SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2020 FAI 38

B458/20

DETERMINATION

BY

SHERIFF S REID ESQ

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

into the death of

IRWIN FRANCIS RODGERS

Glasgow, 25 September 2020

Findings

The sheriff, having considered the information presented at the fatal accident inquiry, Determines, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc., (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act"), that:

(1) in terms of section 26(2)(a) of the 2016 Act, Irwin Francis Rodgers (born on 19 April 1985) (hereinafter referred to as "Mr Rodgers"), then a prisoner within HMP Barlinnie, Lee Avenue, Glasgow, died on Monday 18 June 2018 at approximately 1734 hours within cell 4/37, in D Hall, Level 4, HMP Barlinnie;

(2) in terms of section 26(2)(c) of the 2016 Act, the cause of Mr Rodgers' death was hanging;

THEREAFTER, Makes no findings in terms of sections 26(b), (d), (e) & (f) of the 2016 Act;

Recommendations

AND FURTHER, the sheriff having considered the information presented at the Inquiry, in terms of section 26(1)(b) of the 2016 Act, Makes no recommendations.

NOTE

[1] This determination is made following a fatal accident inquiry into the death of Irwin Francis Rodgers (born on 19 April 1985) ("Mr Rodgers").

[2] At the time of his death, Mr Rodgers was in legal custody within HMP Barlinnie, Glasgow. On 10 May 2018 he had been sentenced to a period of imprisonment of 18 months; this sentence was backdated to 25 January 2018 when he was first remanded in custody; and his earliest date of liberation was calculated as being 24 October 2018. Accordingly, this was a mandatory fatal accident inquiry, in terms of section 2(4) of the Fatal Accidents and Sudden Deaths etc., (Scotland) Act 2016 ("the 2016 Act").

[3] The inquiry was held in Glasgow Sheriff Court on 21 August 2020.

[4] The following parties participated in the inquiry: (i) the Crown (represented by Ms A Allan, procurator fiscal depute, Glasgow); (ii) the Scottish Prison Service ("SPS") (represented by Ms Y. Middleton, solicitor, Anderson Strathern LLP, Edinburgh); (iii) the Scottish Prison Officers Association ("SPOA") (represented by Ms R. Wallace, Thompsons, Glasgow); and (iv) Greater Glasgow Health Board ("GGHB") (represented by Mr W Henderson, solicitor, NHS Central Legal Office, Edinburgh). Due to restrictions imposed

in response to the coronavirus pandemic, each of the foregoing participated in the inquiry proceedings by telephone conference call convened within Court 19 in Glasgow Sheriff Court. No other persons appeared at the inquiry or intimated an interest therein.

[5] Fatal accident inquiries are now governed by the 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"). The form of a Determination is prescribed by rule 6.1 (i.e Form 6.1) of the 2017 Rules which stipulates the inclusion of certain information within the Determination. In the majority of inquiries, that information will be of limited interest. In this Determination, I have set out much of this mandatory information in the attached Appendix.

Procedural history

[6] On 27 February 2020, a notice of an inquiry was given by the procurator fiscal under section 15(1) of the 2016 Act.

[7] A preliminary hearing was initially assigned for 22 April 2020. That hearing was discharged and re-assigned *ex proprio motu* due to the supervening coronavirus pandemic.

[8] At the re-assigned preliminary hearing on 24 July 2020, it became clear that only three parties (SPS, SPOA and GGHB) were likely to participate in the inquiry proceedings, along with the Crown, and that the evidence was likely to be agreed by joint minute. I assigned a fatal accident inquiry for 21 August 2020 and made incidental orders requiring the lodging of a joint minute of agreement and written closing submissions in advance.

[9] I remained concerned at the absence of any representation of the deceased's family. Mr Rodgers' next of kin (his sister) was aware of the proceedings but had expressed no interest

in participating. Accordingly, by interlocutor dated 4 August 2020 *ex proprio motu* I appointed the Crown forthwith to give notice of the proceedings to the deceased's ex-partner, for such interest as she may have in the proceedings, and appointed the ex-partner, if she wished to participate in the proceedings, to make an application to the sheriff to do so in the prescribed form. In the event, no such application was made, and neither the deceased's ex-partner nor any family member participated in the inquiry proceedings.

Information made available to the inquiry

[10] On 21 August 2020, the inquiry was convened.

[11] A joint minute of agreement between the Crown, SPS, SPOA and GGHB was tendered and lodged in process. In terms of the joint minute the following documents and other material were admitted in evidence (comprising volumes 1 & 2 of the Crown's productions and labels):

i. Post mortem report dated 9 August 2018.

ii. SPS file in relation to the deceased.

iii. NHS medical records in respect of the deceased.

iv. General Practitioner medical records in respect of the deceased.

v. Psychiatric records in respect of the deceased.

vi. Book of photographs.

vii. Death in Prison Learning, Audit & Review ("DIPLAR") report of the SPS dated 21 August 2018.

viii. Intimation of death form.

ix. Suicide note.

x. Report by Dr Saduf Riaz, Consultant Psychiatrist, dated 11 February 2020.

xi. Letter dated 20 November 2019 and related Significant Clinical Incident Report dated 7 June 2019 from Glasgow City Health & Social Care Partnership.

xii. Prison Wing CCTV

xiii. Disc containing telephone calls.

[12] No parole evidence was heard. No other evidence was led.

Closing submissions

[13] The written closing submissions for the Crown and the appearing parties were broadly similar in nature. All parties invited me to make purely formal findings only in terms of sections 26(2)(a) & (c) of the 2016 Act; no findings were considered to be appropriate in terms of sections 26(2)(b), (d), (e), (f) & (g) of the 2016 Act, due to the absence of supporting evidence; and, likewise, no recommendations were said to be appropriate, in terms of section 26(4) of the 2016 Act.

Factual circumstances

[14] Having regard to the information presented to the inquiry, I found the following facts to be established:

Events prior to custody on 25 January 2018

(1) Irwin Francis Rodgers (“the deceased”) was born on 19 April 1985.

(2) Mr Rodgers’ early years were spent with his mother and siblings, his father having died prior to his birth.

(3) His childhood was troubled and turbulent.

(4) Mr Rodgers' mother, who herself had a difficult background, had a history of physical violence towards the children.

(5) From an early age there was social work and multi-agency involvement with Mr Rodgers' family, but these interventions often met with resistance from, and non-engagement by, Mr Rodgers' mother.

(6) In November 1992, when he was in primary 3, Mr Rodgers was referred by the social work department to a specialist child and family centre due to his behavioural problems at home and school; further referrals followed in 1995 (including a referral by his GP on the ground that Mr Rodgers was "out of parental control"); but on each of these occasions the referrals failed due to non-engagement by Mr Rodgers' mother.

(7) In 1996, due to his ongoing behavioural problems and aggressive outbursts, Mr Rodgers was suspended from school; again, he was referred to a specialist child and family centre day unit to identify strategies cope with his behaviour; but, again, Mr Rodgers' mother failed to engage with the referral, appointments were missed, and the referral failed.

(8) In January 1997, when he was 11 years old, Mr Rodgers was referred to the community psychiatric nurse within Renfrewshire Health Care NHS Trust for assessment and management of his "behaviour problem"; but, again, the referral failed due to lack of engagement by Mr Rodgers' mother.

(9) By the age of 13, Mr Rodgers was drinking alcohol to excess.

(10) By the age of 14, Mr Rodgers was using cannabis, amphetamines, ecstasy, diazepam and alcohol on a regular basis.

(11) In 1998, due to his behaviour, he was placed at Crosshill Children's Home; then, shortly afterwards, he was placed at Ballickinrain Residential School (initially on an emergency basis); and, for two years thereafter, despite periods of stability, Mr Rodgers experienced placements at Kibble Residential School and Kerelaw Residential School on a secure warrant.

(12) Throughout this period of time, his relationship with his mother and siblings remained fraught with difficulties.

(13) In June 2000, when he was 15/16 years old, Mr Rodgers received offers to engage with the local authority social work department's Children's Group Work Team and with NCH's Gap Project, but to no avail.

(14) By the spring and summer months of 2001, Mr Rodgers was again accommodated by the local authority following the breakdown of his relationship with his mother (with whom he had at that time been living for a period of several weeks); and the local authority placement then itself broke down due to Mr Rodgers' aggressive and violent behaviour towards social work staff.

(15) For many years during this period, Mr Rodgers had been subject to a compulsory supervision order of the children's hearing; but in June 2001 this compulsory supervision order was terminated by the children's hearing because Mr Rodgers had continued to offend throughout the subsistence of the order and he had

exhausted, without success, all of the primary supports made available to him by the local authority social work department.

(16) In July 2001 Mr Rodgers was referred by his GP to the psychiatric department of Renfrewshire & Inverclyde Primary Care NHS Trust as "an urgent appointment"; but he failed to attend, and he was discharged without assessment.

(17) On 28 February 2002, Mr Rodgers' formal record of criminal offending commenced when he was convicted on summary complaint in Greenock Sheriff Court of a charge of theft, and sentenced to a period of imprisonment of 3 months.

(18) In March 2002, having re-offended immediately upon his release, the sheriff at Greenock ordered that Mr Rodgers undergo a psychiatric assessment.

(19) On 29 March 2002, Mr Rodgers was assessed, while on remand, by a consultant psychiatrist at Ravenscraig Hospital who reported that Mr Rodgers displayed "no symptoms of psychiatric illness" but, rather, a severe history of substance abuse, mainly alcohol, to which his offending behaviour was largely attributed.

(20) In May 2004, the sheriff at Greenock again ordered that Mr Rodgers undergo a psychiatric assessment, prior to sentencing him in respect of further offending.

(21) On 10 May 2004, Mr Rodgers was assessed by a specialist registrar in psychiatry at Ravenscraig Hospital who also reported that Mr Rodgers was not, at that time, suffering from a psychotic disorder, but had instead "a serious alcohol problem with clear features of alcohol dependency".

(22) At around this time, in 2004/2005, when he was about 19 years old, Mr Rodgers left Scotland and, for many years thereafter, lived an itinerant lifestyle in England, accruing multiple further criminal convictions and custodial sentences.

(23) In April 2011 and again in April 2015, HM Prison Service, England recorded that Mr Rodgers had been diagnosed as suffering from bi-polar disorder, but the records of HM Prison Service do not disclose any further details of the diagnosis (specifically, by whom and when it was made).

(24) By letter dated 11 June 2015 to HM Prison Service, Mr Rodgers' GP (Dr B Greenhalgh, Beacon View Medical Centre, Gateshead) stated that Mr Rodgers had previously been diagnosed with bi-polar disorder, and had been prescribed quiatepine (an anti-psychotic medication), but the letter does not disclose any further details of the diagnosis (specifically, by whom and when it was made).

(25) Records from South Tyneside NHS Foundation Trust dated 7 June 2016 record "confusion" as to Mr Rodgers' precise mental health diagnosis (with his GP having reported that Mr Rodgers was suffering from bi-polar disorder, but prison mental health services reporting that he suffers from schizophrenia); but that, in any event, Mr Rodgers was then continuing to present "with symptoms typical of a severe enduring mental health problem".

(26) In 2015/2016, while living in Gateshead, England, Mr Rodgers engaged on four or five occasions with the area health authority's mental health services, following several arrests by the police, for drunk and disorderly conduct, and

trespass on railway tracks; following his arrest, he had disclosed to police that he intended to kill himself; and, during a mental assessment by Nottinghamshire County Council in February 2016, he repeated these suicidal assertions, though he was reported to be difficult to assess due to his hostility and lack of coherence, and that his threats of self-harm were considered to be "principally a manipulative device".

(27) In 2016, Mr Rodgers returned to Scotland, and thereafter came to be referred by the Crisis Team of Inverclyde Health & Social Care Partnership Crisis ("Inverclyde HSCP") for psychiatric assessment.

(28) On 23 November 2016, Mr Rodgers was assessed by a consultant psychiatrist of Inverclyde HSCP, during which Mr Rodgers reported that he had been psychiatrically assessed on multiple occasions whilst in prison in England, but with no formal diagnosis having been made; the consultant psychiatrist concluded that it was "unlikely" that Mr Rodgers was suffering from a psychotic illness but that, rather, his difficulties appeared to represent the impact upon his personality of his deprived and difficult childhood and previous misuse of alcohol and illicit substances; a review appointment was arranged; Mr Rodgers failed to attend; and he was discharged from the referral in 2017.

(29) On 10 May 2018 at Glasgow Sheriff Court Mr Rodgers was sentenced to a period of 18 months' imprisonment in respect of seven charges of assault and assault to injury to which he had tendered pleas of guilty; this custodial sentence was

backdated to 25 January 2018, when Mr Rodgers was first remanded in custody; and his earliest date of liberation was 24 October 2018.

Events from 25 January 2018 (following admission to HMP Barlinnie)

(30) "Talk to Me" is the Scottish Prison Service's suicide prevention strategy within prisons, whereby all prisoners are assessed by staff to be either "at risk" or at "no apparent risk" of suicide or self-harm.

(31) On 25 January 2018, upon his admission to HMP Barlinnie on remand, Mr Rodgers was subjected to the "Talk to Me" risk assessment.

(32) In the course of the assessment, it was noted that Mr Rodgers had a history of both mental health issues and of self-harm, with Mr Rodgers himself reporting that he had had diagnoses of personality disorder and schizophrenia, that he had previously attempted suicide (the most recent such attempt having taken place at Christmas 2017, according to Mr Rodgers), and that, prior to his admission to prison, he had been under the care of community mental health services.

(33) However, in the course of the assessment, Mr Rodgers also stated that he had no present issues or concerns, and that he had no thoughts of self-harm.

(34) Following the assessment, Mr Rodgers was recorded as being at "no apparent risk" - and, as such, was not considered to require support on the SPS "Talk to Me" strategy at that time.

(35) On 26 January 2018, Mr Rodgers was seen by one of the prison's general practitioners for a routine physical examination and medication assessment; he

reported that that he had no current thoughts of deliberate self-harm or suicide, but that, prior to his imprisonment, he had been awaiting an appointment for a psychological assessment in the community and had been prescribed quetiapine; the general practitioner prescribed quetiapine for self-administration by Mr Rodgers and referred him to the prison's mental health team for further assessment.

(36) On 13 February 2018, a senior mental health nurse carried out a mental health assessment of Mr Rodgers; he reported that his medication was effective, that he was coping well in prison, that he was aware of the support networks available, and that he was having no thoughts of suicide or self-harm, although he did describe that he used self-harm as a coping strategy when annoyed or angry with others; and, following the assessment, it was concluded that Mr Rodgers gave no cause for concern, and that no further input was required from the mental health team.

(37) Thereafter, Mr Rodgers was again risk-assessed under the "Talk to Me" strategy on the following occasions: (i) on 29 January 2018, following his return to the prison from a hospital appointment; (ii) on 26 February 2018, following his return from participation in an identity parade; and (iii) on 10 May 2018, following his return from an appearance at court for sentencing; on each of these occasions, Mr Rodgers was recorded by staff as being at "no apparent risk" in terms of the "Talk to Me" strategy and was not considered to require any additional support.

(38) On the occasion of the latter risk-assessment (on 10 May 2018), the NHS nurse who assessed Mr Rodgers recorded that Mr Rodgers had reported to her that he had been diagnosed with schizophrenia nine years earlier, that he regularly saw his psychiatrist for this when at liberty, that he received medication for his mental health, that his last suicide attempt had occurred two years earlier when he had jumped in front of a train, but that he denied any current thoughts of self-harm or suicide.

Events of 23 May 2018 to 15 June 2018

(39) On 23 or 24 May 2018, Mr Rodgers made a written self-referral to the prison's mental health team, in which he explained the reason for his referral as follows:

> "To get help with state of mind as it is done in this is the fourth referral form that aye have put in in the last 2 months…"

(40) Notwithstanding the terms of Mr Rodgers' self-referral form, prior to this written self-referral on 23 or 24 May 2018, no other self-referrals had been received by the prison's mental health team from Mr Rodgers.

(41) Mr Rodgers' self-referral form was received by the mental health team of NHS Greater Glasgow & Clyde on 24 May 2018, it was discussed at an allocation meeting on 28 May 2018, and it was categorised as a "routine referral".

(42) On 8 June 2018 (14 days after the deceased's self-referral) Mr Rodgers was seen by the senior mental health nurse for assessment.

(43) Mr Rodgers was upset and emotional throughout the assessment; he stated that he did not see the point in living anymore; he stated that he wished to kill himself; he stated that he had had such thoughts earlier that day and that, if he had the chance, he would "jump over the bannister on the landing".

(44) During the assessment, Mr Rodgers disclosed that Police Scotland had visited him in relation to time spent by him in his youth within the children's care system, and in connection with alleged abuse; Mr Rodgers explained to the nurse that he had not been expecting this visit, and he felt that it had had an impact upon his feelings.

(45) Following this assessment, it was decided that Mr Rodgers be placed immediately on the "Talk to Me" strategy; that he would be moved to a "safer cell" with stronger clothing, and with observations carried out every 15 minutes by prison staff as per SPS procedures; and a case conference was scheduled for the following day (9 June 2018) at 10am.

(46) Mr Rodgers was also offered further medication (a sedative) to assist him with sleep, but this was declined by him.

(47) At the case conference the following morning, on 9 June 2018, Mr Rodgers strongly denied that he had any thoughts of suicide or self-harm.

(48) Nevertheless, NHS staff recorded him as remaining "at risk" in terms of the "Talk to Me" strategy; a care plan was established; as part of this care plan, it was agreed that he should be referred for relocation to the high dependency unit ("HDU") within HMP Barlinnie, a referral which Mr Rodgers supported;

meantime, it was decided to return Mr Rodgers to his own cell, with observations reduced to once every 60 minutes, it having been noted that Mr Rodgers had a cell mate whom he got on well with and that returning to his own cell would allow him access to his own clothing and other personal items; and he was scheduled for psychiatric assessment and a further case conference discussion the following week.

(49) On 12 June 2018, at the further case conference, Mr Rodgers continued to deny any thoughts of suicide or self-harm; he stated that he was having difficulty sleeping due to being frequently woken as a result of the required 60 minute observations; he requested to be taken off this 60 minute monitoring regime (the same request having been made by him to other SPS prison staff when they had attended at his cell on 10 & 11 June 2018); he stated that he would be happy to be removed from the "Talk to Me" strategy and "very keen to get a sleep", free from the disturbance of the 60 minute observation regime which was making him "irritable"; and he gave assurances at the case conference that he would speak to staff should he require help or input.

(50) However, it also transpired at the case conference that Mr Rodgers had not been moved to the HDU (in compliance with the previously-agreed referral); this was because SPS staff had (unknown to Mr Rodgers) decided that he was not suitable for such a move, having failed to meet SPS criteria; instead (again, unknown to Mr Rodgers), SPS staff had referred him for relocation elsewhere, namely to the upper section of Block D (known as the "DSU") which was considered to be a

smaller and quieter section of the block than the larger hall in which Mr Rodgers was then housed.

(51) The outcome of the case conference on 12 June 2018 was that Mr Rodgers was recorded as being at "no apparent risk" and was removed from the "Talk to Me" strategy (though it was recorded that he was to remain on the prison's mental health team "caseload" and was to be referred to SPS for relocation to the DSU).

(52) On 14 June 2018, Mr Rodgers was moved to a single cell within the upper section of Block D (referred to as the "DSU").

(53) On 15 June 2018, Mr Rodgers underwent a further psychiatric assessment within the prison by a consultant forensic psychiatrist.

(54) During this assessment (on 15 June 2018) Mr Rodgers discussed his mental health; he self-reported that he suffered from "either schizophrenia or bipolar disorder"; he could not clarify who had discussed these diagnoses with him; he was unclear when or by whom he had first been prescribed quetiapine; while he had experienced no psychiatric hospital admissions, he admitted to a long history of self-harming behaviour (which the consultant forensic psychiatrist reported to be "certainly evidenced by visible old linear scars over his forearms"); that the medication prescribed to him in prison was effective but that he continued to have difficulty sleeping; and that he had no thoughts of suicide or self-harm at that time.

(55) Further, during this assessment (on 15 June 2018), Mr Rodgers spoke openly about his relationship with his fiancée; that he looked forward to seeing her; and

that he was planning a future with her; that his fiancée visited him at the prison frequently, but that in recent visits she had expressed doubts about the relationship continuing; and that these doubts had stemmed from his being placed on the "Talk to Me" strategy.

(56) The consultant forensic psychiatrist concluded that Mr Rodgers may well be suffering from a psychotic illness (though not a depressive disorder); he continued his prescription of quetiapine (though with a changed dosage); and he encouraged Mr Rodgers to seek support from the prison's mental health team should he feel the urge to self-harm during his remaining period of custody.

(57) There is no written record of the consultant forensic psychiatrist having reported, to the prison or NHS staff, prior to Mr Rodgers' death, the outcome of his assessment; and, instead, the psychiatrist's written report (dated 19 June 2018) bears to have been issued only after Mr Rodgers' death.

Events of 18 June 2018

(58) At approximately 3.25 pm on Monday, 18 June 2018, Mr Rodgers left his cell and made a phone call to his fiancée; the call lasted around 10 minutes; during the call, Mr Rodgers advised that he had booked a prison visit for his fiancée on the morning of the coming Friday and asked if she would be attending; Mr Rodgers' fiancée stated that she would not be attending, and referred to an earlier conversation with Mr Rodgers on the previous day in which she had told him not to book a visit; the conversation continued with Mr Rodgers and his fiancée

discussing how she wished to end the relationship; Mr Rodgers stated that he wished the relationship to continue; he repeatedly asked if he could still use his fiancée's home address for the purpose of his early release from prison, which she eventually agreed to; Mr Rodgers continued to request that she attend for the visit that Friday to discuss the relationship further; his fiancée continued to decline to do so; Mr Rodgers ended the call by stating that he would telephone his fiancée again on the coming Thursday.

(59) At approximately 3.37 pm, Mr Rodgers returned to his cell.

(60) At approximately 5.15 pm, prison officers Stewart Summerhill and Laura McRoberts were working at the upper section of Block D; prison officer Summerhill was unlocking the prisoners' doors to allow them to attend for dinner; on approaching Mr Rodgers' cell (number 4/37) he opened the door but could not see Mr Rodgers within the cell area; prison officer Summerhill then entered the cell and discovered Mr Rodgers to be suspended from the rear of the bunk bed with a ligature around his neck; the ligature was made of black shoe laces which were attached to the end of the bunk bed.

(61) Prison officer Summerhill immediately alerted other staff members by both shouting and using his radio, using the recognised code words "code blue".

(62) Prison officers Laura McRoberts and Douglas Haggerty attended at Mr Rodgers' cell.

(63) Prison officer McRoberts left the cell area to retrieve safety scissors to cut the ligature whilst prison officers Summerhill and Haggerty lifted the deceased to relieve the pressure on his neck.

(64) Prison officers Summerhill and Haggerty were able to remove the shoe laces from around Mr Rodgers' neck and he was placed on his back on the floor of the cell.

(65) Cardio-pulmonary resuscitation ("CPR") was commenced by prison officer Haggerty.

(66) During this time, other prison staff members attended at the cell (including prison officer Martin McGrory, who was instructed to commence an incident log).

(67) At approximately 5.21 pm, medical staff arrived at Mr Rodgers' cell in response to the "code blue" call; they found Mr Rodgers to be unresponsive, with no pulse, and to have fixed and dilated pupils, and vomit in his airway; they took over CPR from the prison staff with nurse practitioner Deborah Byrne commencing chest compressions and Dr Joseph Daly providing oxygen management.

(68) At approximately 5.22 pm, an ambulance was contacted to attend.

(69) Three cycles of CPR were administered to Mr Rodgers, each for a period of two minutes, but the deceased failed to respond, whereupon the decision was taken by Dr Joseph Daly to stop resuscitation attempts.

(70) At approximately 5.34pm, Dr Joseph Daly pronounced Mr Rodgers' life to be extinct.

(71) Mr Rodgers' cell was secured and sealed, pending the arrival of the police.

(72) At approximately 6.56pm, police constables Stephen Armstrong and Aidan Reilly arrived at Mr Rodgers' cell; the seal was removed from the door; both police officers entered the cell; they carried out some checks on Mr Rodgers, whose body remained in situ, as well as a search of the cell area and its contents.

(73) During this search, a short letter written by Mr Rodgers and addressed to his fiancée was found on the desk within the cell and a photograph was discovered (depicting Mr Rodgers and his fiancée) lying next to Mr Rodgers' body; prison officers Summerhill and Haggerty advised the police officers that the photograph had been taped to Mr Rodgers' chest prior to their commencement of CPR.

(74) The short letter bears to be a suicide note, and bears to provide an explanation that Mr Rodgers had chosen to end his life due to the breakdown of his relationship with his fiancée.

(75) At approximately 7.54pm, officers from Police Scotland criminal investigation department arrived at Mr Rodgers' cell, followed by a scenes of crime officer at approximately 8.25 pm.

(76) General view photographs were thereafter taken of Mr Rodgers' body, the cell and its contents.

(77) At approximately 9.50pm, Mr Rodgers' body was removed from the cell.

(78) CCTV footage taken from the prison shows Mr Rodgers being let out of his cell at approximately 3.25pm on Monday, 18 June 2018 and going downstairs to the telephone area; it depicts Mr Rodgers returning to his cell at around 3.37 pm; prison officer Haggerty is seen conducting a prisoner "numbers check" on all prisoners within the upper section of Block D from 3.43 pm; prison officer Haggerty attends at Mr Rodgers' cell at approximately 3.44 pm and conducts a check through the cell door hatch (it being a matter of agreement in the joint minute between the parties that Mr Rodgers was observed to be alive at this time); at approximately 5.13 pm, prison officer Summerhill is seen to begin opening the prisoners' cell doors for them to collect their evening meal; at around 5.15 pm, prison officer Summerhill attends at Mr Rodgers' cell, unlocks the cell and shouts into the cell, but does not enter the cell; at approximately 5.18pm, prison officer Summerhill then re-attends at Mr Rodgers' cell, having failed to see him within the feeding area; the CCTV footage then shows prison officer Summerhill entering Mr Rodgers' cell before coming back outside and alerting other members of staff by shouting "code blue" over the bannister; prison officers Haggerty and McRoberts are seen to run upstairs to Mr Rodgers' cell, with prison officer McRoberts immediately leaving the cell and returning with safety scissors, shortly followed by other members of staff; and the CCTV footage shows no other person entering or leaving Mr Rodgers' cell during the period between the "numbers check" at 3.44 pm and the discovery of Mr Rodgers at 5.18 pm.

Post mortem

(79) On 21 June 2018, a post mortem examination of Mr Rodgers' body was conducted at the Queen Elizabeth University Hospital, Glasgow by Dr Marjory Turner, consultant forensic pathologist, from which examination Dr Turner recorded the cause of death as hanging.

Discussion and conclusions

[15] From the information available to the inquiry, it appears that Irwin Rodgers endured a troubled life, scarred at the outset by childhood neglect, corrupted by alcohol and substance misuse, and blighted by recurring instability in his mental health, ending in death by suicide in a prison cell.

[16] It was a sad end to a turbulent life. His sister, upon receiving news of Mr Rodgers' death from SPS, acknowledged that his life had been troubled at times, and that his premature death was not entirely a surprise.

[17] A key issue in the present inquiry concerned the quality of health care provided to Mr Rodgers during his period in custody at HMP Barlinnie.

[18] Dr Saduf Riaz, a consultant psychiatrist, was asked by the Crown to provide an opinion on the standard of mental health care provided to Mr Rodgers. His report forms Crown production number 10 of process, the terms of which are agreed by joint minute of the participating parties.

[19] Dr Riaz concluded that Mr Rodgers was identified at the outset as having a history of mental health problems, as well as being a previous suicide risk. He opined that Mr Rodgers was referred appropriately and, indeed, was "robustly assessed", including following Mr Rodgers' self-referral. When Mr Rodgers' risk of suicide increased he was put on established suicide prevention strategies and was also managed well. This included prison and health care staff working together, and Mr Rodgers receiving assessments from a registered mental health nurse and consultant psychiatrist, with plans for further follow-up.

[20] Dr Riaz concluded that there was no warning that Mr Rodgers' risk of suicide had increased to the point that he was going to make an attempt on his own life, with the evidence suggesting the opposite, namely that his risk of suicide was reducing.

[21] In Dr Riaz's opinion, Mr Rodgers' death could not have been prevented by reasonable precautions and there were no defects in his mental health care in custody.

[22] Dr Riaz concluded that there was no deficiency in the care provided to Mr Rodgers, and he made no criticism of the mental health care received by Mr Rodgers, either at a systemic or individual level. He expressed the opinion that Mr Rodgers was provided with a good standard of mental health and prison care.

[23] The Crown and other parties participating in the inquiry invited the court to make formal findings only in terms of section 26(2)(a) & (c) of the 2016 Act in respect of Mr Rodgers' death.

[24] Having carefully considered the terms of the agreed productions, the joint minute and the written closing submissions, I agree that only such formal findings should be made in my Determination.

[25] No findings were said to be appropriate under sections 26(2)(b) & (d) of the 2016 Act because there was no "accident" in the present case. No submissions were made in support of any findings in terms of section 26(2)(e) of the 2016 Act (regarding any precautions which could reasonably have been taken and which might realistically have resulted in the death being avoided), or in terms of section 26(2)(f) (regarding any defect in the system of working which contributed to the death). Standing the nature of the evidence before me (including the terms of the expert report from Dr Riaz), I concluded that there was indeed no proper evidential basis before me on which to make any such findings.

[26] Further, I am satisfied that there are no other facts relevant to the circumstances of the death which ought to be included as formal findings in my Determination, in terms of section 26(2)(g) of the 2016 Act.

[27] Lastly, given the nature of the evidence and submissions before me (including the terms of the expert report from Dr Riaz), it would not be appropriate to make any formal recommendations, in terms of section 26(1)(b) of the 2016 Act.

Issues of concern

[28] Notwithstanding the foregoing, there are four aspects of the evidence that have caused me concern.

[29] While there is no adequate evidential basis, in the context of this inquiry, to make any formal findings or recommendations touching upon any of these issues, I consider it appropriate to record my concerns for the benefit of the parties, other interested persons, and the wider public interest.

[30] The four issues of concerns are as follows:

(i) The inability of the prison staff and health professionals involved in his care to gain full access to Mr Rodgers' complete health records.

(ii) A lack of clarity as to the circumstances in which a prisoner, who may be in need of additional care and support, may be referred to the HDU within HMP Barlinnie;

(iii) The extent to which the SPS "Talk to Me" strategy may be capable of being circumvented by prisoners who hide their suicidal thoughts in order to avoid becoming subject to those strategies, or to be released from them prematurely; and the extent to which removal of a prisoner from the "Talk to Me" strategy should coincide with the removal of other protective factors.

(iv) The presence of certain deficiencies in prison mental health care record-keeping.

I shall address each in turn.

Issue 1: Access to prisoner health records

[31] A recurring theme of the information available to the inquiry was that the health professionals and prison staff involved in the care of the deceased had no direct or complete access to Mr Rodgers' community mental health records, from both Scotland and England.

[32] As a result, in my judgment, the health professionals and SPS staff appear to have been overly-dependent upon the recollections provided by Mr Rodgers himself as to, for example, his mental health diagnoses and prescribed medication.

[33] This unsatisfactory state of affairs was compounded by the fact that, by all accounts, Mr Rodgers was himself "a vague historian" (per the significant incident report dated 20 November 2019: Crown production No 11, page 708). Indeed Mr Rodgers' own GP, at the date of his first referral for psychiatric assessment, described him as a "rather unreliable character" and his incoherence and inconsistency is a recurring feature of his documented assessments over many years thereafter.

[34] Undoubtedly, Mr Rodgers' mental health history was complex and confused. But the challenges presented to the SPS and NHS staff involved in his prison care were exacerbated by the absence of direct and complete access to his community health records (both in Scotland and England). The prison staff and health professionals required to rely, in part, on Mr Rodgers' own vague recollections, supplemented by such incomplete records as were available. Even by the date of his last assessment (on 15 June 2018), it was unclear to the consultant psychiatrist when, why or by whom Mr Rodgers had been prescribed anti-psychotic medication.

[35] In this case, the lack of clarity as to the deceased's mental health history was compounded by the fact that Mr Rodgers had spent a significant length of time in England (and within the English prison system). This appears to have contributed to a disconnect or lack of cohesion in the sharing of information between cross-border prison and community health authorities regarding Mr Rodgers' mental health history.

[36] Written expert evidence was available to the inquiry regarding this issue, from both Dr Saduf Riaz, consultant psychiatrist, and Rhoda Macleod, Head of Adult Services (Sexual Health, Police Custody & Prison Health Care) of Glasgow City Council Health & Social Care

Partnership ("HSCP"). In their written evidence, admitted by joint agreement, both experts recommended that improvements should be made to allow health professionals responsible for the care of prisoners to have better access to prisoners' health records.

[37] Ms Macleod's significant clinical incident report dated 20 November 2009 recommended that a system be developed to:

> "… ensure health care staff have access to all relevant health care record systems to improve information, communication and support timely care…".

She recommended that a "pathway" be developed to "support access to health information for prisoners already in health and care services" to allow health care professionals and prison staff to have a greater "understanding of what treatment and care has been provided before imprisonment".

[38] Likewise, Dr Riaz recommended having "... a central database for health records…", suggesting that that would:

> "assist with understanding the mental health histories of prisoners as well as help[ing] with making more accurate diagnoses".

[39] It cannot be said, on the evidence, that the absence of better access to community health records contributed, to any extent, to Mr Rodgers' death or was otherwise a relevant material fact or issue in this inquiry; still less, absent such evidence and submissions, do I consider it appropriate to make any formal recommendation. The prison staff and health authorities appear to have had sufficient information available to them adequately to alert them Mr Rodgers' mental health issues.

[40] Nevertheless, I merely express my concern (shared by the body of expert evidence available to the inquiry) as to the quality of access afforded by prison healthcare professionals to

the community health records of prisoners. If better access was provided to such community health records (perhaps by way of a "central database" per the recommendation in Dr Riaz's report: Crown production No 10, page 701), a clearer and more reliable understanding may be achieved of the past and current mental health histories of prisoners and thereby enable the prison healthcare professionals to make more informed, confident and accurate diagnoses and decisions regarding the care and treatment of affected prisoners. This would also prevent an over-reliance upon potentially incomplete and unreliable information provided by prisoners themselves.

Issue 2: Lack of clarity regarding criteria for referral to Barlinnie's HDU

[41] The evidence before the inquiry disclosed a lack of clarity as to the circumstances in which a prisoner, who may be in need of additional care and support, may be referred to the HDU within HMP Barlinnie.

[42] According to the Significant Clinical Incident Report dated 20 November 2019 from Glasgow City HSCP (Crown production No 10, page 709), "officially, HMP Barlinnie does not have a High Dependency Unit" but, instead, has a 50 bed residential care unit where prisoners who have additional needs can be accommodated. Understandably, SPS staff control who is accommodated within this unit. However, the difficulty that emerged from the evidence is that there is no clear understanding among the prison health care professionals as to the selection criteria applied by SPS for prisoners to gain access to the HDU. It appears from the information before this inquiry, that the selection criteria have not been communicated to the NHS health professionals involved in prisoner care.

[43] This issue of concern emerged in the present case because, at the multi-disciplinary case conference on 9 June 2018, Mr Rodgers had requested a move to the HDU; all the health professionals supported the request; a referral to this effect was made; however, it transpired that, unknown to Mr Rodgers, the referral was subsequently refused by SPS staff for reasons that were never communicated to him or to NHS healthcare professionals, other than in the unilluminating terms that Mr Rodgers did not meet the SPS selection criteria (whatever they were). The SPS refusal of the referral only came to light on 12 June 2018.

[44] The Glasgow City HSCP Significant Clinical Incident Report dated 20 November 2019 (Crown production No 10, page 712) recommends greater transparency, specifically, that the SPS should disclose to the prison healthcare staff the admission criteria to the HDU in order to "support timely and effective referrals". This seems entirely sensible.

[45] Again, it cannot be said, on the evidence, that this issue contributed, to any extent, to Mr Rodgers' death, or that it was otherwise a relevant material fact to the circumstances of this death; still less, absent such evidence and submissions, do I consider it appropriate to make any formal recommendation.

[46] Instead, I merely express my concern, shared by Glasgow City HSCP, regarding the lack of transparency surrounding the selection criteria and procedures to access the HDU within HMP Barlinnie. It would be prudent for healthcare staff to be made aware by SPS of the admission criteria and procedures, in order to support timely and effective referrals for prisoners in need.

Issue 3: Review of SPS suicide prevention strategies

[47] Notwithstanding Mr Rodgers' long history of mental health issues, as well as his recent assessed suicide risk, all of which had resulted in him being placed on the "Talk to Me" strategy, he was then removed from that protective strategy on 12 June 2018, just 6 days prior to his suicide.

[48] Firstly, it is of some concern that one of the recorded reasons for removing Mr Rodgers from the protective "Talk to Me" strategy, was to allow him to get a good sleep (see Crown production number 3, page 190; entry dated 12 June 2018).

[49] It also emerged from the assessment carried out on 15 June 2018 (just 3 days prior to the suicide) that Mr Rodgers had disclosed that his fiancée was not happy that Mr Rodgers had been placed on the "Talk to Me" strategy and that this was causing difficulties in the relationship.

[50] In his expert report, Dr Riaz expresses the opinion that, from his experience, prisoners do not always find suicide prevention strategies supportive and can hide their suicidal thoughts in order to avoid becoming subject to those strategies, or in order to leave them early.

[51] I must emphasise that there is no substantive evidence in the present case to justify the conclusion that, in this case, Mr Rodgers was masking his suicidal thoughts in order to extract himself from the "Talk to Me" strategy. However, one is left with the nagging concern that, perhaps, Mr Rodgers might have been doing just that, simply in order to get a better sleep, or to remove himself from the strategy for the sake of preserving his relationship with his fiancée.

[52] While, in the context of this inquiry, I acknowledge that these concerns can amount to no more than speculations, nevertheless I share Dr Riaz's expressed concern that the risk exists that

prisoners may hide their suicidal thoughts in order to avoid becoming subject to those strategies, or to leave them early; and would echo his suggestion that such strategies might benefit from review to ensure they are robust against such prisoner circumvention.

[53] Secondly, the timing of Mr Rodgers' removal from the "Talk to Me" strategy is of concern to me. That is because it coincided, shortly thereafter, with Mr Rodgers being relocated to a *single* cell in the DSU (the prior referral to the HDU having failed), with no formalised routine of monitoring or observation. The upshot was that Mr Rodgers was removed from the protective "Talk to Me" strategy and was transferred to a single cell elsewhere, with no routine monitoring.

[54] This coincidental timing is of concern because, according to the Vision notes of the health consultations with Mr Rodgers on 9 & 12 June 2018, Mr Rodgers is expressly reported as getting on well with his cell mate, and that he was happy to continue to share.

[55] It might be assumed that the sharing of a cell with a cell mate, with whom he got on well, was a protective factor in the prevention of suicide or self-harm. (I say this because, in his expert report, Dr Riaz also observes that it "may have some value" for prisoners to share cells or for there to be a buddy system for those that have a history of suicide attempts.) In the event, having been removed from the "Talk to Me" strategy on 12 June 2018, and then relocated shortly thereafter to a single cell elsewhere, Mr Rodgers appears to have lost both the protective influence of a cell mate (with whom he got on well) and the protection of the SPS suicide prevention strategy.

[56] Accordingly, a concern arises from the evidence as to whether the SPS "Talk to Me" strategy might benefit from review (i) to ensure it is sufficiently robust against such prisoner

circumvention and (ii) to ensure that prisoners are not routinely withdrawn from its protective embrace without adequate justification, including adequate countervailing protective factors being in place.

[57] That said, in fairness, I must repeat that, according to the expert evidence to this inquiry, which I have accepted, there was no material deficiency in Mr Rodgers' care either on a systemic or individual basis; that his care demonstrated an example of good mental health care; that he was identified as having a history of mental health problems as well as presenting as having had a previous risk of suicide; that he was referred appropriately, "robustly assessed" and managed well on the SPS suicide prevention strategies (per opinion of Dr Riaz: Crown production number 10, page 700, paragraph 11). In light of this evidence, I have made only formal findings and I make no formal recommendations.

Issue 4: Deficiencies in electronic record-keeping

[58] Certain incomplete and erroneous entries appear within the electronic health records maintained for Mr Rodgers.

[59] Specifically, it is not always possible to identify from the so-called "Vision" records (being the electronic NHS records) the author of each entry and the role held in the related organisation. Clearer identification of the author and their designation may be useful. This is confirmed in the Glasgow City Council HSCP Significant Clinical Incident Report dated 20 November 2019: Crown production number 11, page 710).

[60] In addition, there is no record in the "Vision" electronic records (Crown production No 3, page 190 *et seq*) confirming that the original referral to HDU had been refused, or why;

there is no record of when the "re-referral" to HDU was made, or by whom; there is no electronic record on Vision of when Mr Rodgers was transferred from his shared cell to another part of the prison. The only record of this relocation appears in the SPS Diplar Report (Crown production number 7, page 685) which bears to record that Mr Rodgers was relocated from B Hall 2/17 to DSU 4/37 on 14 June 2018. (The date of Mr Rodgers' internal relocation is erroneously referred to as "15 June" earlier in the Diplar Report (at page 682) but the parties were agreed in the joint minute that the date of relocation was 14 June 2018.) Lastly, a consultant psychiatrist conducted a psychiatric review/assessment of Mr Rodgers on 15 June but, again, this is not recorded in the Vision electronic notes. (The consultant's letter dated 19 June 2018 – one day after Mr Rodgers' death – is included within Crown production number 3, at pages 226 – 229.) The Glasgow City Council HSCP report dated 20 November 2019 (Crown production number 11, page 709) records that the consultant psychiatrist "fed back her findings" to nursing staff after the assessment – but, again, no such communication is recorded in the Vision notes.

[61] Again, in fairness, on the basis of the evidence available to this inquiry, there is no adequate basis to conclude that any of these record-keeping deficiencies had any contribution or relevance to the circumstances of the death. Accordingly, I make no formal findings or recommendations in relation to these issues, but, instead, merely record my concerns regarding them in the interests of maintaining and improving standards in the future.

[62] Finally, I offer my condolences to the family and friends of Mr Rodgers.

APPENDIX

The legal framework

[A1] The purpose of a fatal accident inquiry is set out in section 1(3). It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (see section 1(4)). A fatal accident inquiry is inquisitorial, not adversarial (see rule 2.2.(1)).

[A2] Section 1(2) provides that an inquiry is to be conducted by a sheriff. In terms of section 3(5) of the Courts Reform (Scotland) 2014 Act, the sheriff principal of a sheriffdom may exercise in his or her sheriffdom the jurisdiction and powers that attach to the office of sheriff. Inquiries which raise issues of particular significance and those which may attract a significant degree of public interest are regularly presided over by sheriffs principal. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1) or, in this case, the sheriff principal.

[A3] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate. A determination under section 26 is to be in Form 6.1 (see rule 6.1)

[A4] The findings the sheriff is required to make are set out in section 26(2), namely, (a) when and where the deaths occurred; (b) when and where any accident resulting in the deaths occurred; (c) the cause or causes of the deaths; (d) the cause or causes of any

accident resulting in the deaths; (e) any precautions which (i) could reasonably have been taken; and (ii) had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided; (f) any defects in any system of working which contributed to the deaths or any accident resulting in the deaths; and (g) any other facts which are relevant to the circumstances of the deaths.

[A5] The making of recommendations is discretionary. The recommendations which the sheriff is entitled to make are set out in section 26(4). The recommendations must be directed towards (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances. Recommendations may (but need not) be addressed to (i) a participant in the inquiry; or (ii) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.