SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2023] FAI 3

GLW-B241-21

DETERMINATION

BY

SUMMARY SHERIFF D MCCONNELL

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

into the death of

PHILIP JOHN HUTTON

GLASGOW, 5 January 2023

The sheriff, having resumed consideration of the cause, Finds and determines that 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") the following:

(1) In terms of section 26(2)(a) of the 2016 Act that Philip John Hutton, born 31 October 1979, died at some time between 20:30 hours on 5 December 2019 and 07:20 hours on 6 December 2019 within Cell D-10, Level 1, Kelvin Hall, HMP Low Moss. He was pronounced dead at 07:38 hours on 6 December 2019. His death was not accidental. He committed suicide.

(2) In terms of section 26(2)(c) of the 2016 Act, that the cause of death was:

1(a) Hanging.

(3) In term of section 26(2)(e) of the 2016 Act, there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

(4) In terms of section 26(2)(f) of the 2016 Act, there was no defect in any system of working which contributed to the death.

(5) In terms of section 26(2)(b) and (d) of the 2016 Act, there was no accident on which to base any findings.

(6) In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death), that there are no other facts which are relevant to the circumstances of the death.

(7) In terms of section 26(1)(b) of the 2016 Act I have no recommendations which might realistically prevent other deaths in similar circumstances arising from the evidence.

(8) There are no observations I have to make about the system of working within Kelvin Hall, HMP Low Moss, Glasgow arising from the evidence or relevant to the death of Philip Hutton.

NOTE:

Introduction

[1] This is mandatory Inquiry into the death of Mr Philip John Hutton in terms of section 4(a) of the 2016 Act.

The proceedings and the parties

[2] Preliminary hearings took place at Glasgow Sheriff Court on a number of occasions before the Inquiry itself which was held from 19 July 2022 to 22 July 2022; on 17 and 18 August 2022; and 11 October 2022. Miss J Guy, procurator fiscal depute, represented the Crown, Mr A Rodgers represented the Scottish Prison Officers' Association, Mr N McIntosh represented the Scottish Prison Service ("hereinafter referred to as SPS"), Mr D Davidson (counsel), represented Greater Glasgow Health Board, Mr J Varney, Mrs K Railton and Miss E Skett represented the Chief Constable, and Mr R Conway (Solicitor advocate) represented the family of Mr Hutton.

The sources of evidence

[3] Three joint minutes of agreement were entered into by the parties. I heard evidence from seven witnesses who all gave evidence in person at Glasgow Sheriff Court. I also had the benefit of affidavit evidence from Mr Hutton's family: AH and AR. A large number of productions were submitted in advance of the hearing. Several productions were lodged in the course of the hearing. At the conclusion of the evidence all parties submitted full and detailed written submissions which were supplemented by oral submissions. I am grateful to parties for their assistance in the preparation and conduct of the Inquiry.

The legal framework/the purpose of this Inquiry

[4] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules") govern fatal accident inquiries. The purpose of the Inquiry in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the Inquiry is not to establish civil or criminal liability. The process is inquisitorial in character. The Procurator Fiscal represents the public interest at the Inquiry. This Inquiry was mandatory in terms of section 2(1) and (4) of the 2016 Act as Mr Hutton was in legal custody at the time of his death.

[5] As regards the circumstances, the sheriff must make findings regarding:

(a) when and where the death occurred;

(b) when and where any accident resulting in the death occurred;

(c) the cause or causes of the death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which –

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

(f) any defects in any system of working which contributed to the death or any accident resulting in the death; and

(g) any other facts which are relevant to the circumstances of the death.

[6] In terms of section 26(4) the sheriff is entitled to make recommendations regarding:

(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.

A summary of the parties' positions

[7] The Crown's primary submission was to invite the Court to make the mandatory formal findings, that is to determine when and where the death of Philip Hutton occurred, and the causes of Mr Hutton's death in terms of section 26(2)(a) and (c) of the 2016 Act. Specifically in terms of section 26(2)(a) of the 2016 Act that the Court find that Mr Philip Hutton's death occurred at 07.38 on 6 December 2019 within Cell D10, Level 1, Kelvin Hall, HMP Low Moss, and that Mr Hutton's death was not due to any accident. Further, in terms of sections 26(2)(e) and (f) that there were no defects in the system of working which contributed to the death of Mr Hutton, nor were there any reasonable precautions, which might reasonably have prevented the death. In relation to section 26(2)(g), whilst the Crown did not invite the Court to make any findings in relation to reasonable precautions or defects in the system of working) it was submitted by the Crown that it may be appropriate for the Court to comment on a number of issues which had arisen as being <u>potentially</u> relevant to the circumstances of Mr Hutton's

death. Arising therefrom, the Crown submitted that the Court may wish to make recommendations under section 26(4)(b) of the 2016 Act, to the effect that the Police Service of Scotland must ensure all staff working in police custody suites understand the purpose of the SPS Supervision Level on the Prisoner escort form (PER) and also that the Scottish Prison Service ensure that their Talk to Me (hereinafter referred to as TTM) training ensured that staff had an accurate understanding of the SPS supervision level on the PER form.

[8] Further it was submitted that additional training might be provided in relation to the "widespread preference" to use safer cells within HMP Low Moss as well as additional training in respect of the completion of full and detailed notes of the TTM paperwork by staff and additional training on the different policies to be used when prisoners are at risk of suicide and when prisoners are at risk of self-harm.

[9] On behalf of the family of Mr Hutton it was accepted that in relation to sections 26(2)(a) to (d) that the formal findings in fact as contained with the joint minutes of facts are agreed in relation to the circumstances of Mr Hutton's death. In relation to section 26(2)(e), it was submitted that it would have been reasonable on 3 December 2019 for nurse Christine Campbell at Low Moss Prison not to proceed to carry out her reception risk assessment on Philip Hutton until such time as she had access to and had considered at least his present medical records.

[10] It would have been reasonable for her to note from the prisoner escort form that Mr Hutton was a sex offender and would be subject to some kind of segregation and/or separation.

[11] It was also submitted that it would have been reasonable for Dr Ahmed not to proceed to examine and consult with Philip Hutton without reference to his medical records and, that in the absence of this information that neither Nurse Campbell nor Dr Ahmed could carry out a suitable and sufficient Reception Risk Assessment. If this had been done that either Nurse Campbell or Dr Ahmed would have found that Philip Hutton was at some risk of suicide, and that as a minimum, on further enquiry that his belt should have been removed which would realistically have avoided his death by hanging in December 2019.

[12] It was further submitted that if an individualised care assessment had been carried out that it would have been reasonable for staff to be aware of the availability of a disposal short of the safer cells regime, and that all of the foregoing matters should be addressed by training by Scottish Prison Service in association with the NHS. Further, in terms of sections 26(2)(f) and section 26(1)(b) and 26(4) it was submitted account should be taken of the publication of the Independent Review of the Response to Deaths in Prison Custody report dated November 2021 and that the Court should share issues of concern which had arisen during the course of the inquiry with the Deaths in Prison Custody Action Group which has been recently constituted following upon the independent review.

[13] The remaining Parties to the Inquiry invited the Court to make the mandatory formal findings only.

Factual circumstances:

Events leading to circumstances of the deceased and his death

[14] On 2 December 2019 Philip John Hutton, born 31 October 1979 was arrested by Police Scotland in respect of an allegation of breach of bail. He was processed into custody at St Leonard's Police Office by Police custody support officer Jacqueline Ford shortly after midnight on 3 December 2019.

[15] He was not assessed as being at risk of suicide whilst in police custody.

[16] Mr Hutton appeared at Stirling Sheriff Court on 3 December 2019 where he pled guilty to a breach of bail and breach of section 38 of the Criminal Justice and Licensing (Scotland) Act 2010. He was remanded in custody within Her Majesty's Prison, Loss Moss pending completion of Criminal Justice Social Work Reports and allocated Cell D-10, Level 1, Kelvin Hall, HMP Low Moss. Mr Hutton was due to appear for sentencing at Stirling Sheriff Court on 8 January 2020. He was accordingly in legal custody at the time of his death.

[17] Mr Hutton had been sentenced to periods of imprisonment on 21 occasions. The first period of imprisonment was in December 2004. He had been imprisoned at Her Majesty's Prison Low Moss previously and was known to staff there. Mr Hutton had previously been convicted of a sexual offence. From 3 December 2019 to 6 December 2019 there were at least four prisoners convicted of sexual offences in D section, Level 1, Kelvin Hall where Mr Hutton was located.

[18] Prior to December 2016 the SPS suicide risk management strategy was named ACT2Care (hereinafter referred to as "ACT"). On 5 December 2016 ACT was replaced

by a revised strategy known as "Talk to Me", the prevention of suicide in prison strategy.

[19] A group of experts contributed to the development of TTM. These included experts in suicide prevention together with NHS senior managers, representatives from the Samaritans , Breathing Space and Families Outside (which is a charity working with families of prisoners), psychiatrists and other mental health practitioners, personnel from the SPS and representatives from the mental health division of the Scottish Government.

[20] As part of TTM, all prisoners are assessed upon entry or re-entry to an SPS establishment. In addition, any individual working with a prisoner may initiate a TTM assessment should they have concerns about a prisoner at any time. It is not restricted to those times when a prisoner enters or re-enters an establishment. Staff are trained on "cues and clues" and precipitating factors and are alive to prisoners' moods changing when, for example, their circumstances change.

[21] The SPS' TTM strategy can be seen at SPS production 1 and the SPS' TTM guidance can be seen at SPS productions 4 and 5.

[22] If a prisoner is assessed as being "at risk" during a TTM assessment then a case conference takes place and an appropriate care plan is put in place with measures which can include removal of clothing/items that could be utilised as a ligature and transfer to

a safer cell (a cell with no ligature points) with safer clothing and bedding, (which is more difficult to rip or tear and therefore to be used as a ligature).[1]

[23] Prisoners can also make a self-referral to the mental health team within SPS prisons in order to access mental health support and treatment.

[24] Mr Hutton had never been placed on TTM or ACT during any period of incarceration prior to his admission to HMP Low Moss on 3 December 2019.[2]

[25] Upon his admission to HMP Low Moss on 3 December 2019 Mr Hutton underwent a TTM reception risk assessment.[3]

[26] There are six parts to the reception risk assessment that was carried out in relation to the Mr Hutton. Firstly Mr Hutton was assessed by prisoner officer Ryan McStay who completed parts 1 to 5 of the reception risk assessment.

[27] Mr McStay had received the mandatory training in TTM and was competent in terms of TTM procedures to carry out this assessment. Mr McStay circled part 2 of the TTM reception risk assessment form to indicate that he had read and understood the (PER) form relating to Mr Hutton. Mr McStay noted on part 4 of the reception risk assessment form that Mr Hutton had no concerns being in Low Moss; was not suicidal or considering self-harm; maintained good eye contact during the assessment; spoke well throughout; stated he had anxiety and that he had no anger issues.[4]

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[1] SPS production 1 page 8
[2] Crown production - SPS PR2 record for Mr Hutton
[3] Crown production 4, pages 45 to 47
[4] Crown production 4, page 46

[28] Mr McStay, (who had dealt with Mr Hutton during a previous period in Low Moss) concluded that Mr Hutton posed no apparent risk of suicide.

[29] Mr Hutton was then assessed by Nurse Christine Campbell who completed part 6 of the reception risk assessment. Nurse Campbell ticked the form to confirm that she had read and understood the PER form and all information recorded in respect of Mr McStay's assessment. Nurse Campbell noted that Mr Hutton stated that he was suffering from depression and anxiety but was receiving medication and was feeling stable. She confirmed from the cardex part of his medical records that he was prescribed sertraline. She noted that the deceased strongly denied any thoughts of self-harm/suicide on admission. Nurse Campbell also therefore assessed Mr Hutton to be of no apparent risk of suicide.[5]

[30] In terms of rule 32(1) of the Prisons and Young Offenders Institutions (Scotland) Rules 2011 (hereinafter referred to as "the 2011 Rules"), an untried prisoner such as Mr Hutton, may wear his or her own clothing subject to a number of exceptions as set out in rule 32(2) of the 2011 Rules.

[31] HMP Low Moss have an items in use policy which sets out a list of approved items which prisoners are allowed access to whilst in the prison. The list of approved items includes a belt which is light with no large buckle.[6] The SPS do not provide belts to prisoners but they are allowed to retain their own belts if they wish to do so

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[5] Crown production 4, page 47

[6] SPS production 3

providing they are not subject to a TTM care plan which specifically includes the removal of clothing that can be used as a ligature.

[32] Upon his admission to HMP Low Moss, Mr Hutton was wearing a belt and wished to continue to wear it in prison following his admission.[7] Mr Hutton was permitted to wear his belt in terms of rule 32 of the 2011 Rules and HMP Low Moss items in use policy.

[33] On 4 December 2019, Mr Hutton attended a consultation with Dr Rahil Ahmed in the prison's health centre. Dr Ahmed was then working as a general practitioner in the prison's health centre. Dr Ahmed had access to Mr Hutton's medical records although he did not fully access these. He consulted the cardex to check Mr Hutton's current medication and he continued his prescription for sertraline and prescribed Lithium to assist with the symptoms of alcohol detoxification. Dr Ahmed noted that Mr Hutton maintained good eye contact and had no suicidal ideation.[8]

[34] At around 2030 hours on 5 December 2019 prison officer Dominic Marky placed Mr Hutton in his cell, D-10, Level 1, Kelvin Hall, HMP Low Moss. Mr Hutton was the sole occupant of the cell. Mr Marky described Mr Hutton as being polite, easy to talk to and displaying no signs of behaviour that caused him any concern.

[35] At around 0720 hours on 6 December 2019 Mr Hutton was discovered within his cell, hanging from his bathroom door with his belt fixed around his neck as a ligature by prison officer Kieran Lecky.

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[7] Crown production 4 page 48

[8] Dr Ahmed's attendance note is contained in Crown production 7 page 364

[36] Medical assistance was immediately requested however there was no sign of life and post mortem staining and rigor mortis were present.

[37] Paramedics were contacted, attended and life was pronounced extinct at 0738 hours on 6 December 2019 by paramedic Rose Stewart.

[38] A post mortem examination was carried out by pathologist Dr Sharon Melmore who stated the cause of death to be 1(a) hanging.[9]

[39] Mr Hutton made no phone calls and had received no visits during this last period of imprisonment.

[40] On Saturday, 30 November 2019 Mr Hutton had made a complaint at Stirling Police Office that he had been abused as a child, all as outlined in a letter from COPFS to Conway Accident Law Practice Ltd.[10]

[41] SPS staff and health care staff were not made aware of this complaint during Mr Hutton's final period of imprisonment.

[42] Following Mr Hutton's death, Mr Hutton's family informed the prison chaplain that Mr Hutton's brother, had committed suicide on 31 December 2017. SPS staff and health care staff were not aware of this during Mr Hutton's final period of imprisonment.

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[9] Crown production 2 is a copy of the post mortem and toxicology report
[10] Family production 1/14 of process

Summary of the witnesses' evidence to the Inquiry:

[43] AH and AR attended every day of the Inquiry. Their evidence is contained within affidavits which are summarised below.

Family affidavits;

[44] At the time of his death, Mr Hutton was married to AH. They were married on 24 September 2011. They had no children together however AH has one son, AR.

[45] AR was 13 years old when Mr Hutton and AH met. Mr Hutton was a father figure to AR, who referred to him as his stepfather.

[46] Throughout the course of their marriage, Mr Hutton was in and out of prison. At the time of his death they were still together as a couple although they lived in separate homes. Mr Hutton moved into his own home around 2018.

[47] Mr Hutton suffered from alcoholism which contributed to their living separately. They lived about a ten minute walk from each other and saw each other every day. They had a good relationship with Mr Hutton waking AH up every morning with a cup of coffee.

[48] At the time of his death Mr Hutton was suffering from anxiety and depression.

[49] AH last saw Mr Hutton on Monday, 2 December 2019 when he attended at her house.

[50] AH had previously visited Mr Hutton during each period of incarceration and she had fully intended to visit him in Low Moss.

[51] Prior to going into prison in December 2019 Mr Hutton told AH and AR that he had made reports to Police Scotland about childhood abuse. AR felt that Mr Hutton was struggling with his mental health more than usual.

[52] Mr Hutton's family described him as a very nice person when he was not drinking. As a father figure to AR, he spent a lot of time with him when he was younger going hillwalking, cycling and doing other outdoor activities.

Witness - DS Martin Smith

[53] DS Martin Smith has been a police officer for 21 years and is currently a detective sergeant with the criminal investigation department in Edinburgh.

[54] He was duty custody sergeant when Mr Hutton was processed into custody shortly after midnight on 3 December 2019. He described his training, duties and responsibilities as a custody sergeant but confirmed that he had not actually carried out the role of custody sergeant for a couple of years.

[55] He explained that in St Leonard's custody suite in December 2019 duty staff were a mixture of police officers and civilian custody support officers. DS Smith did not recollect any interaction with Mr Hutton during his time in St Leonard's Police Station but by reference to the police custody records[11] he could say that the majority of the records had been completed by police custody support officer (PCSO) Jacqueline Ford.

[11] Crown production 3

[56] He spoke to the routine handover briefing in relation to those who were in custody and advised that Mr Hutton had arrived at 0036 am when he authorised his detention.

[57] DS Smith confirmed, that the custody records, contain a list of 21 questions which cannot be deviated from. They contain the questions that PCSO Ford asked Mr Hutton together with the answers he provided. He confirmed that Mr Hutton answered no when asked if he was dependant on alcohol and he could not personally recall whether Mr Hutton was under the influence of alcohol that night.[12]

[58] Mr Hutton answered "yes" regarding mental health problems but there was no additional information contained within that section. Mr Hutton denied having suicidal thoughts and had not seen a community psychiatric nurse (CPN) whilst in police custody. He confirmed that PCSO Ford had access to Mr Hutton's criminal history on the police national computer, but not to reports made to police as a witness in the last few days. He explained the vulnerability decision in the records,[13] which is more about mental health and physical health, whilst the <u>risk</u> assessment decision related more to conduct or behaviour. Mr Hutton was assessed as highly vulnerable, because of a previous marker for alcohol dependency (despite his initial denial), and also because he was prescribed medication for mental health issues. Ms Ford made the decision regarding his vulnerability level.

[12] Crown production 3, pages 14 and 15
[13] Crown production 3, page 16

[59] DS Smith confirmed that Mr Hutton was not recorded as vulnerable to suicide and self-harm but he was high vulnerability because of the alcohol issue. He confirmed that a decision on the level of observation to be carried out on a prisoner based on their vulnerability would be taken after discussions with the processing officer. The options available were; constant observation with an officer sitting outside the cell at all times; CCTV observation at all times with two police officers watching on a screen; or personal observations every fifteen minutes, every half hour or hourly.

[60] Mr Hutton was placed on a fifteen minute observation level by camera and person. Each visit is recorded on the computer as well as a physical recording of the visit on a cell sheet and on the national custody system. Mr Hutton was subject to a standard search, which means that shoes are removed from detainees. Belts are always removed in police custody and he could see from the record that Mr Hutton's belt was removed and then returned to him when he left police custody to go to Court. He decided at 5am that Mr Hutton be moved to hourly observations, which is the minimum period of observation in police custody. He explained that if a detainee is asleep they will be roused because they have to provide a verbal response to the observing officer.

[61] He spoke to the PER which had been completed in respect of Mr Hutton.[14] He confirmed it would have been completed in respect of Mr Hutton when he left police custody and thereafter it would be added to by GeoAmey staff at Stirling Sheriff Court and that it would go with him to prison. It is populated with information contained in

[14] Crown production 4, pages 43 and 44

the custody system and is a physical note that accompanies a person's custodial journey. Mr Hutton's SPS supervision level was assessed as medium. There was a check in the box for risks and for segregation because Mr Hutton was a registered sex offender. The box for drug/alcohol issues was checked with a cross and a question mark. The box for bereavement was not marked.

[62] Mr Hutton was placed on an elevated observation level initially, and DS Smith's evidence was that it could not be inferred from the police custody records that Ms Ford had decided that Mr Hutton was at an elevated risk of self-harm and suicide. His alcohol dependency was potentially dangerous and he clarified that the assessment of Mr Hutton as medium risk in relation to a number of matters was in his view a vulnerability decision and was not related specifically to suicide risk. He re-iterated that it was more likely to relate to Mr Hutton's alcohol dependency, together with his denial of same, combined with his disclosed mental health issues.

[63] At the time Mr Hutton left police custody he had a marker for a single cell but was not assessed as being at risk of self-harm or suicide.

[64] He agreed that most detainees spend a matter of hours within police custody.

Witness - Ryan McStay

[65] Ryan Michael McStay has worked as a prison management officer within Low Moss Prison for over four years. His job entails working with and managing prisoners.

[66] He received training in the TTM process as a new recruit in 2018 and then mandatory refresher training in 2021.

[67] He described the reception risk assessment form and the type of questions asked of a prisoner. There are no electronic prompts and questions are designed to be asked in a relaxed conversational manner to put prisoners at ease.

[68] In December 2019 he was working within HMP Low Moss, carrying out TTM assessments in relation to prisoners entering Low Moss.

[69] He spoke to the PER form which accompanied Mr Hutton to Low Moss. His understanding of the purpose of the PER form was that it gave SPS officers an idea of Mr Hutton's time in police custody in relation to any medical issues or behaviour.

[70] He spoke to the TTM reception risk assessment which he completed in respect of Mr Hutton. The time recorded for the start of the process was 1930 hours. However, he accessed the prisoner record system (PR2) to obtain Mr Hutton's personal details which allowed him to complete parts 1 and 2 of the assessment in advance.

[71] The (PR2) holds information about previous convictions, and whether a prisoner had previously been on TTM. He checked the PR2 for Mr Hutton, including the section entitled "risk and conditions". From there he obtained information which he recorded in the form as, "previous protection sex; sectarian; juvenile visitors not allowed".[15] There was no record of Mr Hutton having previously been on TTM or MORS (Management of Offenders at Risk of any Substance).

[72] Before the TTM assessment, as per procedure, Mr Hutton had a full body search, his property would be removed and logged and prison clothing would be issued.

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[15] Crown production 4: pages 45 and 46

Mr Hutton was permitted to retain, his own trousers, shoes and belt in accordance with SPS regulations.

[73] Following this, each prisoner is assessed by a prison officer in relation to the TTM procedure followed by a nurse. If any concerns arose throughout the entire process the TTM procedure could be implemented.

[74] In his experience ten minutes to complete the TTM assessment is standard, although he could spend longer and has taken up to an hour before. As this was not Mr Hutton's his first time in custody his details would already be on the PR2 system thus shortening the time taken to complete the TTM assessment.

[75] Mr Hutton said he had no issues in relation to family matters and that he had expected to be remanded.

[76] Whilst there is no set list of questions, the list of questions typed in part four of the form are routinely asked. Namely: first time in custody? sentence/remand expected? any issues with family contact expected? and if feeling suicidal at the moment?

[77] He told Mr Hutton that he would be placed on protection because of his conviction for a sexual offence.

[78] Mr Hutton told him he suffered from anxiety, although he was not showing any signs of anxiety during the risk assessment process and Mr McStay recorded this on the form. When he asked Mr Hutton (bluntly), if he had any self-harm thoughts or suicidal thoughts Mr Hutton answered no, and this was recorded as, "not at present".

[79] Despite this denial, Mr McStay observed how Mr Hutton acted and whether there was any contradictory conduct or behaviour.

[80] He recalled that Mr Hutton made good eye contact and that there were no tell-tale signs that he was at risk such as biting nails, or "speaking at a hundred miles per hour". He had no impression that Mr Hutton was suicidal.

[81] He confirmed that SPS risk was not categorised as high, medium or low and he agreed that it might be helpful if it was categorised in that way.

[82] Mr Hutton was on offence related protection and as a consequence, he would have access to recreation and association, but only with other sex offenders.

[83] He thought Mr Hutton would have one hour recreation and one hour of exercise in Kelvin Hall but would spend the remainder of the time in his cell. In contrast to mainstream prisoners, protected prisoners ate alone in their cells, and did not participate in work.

[84] He was familiar with the SPS document[16] which contained a list of cues and clues, or factors to be taken into account in relation to the way a prisoner is presenting, including whether a prisoner was not speaking, was tearful, failing to make eye contact or fidgeting. These clues could indicate that a prisoner was at risk. He knew Mr Hutton personally from previous periods in Low Moss, and if he had had any concerns about him he would have raised these concerns with the nurse.

[16] SPS second inventory of productions, production No 4 page 6

[85] He had initiated TTM over fifty times, had no difficulty in doing so, describing it as a great and ongoing responsibility.

[86] He was unaware of Mr Hutton's recent allegation of historic childhood abuse or the suicide of Mr Hutton's brother, and he would not have asked those questions unprompted but if either had been raised he would have discussed further.

[87] His evidence was that a prisoner placed on TTM would be put into a 'safer cell' with no ligature points. They would be isolated and given safer clothing. Their own clothing including belts would be removed. He then explained that if he had assessed Mr Hutton as at risk of suicide, he would have been placed on TTM and a care plan would have been devised in consultation with the nurse and his floor line manager (FLM). This individualised care plan may have included the removal of his belt. However, as Mr Hutton was not assessed as being at risk he was not placed on TTM.

[88] He had no recollection of participating in a case conference where the decision taken was simply to remove a belt and he disagreed with the proposition that if he had assessed Mr Hutton as being of low or medium risk of suicide he could have addressed that risk by simply removing Mr Hutton's belt. If Mr Hutton had expressed suicidal intent the measures he would have implemented were a safer cell and safer clothing. However, Mr Hutton was not assessed as at risk so he would not simply remove his property including his belt.

[89] Mr McStay was referred to the list of verbal and non-verbal warning signs in the TTM documentation[17] and was invited to score Mr Hutton. He scored Mr Hutton zero for all, and reiterated that Mr Hutton made good eye contact, spoke well throughout the assessment, was calm, pleasant and polite and disclosed that he suffered from anxiety. He had expected to be remanded. If Mr Hutton had displayed any outward signs which led to concern he would have been placed on TTM.

[90] He recognised his responsibility and duty of care and he, personally would not take any risks in making his assessment. He stated in evidence , "it's quite a low threshold to put at risk." He had been shocked to learn that Mr Hutton had taken his own life. Unfortunately, he was aware of other prisoners who had "presented as okay", were not placed on TTM as a result and went on to take their own lives.

Witness - Dr Rahil Ahmed

[91] Dr Ahmed is a self-employed session GP who qualified in 1987. His professional qualifications are Batchelor of medicine and surgery (MBBS) and Fellow of the royal collage of surgeons (FRCS). He qualified as a GP in 2007. In December 2019 he was working as a sessional GP for the NHS in various locations, including in the SPS at HMP Low Moss.

[92] Included in his GP training rotation was a period working on a psychiatric ward. He considered that he had a reasonable level of expertise in relation to suicide

[17] SPS production 4 page 7

prevention and has an awareness of pre-disposing markers for self-harm and suicide from his psychiatry ward training, continued reading, and attendance at courses.

[93] He currently works at HMP Low Moss, Barlinnie and Greenock as a GP and looks after prisoners from admission until release. Their health concerns are his responsibility.

[94] He is fully aware of TTM, through awareness training required by TTM. He was not required to attend core training, as he is a qualified doctor.

[95] His role is to look after a prisoner's health and to assess them on arrival, and to arrange for any detox required in relation to alcohol or drugs with follow-up assessments. He is not always told why the patient is in prison.

[96] From the records, he spoke to having had two consultations with Mr Hutton during his admissions to HMP Low Moss. The first was on 4 January 2015 and the second on 4 December 2019. Both were admission consultations.

[97] He stated that he had no access to the PR2 system but had access to some medical records. He had access to what he referred to as the cardex which contained information about a prisoner's prescriptions. He could generally get access to GP records, blood tests, hospital tests and outstanding appointments and medical records from previous admissions on a system called Docman. If he required to see additional records he could request access if they were not visible on the system.

[98] He prepared for a new admission consultation by checking the nurse consultation notes and noting in particular any medical conditions discussed with the patient. He would not read all of the prisoner's medical records as that would not be

possible. He would not require to access the records unless he had specific concerns. The main purpose of a consultation is to ensure patient safety, treat for withdrawals from drugs and alcohol and to ensure that any prescribed medication is continued to ensure continuity of care. In relation to Mr Hutton, he had noted that Mr Hutton had a history of asthma, mental health issues, and that his observations were good. He did not receive Mr Hutton's TTM admission paperwork or the PER form. He would only receive the TTM paperwork if Mr Hutton had been placed on TTM.

[99] Dr Ahmed said that he had no concerns about Mr Hutton's mental health at the consultation and there was nothing that required him to look further into his medical records. He spoke to many prisoners with mental health problems and he required to make sure there was no immediate threat. He noted that Mr Hutton had made good eye contact and had no suicidal ideation based on questions and his own observations of body language and behaviour and how the questions were answered.

[100] He has experience of assessing prisoners with mental health difficulties and assessing suicide risk. He has dealt with those at risk of suicide many times and has developed a substantial level of expertise in dealing with those at risk. In his estimation, around two-thirds of the prison population suffered from some form of mental health/addiction issues.

[101] Mr Hutton had told him that he was drinking vodka daily and accordingly he started him on an alcohol detoxification (librium) that day. He also continued Mr Hutton's current medication after accessing his GP prescriptions. Mr Hutton was prescribed sertraline for anxiety. There was nothing in his current prescriptions that

caused him any concern. A priority generally is to treat potential withdrawals from alcohol or drugs which could be extremely serious.

[102] He believed the biggest risk factor for Mr Hutton was alcohol abuse.

[103] Mr Conway on behalf of the family, suggested that Dr Ahmed could have accessed the medical records further and could have looked at them in more detail. Dr Ahmed pointed out that there were hundreds of pages of records and that he had looked at the records to see the prescription but it was not possible to look at all of the medical records for every prisoner.

[104] He said that if a patient presented to him with mental health concerns and he did not deem them to be at risk of suicide he would carry out his own assessment. He might prescribe medication, get the mental health team involved or refer him to the mental health or psychiatric nurse, or a psychiatrist which is what he would do in the community. He pointed out that such referrals tend to happen much more quickly in prison and that there were no time limits on how much time he could spend during a consultation. He said that prison GPs are always available and prisoners are seen immediately.

[105] Dr Ahmed said that if he had felt the slightest doubt in relation to Mr Hutton being at risk he would have initiated TTM and Mr Hutton would have been put in a safer cell, given anti-ligature clothing and that a plan would be devised for his care. According to his notes, he had no such concerns that Mr Hutton was at risk of self-harm or suicide - he seemed fine. He intended to review Mr Hutton regarding his detoxification.

[106] He confirmed he would "probably not" change his decision had he seen all of the medical records. Mr Hutton seemed fine on the day and he would have reassessed him when his detox was complete.

Witness - Christine Campbell

[107] Christine Campbell is a nurse coordinator with Forth Valley Health Board. Previously she was employed full-time by Greater Glasgow Health Board. She qualified as a nurse in 2011 with a degree in nursing. She adopted the terms of her witness statement dated 13 June 2022.

[108] She began working in the SPS in 2016 as a primary care nurse and her general duties included administering medication, triaging prisoners with healthcare issues, dealing with medical emergencies and processing admissions to prison. She is fully trained in TTM suicide prevention.

[109] She assessed Mr Hutton on 3 December 2019 when she was working within HMP Low Moss as part of the admission process.

[110] She has had no specific mental health training, but estimated that she had completed in excess of 100 TTM reception risk assessments. She had placed prisoners on TTM if required and had no difficulty doing so if she thought there was a risk of suicide.

[111] She was aware of the list of cues and clues and verbal and non-verbal warning signs in the TTM guidance and took account of all of this when undertaking the reception risk assessment.

[112] On 3 December 2019 she was on duty as the senior nurse running the health centre. She was due to end her shift at 9pm. She completed the NHS paper admission form with Mr Hutton.[18] The prison officer completes their part of the TTM assessment first, the paperwork would be passed to her, and she would read it and then complete her part of the assessment. She had completed a paper admission on this occasion, which indicated to her that there may have been an issue with access to the computer system that night. She did not specifically recall the consultation and assessment in respect of Mr Hutton.

[113] She confirmed that the purpose of the nursing assessment was to establish the health needs of each prisoner. She also completed a TTM assessment. The NHS side of things related to the whole package of healthcare required, whereas the SPS TTM policy and assessment is specific to suicide management.

[114] She prepared for the assessment/consultation by looking at the PER form and the TTM assessment completed by Mr McStay but did not discuss Mr Hutton's assessment with Mr McStay. She did not look at Mr Hutton's medical records because she had no access to his medical records held on computer.

[115] Generally, she looked at a prisoner's medical history as held in the records however it is not mandatory for staff to check the records. She said that nurses can access hospital and GP prescriptions and hospital admissions but not GP notes in the community due to issues of confidentiality. She would also have access to past prison

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[18] Crown production No 7, page 379

medical records. Whilst accepting that it might be helpful to know about previous access to psychiatric or psychological care, the extent of anxiety and the severity of alcohol abuse, she said that because a patient's condition is not static her assessment is based on how a patient presented to her at the time of admission rather than his presentation six months or a year ago. She refuted the suggestion that if she had had access to Mr Hutton's records and seen notes from earlier admissions she would have assessed him as being at some risk at the time she saw him. Mr Hutton had been assessed by many health professionals in the past and none had noted that Mr Hutton had expressed a desire to self-harm or was suicidal.

[116] Her position was that nothing in the medical records put to her in evidence, was at odds with what she wrote in the TTM assessment.

[117] Her medical priorities when completing the admission process, were conditions such as diabetes and epilepsy and drug/alcohol withdrawal because of the risk of seizures. Mental health is also a priority and she assessed whether the patient was at risk of self-harm or suicide. Mr Hutton said he had hay fever and told her that he had an alcohol problem, saying that he had been drinking a bottle of vodka a day, and that his last drink was a day ago. He said he had suffered from depression and anxiety for the past two to three years but was okay medically and had not seen a psychiatrist or a psychologist or CPN.

[118] She saw from the cardex that he was prescribed sertraline. She referred to the on-line systems that can be accessed, namely, Vision which includes prison records and lists consultations and Docman which contains anything scanned from previous visits in

prison including the cardex which contains prescription details and other scanned documents.

[119] She disagreed with the suggestion that the medical records in relation to Mr Hutton showed a severity of mental health issues which were elevated beyond what she had noted, explaining that she knew he was alcohol dependent and suffered from anxiety and depression.

[120] She did not use a checklist for the TTM assessment, rather it was conducted as a conversation. Her practice was to ask about current and previous mental health treatment and whether the patient had previously attempted suicide. Had Mr Hutton revealed his allegation of childhood abuse to her, she would have considered that as a relevant factor during her assessment. She would have asked Mr Hutton whether he had self-harmed in the past or attempted suicide. She would observe the patient's mood, how they interacted, their eye contact and their behaviour. Unfortunately, she did not complete the appropriate section of the TTM form which related to Mr Hutton's presentation. She acknowledged that this is an important part of the form and reiterated that she always considers a patient's presentation in assessing risk and that just because she did not write it down on this occasion did not mean that she did not do it. She had noted that Mr Hutton "strongly denied" any suicidal thoughts.

[121] There is no time limit for carrying out admission assessments and she has spent over an hour with a patient. Based on the times noted on the forms applicable to Mr Hutton, her estimate was that she spent between forty minutes to an hour with him, which was fairly typical. She did not feel under pressure to rush any assessments that

evening (including Mr Hutton's). If she had had any concerns about Mr Hutton she would have assessed him as at risk and spoken with one of the prison officers in order that he could be placed in a safer cell and put under observation.

[122] Thereafter an immediate case conference with the FLM, the assessing prison officer, the person at risk and herself would be convened. They would assess the needs of that person, decide what observations were required, what the concerns were and what the care plan should be.

[123] She would always request a safer cell and anti-ligature clothing if she assessed that there was a risk. If she thought there was any risk no matter how minor she would put the patient straight on TTM. At the case conference the nature of the risk would be established and it would be decided then what items the patient was allowed to have and what observations were required. She was not aware of any situation where a patient was deemed to be at risk and the only measure was to remove their belt.

[124] Unfortunately, she had experienced the completely unexpected death of a patient who had been assessed as no apparent risk, was not placed on TTM and had then committed suicide.

Witness - Lesley Catherine McDowall

[125] Ms McDowall previously worked as head of health strategy in the SPS. She left the SPS in October 2021 to take up a senior role with the Scottish Government.

[126] She is a qualified nurse and started working as a nurse practitioner in SPS at HMP Cornton Vale in 1997, working for the SPS for 23 years.

[127] In 2011 MS McDowall became clinical advisor in the SPS. In 2019 she became health strategy and suicide prevention manager. Her responsibilities included policies and procedures relating to health matters including mental health, suicide prevention with overall responsibility for the review of deaths in custody.

[128] Ms McDowall was involved in the development of TTM which took around two years from 2015 until it was launched on 4 December 2016. TTM is not a SPS policy, rather it is a multi-agency policy written with input from mental health experts and partners.

[129] Ms McDowall worked as a frontline member of staff in the SPS for 13 years and has expertise in relation to suicide prevention in a prison setting.

[130] TTM relates to suicide prevention not self-harm. There are accordingly different strategies in relation to suicide prevention and self-harm.

[131] A group of experts contributed to the development of TTM. These included experts in suicide prevention, NHS senior managers, Samaritans, Breathing Space, psychiatrists and other mental health practitioners, SPS, representatives from the mental health division of the Scottish Government and Families Outside (which is a charity working with families of prisoners). She agreed that although the majority of the participants were from the SPS, this was because input from operational SPS staff was required in the various work streams. In fact, most sections of the policy were written by experts not the SPS. They sought an evidence-based approach in devising the new strategy which was aligned with the newly written Scottish Government Suicide Prevention Strategy.

[132] The TTM policy is contained in three key documents.[19] There is a strategy document and then guidance parts one and two.

[133] The policy promotes a person-centred approach, with staff tasked with identifying particular risks. The assessor should identify what the risk is, what the need is and includes deciding what items a person should be allowed to retain in their possession. It is not policy that a safer cell is inevitable in all cases.

[134] Ms McDowall's position was, that prior to TTM staff typically defaulted to use of safer cells. Input received from prisoners was that the experience of a safer cell often made prisoners feel worse.

[135] She described TTM training, which is divided into core training (for SPS staff), awareness training (for doctors in SPS) and refresher training which all staff require to do after 3 years. Doctors, only require to do TTM awareness training because they already have knowledge and expertise in relation to suicide prevention. The NHS has responsibility for their staff conform to a memorandum of understanding.

[136] Staff are trained and encouraged to identify cues and clues and specific risks and then to address that risk and put in place an appropriate care plan. She disagreed that ACT contained more prompts to assist staff to identify risks. The precipitating factors have not changed and these are contained in the guidance for TTM. By design, there is no longer a tick list format however precipitating factors are listed in the guidance and staff have access to the guidance which contains all the prompts. The rationale for the

[19] SPS production 1

departure from a checklist format was that the advice from the mental health experts reviewing the strategy was that a checklist is not an effective way of carrying out a risk assessment.

[137] Since Mr Hutton's death the TTM paperwork has been changed (in 2020)[20] and a short checklist was added in parts four and six.

[138] She was referred - to the PER form relating to Mr Hutton and explained that the SPS risk category has nothing to do with suicide prevention. Instead, it relates to the SPS supervision level and is an assessment of the risk a prisoner presents in public or in transit. During the TTM reception risk assessment the officer considers what is written on the PER form.

[139] In her experience, anyone coming into custody is automatically deemed a medium risk unless the police have information to designate them as high risk.

[140] She spoke to the cues and clues which staff are trained to look out for - verbal and non-verbal signs which includes what the prisoner says but also how they present.

[141] Those conducting the assessment should try to have a conversation with the prisoner, not simply ask a list of questions, and whilst it is not routine to ask whether there has been any previous suicide of family members, it may be asked in the course of the conversation.

[142] As a nurse, she would always ask about self-harm as part of the assessment process however she emphasised that self-harm does not automatically mean that a

[20] SPS second inventory of productions, production 5, pages 11 - 13

person is at risk of suicide - rather a history of self-harm is one factor to be considered along with other mental health issues, depression, and suicide in the family. Even if a prisoner has all of those risk factors it does not mean that they are automatically at risk of suicide.

[143] SPS staff cannot access confidential NHS systems but nurses completing the process have access to the Vision system if the prisoner had been in custody before. They can access information about current or previous health conditions, medication required and documented mental health issue. A nurse can also access the patient's community emergency care summary but they would not get access to the full records. If further access was required they would have to ask the GP for access.

[144] Within 24 hours of admission to prison, a prisoner undergoes three different assessments by persons with different skill sets, namely, the prison officer, the nurse and the GP.

[145] Following the TTM assessment the prisoner is either assessed as "no apparent risk" and goes to mainstream accommodation or assessed as "at risk" and placed on TTM.

[146] The risk assessment outcomes changed with TTM from "no apparent risk", "high risk" and "low risk" to "no apparent risk" or "at risk", on the advice of mental health and suicide prevention professionals who recommended avoiding terminology which was not used in psychiatric facilities. Instead, by assessing someone as "at risk" staff must put together a care plan that meets the individual's needs. Historically if someone was assessed as "high risk" they were always put in a safer cell, all items were removed

from them and they were given safer clothing. TTM policy is that if a person is "at risk" staff identify the risk and address it through the care plan. The purpose is to address the immediate risk of suicide, keep the prisoner safe, and to get them to a point where they are no longer deemed to be at risk of suicide.

[147] Each individual case conference would decide whether removal of a belt was appropriate but if a person was assessed as "at risk" it would be highly likely that their belt would be removed. The case conference would also consider whether the prisoner should be moved to a safer cell and would determine the time between interactions with the prisoner and what support and services needed to be put in place to assist with recovery.

[148] A safer cell should not always be used as part of a care plan given that it is not a therapeutic environment. It is a stark room with no personal items. It has no curtains, very little (moulded) furniture. The bed is usually moulded concrete with a safer mattress which is extremely uncomfortable. Often there is no television or electricity in the cell. These measures should only be used where it is considered that there is an immediate risk of suicide which requires the prisoner to be in a safer cell.

[149] There is support available to a prisoner seeking help for mental health issues. In every Scottish prison, prisoners can self-refer to the NHS by filling out a form which goes to the prison health centre. Prisoners can post the form in a box which is emptied by a nurse to ensure confidentiality. SPS staff can also make a referral if they have concerns about the mental health of an individual prisoner.

[150] Ms McDowall recognised that every suicide in prison is a cause for concern. She spoke to SPS statistics, which show that there have been 33 suicides in prisons between 2011 and 2015 and 70 suicides between 2015 and 2022.[21] There has been an increase in prison population, and the statistics required to be considered in this context. She pointed out that around 22,000 people enter prison every year.

[151] In the last ten years there have been eight suicides where a belt has been used which equates to about 9% of suicides in prisons.

[152] She explained that the SPS policy is to allow belts in use, because a belt is a day to day item just like t-shirts, shirts, trousers, shoes with laces and bedding all of which could be used as a ligature. The rationale is that the SPS is trying to provide as normal an environment as possible for prisoners.

[153] Statistically, bedding (normally sheets) was the most commonly used ligature, used in 55% of completed suicides. Shoelaces were used in 20% of cases and other unknown items were used in 10%. In the view of the SPS simple removal of a belt in itself would therefore not prevent access to a ligature. She explained that safer clothing is only used within a cell. It is uncomfortable and stigmatises prisoners in a way which is deemed to be wholly inappropriate and inhumane. She pointed out that prison is not an easy experience, and being able to retain some personal items and clothing is positive. Removing personal items and placing people in uncomfortable clothing and cells could arguably increase mental health issues and suicide.

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[21] SPS inventory of productions 7, production 42

[154] Extensive research had been carried out to source a material that was difficult to rip but comfortable. Despite that, safer clothing remains very uncomfortable and she described it as “a necessary evil” to keep people safe.

[155] Regarding, the observation of prisoners - her position was that it would be wholly inappropriate in a prison setting to observe someone every 15 minutes and to wake them up at intervals every night on a long-term basis. (cf police custody when the duration of detention is generally restricted to hours). Those in prison custody have rights to a therapeutic, safe and supportive environment and continual watching of a prisoner not considered to be “at risk” would be inappropriate and would affect the prisoner/staff relationship and the prisoner’s mental health. Instead, staff are trained to check on prisoners at several points throughout the day and are trained to note any prisoners not observing their usual routine. All staff on the hall are TTM trained and can instigate TTM if they believe a prisoner is at risk of suicide.

[156] Ms McDowall was referred to the expert report lodged on behalf of the family.[22]

[157] In her opinion certain parts of the report contained errors in terminology, misunderstandings about the Scottish prison setting and factual inaccuracies. She disagreed with several of Ms Caffrey’s conclusions.

[158] For example, her opinion is that police suicide prevention measures such as constant observation, cannot be applied in prisons because those in police custody are generally only there for a short period. (see above).

[22] Ms Caffrey’s report (next of kin second inventory of productions, production 3, page 9 at 424

[159] She pointed out that prisoners in custody in Scotland for sex offences are not segregated, which meant that a prisoner would be kept outside the mainstream and isolated from all other prisoners. Instead, SPS policy is to separate mainstream prisoners from sex offenders to allow sex offenders to have a full regime with access to the same services as other prisoners. This reduces the risk of violence or assault from mainstream prisoners.

[160] She also disagreed with Ms Caffrey's, conclusion about suicide risk, stating that current statistics demonstrate that persons in prison for a sex offence are at no higher risk of suicide than the general prison population. Indeed those who are imprisoned for an offence of significant violence are at much higher risk.

[161] TTM was written in partnership with several organisations, and experts, who are now members of the National Suicide Prevention Management Group (NSPMG) a body which has overall governance of TTM. Any changes, amendments or recommendations from FAIs and from HM Inspectorate of Prisons in Scotland are considered by that group who make recommendations to the SPS on any changes they consider necessary. In devising TTM, the SPS worked with current leaders and practitioners in suicide prevention and mental health care.

[162] She was referred to HM Inspectorate of Prisons in Scotland, Independent Review of the response to Deaths in Prison Custody Report November 2021.[23] She said she was open to and welcomed independent review.

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[23] Second inventory for the family 11/12/13

[163] She pointed out that an independent evaluation of TTM was carried out in 2018, and that monthly audits are done. She was personally unaware of feedback that staff found the three TTM documents difficult to use or that they struggle to complete paperwork because there are no prompts. Her position was that the audits carried out suggested that safer cells were used less frequently under TTM.

[164] She did not accept that a belt is the easiest ligature to use if accessible, saying that over 50% of prisoners used a sheet as a ligature, and accordingly disagreed with the proposition that removing a belt would stop someone completing suicide by ligature. Ms McDowall said that the NSPMG had specifically looked at this matter in 2021. Reference was made to an options paper which was sent to members in advance of the meeting on 19 August 2021.[24]

[165] At the meeting on 19 August 2021 feedback was received on the options paper: five members voted for option 2 of 4, namely, "Prisoners are allowed to have belts as long as they are not on the TTM policy". Three voted for option 3 - "Prisoners are allowed to have belts so long as they are not being held in safer cell" and one voted for option 4 - "the status quo and current process to remain - all prisoners allowed belts."

[166] There was further discussion at the meeting and wider feedback was sought.

[24] SPS inventory of productions 3, production 26, the minutes of the NSPMG 27 April 2021

Witness - Stephen Joseph Coyle

[167] Stephen Joseph Coyle, is head of justice in the Scottish Prison Service, having held that position since November 2019. He has oversight and responsibility for a number of teams, including the health team which is responsible for the physical and mental health of prisoners.

[168] He started his career in the SPS in April 1989, initially as a prison officer, thereafter progressing to deputy governor then governor, prior to his present role. He has had first-hand experience of managing prisoners at risk of suicide and now has responsibility for suicide prevention at a more strategic level. He chairs the NSPMG which deals with the whole prison estate.

[169] The NSPMG is the steering group responsible for the governance of the TTM strategy. It is a multi-disciplinary group and membership includes SPS, NHS boards, Public Health Scotland, Families Outside, Breathing Space and the Samaritans.

[170] The remit of this group is to monitor and review the national strategy, review all self-inflicted deaths in custody and monitor progress against any actions identified through the DIPLAR process, review all FAI determinations and monitor any actions identified for SPS, monitor local activity and issues and agree any actions or changes to policy that are required to improve the safety of those at risk in prison.

[171] The NHS have two representatives covering both mental health and clinicians, one of whom is the national lead in Scotland for mental health.

[172] Families Outside is an organisation that works exclusively on behalf of families affected by imprisonment in Scotland, Breathing Space is a third sector organisation

which provides a supportive space for anyone experiencing low mood, depression or anxiety and for whom there is a free phone line in prisons. The chief executive of Breathing Space sits on the NSPMG as does the chief executive of the Samaritans.

[173] As Chair, Mr Coyle ensures that the various organisations are given the opportunity to make representations or share opinions. He stated that it is important that the group maintains independence from the SPS to provide external scrutiny.

[174] Any changes to the suicide prevention policy would require consultation with the various groups represented in the NSPMG including the operational representatives.

[175] He spoke to the minutes of the NSPMG meeting on 27 April 2021[25], which he chaired. This was the first time that belts were considered following upon Mr Hutton's death in 2019.

[176] The group considered three FAI Determinations, including the determination concerning a death by suicide at HMP Glenochil in 2019 where a belt was used as a ligature, (Death of Gary Munro).

[177] There had been discussion around allowing belts in prisons, in the course of which he postulated that the possible concern with a belt may be the immediacy, thereby posing a higher risk whereas with other items prisoners need to tailor the method.

[178] When the group met in August 2021 there was another discussion on the use of belts however he was not in attendance at that meeting. [26]

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[25] SPS production volume 1, number 25/1

[26] SPS production 26, page 2, paragraph 5

[179] A majority favoured allowing access to a belt if a prisoner was not on TTM. It was agreed that a Governors and Managers Action (GMA) be drafted to be shared with Governors in Charge, (GICs), Suicide Prevention Coordinators (SPCs) and TTM trainers with the aim of implementing very quickly. The next meeting of NSPMG was May 2022. Usually this group meets quarterly and there were meetings scheduled for November 2021 and February 2022 but these did not take place because of Covid outbreaks.

[180] The feedback from the options paper sent out for consultation was that the wholesale removal of belts was thought to be contrary to the principles of TTM and that simply removing a belt would not prevent access to other ligatures.

[181] He referred to SPS statistics in relation to prison suicides 2011-2022[27] and confirmed that this data was considered and did not support the removal of belts. None of the group considered it to be appropriate or proportionate to have all items which could potentially be used as a ligature removed.

[182] He spoke to the NSPMG minutes from 10 May 2022.[28] He chaired this meeting at which there was a general discussion about the need for individual risk assessment and care planning. The group did not support the automatic removal of belts. The Samaritans, in particular, were keen to observe the principles of TTM and care planning and opposed the blanket removal of belts. The concluded group view was that belts should be considered in the context of individual care plans which are devised at the

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[27] SPS eighth inventory of productions SPS; production No 42
[28] SPS eighth inventory of productions production 44

case conference when the TTM strategy is initiated. Accordingly, persons who are not assessed as at risk of suicide will not be placed on TTM and will be permitted to retain a belt.

[183] A GMA document dated 18 July 2022 was circulated to advise governors and directors of the outcome of the NSPMG consultation regarding the use of belts for those presenting as at risk of suicide.[29] The outcome was that in consultation with the NSPMG it was agreed that the TTM case conference should carefully consider all aspects of risk in determining the most appropriate location for an individual, the items of clothing and bedding that they are provided with, and the items they are allowed access to within their accommodation, including belts.

[184] He confirmed that the NSPMG will continue to monitor the retention of belts. He was well aware of recent reports in relation to deaths in custody. In his view there is a change in the landscape in relation to suicide prevention in the community. There is a new national suicide prevention strategy and the NSPMG will consider all of this information which will be looked at alongside a review of the TTM strategy and determine whether any changes should be recommended.

[185] Regarding the PER form, he confirmed that the "SPS Supervision Level - High, Medium and Low" is a prisoner categorisation which would previously have been characterised as an "assessment of dangerousness". It is not however a suicide risk assessment.

[29] SPS production No 41, the GMA 18 July 2022

[186] In his view, it was the ideation of suicide not the presence of a belt which caused somebody to attempt suicide.

[187] He agreed that one of the key strategies in TTM was to prevent prisoners being put into safer cells as a default because prisoners do not want to be in that environment. Safer cells should only be used in extreme circumstances and it is not in accordance with TTM policy to automatically put everyone in a safer cell.

[188] Regarding access to medical records - he explained that a GP could access records related to the prisoner's previous period in prison. He was not clear about access to general GP records from the community but would expect a GP to look at prison records if they were available. A GP can initiate TTM which would lead to a case conference and it would be the case conference which would decide what the care plan would be.

[189] He opined that being a registered sex offender per se was not an elevated marker for suicide, it was a marker for a separate cell.

[190] Mr Coyle considered the issues of mental health difficulties and alcohol problems and stated that those who come into prison often have multiple issues including mental health and alcohol issues. In relation to the accumulation of a number of factors leading to risk, including childhood abuse and a family history of suicide (as in Mr Hutton's case). It may be a cause for concern particularly around anniversary dates <u>if</u> prison staff were made aware of these matters.

[191] When asked whether being a "segregated" prisoner was also a marker for an elevated risk of suicide, he explained that rule 95 allowed prisoners to be put on

protection for their own safety and for the safety of others. Generally, this is in a normal hall environment with other prisoners. It was suggested to him that Mr Hutton as a sex offender allocated to a single cell would likely spend 22 out of 24 hours in that cell. He thought that was unlikely, in that a prisoner in Mr Hutton's case would be able to socialise within the prison population albeit in a separate unit away from the main prison population. He observed that the sex offence was for a previous matter and also that most prisoners wanted a single cell.

[192] He commented that staff should not have to go to the central desk for TTM guidance because they would generally be well versed in the principles and the guidance.

[193] He reiterated that TTM places greater emphasis on case conferences and individual care plans which included a consideration of all factors. He disagreed that a TTM assessor simply relied on cues and clues to the exclusion of predisposing and precipitating factors.

Witness - Joanne Caffrey

[194] Ms Caffrey produced a report, lodged by the family, which including appendices ran to some 133 pages.[30]

[195] Regarding her qualifications and experience - she stated that she had worked as a police officer in Cumbria from 1990 until August 2013. She worked as a custody

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[30] Second inventory of productions for the family, production 2

sergeant in the force from 1997 to 2003 following upon which she was involved in training for safer custody at police headquarters. During her police career she dealt with the reception of persons in custody and had personal experience of processing and assessing those received into police custody.

[196] She left Cumbria Police in 2013 and started her own business Total Train Limited. Her stated passion is "safer custody" which she said was an umbrella term which was brought into the UK in 2002 by the UK Government and adopted from European standards.

[197] She confirmed that she had given opinion evidence before and has been instructed directly by the coroner in England in relation to deaths during restraint in custodial settings, the Police Ombudsman in Northern Ireland, the Independent Police Complaints Commissioner in England, the Ministry of Justice in England and the Crown in Scotland. She considers herself experienced in relation to ligature deaths. She accepted that she had no experience of managing prisoners in a prison or of suicide prevention in Scottish prisons but she said that she has expertise in relation to UK wide safer custody in a range of settings. She understood her duty to the Court.

[198] She agreed that police and prison custody are different environments but suggested there were some similarities. There are differences in the paperwork used but the principle is the same across the board in relation to joint risk assessments. In relation to the management of a prisoner at risk of suicide her particular area of expertise is in relation to ligature risk assessments which she accepted was a narrow field. She explained the concept of a ligature triangle - the item, the point and the opportunity.

Much of the training she provides is about how to conduct ligature assessments and the ligature environment. She is also able to give expert evidence on the use of force. She has particular experience in anti-ligature cells having audited all the cells in Cumbria and trained on how to conduct a room assessment.

[199] She described a prison safer cell as one stripped of most items of comfort containing only a mattress and a chair. She agreed that safer cells are not therapeutic for a person in distress and indeed, can increase distress and risk.

[200] She spoke to a number of recognised risk factors which increased the risk of suicide - having mental health issues is a risk factor, but she acknowledged that not everyone who has mental issues is a suicide risk - rather it is a factor to consider.

[201] She said that the SPS is the only sector she is aware of where there is no grading of risk.

[202] It was her opinion that prompts and checklists are useful and have a place. They are used in other settings, for example, the Ministry of Justice and Police Scotland. She agreed that the prompt list is not the end of the matter as there is a danger of it becoming a tick box exercise so training is required.

[203] She accepted that the 10 minutes taken by Mr McStay for his assessment might be reasonable. Her experience of assessing in police custody is that an assessment can be 10 to 30 minutes at a superficial level.

[204] She accepted that prisoners can be deemed as no apparent risk and not placed on TTM but then go on to take their own life. She accepted that a risk assessment in a custodial setting is not a definitive science taking account of the fact that human

behaviour is complex and a prisoner can present as fine even when they have made up their mind to take their own life.

[205] She accepted that she was not an expert on clinical matters and was unable to comment on the content of the medical records or to criticise Nurse Campbell's assessment as a nurse.

[206] She accepted that she has not operated TTM and indeed has not worked in any prison setting and therefore was not in a position to criticise Mr McStay. However, it was her opinion based on the paperwork, that there were factors, which would have indicated further enquiries in relation to identifiable risk.

[207] She was asked whether it was her position that prisoners who are not assessed as at risk of suicide should not be permitted to have a belt. Her evidence was that this is a decision for the individual custodial sector but pointed out that there is no human right to say a prisoner must have a belt.

[208] She confirmed that it was not her opinion that all prisoners should be put in anti-ligature safer cells but in her view there should be a spectrum of cells rather than an all or nothing.

[209] She confirmed that in her expert opinion there was not enough in the paperwork or the assessments to suggest that Mr Hutton might be at risk of suicide. There were insufficient markers for him being at risk of suicide. However, if she had been tasked with assessing him she would have undertaken further investigation, perhaps during the course of a case conference. She said that the markers which would have raised concerns to her were the sex offence, the mental health issues and the withdrawal from

alcohol. It was her position that Mr Hutton was at risk of distress which may have indicated further investigations.

[210] There were objections to the evidence of Ms Caffrey by several of the parties, that generally, she did not have the requisite knowledge or expertise in relation to suicide prevention in Scottish prisons to allow her to give skilled evidence of fact. Mr McIntosh, on behalf of the SPS challenged Ms Caffrey's credibility and reliability in connection with a matter, which arose concerning a particular section of her report. I do not intend to rehearse in detail this chapter of evidence. It was not a section of her report or her evidence, which was of any real relevance to this Inquiry (insofar as the section dealt with environmental factors such as ligature points and risk arising therefrom) and ultimately, having considered her evidence as a whole, it did not affect my assessment that she was credible and reliable in relation to the evidence she gave which was within the parameters of her area of expertise. In relation to her evidence as a whole it was conceded by all parties that her evidence was admissible and that it was a matter of what weight the Court gave to certain aspects of her evidence. I have proceeded on that basis.

[211] Ms Caffrey properly acknowledged the limitation of her expertise and in my view endeavoured not to proffer opinions that strayed beyond the bounds of that expertise. She accepted that she had absolutely no experience of working in prisons and that her particular field of expertise in relation to the management of prisoners at risk of suicide, is in relation to ligature risk assessments and audits which she accepted was a narrow field. (See paragraphs [196] to [198] above.)

[212] Consequently, I found much of her evidence to be of limited assistance in relation to matters pertinent to the Inquiry.

Discussion and conclusions

Submission for the family in terms of section 26(2)(e): Any precautions which - could reasonably have been taken and had they been taken, might realistically have resulted in the death ..being avoided.

[213] It was submitted on behalf of the family that it would have been reasonable for Nurse Campbell to delay her reception risk assessment of Mr Hutton until such time as she had access to, and considered at least his present medical records.

[214] It was also submitted that it would have been reasonable for her to note from the PER form that Mr Hutton was a sex offender and would be subject to some kind of segregation and/or separation.

[215] Overall, I found Nurse Campbell to be a credible and reliable witness.

[216] She stated that she had access to <u>some</u> of Mr Hutton's medical records, although she could not recall exactly what records were available to her during the assessment. At the minimum, she viewed the cardex, which documentation allowed her to check what medication Mr Hutton was currently prescribed.

[217] I accepted her evidence, that she did not feel rushed that evening and that in the circumstances she did not feel that it was necessary to check the medical records further. I accepted her evidence that although certain of a prisoner's medical records are available it is not mandatory to check all of them. It is effectively a matter of clinical

judgement in each case and in this instance she was satisfied that she could properly exercise her judgement on the basis of the available records. I was also satisfied that had she considered that further information was necessary, she would have taken appropriate steps to access and check the records further.

[218] Mr Hutton disclosed to her that he had a history of depression and anxiety and she observed from the cardex records that he was being prescribed sertraline for these conditions. He advised her that his condition was presently stable as a result of his treatment and her evidence was that she had no reason - from his presentation or otherwise, to doubt him in this regard. Whilst it is unfortunate that she failed to contemporaneously record her observations of Mr Hutton's presentation in the appropriate section of the TTM form, I accepted her evidence that she always considered presentation when assessing risk and on balance conclude that she had done so on this occasion. In relation to her notes in general, I concluded that although they were brief they were sufficient and adequate in the circumstances.

[219] Mr Hutton also disclosed to her that he had an alcohol problem and had been drinking a bottle of vodka a day. I am satisfied however that he did not tell her about two particular issues which might well have been troubling him - namely, the impending anniversary of his brother's suicide and his recent disclosure to Police Scotland that he had been abused as a child.

[220] It was a matter of agreement that there was, in any event, no mention of these issues in any of Mr Hutton's medical records, nor were there any entries suggesting that

Mr Hutton had previously expressed suicidal ideation either in the community or in a custodial setting.

[221] A similar submission was made on behalf of the family in respect of Dr Ahmed, namely, that it would have been reasonable for Dr Ahmed not to proceed to examine and consult with Mr Hutton without reference to his medical records.

[222] Dr Ahmed's evidence was that he was aware that Mr Hutton had a history of anxiety and depression, and that he had been treated with medication to control these conditions. He accessed the available medical records to check Mr Hutton's current prescription and to ensure any such prescriptions were continued. He also knew that Mr Hutton had an alcohol problem and prescribed him librium to assist with the detoxification process in custody.

[223] I found Dr Ahmed to be credible and reliable and I accepted his evidence that in the circumstances, he did not consider that he required to access any further information from Mr Hutton's available medical records to enable him to carry out his assessment. I considered that this was a decision based on clinical judgement, which he was entitled to make. Further, I accepted his evidence that he identified no basis for any concerns about suicidal ideation on the part of Mr Hutton, at that time. This was also a matter within his professional judgement.

[224] As with Nurse Campbell, had Dr Ahmed decided to further access Mr Hutton's available medical records, these records contained no mention of the two matters described above, nor any entries regarding previous attempted suicides or any suicidal ideation either within the community or in a custodial setting. Indeed, I concluded that

that the available records largely confirmed what Mr Hutton had disclosed in relation to his mental health issues and alcohol problem.

[225] I accepted that both Nurse Campbell and Dr Ahmed were appropriately qualified and sufficiently experienced to carry out their assessments of Mr Hutton. I accepted as credible and reliable their evidence that neither considered that they required further access to Mr Hutton's medical records to complete their assessments in the circumstances, but had they felt it necessary for any reason they would have investigated further. I heard nothing in the evidence as a whole, which undermined those positions.

[226] In conclusion, I do not accept the submission made on behalf of the family, that further enquiry into Mr Hutton's medical records would have disclosed that Mr Hutton was at "some risk of suicide".

[227] I considered also the criticism raised in relation to the PER form and Mr Hutton's status as a sex offender. Nurse Campbell gave evidence that she prepared for a TTM risk assessment by reading both the PER form and the prison officer assessment. In Mr Hutton's case both of these documents made mention of his present status. I accepted, on balance that Nurse Campbell followed her normal procedure in the present case.

[228] Regarding that status and purported implications arising therefrom - I accepted as credible and reliable the evidence of Ms McDowall that sex offenders are not "segregated" in the sense of being isolated from all other prisoners. Instead, they are placed in a designated area of the prison with others of similar protected status. Further

I accepted that the current available statistics demonstrate that a prisoner in custody for sexual offending is at no higher risk of suicide than the general prison population. In other words, the mere fact of sex offender status does not give rise to an elevated risk of suicide.

The issue of belts

[229] Whilst it was not part of the family's general position that belts should be removed from all prisoners, the proposition was that the Inquiry should find that:

> "further investigation by Dr Ahmed would have found that the deceased was at some risk of suicide, and that as a minimum on further enquiry his belt should have been removed which would realistically have avoided his death"

[230] It was a matter of agreement that in terms of rule 32(1) of the Prisons and Young Offenders Institutions (Scotland) Rules 2011, a prisoner such as Mr Hutton may wear his own clothing subject to certain exceptions and further that HMP Low Moss have an "items in use" policy which sets out a list of approved items. Belts are included in the list of permitted items.

[231] In accordance with this policy, belts are not supplied to prisoners but they may retain their own belts if they wish to do so, provided they are not subject to a TTM care plan which specifically included the removal of clothing which could be used as a potential ligature.

[232] I accepted Ms McDowall's evidence about the SPS policy in relation to belts as credible and reliable. I found her to be an impressive witness whose evidence was straightforward, thoughtful and measured. In short, I accepted that belts are permitted

because they are considered to be day-to-day items just like t-shirts and bedding (all of which could be used as ligatures). The rationale for the policy, is firstly, that the SPS, so far as possible seek to create a normal and therapeutic environment for prisoners and that the unjustified blanket removal of personal effects would undermine the prisoner/officer relationship as well as creating an environment, which was not conducive to the general well-being of prisoners. Accordingly, I accepted Ms McDowall's evidence that there should be a clear and proportionate reason for preventing a prisoner from retaining and using personal items permitted in terms of SPS rules.

[233] Further, I accepted as rational, the view that removal of a belt would not prevent access to a ligature. Indeed to remove the risk altogether, more draconian steps would be required, such as recourse to safer clothing which is extremely uncomfortable, in conjunction with the use of a ligature proof "safer cell" which as indicated is not considered to be a therapeutic environment.

[234] I also accepted the evidence of Mr Coyle, that the use of belts in prison has been fully considered on a number of occasions, including, most recently by the NSPMG following the death of Mr Hutton. Mr Coyle was an impressive witness who gave evidence in a measured and thoughtful fashion. He confirmed that the NSPMG, of which he is chair, would continue to monitor the provision of belts.

[235] In this regard, he made reference to a meeting of the NSPMG. In May 2022, when a decision was formally made by the NSPMG that prisoners should continue to be

allowed access to a belt, unless a TTM case conference deemed it necessary to remove a belt.

[236] Both Mr Coyle and Ms McDowall made reference to SPS statistics in relation to items used as a ligature in deaths by hanging in Scottish prisons. These statistics showed that from 2011 to July 2022 there had been 93 deaths by hanging in Scottish prisons. Of these 93 deaths by hanging 51 (55%) used bedding as a ligature; 19 (20%) used shoelaces as a ligature; (10%) used another item or the ligature item was unknown; <u>8 (9%) used a belt as a ligature</u>; and 6 (6%) used clothing as a ligature. I accepted, in the absence of any evidence to the contrary that these statistics were accurate and demonstrated that the use of belts as ligatures occurred in a minority of instances.

[237] Mr Coyle confirmed that in the eight cases where a belt was used as a ligature, none of the individuals were on TTM at the time and so would therefore have had access to a number of the other items listed above.

[238] Mr Coyle confirmed that none of the NSPMG member group representatives suggested that removing all items that could be used as a ligature from all prisoners would be a proportionate or appropriate response. Key considerations of the NSPMG were the need for an individualised risk assessment and care plan (per the ethos of TTM).

[239] I accepted on the evidence before the Inquiry that the NSPMG has given full consideration to the policy in relation to belts, most recently in May 2022. On the evidence before me, I accept that they were entitled to reach the conclusion they did

on the policy relating to the issue of belts. On the available evidence, I accept that a reasoned and rational conclusion was reached.

[240] Whilst the conclusion reached by the NSPMG does not remove the duty of the Court to consider whether a different view on the issue should be reached, I am not persuaded on the available evidence, that a different conclusion is warranted in relation to the policy around removal of belts and I accept the underlying rationale, spoken to by Ms McDowall and Mr Coyle.

[241] I am not persuaded therefor by the submissions made on behalf of the family, that as a minimum, Mr Hutton's belt (and perhaps shoelaces) should have been removed in the circumstances. On the evidence before me, I am not persuaded that there was a clear and proportionate reason for removing Mr Hutton's personal items, nor am I persuaded that simply removing these items from Mr Hutton, was a precaution which could reasonably have been taken and which might realistically, have prevented his death given the existence of a number of other potential ligatures to which he would have had access.

[242] I have already noted above my reasons for rejecting the proposition that Dr Ahmed (or Nurse Campbell) should have made further enquiry into Mr Hutton's medical records. On the evidence, I cannot conclude that these were precautions, which could reasonably have been taken that might realistically have resulted in his death being avoided.

Talk to me

[243] Various criticisms were also made on behalf of the family in relation to the TTM strategy and my attention was drawn to the publication of the Independent Review of the Responses to Deaths in Prison Custody (November 2021).[31]

[244] I was advised that the Scottish Government had very recently set up the Deaths in Prison Custody Action Group to oversee the implementation of the recommendations of the Independent review. I am grateful to Mr Conway on behalf of the family for bringing this to my attention.

[245] It was accepted on behalf of the family (and by the other parties to the Inquiry) that there was insufficient evidence before the Inquiry to allow the Court to make wide-ranging recommendations in relation to the TTM strategy. However, Mr Conway raised several areas of concern on behalf of the family in relation to TTM which I will address.

[246] The main concerns related to the lack of prompts and checklists in the TTM paperwork (particularly when compared to those said to be available in its predecessor ACT) and the binary nature of the risk assessment outcome in TTM.

[247] I accepted the evidence of Ms McDowall that TTM is a multi-agency strategy which was developed by a group of experts in the field of suicide prevention and mental health as well as other key stakeholders and partners. She confirmed that when TTM was being devised, that the use of checklists had been fully considered and ultimately

[31] Second inventory of productions for the family, 10/11 of process

rejected, as had the multi categorisation of risk. Her evidence in relation to the rationale behind the policy in relation to these issues is rehearsed at length above.[32]

[248] I accepted that evidence and conclude that on the available evidence, the justification for these aspects of the policy appeared to be considered and rational. I was not satisfied on the evidence available to me that either of the criticisms levelled were justified and amounted to defects in the TTM system nor were relevant to the circumstances of Mr Hutton's death, accordingly, I make no findings with regard to these two systemic issues in relation to TTM.

The PER form

[249] In relation to evidence led before the Inquiry regarding the PER form, I accepted that some misunderstandings arose in relation to certain categories of risk included on the form. These are rehearsed in the summaries of evidence above. Ms Guy, on behalf of the Crown, suggested that this might be a matter which could be commented on in terms of section 26(2)(g) as being a fact relevant to the circumstances of Mr Hutton's death.

[250] I consider however, that any such misunderstandings, are <u>not</u> directly relevant to the circumstances of Mr Hutton's death insofar as these misunderstandings in relation to the PER had no significant or demonstrable bearing on the circumstances of Mr Hutton's death - therefore I make no findings in this regard, in terms of section 26(2)(g).

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[32] See paragraphs [130]-[136] and [145] above

[251] I also considered Ms Guy's suggestion on behalf of the Crown, that it may be appropriate to comment on a number of other issues which arose in the course of the Inquiry as being potentially relevant to the circumstances of Mr Hutton's death in terms of section 26(2)(g). I noted the position of the Crown to the effect that - it was concerning that all three personnel who assessed Mr Hutton said that if they had any concerns that he may have been at risk of suicide they would have immediately initiated TTM and would have recommended that he be placed in a safer cell - which is not the correct policy.

[252] The Crown suggested that this was evidence of, "a widespread preference to use safe cells in HMP Low Moss". I do not agree with this conclusion. In the first place it is based on the evidence of three witnesses all of whom were asked to speculate and all of whom gave their evidence with the benefit of hindsight, insofar as they were now all aware of the precise mechanism of Mr Hutton's death. The context of the evidence was that the witnesses were effectively speculating on what measures they <u>would</u> have taken <u>if</u> Mr Hutton had been at risk. I cannot discount the possibility that their evidence in this regard was coloured by hindsight. Furthermore, my assessment of the evidence of the witnesses McStay and Campbell is that they also confirmed that if a prisoner was placed on TTM, they were well aware of the need for a case conference at which, the nature of any risk would be identified and a care plan would be devised to address that risk (in the course of which, presumably, a safer cell may or may not have been selected as the appropriate measure). Mr Hutton <u>was not assessed as being at risk</u> however and the question of a safer cell was <u>not</u> fully considered in the context of a TTM case

conference. I cannot therefore conclude that the evidence of these three witnesses supports the assertion that there is "a widespread preference to use safer cells in HMP Low Moss".

[253] Accordingly, on the basis of the evidence available to the Inquiry, I do not consider that this issue is a fact relevant to the circumstances of Mr Hutton's death, insofar as the issue had no significant or demonstrable bearing on the circumstances of his death. I therefor make no findings in this regard, in terms of section 26(2)(g).

[254] Finally, it was suggested that I might wish to comment on the brevity of the witnesses note taking and also a suggested misunderstanding regarding the separate SPS policies in relation to suicide and self-harm which might be addressed by further training. I have concluded that the notes taken by all three witnesses were brief but adequate and I make no recommendations in this regard. Regarding the suggestion that the three witnesses were confused about the separate policies in relation to self-harm and suicide-based on my assessment of the evidence, I do not believe that this is particularly well-founded and in any event any such confusion had no significant or demonstrable bearing on the circumstances of Mr Hutton's death and so I make no findings or recommendations in this regard.

[255] In the present case Mr Hutton was assessed by three members of staff in HMP Low Moss, all of whom I accepted were adequately experienced and qualified to carry out the assessment as to whether he was at risk of suicide. Directly before that he had been in police custody where he was not assessed as being vulnerable to suicide, (and I accepted the evidence of DS Smith, in relation to Mr Hutton's assessment in police

custody, as credible and reliable). Mr Hutton was last seen alive by Mr Markey prison officer, who placed him in his cell for the evening and who described him as "polite, easy to talk to and displaying no signs or behaviour that caused him any concern".

[256] Mr McStay, Ms Campbell and Dr Ahmed all concluded that there was no apparent risk of suicide at the time of assessment. They reached that conclusion taking account of his presentation at the time, together with a number of other factors and consequently any decision to deprive him of his belt/shoelaces simply did not arise. I accept that these witnesses were entitled to come to the views that they did based on the available evidence.

[257] On the evidence, it seems to me that in the circumstances, the removal of Mr Hutton's belt or even his shoelaces as latterly suggested on behalf of the family, would not have prevented him having access to other potential ligatures.

[258] Regrettably, Mr Hutton gave no signs or indications of any intention to commit suicide to any of the four members of SPS staff who assessed him and interacted with him prior to his death and as such there was no indication that the SPS should have treated him as being at risk of suicide. One of these witnesses (Mr McStay) knew Mr Hutton, having deal with him previously and described him as pleasant, polite and calm. Mr McStay's gave evidence in an open and straightforward manner and I accepted his evidence as credible, reliable and convincing.

[259] Mr Hutton suffered from mental health issues, which he freely disclosed to those assessing him. He suffered from anxiety and depression and had done so for a number of years. He was receiving medication, which was continued by Dr Ahmed. He also

had a serious alcohol problem, which he disclosed, and again Dr Ahmed prescribed medication to assist him with the symptoms of alcohol withdrawal.

[260] Ms Caffry, agreed that on the basis of the recorded assessments there were not sufficient markers to suggest that Mr Hutton might be at risk of suicide. She suggested instead that he was "at risk of distress", which may have indicated a need for further investigation at that time. With regard to her suggestion that further investigation was indicated - I accept and prefer the evidence of the witnesses McStay Campbell and Ahmed - that they were satisfied that they had sufficient information to carry out the TTM assessments and medical assessments at the time.

[261] Further, I note that Mr Hutton was due to be followed up by Dr Ahmed in relation to alcohol withdrawal and I observe, (with reference to the evidence of Ms McDowall) that support is available to prisoners with mental health issues. They can self -refer to services provided by the NHS. Prison staff can also make a referral if concerns arise at any point. Furthermore, the TTM reception risk assessment is not the end of the process. If a prisoner's mental health deteriorates and he is subsequently deemed to be "at risk", then SPS staff can initiate the TTM process at any time.

[262] As noted by Sheriff Shead in his determination following the Inquiry into the death of Garry Munro,

> "There is a material difference between a prisoner at demonstrable risk of suicide and one with mental health difficulties when there is no indication that those difficulties are severe and in any event indicative of a desire to commit suicide."

[263] Unfortunately, whilst it was clear that Mr Hutton suffered from mental health issues and may have had a number of other ongoing concerns, he did not, during his

time at HMP Low Moss present as an individual who appeared to be at risk of suicide. I am satisfied on the evidence that there was no basis on which the SPS should have treated him as being at risk of suicide. Accordingly, I am of the view that, on the evidence before the Inquiry, there are no identifiable precautions which could reasonably have been taken that might realistically have resulted in his death being avoided.

[264] I am satisfied that I should make formal findings of the time, place and cause of Mr Hutton's death in terms of section 26(2)(a) and (c) of the 2016 Act and that I should make no findings in terms of sections 26(2)(b), (d),(e),(f) and (g). Likewise, I have no recommendations to make in terms of section 26(4) of the Act.

[265] Finally, I join with all parties in offering my sincere condolences to the family of Mr Hutton.