessary. He refused to accept medication.

[9] On 5 January he set fire to his cell. He was seen by a mental health nurse, Brenda Fleming, who recorded that he was suffering from command hallucinations which told him to start the fire. An urgent psychiatric assessment was requested.

[10] On 6 January he was seen by Kate Warner also of the mental health team. He refused to take medication because of what he perceived as the side effects but did agree to meet with the psychiatrist later that day.

[11] He was assessed on 6 January 2017 by Dr Serrano, psychiatrist, who was of the view that there was no evidence of psychosis or depression. She considered that he was suffering from pseudo hallucinations and displaying antisocial behaviour with a probable antisocial personality disorder. He was prescribed medication to help him sleep and referred to the prison's psychology services for review. Dr Serrano arranged to see him again on 13 January 2017. Dr Serrano was aware of Liam's psychiatric history

including the drug induced psychosis as well as his upbringing and his stopping of the antipsychotic medication.

[12] During the week between 6 January 2017 and 13 January 2017 Liam's behaviour became more erratic. His presentation caused concern to prison staff and they regularly spoke to the NHS mental health team employed at the prison. He was seen by them on various occasions throughout that week but they did not refer the matter back to Dr Serrano.

[13] On the night of 6/7 January Liam was up all night shouting and banging at his cell door. He was also seen later in the day walking round the exercise yard shouting which shouting did not seem directed at anyone. His room was seen to be very untidy. Brian Leitch, a mental health nurse, was concerned about him and decided he should be kept under observation.

[14] The following night he slept only 4-5 hours and was pacing round his cell shouting and screaming. Again Mr Leitch kept him under observation and arranged for a colleague, Joanne Brogan, to review him during Mr Leitch's absence from the prison since Mr Leitch was on leave for the following four days. Mr Leitch hoped that the sleeping tablets given to Liam following upon his consultation with Dr Serrano would start to have the desired effect.

[15] On 9 January he was assessed by Joanne Brogan, a mental health nurse. Liam was lying down on his bare mattress in his boxer shorts. He said he didn't want to speak to her because, "I'm too tired." There were clothes strewn around his room and the walls and window frames had remnants of food and toothpaste over them. He was

asked about this. Liam would not engage in conversation with Mrs Brogan shouting at her to go away. He appeared manic although Mrs Brogan did have some doubts as to whether all of this was involuntary. She told him to make sure he was taking liquids and his presentation did seem to improve towards the end of the meeting.

[16] On the same date Liam met with Kenny McKenzie, a through care and after care worker from Paisley. Mr McKenzie had dealt with Liam professionally at various points since Liam had first gone into care and had a good relationship with him. He had been asked to see Liam by Brenda Fleming because Liam wanted to make a disclosure. Liam was not however in a good state mentally being distraught and crying uncontrollably. Mr McKenzie told him to stay calm. No disclosure was made.

[17] On 10 January Kate Warner, also of the MHT, spoke to Jim Brown, social worker at Paisley Sheriff Court, regarding Liam's appearance that day and about the fact there were some concerns regarding Liam's mental state. He had been described by prison officers that day as, "talking to voices". He displayed similar behaviour later that day upon his return to Polmont. He was compliant with staff interactions.

[18] On 11 January Liam's behaviour was similar. He did however sleep that night.

[19] On that date he met with Charles Kelly, the head of psychology at the prison. Dr Kelly considered Liam's behaviour to be unorthodox and bizarre. He spoke of broken bones and was tearful. He was very disjointed. He frequently spoke with an Irish accent despite having lived in Scotland all his life. He did not consider Liam to be suicidal.

[20] A case conference in relation to the renewal of Liam's Rule 95 segregation took place on 12 January. This was a multidisciplinary mental health team meeting. It was agreed he was have an officer allocated to him personally in the unit and he should continue in the SRU meantime. Various measures were agreed to be put in place including engagement with psychiatric and psychological services. A Rule 41 application was also discussed.

[21] Rule 41 is essentially a process which provides for better management of an individual with health difficulties. It can be granted for up to 72 hours by the prison governor and thereafter by the Scottish Ministers.

[22] The same day he was seen by Catherine Warner. He was continually banging the cell door and responding to what appeared to be hallucinations. She noted he was due to see the psychiatrist the following day. He was noted by prison officers earlier in the day to be apparently fighting with an imaginary person in the shower and later to be wandering round his cell naked. Later in the day he was banging, shouting and hitting the emergency bell for no apparent reason and was awake all night shouting and wandering round his cell naked.

[23] The following day he was found to be covered in scratches on his back and legs and filthy. He had been throwing himself against the walls of the cell.

[24] Polmont is visited on a regular basis by a psychiatrist on Tuesdays and Fridays. Consideration was given to Liam meeting with the visiting psychiatrist on Tuesday 10 January. Liam was however due to be in Paisley Sheriff Court on that date and therefore could not see the psychiatrist. He seemed calmer after his appearance there

and return to Polmont and no concerns were expressed by anyone who dealt with him that day at Paisley.

[25] He was examined again on 13 January by Dr Serrano at about 11.45am and diagnosed as having disturbed behaviour with possible underlying psychotic symptoms. He denied his scratches related to self-harm. She prescribed an anti-psychotic medication and arranged for him to be reviewed in a week's time and to be monitored in the meantime. She considered that hospital admission was not appropriate at least until anti-psychotic medication had been tried. Liam was distressed at the idea of taking the prescribed drugs but agreed to do so and during the course of the afternoon had calmed down and seemed to be improving. He attempted to telephone his brother Shaun and a friend. There was no answer. At 1545 hours he was taken into the back office to provide him with some food and had a small slice of pizza, some crisps and a slice of bread. He drank two cartons of milk and some diluting orange juice. He went to bed.

[26] He was found hanged in his cell at 1650 hours on that date during a routine check. He had externally compressed his neck with his clothing. There were no signs of life but he was resuscitated. He was transferred to Forth Valley Royal Hospital intensive care unit where he died on 19 January 2017 at 1430 hours.

[27] At all times during this period the prison officers showed empathy and concern towards Liam Kerr.

[28] Talk To Me is the current strategy document to prevent suicide in prison. All those working in the prison are trained in the use of same and receive refresher courses

every three years. It replaced the previous suicide prevention document Act To Care on 5 December 2016. The aim of the strategy is to assume a shared responsibility for the care of those at risk of suicide working together based on an individual's needs, strengths and assets promoting a supportive environment. Where individuals are considered to be at risk of suicide it is open to anyone working in the prison to place the individual on that programme.

[29] None of those who dealt with Liam Kerr after his admission to Polmont, including the mental health team, the prison psychologist, the visiting psychiatrist and the prison officers considered that Liam Kerr was in any way suicidal.

[30] Many involved in Liam's care were unclear as to the purpose and procedure to obtain a Rule 41 order.

Submissions

[31] There was little controversy regarding the evidence itself that I heard. Any dispute related to what I should take from the evidence. I was of the view that all the witnesses I heard did their best to give credible and reliable evidence. In the circumstances I intend simply to refer to certain passages of evidence relating to findings I have been asked to make.

[32] The Crown suggested staffing levels at Polmont in the MHT were inadequate. This was predicated upon evidence given by Brenda Fleming, a mental health nurse practitioner at Polmont, stated that in her view staffing levels were not adequate. No other witness referred to this. The evidence which I heard indicated that, whatever

criticisms might be made of Liam's treatment, from 5 January onwards he was seen throughout that period by the mental health team and seen by a psychiatrist on two occasions and a psychologist during that time. In the circumstances I do not accept that there was any evidence of a lack of staff in the MHT. In saying this I accept that there was possibly a slight delay between a referral being made in respect of Liam on 12 December 2016 and him being seen on 5 January 2017 but in the absence of any apparent urgency and taking into account the Christmas and New Year period that does not seem to me to be an unreasonable delay. Ms Fleming herself accepted that within the community it would normally take two to three weeks to get an appointment.

[33] It was suggested by the Crown that given Liam's behaviour was becoming more erratic he should have been referred to the psychiatrist after the psychiatrist's visit on 10 January 2017. The evidence was that the psychiatrist came to Polmont on Tuesdays and Fridays. Liam was however due to be in court on the Tuesday 10 January and accordingly did not see the psychiatrist on that date but instead waited until 13 January to see her. The Crown has submitted that there should be a procedure to ensure that a person requiring assessment by a psychiatrist on a day he has a court appearance can still be seen the same day. There was however evidence from Dr Serrano that she would have dealt with an emergency call. It is also fair to point out that on Tuesday 10 January Liam went to Paisley Sheriff Court. That process involved Liam being seen by a number of parties but everything indicated that at court on 10 January Liam gave no cause for concern. Had he done so a call could have been made to the psychiatrist for either a visit or advice. In the circumstances I consider there was a system in place allowing for

assessment of someone who is unavailable during the routine visits if there appears to be an emergency and consider this suffices particularly standing the fact the person can still be seen by trained mental health staff at the prison.

[34] The next issue raised by the Crown was that there was insufficient background information available for those making a rule 41 application relating to Liam. However the evidence from Dr Hughes, including the fact that he and the other medical professionals involved in the care of Liam had access to his prison notes, was that there was sufficient background information from a variety of sources about Liam's history. That said I consider in any event that there would be all sorts of confidentiality issues regarding obtaining full medical histories and social work histories in relation to prisoners and particularly remand ones. There would also clearly be logistical ones. I consider in this case however Liam's records were available.

[35] Having touched however upon the question of a rule 41 application, the evidence from the various witnesses was concerning in relation to the fact that I was quite clear that there was a lack of proper understanding by staff in the procedure of the rule 41 application processes. For example Callum McCarthy believed that being placed on a rule 41 was a necessary step before Liam could be sent to hospital. There appeared to be a lack of knowledge of the fact that a rule 41 order could be granted by the prison governor for 72 hours. Lesley McDowall was under the impression that an application could not be made after 3.00pm on a Friday afternoon. The SPS and NHS audit on the death (Death In Prison Learning Audit & Review) refers to "insufficient time to prepare" for a rule 41 application on a Friday and indicates a lack of awareness by staff about a 72

hour rule 41 order. Various versions were given by witnesses about the purpose and procedure for such an application. I do consider that based upon what I heard there is a need for education regarding both the purpose of a rule 41 order and the procedure for obtaining it. That said, in this case I do not consider it made any difference to the eventual sad outcome. A huge amount of staff resources went into dealing with Liam's welfare and I do not consider a rule 41 order would have affected that. He was also regularly monitored. I am however of the view that it is important that both prison officers and NHS staff at the prison have further training in relation to applications under rule 41.

[36] The Crown was also critical of what it referred to as a lack of communication between NHS staff at Polmont and the visiting psychiatrist between 9 January and 13 January to advise of Liam's rapid deterioration following upon Dr Serrano's initial assessment. The notes show that on 5 January Liam was behaving in an unstable manner, banging on the wall and door and screeching and shouting throughout the day and night and keeping the rest of the unit awake. The following day he was behaving in much the same manner but was seen by Dr Serrano. She did not consider he was psychotic. There was no indication of his behaviour worsening on 7 January but instead it continued in the same vein. On 8 January matters seemed to continue as before and it was only on 9 January that the situation seemed to be changed from what it had been when Dr Serrano had seen Liam on 6 January. There is no doubt that there was a deterioration in his behaviour on 9 January but I cannot say that the deterioration was such that, having been seen by Joanne Brogan of the mental health team, as to

necessitate referral to the psychiatrist. He was seen by other MHT staff that week and no urgent referral was made by any of them. I do not think that a referral could have been criticised had that taken place but equally it should be borne in mind that he had seen a psychiatrist a few days earlier who had expressed a view that he was not psychotic. He was due to be seen again by that psychiatrist on 13 January. The MHT staff continued to monitor him and the situation was an ongoing one. A clinical view was taken that the situation did not require referral and I consider that not contacting the psychiatrist was within the range of options reasonably open to the MHT.

[37] The Crown has also suggested that there was a lack of understanding about suicidal behaviour by staff in HMP Polmont. To this end it refers to the fact that Liam displayed some of the cues set out in the Talk to Me training papers but was not placed on the programme. It should first of all be borne in mind, however, in considering this that no one, whether qualified or otherwise, considered Liam to be suicidal. Liam was being seen regularly by mental health staff and their knowledge was substantially beyond what is contained in the Talk to Me training papers. I do not consider it could be said to be a reasonable precaution to have placed Liam on Talk to Me when in the first place no one considered him to be suicidal and perhaps more significantly, even had prison officers failed to spot the cues and clues in Talk to Me there were far more qualified people who were seeing Liam who did not consider him to be suicidal and it is difficult to see in such circumstances when it would ever be appropriate for a prison officer to override the views of the MHT.

[38] The Crown also made reference to the fact that Liam was engaging in what might have been self-harming behaviour in that there was evidence of him having scratch marks on his body. Dr Serrano however was aware of this in her assessment on 13 January. They were only seen for the first time on that date. Liam had been throwing himself about his cell. There were therefore various explanations but most importantly those involved in mental health rightly or wrongly did not consider that they indicated a risk of suicide.

[39] The Crown looks to criticise Joanne Brogan for her assessment that some of Liam's manic behaviour was voluntary but I heard no evidence from a qualified mental health nurse or indeed a psychiatrist as to errors she had made. It is perhaps important to keep in mind as well that Liam was seen by mental health staff on at least 5 January, 6 January, 7 January, 8 January, 9 January, 10 January, 12 January and 13 January. It seems to me that she exercised her clinical judgement, and in the absence of any evidence that she did so in a manner that was professionally incompetent I do not see I can come to a conclusion that this constituted a factor relevant to the circumstances of Liam's death and that Joanne Brogan falls to be criticised. I would stress in any case that since Liam was seen by various other mental health professionals, even assuming Joanne Brogan got her assessment wrong, as she possibly did based on hindsight, none of them took a different view in the days that followed or indeed the days prior to this. In saying this I respectfully agree with the view taken by the sheriff at the FAI into the death of Lynsy Myles (27 February 2004 at page 25) where the sheriff commented as follows:

> "Again lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is a clear appropriate testimony which challenges the treatment a patient receives. The view I take of this matter is that for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff. Before I can find a precaution to be reasonable in the context of a medical issue, there must either be an admission by the treating doctor that he failed to take a precaution or a course of action which he clearly ought to have taken or took the course of action which, in the exercise of ordinary care, ought not to have been taken. Failing that there would require to be established by independent evidence, the manner in which the doctor in a particular area of expertise, and with a particular experience, ought to have acted. There clearly requires to be a standard by which the acting doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification and reflecting the jurisprudence surrounding medical negligence issues it must avoid the situation whereby medical professionals become hamstrung in their treatment of patients because of concern that their view and their clinical judgement may be called into question by a colleague who takes a different view. That is of course the rationale behind the standard approved in *Hunter* v *Hanley* 1955 SC 200."

[40] It is fair to say that the above paragraph does of course relate to a medical negligence situation by a doctor but I do not consider that the ratio is any different in relation to nursing staff.

[41] There does appear to be something of a thread running through the Crown's submission that would in my view be entirely justified regarding the failure to refer matters to Dr Serrano if Liam was not being regularly seen by MHT staff. That however is not the situation.

[42] The Crown is also critical of the lack of recording that Liam was not a suicide risk. I am however a little unclear as to how far it was appropriate to record negative conclusions. That said, by implication I do not consider whether such a conclusion was recorded or not would have made any difference in this particular case but I am satisfied

that suicide as a risk was considered by those dealing with Liam both in the medical staff and at prison officer level. It is also fair to point out that the Talk to Me regime is generally used to increase the monitoring of a prisoner who is deemed to be a suicide risk. It is difficult to see how much more monitoring Liam could have had, bearing in mind the evidence that he was being seen every hour by prison officers.

[43] The Crown also suggests refresher training in relation to Talk to Me. Again I do not consider that this would have made any difference to the eventual outcome here, although I am of the view that in any area of life it is helpful to read guidance documents more than once every three years if indeed that is all they are read particularly when they deal with a major issue in the workplace. I note that in Talk to Me it is stated at page 5 of SPS Production no. 1 that as well as assessments being carried out when a person is admitted to prison assessments will also be carried out following any appearances at court. I have some difficulty with this. As far as I am aware this did not take place in Liam's case following upon his appearance in court on 10 January and in any event it would seem to be possibly too rigid. If, however, what is stated is intended to be the position then obviously it should be carried through. Looking at the key indicators I do consider in any event that there was inevitably an issue of "deferment" as Mr Gillies described it by the prison officers to the NHS staff who took the medical decisions and that such deferment is generally speaking not only inevitable but also appropriate.

Summary

[44] Liam's case is a tragic one. Many of his difficulties in life arose out of factors over which he had no control. As a result he became a very troubled young man.

[45] In hindsight it is clear that when those dealing with Liam considered he was not suicidal they were wrong. However doctors and other health professionals will often come to an incorrect diagnosis. That does not mean that they have been in any way negligent or culpable and it appears in this case that all the health professionals were of the same view which was that Liam was not suicidal. The individuals concerned were all trained and experienced.

[46] Although the Court heard a lot of evidence about Liam's mental health it should be borne in mind that most of the evidence related to a week in Liam's life. It is not surprising that over a relatively short period that the medical staff dealing with him would initially want to monitor him and ultimately to see whether when medication was prescribed his health improved.

[47] The two main criticisms which in my view could be made is that, firstly, NHS and prison staff lacked the knowledge of the procedure and purpose of an application under rule 41 and, secondly, it is my opinion that not enough time is spent on training regarding the suicide prevention guidance contained in the Talk to Me documentation. Whilst no doubt staff do use their knowledge of this on a regular basis, on occasions it can be easy to either develop bad practice or simply be ignorant of part of the advice when it has not been viewed for some time. Suicide is unfortunately something which occurs amongst the prison population and in particular the younger members of that

group. I am of the view that consideration should be given as to whether refresher training should be more frequent than once every three years. I would stress however that these are merely observations and did not in any way affect the outcome in Liam's situation.

[48] Finally the court expresses its condolences to Liam's family and friends.

Summary Sheriff Derek David Livingston

Sheriffdom of Tayside Central and Fife at Falkirk

24.01.2020

Addendum

I do not consider that the Court should make any recommendations in terms of section 26(1)(b) of the 2016 Act. That said I do have two observations which in my opinion should be considered by the SPS.

1. Both NHS staff and prison officers employed at the prison should receive full training regarding applications under rule 41 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011 and in particular the procedures for orders to be made under this rule both by the governor

and by the Scottish Ministers and the purpose of such an application. This is in light of me being satisfied that there is a lack of knowledge about this based upon the evidence I heard.

2. The SPS suicide prevention strategy, currently called "Talk To Me", is important but refresher training in it once every three years is probably inadequate bearing in mind the importance of the issue and the relative frequency with which issues arise. Consideration should be given to increasing the frequency of refresher training in this area.