SHERIFFDOM OF SHERIFF COURT GLASGOW AND STRATHKELVIN AT GLASGOW

[2021] FAI 6

B440/20

DETERMINATION

BY

SUMMARY SHERIFF BARRY JOHN DIVERS

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

into the death of

HUGH BAIRD

Glasgow, 13 January 2021

Findings

The Summary Sheriff, having considered the information presented at the Inquiry, determines in terms of section 26 of the Inquires into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") that:

F1. In terms of section 26(2)(a) of the Act, Hugh Baird (hereinafter referred to as "Mr Baird") born 16 August 1978, then a prisoner within HMP Barlinnie, Lee Avenue, Glasgow died there sometime during the prison lockdown period between 16.45 hours on 7 October 2018 and 06.45 hours on 8 October 2018 within cell C1/24 of C Hall.

F2 In terms of section 26(2)(b) of the Act, no accident took place and therefore no finding requires to be made.

F3 In terms of section 23(2) (c) of the Act, the cause of death was (1a) hanging.

F4 In terms of section 23(2)(d) of the Act, there was no accident and therefore no finding requires to be made.

F5 In terms of section 26(2)(e) of the Act, there were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided.

F6 In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death.

F7 In terms section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

Recommendations

The summary sheriff having considered the information presented at the Inquiry, makes no recommendation in terms of section 26(1)(b) of the Act.

NOTE

[1] This Fatal Accident Inquiry into the death of Mr Baird was held on three days, 14 and 15 October 2020 and 11 November 2020. The Crown was represented by Mr Hill, procurator fiscal depute, Mr Henderson, solicitor, appeared for

NHS Greater Glasgow and Clyde, Mr Rodgers, solicitor, appeared for the Scottish Prison Service Officers Association and, Mr Smith, solicitor, appeared for the Scottish Prison Service ("SPS"). I am grateful to all those appearing for their assistance. Mr Baird's family chose not to participate in the Inquiry. However, it is appropriate for me to record that members of his family did attend and followed the proceedings closely at every hearing, including preliminary hearings.

[2] Preliminary hearings in this case took place on 23 July, 6 August, 1 September and 6 October, all 2020.

[3] At the first of these hearings the Court was invited by all parties to make formal findings under section 26(2)(a) of the Act. All parties were also in agreement that no recommendations were required. Further, I was invited to make these findings without the need of any parole evidence. I was provided with a lengthy joint minute and the Crown productions. I was asked to proceed on the basis of these documents and parties' submissions. At this hearing I was advised by the Crown that Mr Baird's family did not intend to enter proceedings. However, it was brought to my attention that members of his close family were in court and that they had advised the Crown that they intended to attend court to follow the Inquiry.

[4] This was an Inquiry with no natural contradictor. In these circumstances, I had regard to the observations of Sheriff Foulis in a recent Fatal Accident Inquiry reported under reference, 2018 FAI 40. In that case, there were no contentious matters and parties also sought to proceed by way of a joint minute in terms of

section 18 of the Act under reference to the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. With regard to that the learned Sheriff said:

> "It should not, however, be lost sight of that the role of the sheriff at an inquiry is different from that played in adversarial proceedings. This is made clear by reference to the provisions of section 20(2) of the 2016 Act. It accordingly appeared to me that the parties entering into a joint minute and intimating to me that this dealt with the matters which were to be the subject matter of the inquiry did not constrain me from seeking certain information to ensure that there were not matters upon which I should consider evidence in an appropriate form to be presented to me."

[5] Applying this to the matter before me, I decided that it would be appropriate for me to consider the productions lodged in light of the joint minute and consider whether there were matters upon which I might benefit from hearing evidence.

[6] Having carried out this process, I decided that there were such matters upon which I might benefit from hearing evidence. I decided that the focus of the Inquiry should be upon the period of Mr Baird's incarceration from 16 August 2018 (when he first made an attempt to kill himself) to 8 October 2018, when he was found dead.

[7] Upon my communicating this decision to parties at the preliminary hearing on 1 September 2018, I was then invited by the Crown to hold the Inquiry by way of teleconference. No objection was made by any other parties. This motion was, of course, made against the background of the current pandemic. I was reminded of the terms of Schedule 4 of the Coronavirus (Scotland) Act 2020. This essentially provides that the requirement to attend court does not apply unless the court considers that attendance by electronic means would prejudice the fairness of proceedings or otherwise be contrary to interests of justice.

[8] It should be noted that, at this time, the facility for holding such hearings by way of video platforms such as Webex was not available within this court. This is a position which has now changed.

[9] I decided that the Inquiry should be conducted in court. The phrase, "interests of justice" is a wide one. It is trite to state that it includes the requirement that justice is seen to be done. Mr Baird's family had by this time attended every hearing of the case. They had indicated they would attend every substantial hearing. Representatives of the press had also been present. If the hearing had proceeded by electronic means that would mean by teleconference. I was not satisfied that that would, in the particular circumstances, allow justice to be seen to be done.

[10] Accordingly, I refused the Crown's motion.

Crown witnesses

[11] The Inquiry proceeded in court in the normal way. I heard evidence from seven witnesses over two days (14 and 15 October 2020). Those witnesses were:

(i) Elizabeth McGregor, Mr Baird's mother.

(ii) Katie Bell, Practitioner Nurse, HMP Barlinnie.

(iii) Nicole Morrison, Mental Health Nurse, HMP Barlinnie.

(iv) Mark Sprott, a Front Line Manager, HMP Barlinnie.

(v) Norman Whyte, Prison Officer, HMP Barlinnie.

(vi) Joseph Cairns, Prison Officer, HMP Barlinnie.

(vii) Dr Gordon Skilling, Consultant Forensic Psychiatrist at the State Hospital.

[12] Witnesses (i) to (vi) spoke to their dealings with Mr Baird during his incarceration. Dr Skilling spoke to his report on the psychiatric care and treatment of Mr Baird while in prison, which report had been prepared for this Inquiry. He had had no dealings with Mr Baird. I found all the witnesses to be credible and reliable.

[13] Thereafter I heard submissions on 11 November 2020. I was greatly assisted by the written submissions that were submitted by all parties in advance of this hearing and to parties' oral submissions made at this hearing.

Timeline of events relating to Mr Baird prior to his death in HMP Barlinnie and shortly thereafter

[14] The following is a summary of the principal relevant events in this Inquiry.

[15] Mr Baird was born on 16 August 1978. He was 40 at the time of death.

[16] On 23 April 2018, Mr Baird appeared on petition at Glasgow Sheriff Court charged with the murder of his partner, Jennifer Morgan on 18 April 2018. At this time he was committed for further examination. He was remanded in custody within HMP Barlinnie.

[17] On 30 April 2018, Mr Baird was interviewed by a consultant forensic psychiatrist instructed by the Crown. As a result of this interview a report was produced of same date. In this report Mr Baird is described as being fit for trial. No

evidence is identified for Mr Baird's responsibility for his actions being diminished at the time of the alleged offence.

[18] On 1 May 2018, Mr Baird appeared again at Glasgow Sheriff Court. He was fully committed and remanded in custody again at HMP Barlinnie.

[19] On 18 May 2018, Mr Baird was interviewed by a consultant forensic psychiatrist instructed by his solicitors. From that interview a report was produced, dated 14 June 2018. The purpose of this report was to assess whether Mr Baird was sane and fit to plead and to explore whether a relevant special defence might be available to him at a future trial. In that report it is noted that Mr Baird denied any thoughts of self-harm. The conclusion of the report is that Mr Baird was sane and fit to plead and that no special defence was open to him. No recommendation was made for any mental health disposal. No requirement was identified for assessment in a psychiatric setting.

[20] On 25 May 2018, Mr Baird's solicitors wrote to HMP Barlinnie. In that letter it is said, *inter alia*, that:

> ",… it has been brought to our attention that Mr Baird may seriously harm himself due to the nature of the charges for which he is remanded. We bring this to your attention so that the appropriate action can be taken. Our client has advised us that he has requested to speak to the mental health team at HMP Barlinnie but so far this has not taken place. We would be obliged if you could treat this matter with the utmost urgency given the nature of the concerns raised above.
>
> It may be of assistance to you to know that we have instructed a defence psychiatrist to provide us with a report in respect of Mr Baird. The instructed psychiatrist is Isobel Campbell however, she has not yet provided us with her full report and therefore we are unaware whether she also has concerns regarding Mr Baird's safety".

[21] By coincidence, on the same date, a mental health assessment took place of Mr Baird. This was in response to two self- referrals in which he had reported poor sleep, voices, flashbacks and visions. It was noted that he appeared fairly kempt but sullen and tired and that he did not engage. However, he denied any thoughts of wanting to harm himself or end his life. He was not distracted or distressed. No diagnosis of psychotic illness or major mood disorder was made. Mr Baird terminated the assessment reporting that health care was "useless".

[22] On 25 June 2018, Mr Baird was again seen for a mental health assessment. This appears to have been as a result of his self-reporting as not sleeping and having "horrible thoughts". No evidence of psychosis was identified. He was not noted as distracted, distressed, anxious or agitated. However, he was noted as appearing frustrated and irritable. He denied any thoughts of intent of suicide or self-harm. A discussion took place as to a referral to a stress clinic. Mr Baird stated that this was not required at this time.

[23] On 15 August 2018, Mr Baird phoned his mother. He told her that he loved her. He also phoned other family members and told them that he loved them. Mrs McGregor was concerned for her son after her call. She phoned his solicitor, who advised her to call HMP Barlinnie. She did this. Mrs McGregor identified herself to a female member of staff and explained her concern for her son. She requested that the staff watch her son. She advised that she was concerned that he would do "something silly". Mrs McGregor was told that someone would be sent over to C-Hall and she was not to worry.

[24] On 16 August 2018, Mr Baird was found unresponsive within his cell. Mr Baird had self-inflicted puncture wounds to his neck. These wounds had been administered using sharpened plastic cutlery.

[25] Mr Baird was conveyed to the Queen Elizabeth University Hospital, Glasgow. He had a deep wound to the left side of his neck overlying the carotid sheath. He was treated with five staples to his neck and discharged.

[26] He was returned to HMP Barlinnie later that day. At this time a Talk To Me ("TTM") assessment took place. TTM is the strategy used by the SPS to prevent suicide in prison. All staff that come into contact with prisoners are trained on TTM. It is designed so that at any time anyone who is involved in the life of any prisoner can raise a concern. These concerns can also be raised by people outwith the prison estate. Prisoners can also self-refer. The TTM strategy is engaged if a prisoner is identified as being at risk of suicide. Following the TTM strategy being triggered an assessment takes place. A TTM assessment involves an assessment by a prison officer and a nurse. If either the officer or the nurse have any concerns they can mark the prisoner as being "At Risk". In those circumstances, a case conference is held. This is a meeting involving prison officers, a nurse and the prisoner. From this case conference an appropriate care plan is put in place. This care plan involves regular reviews by case conference. If the prisoner is assessed as being of "No Apparent Risk", no action is taken. This designation can change. As part of the TTM strategy, a "book" is maintained on the hall which includes the records of the assessments and case conferences as well as notes on day to day interactions.

[27] Mr Baird was assessed as being "At Risk". He was placed in a safety cell with anti-ligature bedding and clothed in anti-ligature clothing with no access to cutlery or a kettle. He was placed on 15 minute observations. A case conference was organised.

[28] On 17 August 2018, Mr Baird appeared at Glasgow High Court for a preliminary hearing. A dedicated floating trial was assigned for 15 October 2018. Mr Baird was returned to HMP Barlinnie on remand.

[29] On this same date the first case conference was held under the TTM regime. At this time Mr Baird was still considered to be "At Risk". The decision was made for the same TTM regime to continue.

[30] A second case conference was held on 20 August 2018. At this case conference Mr Baird stated that he had no recollection of cutting his throat. However, he was able to advise that on 16 August 2018, he had taken a New Psychoactive Substance ("NPS") or so-called "legal high". He also said that he would not take a NPS again, that he had "learned his lesson" and that he had no suicidal thoughts and just wanted to return to a "normal way of life". At this case conference it was also noted that Mr Baird had managed well on TTM. A decision was made to continue Mr Baird on TTM. He was still regarded as being "At Risk". However, it was also decided that he be placed in normal accommodation. He was to have normal clothing and all items (such as cutlery and a kettle) were to be in use. Observations were reduced to every 60 minutes.

[31] On 23 August 2018, a further case conference was held. At this case conference, Mr Baird denied any thoughts of harming himself. He stated that he never had thoughts of killing himself, that he did not remember hurting himself and that if his mood were to change, he would speak to staff. The outcome of this case conference was that Mr Baird was still recorded as being "At Risk" and the decision was made to continue him on TTM.

[32] On 28 August 2018, the final case conference concerning Mr Baird under the TTM regime was held. At this case conference, Mr Baird again denied any suicidal thoughts. He again offered the explanation that the incident on 16 August 2018 had happened because of the effects of trying a NPS. He stated that he would not do anything like that again, that he felt "brand new" but that he was "raging" that he was still on TTM after 10 days. He also said he would talk to staff if he had any issues. As a result of this case conference Mr Baird was regarded as no longer being "At Risk". He was designated as being, "At No Apparent Risk". Accordingly, the decision was made to remove him from the TTM regime.

[33] He was placed in cell C1/24 (a single occupant cell) within C Hall, HMP Barlinnie.

[34] He remained there until 8 October 2018.

[35] In terms of the TTM strategy, if any member of prison staff has a concern about a prisoner they can complete a "concern form". This initiates the TTM process. If anyone external to the SPS raises such a concern, this can also initiate the TTM process. During the latitude, 28 August 2018 to 8 October 2018, no such

concerns were raised either internally or externally regarding Mr Baird being a potential risk of suicide or self- harm.

[36] On 3 September 2018, Mr Baird spoke with a doctor concerning whether he required to be supervised when he took certain medication. At this meeting there was a discussion about the events of 16 August 2018. Mr Baird denied that he had ever been suicidal and denied any suicidal ideas. He said he was not thinking of taking an overdose.

[37] On 17 September 2018, Mrs McGregor made a phone call to the prison concerning her son. This call had been prompted by a visit by another family member who reported Mr Baird to have a mark on his head.

[38] On 24 September 2018, Mr Baird made a self-referral to see a nurse. His reason for so doing was as described in the self-referral form as "My head is not right. I do not sleep from thoughts and voices, now seeing stuff". He also made reference to a physical problem with his nose.

[39] On 1 October 2018, Mr Baird was the subject of a mental health assessment. He reported that he was struggling to relax, that he had "constant thoughts racing around his head" and that he could not "switch off ". He again reported that he was not sleeping and that this was due to worrying about his future. The assessment was carried out by a mental health nurse. Following this assessment, no formal diagnosis of major mental illness or mood disorder was made. Mr Baird was settled and appropriate during the interview. He did not seem agitated, anxious, distressed or distracted. He was clean and kempt. Again he explained that his actions on

16 August 2018 were as a result of being under the influence of a NPS. He denied all thoughts of suicide or self-harm. He gave no cause for concern during the interview. He reported as being aware of available support networks. It was suggested that he have counselling, to which he, unenthusiastically, agreed.

[40] At approximately 16.45 hours on 7 October 2018, Mr Baird was locked in his cell. This was in accordance with prison lockdown procedure. He gave no cause for concern at this time.

[41] At approximately 06:45 hours on 8 October 2018, Prison Officers, John Cairns and John Stokes attended at Mr Baird's cell as part of their morning cell checks. They opened the cell door and observed Mr Baird to be hanging from the cell ceiling. They exited the cell and alerted other staff to a "code blue". This indicates an emergency involving suffocation or lack of oxygen.

[42] Mr Baird was alone in his cell. He was hanging by a ligature around his neck. A chair was close by. The ligature was fashioned from a prison issue bed sheet which had been secured to the ceiling light fixture in which two holes had been burned. A prison issued cable tie had been used to assist in securing the material to the light. He had used prison issued cable ties to secure his wrists to the belt loops of his trousers. This meant his hands could not be moved from his hips.

[43] Mr Baird was cut from the ligature. As he was placed on the floor of the cell it was observed that he was cold to the touch. Rigor mortis and post mortem lividity were present. Therefore, resuscitation by CPR was not attempted.

[44] Paramedics from the Scottish Ambulance Service attended and pronounced life extinct at 07.15 hours.

[45] Police officers arrived a short time later and secured the scene.

[46] Writing was observed on the cell wall which read "I will take the voices away myself, too late for two people who loved each other, tell all I'm sorry in my family and Jen's xxx".

[47] At 14:00 hours the body of the deceased was conveyed by ambulance to the Queen Elizabeth Hospital. Upon removal of the deceased's clothing a suicide note was discovered.

[48] The deceased was subject to a post-mortem examination on 11 October 2018. The cause of death was found to be (1a) ligature suspension by the neck.

[49] The SPS carried out a Death in Prison Learning Audit and Review ("DIPLAR") on 14 November 2018. The conclusion of the DIPLAR was that there were no indications that Mr Baird was suicidal prior to his death and therefore there were no indicators which would have led staff or partners to believe that Mr Baird was a risk of suicide at the time of his death.

Submissions

[50] I am grateful for the written submissions provided by parties and amplified in court. They have been of considerable assistance. I mean no disrespect by not setting those out at length. All represented parties sought formal findings.

[51] There was no natural contradictor in this Inquiry. However, having asked parties to concentrate upon that period following Mr Baird's first suicide attempt, I am grateful for the depth to which this period was explored.

Conclusion

[52] At the outset, it is important to be clear that Mr Baird's actions on 16 August 2018 (whatever was the motivation) were serious enough, in their implementation, to be more accurately described as an attempted suicide as opposed to an example of "self- harm". I found it surprising that certain witnesses when giving their evidence referred persistently to this as an incident of "self-harm". This phrase is also used regularly within Mr Baird's prison medical records to describe this incident. In the DIPLAR documentation the events of the 16 August 2018 are described as being "self-injurious behaviour". Though strictly speaking a suicide attempt resulting in injury, as was the case here, is an incident of self-harm, there is, in my view, a clear difference in emphasis and tone. As Dr Skilling recognised, "self-harming" is a phrase which could also be used to describe the infliction of minor cuts to relatively safe parts of the body such as the arm. What Mr Baird did was to stab himself in the neck. It left a deep wound to the left side of his neck overlying the carotid sheath. Dr Skilling preferred the description of this incident as an attempt at suicide. I agree. The action speaks for itself. Words are important. They are all we have to describe an event accurately and an inaccurate description of an event can have consequences. Someone who is described as having recently "self-harmed" might

not be thought to be a suicide risk in the future; someone who is described as having recently attempted suicide might be thought to pose such a risk. This could have obvious important consequences.

[53] However, such a description did not have consequences in this case. Immediately upon Mr Baird's return from hospital he was categorised as being "At Risk" and a TTM case conference was scheduled to take place the following day. As a result of this conference, a care plan was put in place. Mr Baird was placed in an anti-ligature cell. He had no access to cutlery or a kettle. He was placed on observations at 15 minute intervals.

[54] It is tolerably clear that, had these measures been in place as at 8 October 2018, then Mr Baird would not have been able to take his life. From this statement two issues arise:

(i) Firstly, whether any criticism should be made of the decision to remove Mr Baird from the protection of the TTM strategy?

(ii) Secondly, whether Mr Baird, having been removed from the TTM strategy, ought to have been made, prior to his suicide, subject again to the TTM strategy?

[55] I take these issues in order. In considering them it is of course important to consider the full context in which the relevant decisions were made.

First issue

[56] It might be thought that one of the best predictors of future behaviour is to look at past behaviour. Given that Mr Baird had attempted suicide in prison in the recent past, was it not reasonably foreseeable that he would attempt to do this again? Should that not have resulted in his being continued on TTM?

[57] In the lead up to Mr Baird's first suicide attempt, there was no concern from staff in HMP Barlinnie about Mr Baird being at risk of suicide. No one gave consideration to triggering the TTM strategy. Though he presented as someone suffering from stress and not sleeping, the two mental health assessments during this time did not give rise to any concern that he might be "At Risk".

[58] This was at odds with what seemed to be the position of those who were close to Mr Baird outside of prison. On 25 May 2018, his solicitor wrote to prison authorities warning of such a risk. On the evening of 15 August 2018, his mother called the prison and told them that she was concerned he was going to do "something silly". There was no record of this call in the prison records. That it was not recorded in the prison records is concerning. Further, it is not clear what action was taken in response to this call (if any). If I were considering a fatality arising from Mr Baird's actions on 16 August 2018, this would be very important. However, this Inquiry is not considering a fatality from that date. This call is only important as context to what happened on 8 October 2018.

[59] It also important to note that two independent psychiatrists consulted with Mr Baird during this time. Each prepared reports that were made available to me.

Of course the fact that this step was taken at all indicates that there was some concern from both the Crown and the defence as to Mr Baird's mental health. Both of these reports had as their primary focus whether Mr Baird was fit to stand trial and his state of mind at the time of the alleged offence, as opposed to whether he was at risk of attempting to take his own life. However, in their general observations about Mr Baird, neither psychiatrist expressed any concern about Mr Baird being a risk to himself. Neither had they any recommendations to make in that regard.

[60] Be that as it may, in any event, after 16 August 2018, whatever had been, or should have been the views of the prison authorities leading up to that date, they now knew, or ought to have known, that Mr Baird was someone who had attempted to take his life.

[61] Accordingly, upon his being released from hospital, the prison authorities were correct to recognise that he should be regarded as being "At Risk". The decision to immediately make him subject to the TTM strategy was therefore correct. Nor can any criticism be made of the decision(s) to keep Mr Baird on that regime (with modifications) until 28 August 2018. Those decisions were prudent and proper.

[62] Further, I am satisfied that the decision to remove Mr Baird from the TTM strategy on 28 August 2018, was also appropriate. This is for two reasons.

[63] Firstly, that there was no concern as to how Mr Baird presented at this case conference. I heard and read evidence that he made good eye contact and expressed a reasoned desire to be removed from TTM.

[64] One concern I had was that a prisoner, having determined to take his life, may be able to falsely present as well for a short time in an 'interview' situation such as a case conference. That he might therefore be able to give a false impression and deceive those speaking with him, knowing that this might result in removal from TTM.

[65] However, I am satisfied that the decision of 28 August 2018 was not made purely upon how Mr Baird presented at this case conference. I was impressed with the evidence of Joseph Cairns. Mr Cairns is an experienced prison officer. He has worked for the SPS for 23 years (six of those in HMP Barlinnie). During the time Mr Baird spent in C-Hall, Mr Cairns was working there. He was also one of the three members of staff at the case conference on 28 August 2018. He also took part in the case conference of 23 August 2018. Importantly, in my view, Mr Cairns was someone who had regular contact with Mr Baird in the period after 16 August 2018. He worked with Mr Baird during this period. He described how he would try to get to know prisoners. He would look for changes in their mood. He would assess things constantly.

[66] Mr Cairns described Mr Baird as a polite man, who enjoyed exercise. He stated that, as a result of his regular interactions with Mr Baird, he had no concerns

about Mr Baird being "At Risk". This assessment of Mr Baird, is supported by contemporaneous notes, in the TTM records, made by other prisoner officers.

[67] In the circumstances, at the TTM case conferences on 23 and 28 August 2018, Mr Cairns brought an invaluable background of knowledge as to how Mr Baird was conducting himself on a daily basis. He was able to contribute this context to the decision making process. My understanding is that this is why, within the TTM strategy, there is a requirement for an officer from the prisoner's hall to attend at case conferences.

[68] Neither Mr Sprott or Ms Bell, the other two participants present knew Mr Baird prior to meeting him at the case conference. They were making their assessment of Mr Baird on what they saw before them and what they read in the TTM "book". No criticism should be made of them for that. I heard evidence that this is often how TTM case conferences proceed. With two of the three participants coming from prison management (Mr Sprott) and medical staff (Ms Bell) it is often the case that such people have had no prior dealings with the prisoner. Mr Sprott was the manager of a different hall. The picture before me seemed to be that such participants often find out at short notice that they are to take part in such conferences. They are then given a short time to read through the prisoner's TTM "book" to identify and digest what has happened previously.

[69] Both Mr Sprott and Ms Bell were candid when giving their evidence that they could not remember reading through Mr Baird's TTM "book". They could only describe what they "would have done" or what they "probably" did, that this

"would" or "probably would" have involved them reading through the TTM "book". Ms Bell's evidence appeared to be that the usual practice was that the TTM information was made available "just prior" to the prisoner entering the room.

[70] I am prepared to accept that both Mr Sprott and Ms Bell did read through the Mr Baird's TTM records just prior to the case conference on 28 August 2018. I do not find that that their lack of previous dealings with Mr Baird contributed to a wrong decision being made on 28 August 2018. In that regard I note the continuity of involvement of Mr Cairns with his background knowledge of Mr Baird.

[81] However, I do consider that it would be beneficial if sufficient time was always allowed for staff who take part in TTM case conferences, in particular those who have no previous dealing with the prisoner, to be able to read through and familiarise themselves with the subject's TTM record. Given that I have found that Mr Sprott and Ms Bell did familiarise themselves with Mr Baird's TTM documentation prior to this final case conference, in all the circumstances of this case, I have decided not to make this a formal recommendation.

[82] I turn now to the second reason why I consider the decision of 28 August 2018 to be appropriate, that being that Mr Baird provided staff with a consistent, plausible and specific explanation for his attempted suicide (his taking of a NPS), so that this attempt was something he did when he was in an intoxicated state and not thinking properly. This gave credibility to his stating that he had no suicidal intention. It gave weight to his desire to be removed from the TTM strategy.

Importantly, having identified the explanation for why he had acted in this way, he was clear that he would not do it again.

[84] This forgoing explanation, when set against the background I have described as to how Mr Baird was presenting, both at the case conference and day to day on C-Hall, leads me to conclude that the decision to remove him from the TTM strategy and categorise him as "At No Apparent Risk" was an appropriate one.

[85] I heard evidence about the number of prisoners at HMP Barlinnie and the practical problems from a resourcing stand point that could arise if prisoners were kept on the TTM strategy. That is no doubt true. However, it is not relevant to this case. Issues such as that would only be relevant if a lack of resources had contributed to Mr Baird being removed from TTM when he should still have properly been regarded as "At Risk". That did not happen. For the reasons given, as at 28 August 2018, Mr Baird was no longer considered "At Risk". There being "No Apparent Risk", the decision to remove him from the TTM strategy was correct.

[86] I turn now to the second issue

Second Issue

[87] The decision having been made to remove Mr Baird from the TTM strategy, the next question which requires to be answered is whether he should, at some point prior to 8 October 2018, have been made subject to the TTM strategy again?

[88] In order to have been made subject to the TTM strategy again, Mr Baird would have had to have been considered "At Risk". At no time was he so regarded by the prison authorities. Should he have been?

[89] Mr Cairns gave evidence that after Mr Baird was removed from TTM, he still "kept an eye on him" during the period in which they were in regular contact. Using the language of the TTM strategy, he looked for "cues" and "clues" as to whether he should have concerns about Mr Baird. Mr Cairns explained that throughout this time if he had had any concern about Mr Baird, he would have spoken to him and, if his concerns persisted, he would sought to put him back on the TTM strategy. Mr Cairns said that Mr Baird's mood gave him no concern during this period and that Mr Baird continued to go to gym.

[90] With regard to the mental health assessment on 1 October 2018, this was generated by a self- referral by Mr Baird. This concerned his struggling to relax and sleep. He specifically denied any thoughts of suicide or self-harm. He again provided a consistent explanation for what had occurred on 16 August 2018, as being as a result of having taken a NPS. As previously observed, the note in the prison medical records of this assessment refers to the incident on 16 August 2018 as involving "self-harming". At this assessment Mr Baird did not appear anxious or agitated. He did not seem distressed or distracted. This corresponds with the picture of Mr Baird given by Mr Cairns at this time.

[91] It is initially concerning to see a mental health assessment taking place a week before the subject commits suicide. However, on closer consideration, this

assessment concerned a man who was reporting an inability to relax and sleep, as opposed to someone who seemed to be at risk of taking his life.

[92] Against this background, I find that there were no internal warnings signs, or "cues and clues" during the period 28 August to 8 October 2018, which might, or should have, alerted prison staff that Mr Baird was possibly "At Risk" thus triggering the TTM strategy.

[93] Were there any other warning signs, external to the prison? In the lead up to Mr Baird's suicide attempt on 16 August 2018, both his solicitor and his mother had contacted prison authorities with concerns that he might be at risk of harming himself.

[94] Mrs McGregor gave evidence that during this period between 28 August 2018 and 8 October 2018, she was upset about her son. She worried about him constantly. She explained that on one occasion during her visits, about four weeks after his first suicide attempt, he had said to her that "he was not going to court". She explained that she thought this remark meant he was going to do "something stupid". On occasion she said that after her prison visits she was very upset and in tears. She said that she spoke to prison staff. She did not convey any specific concerns to them that Mr Baird was going to do something to harm himself.

[95] Her phone call to the prison on 17 September 2018, concerned a mark on Mr Baird's face which had been noted by another family member while visiting.

[96] My clear impression of Mrs McGregor was of someone who at this time was a devoted and loving mother who constantly did all she could to help her son in what was a very stressful situation.

[97] I am satisfied that there were no external warning signs which should have alerted the prison authorities to the need to re-categorise Mr Baird as being "At Risk".

[98] One further factor I considered was a notable feature of this case, went unmentioned in any of the prison records, or in the evidence of any of the staff who had dealings with Mr Baird, namely the possible significance of the date when Mr Baird's first suicide attempt occurred. It was on his 40th birthday and the day before he was to first appear in the High Court for a preliminary hearing. It seems surprising that these coincidences were not identified as possible precipitants or destabilisers for Mr Baird and at least discussed with him. The potential importance of this going forward was obvious. If Mr Baird's suicide attempt had been linked, for instance, to his imminent appearance in court, then he might have been considered at risk when other court dates approached. This in turn may have allowed for the reactivation of the TTM strategy in advance of such dates.

[99] Dr Skilling pointed out potential difficulties with such an approach. There are many hundreds of prisoners in HMP Barlinnie. Each may have multiple significant events through a year which could act as a destabiliser and push a prisoner towards suicide. Monitoring these would be very difficult.

[100] That would seem to be correct. However, few of those prisoners will have had a recent record of attempting suicide on the evening before their last court appearance. This reduction in numbers would make identification easier and more manageable.

[101] However, in all the circumstances of the present case, I do not find that such a link in any way contributed to Mr Baird's suicide. If the destabiliser was the significant milestone of his 40th birthday, then that had passed. I heard no evidence of any other such anniversaries. If it was his appearance in court, this was eight days away. If there had been thought to be a link between his previous suicide attempt and his last court appearance, then when, in advance of his next court appearance, should he be considered at risk? Should this be the night before? A week before?

[102] Further, and importantly, Mr Baird had provided a credible explanation for his previous attempt at suicide (the taking of a NPS) and he had said he would not take it again. This explanation also has to be considered in the context of his behaviour giving no cause for concern for five to six weeks leading up to the suicide.

[103] For all these reasons, I have no criticism to make of Mr Baird not being made the subject again of the TTM strategy between 28 August and 8 October 2018.

[104] Passing reference was made in the evidence and in submissions, to Mr Baird's use of cable ties obtained from prison laundry bags in his suicide. As discussed above, the substantial focus in this Inquiry was whether, at the time of his suicide, Mr Baird should have been subject to the TTM strategy. As such this was an

ancillary matter. In any event, I was advised that as of December 2019, the SPS no longer use cable ties on prison laundry bags. As such I have no recommendation or finding to make.

[105] As Dr Skilling said during his evidence, suicide is a complex and unpredictable behaviour. This is especially so when a person presents as Mr Baird did in the weeks leading up to his suicide. He repeatedly denied any suicidal intent when asked. He gave no cause for concern to those who had regular contact with him. He was also able to provide a cogent, credible and consistent explanation for a previous suicide attempt and explain, in a rational way, why this was not going to happen again. In all the circumstances, Dr Skilling said that he could not see how Mr Baird's suicide could have been prevented. For the reasons given, this is a view with which I agree.

[106] I offer my sincere condolences to Mr Baird's family.