SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2023] FAI 9

B935-22

DETERMINATION

BY

SUMMARY SHERIFF VINCENT LUNNY

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

into the death of

JAMIE DAVID HAMILTON BURNS

Glasgow, 8 February 2023

The Summary Sheriff, having considered the information presented at an inquiry on 4, 5 and 6 January 2023 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 finds and determines:

(1) That in respect of paragraph (a) of section 26(2), Jamie David Hamilton Burns born 23 February 1986, was last seen alive at 1710 hours on 12 September 2020 was pronounced dead at 0840 hours on 13 September 2020. He was at that time a prisoner in HMP Low Moss, 190 Crosshilll Road, Bishopbriggs, Glasgow G64 2QB.

(2) That in respect of section 26(2), paragraph (c), the cause of death was hanging.

(3) I have no findings to make under paragraphs (b), (d), (e), (f) or (g) of section 26(2) of the Act. I have no recommendations to make under section 26(1) (b).

NOTE:

LEGAL FRAMEWORK

[1] This Inquiry was held under section 1 of the 2016 Act. This was a mandatory inquiry in terms of section 2(1) and (4) of the 2016 Act as Mr Burns was in legal custody at the time of his death. The purpose of the inquiry was to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

PROCEDURAL HISTORY

[2] The Procurator Fiscal issued notice of the Inquiry on 7 July 2022. A preliminary hearing took place at Glasgow Sheriff Court on 9 September 2022. Mr Ali, Procurator Fiscal Depute appeared for the Crown. Mr Devlin appeared for the Scottish Prison Service (SPS) and Mr Rodgers for the Prison Officers' Association Scotland (POAS). The next of kin of Mr Burns was represented by Ms Buist. Further preliminary hearings took place on 14 October and 30 November 2022. Those appearing remained the same but for the replacement of Mr Devlin by Mr Considine for the Scottish Prison Service.

[3] The inquiry commenced on 4 January 2023. The same people appeared as above; with Mr Considine again appearing for the Scottish Prison Service. Mrs Burns, the mother of Jamie Burns and next of kin, was not in attendance. Jenna Burns, the sister of Jamie Buns and a witness to be called in the course of the Inquiry, was also not in attendance. I was advised that they were unable to attend court from their home in Alloa on account of industrial action on the railways. I was further advised that both Mrs Burns and Jenna Burns suffered from health

conditions that made travel difficulty. There were no other options open to them to attend court on 4 January 2023.

[4] A joint minute of agreement was tendered on behalf of the parties and this was received by the court. Mr Ali read out the terms of the Joint Minute of Agreement. That having been done, I adjourned the matter overnight to 5 January 2023 to allow Mrs Burns and Jenna Burns to attend court.

[5] Mrs Burns and Jenna Burns both attended court on 5 January 2023. Jenna Burns was called by Ms Buist as a witness on behalf of the next of kin. During the course of her evidence (discussed more fully at paragraph [9] below) she indicated that she had received a letter and religious drawing from her brother shortly before his death. The contents of this letter caused her to fear that her brother would commit suicide. The family had brought the letter to court with them. This letter had not been mentioned at any of the procedural hearings. After a short adjournment for the letter to be produced and copied to all parties, it was lodged as Production Number 1 for the next of kin. Jenna Burns further gave evidence that she had called either Low Moss Prison or the police to advise them that she feared her brother would commit suicide. She later clarified that the call she made may have been too late and taken place after Mr Burns' death. Following submissions from Mr Considine on behalf of the SPS with regards to the recording of incoming calls to the prison, I adjourned the Inquiry overnight to allow investigations to take place as to whether the prison had a record of any call around the time of Mr Burns' death from a family member expressing concerns that Mr Burns would commit suicide.

[6] On 6 January 2023 the inquiry continued in the absence of the next of kin who were unable to attend on account of travel difficulties. Mrs Burns and Jenna Burns had indicated on 5 January they were content for the Inquiry to continue and conclude in their absence.

[7] Mr Considine advised the Inquiry that further investigations confirmed that no such call raising suicide concerns about Mr Burns had been logged at the prison. If such a call had taken place then the procedure is that the call would have been logged and the matter referred to the SPS Talk To Me suicide prevention programme. Parties then agreed a second joint minute of agreement with regards to this particular issue which was read into the evidence by Mr Considine. Thereafter parties delivered their respective submissions on the proposed outcome of the Inquiry.

CIRCUMSTANCES

[8] The following narrative is taken from relevant passages of the first agreed Joint Minute:

> **Background**
>
> 1. On 20 August 2020 at Falkirk Sheriff Court, JAMIE DAVID HAMILTON BURNS, date of birth 23 February 1986 (hereinafter referred to as 'the deceased'), was sentenced to a period of 4 months imprisonment having tendered a plea of guilty to a contravention of Section 38 of the Criminal Justice and (Licensing) Scotland Act 2010 and a breach of bail conditions in contravention of section 27(1)(b) of the Criminal Procedure (Scotland) Act 1995. The deceased had

been remanded in custody on the aforementioned charges since 20 July 2020 (all as shown at Crown Production Number 5 at pages 80 and 82-83). Since the date of his remand, the deceased had been incarcerated at HMP Low Moss (hereinafter referred to as 'the prison') and following his sentence being imposed his earliest date of liberation was calculated as 19 October 2020 and sentence end date as 19 December 2020 (as shown at Crown Production Number 5 at page 79)

2. […]

3. At the date of his death on 13 September 2020 the deceased was a prisoner of HMP Low Moss. He was accordingly in legal custody as at the date of his death.

4. […]

Mental Health Assessments and the Talk to Me Strategy

5. On 20 July 2020, when the deceased was remanded in custody and admitted to HMP Low Moss, he was a late arrival to the prison due to transport issues from Falkirk Sheriff Court. Consequently, there were no medical staff at the prison to carry out admission assessments regarding the deceased's mental health and risk of suicide. As a precaution, the deceased was placed on Talk to Me overnight and placed on 15-minute observations (as shown at Crown Production Number 5, pages 47 and 49-50). Talk To Me is the Scottish Prison Service's Prevention of Suicide in Prison Strategy (PSIPS) whereby all prisoners on reception to prison are assessed by staff to be either 'at risk' or 'no apparent risk' of suicide or self-harm. If prisoners are assessed as 'at risk' appropriate

actions can be taken such as anti-ligature clothing or cells and placing prisoners on observations. A prisoner can be placed on Talk To Me at any time.

6. The deceased was seen the following day on 21 July 2020 by the prison General Practitioner Dr Dominique Van Den Meersschaut who noted his history of psychiatric borderline bipolar and schizophrenia and that he had stopped taking his mental health medication, Olanzapine and Mirtazapine. Witness Meerschaut also noted the deceased had ongoing illicit drug use of heroin and diazepam. The deceased was prescribed a standard detoxification medication regime of diazepam and dihydrocodeine (all as shown at Crown Production 3, page 5).

7. The deceased was also seen by witness Doris Wilson, Nurse, who assessed the deceased as displaying no apparent risk of suicide and no deliberate thoughts of self-harm and removed from Talk to Me, though noted a previous suicide attempt 14 years previously whilst under the influence of alcohol (as shown at Crown Production 5, page 48 and Crown Production Number 3, pages 4-5).

8. On 28 July 2020 the deceased self-referred to the prison mental health team. He was not seen by the mental health team at that time but was referred to the addictions team for initial assessment. This was due to the deceased's recorded medical and psychiatric history demonstrating no formal psychiatric diagnosis but a history of contact with community addictions services (as shown at Crown Production 3, page 4).

9. On 11 August the deceased again self-referred to the prison mental health team, stating he was schizophrenic and could not sleep. The mental health team noted that he was awaiting assessment by the addictions team and sent a letter to the deceased advising him of same (as shown at Crown Production 3, page 4).

10. The deceased attended a virtual court on 20 August 2020 by remote link where he was sentenced to 4 months imprisonment. He was assessed by Witness Alexandria Moen, Mental Health Nurse, and placed on Talk to Me with 30-minute observations due to making bizarre and paranoid comments whilst stating he was devastated by the sentence imposed by the court. However, he denied any thoughts of suicide or self-harm (as shown at Crown Production 3, page 4).

11. A case conference took place the following day on 21 August 2020 and the deceased strongly denied any thoughts of suicide or self-harm, stating he made the unusual comments the previous day as he was in a bad mood and did not mean them. He was removed from Talk to Me (all shown at Crown Production 3, page 4).

12. On 5 September 2020 the deceased refused to take his prescribed methadone despite encouragement from witness Charlotte Gee, Nurse and requested a review with the addictions team. A substance misuse review was held on 7 September 2020 where the deceased had been continuing to refuse his prescription of methadone and voiced bizarre beliefs such as refusing his methadone to remove himself of “negative forces” and that he had been visited

by a deceased relative who had attempted to encourage him to complete suicide by telling him he would be able to walk through walls. However, the deceased denied he was influenced by this or that he had any suicidal thoughts. Witness Gee noted he appeared anxious, with poor eye contact and rapid speech with low tone, causing her sufficient concern to make an urgent referral to the mental health team (all as shown at Crown Production 3, page 4).

13. The deceased was seen by witness Siobhan Welsh, Mental Health Nurse, on 9 September 2020 for the purpose of a mental health assessment. It was noted the deceased conversed freely throughout the assessment and maintained good eye contact, his appearance was reasonably tidy, and his mood appeared bright with no evidence of agitation or anxiety. At the assessment he continued to voice bizarre and grandiose statements that he has a higher purpose in life and that the end of the world is coming. The deceased was referred to the Mental Health Team (MHT) due to the content of his speech, though it was noted this presentation of bizarre thoughts was not novel or unusual for the deceased and he appeared to have been voicing such beliefs for considerable time. He was scheduled to see the visiting psychiatrist the following week (all as shown at Crown Production 3, pages 3-4).

14. The following day on 10 September 2020, the deceased was placed on a Rule 95 (removal from association) by witness George Rose, Prison Officer, due to the deceased displaying erratic behaviour and presentation who cited the deceased making references to being abducted by aliens and voicing religious

beliefs while requesting a single cell. The deceased later clarified to witness Rose that he had an issue with another prisoner, hence expressing a wish for a single cell. An urgent mental health referral was made by the witness Rose and the deceased was listed for review on 14 September 2020 (as shown at Crown Production 3, page 2; Crown Production 5, pages 37-39 and Crown Production 6, page 3).

15. The deceased was placed on a Rule 95, removal from association, as this allowed prison staff to engage more directly with him one a one-to-one basis in the ensuing days; serving food directly to him in his cell, and allowing him access to phones and exercise and ultimately to keep him settled until he was reviewed by the Mental Health Team on 14 September 2020 (as shown at Crown Production 5, page 39 and Crown Production 6, page 4).

16. The deceased had his final contact with healthcare staff prior to his death on same date when he declined to take his methadone. It was noted by witness Heather Johnstone, Nurse, that he had refused methadone for the previous 8 days (as shown at Crown Production 3, page 2).

Circumstances of death

17. At approximately 1618 hours on 12 September 2020 the deceased was within cell C108 in Clyde wing of the prison (hereinafter referred to as 'the cell), he was the single occupier of said cell. Witness Cindy Knowles, Prison Officer, is seen on CCTV opening the cell door to serve the deceased dinner. The deceased

is seen leaving his cell and returning at 1619 hours and closing the door. Witness Roy Montgomery, Prisoner Officer, checked into the cell at 1710 hours for the evening count and lock-up with everything in order. There was no further interaction with the deceased's cell by prison staff until 0810 hours the following day (all as shown at Crown Label 1).

18. At approximately 0810 hours witness Knowles unlocked the cell door. On entering the cell, the deceased was discovered hanging from a ligature which had been tied to the top of the cell toilet door.

19. Witness Knowles called for assistance, using her radio to call a 'Code Blue' to alert medical staff that they were urgently required to attend at the cell. Witnesses Robert Hoehle, Paul Hagan and Roy Montgomery, Prison Officers, attended at the cell to provide assistance. Witness Hoehle could not detect a pulse on the deceased's left wrist and noted him to be cold to touch and rigid. Witnesses Montgomery and Hagan assisted in supporting the weight of the deceased to allow the witness Hoehle to cut the ligature and thereafter moved the deceased onto the cell floor.

20. Witness Heather Johnstone, Nurse, and witness Laura Connelly, Practitioner Nurse, attended at the deceased's cell in response to the 'Code Blue' to give medical assistance. Witness Connelly removed the ligature from the deceased's neck and it was evident he had been dead for a number of hours with rigor mortis having set in and post mortem staining. Witnesses Johnstone and Connelly checked the deceased for a carotid pulse, brachial and radial pulse, all

of which were negative. A pulse oximeter was also used to check for oxygen, saturation and a pulse, none of which were present. Witness Johnstone noted his pupils were fixed and dilated, whilst the deceased's body was cold to touch.

21. Witnesses Johnstone and Connelly agreed it would be futile and inappropriate to administer cardiopulmonary resuscitation (CPR) given it was clear the deceased had been dead for a number of hours.

22. Witness Andrew Pearson, Paramedic, attended at the prison at approximately 0825 hours and pronounced death at 0840 hours.

Police investigation

23. Police Scotland were contacted at approximately 0900 hours on 13 September 2020 and made aware of the death of the deceased. Witnesses Detective Constable Stephen McCabe and Detective Constable Greg Stewart attended and examined the deceased's cell.

24. Witness Colin Lovatt, Police Constable, and witness Gillian Porteous, Police Constable attended at HMP Low Moss to search the deceased's cell. A number of handwritten letters (Crown Productions 8, 10 and 11) and a chaplain request form (Crown Production 9) were located within as well as an open Bible on the deceased's bed.

25. The inside of the deceased's cell was photographed by a Scene of Crime Examiner (as shown at Crown Production 7). Photographs off the ligature were obtained (as shown at Crown Production 7, pages 31-32).

26. Thereafter, witnesses Lovatt and Porteous arranged for the deceased to be conveyed to the Queen Elizabeth University Hospital (QEUH) mortuary by private ambulance for the purposes of a post-mortem examination.

Post-mortem

27. A post-mortem examination was carried out on 23 September 2020 at the Queen Elizabeth University Hospital, Glasgow by Forensic Pathologist Dr Julia Bell. The cause of death was certified as:

1a: Hanging

28. Blood and urine samples were analysed with a low level of methadone detected, which was prescribed to the deceased. No other drugs were detected.

29. In terms of natural disease, the examination found there was some microscopic inflammation and scarring of the liver, which was most likely due to drug abuse.

Death in Prison Learning, Audit and Review (DIPLAR)

30. The DIPLAR listed the extensive contact the deceased had with healthcare and mental health services in the months and years leading up to his death, meanwhile it is noted he had an extensive offending history and spent numerous periods in and out of prison since 2003 with his drug addiction a primary factor in offending. It is suggested that the deceased had a difficult

family background and a difficult relationship with his mother, due to her issues with alcohol, and his lifestyle became increasingly chaotic after the death of his grandmother and the termination of his mother's relationship with his stepfather (all as shown at Crown Production 6, pages 2-3).

31. The DIPLAR notes he had a long history of offending and chaotic substance misuse – he admitted to using illicit diazepam, heroin and cocaine before entering HMP Low Moss and had numerous non-fatal overdoses in the preceding 2-year period. An assessment by a Consultant Psychiatrist in the community in 2019 identified there was nothing to suggest schizophrenia or bipolar disorder and no thoughts of self-harm. The DIPLAR notes that previous consultations indicated the deceased may have emotionally unstable personality disorder linked to trauma and substance abuse (all as shown at Crown Production 6, page 4).

32. The section describing the deceased's behaviour and mood in the months prior to his death noted that the deceased was seen by the prison chaplain every Monday, where he would express unusual religious beliefs, but the prison chaplain agreed there was nothing to suggest any suicidal ideation and he had no concerns of the deceased completing suicide or self-harming (as shown at Crown Production 6, page 4).

33. The DIPLAR concluded at Crown Production 6, page 8:

> "When staff witnessed the change in Mr Burns' behaviour they escalated their observations to the FLMs who made the referral to MHT to have him assessed.

> When the question was raised as to whether an earlier intervention could have made a difference, it was felt that would remain unknown.
>
> The passing of Mr Burns was a tragic event. Responding staff noticed the change in Mr Burns' presentation and took action to seek him support with a degree of urgency. NHS responded and Mr Burns was assessed relatively quickly after the referral was made – with an appropriate follow up scheduled after the weekend.' (as shown at Crown Production 6, page 7)
>
> No learning points or recommendations were identified in respect of the deceased. An action point was identified to note that nursing staff are now at the prison until 10pm, as opposed to 8pm, and therefore the practice of placing prisoners who arrive late to the prison on Talk To Me by default is no longer in operation (as shown at Crown Production 6, page 12)."

Expert Report

34. Dr Gordon Skilling is an NHS Consultant Forensic Psychiatrist. He was asked to provide an opinion on the standard of mental health care provided to the deceased while he was a prisoner at HMP Low Moss. In preparing his report, Dr Skilling reviewed the Death in Prison Learning, Audit and Review (DIPLAR), the deceased's Scottish Prison Service File, the Post-mortem report and the deceased's NHS medical records, psychiatric records, and GP records. Dr Skilling's report forms Crown Production Number 14 (pages –1-9).

35. Dr Skilling opines there is sufficient evidence that the deceased did have a mental disorder, which was most likely a personality disorder. Moreover, the deceased may well have experienced brief periods of psychosis due to abuse of

illicit drugs and an exacerbation of underlying personality traits as a result of repeated head injuries in the past.

36. Dr Skilling is satisfied that there was no deficiency in the care provided to the deceased. He states that he has no criticism to make on either a systems or individual basis and that the deceased was provided with a reasonable standard of mental health care in HMP Low Moss. The deceased was identified as having a history of mental health problems and addictions as well as his troubled background of offending.

37. Dr Skilling states that the deceased was referred appropriately and was robustly assessed, and was also seen following subsequent self-referrals. Concerns regarding his mental health were acted on appropriately and timeously and he was seen by the mental health team. The mental health assessment of 9 September 2020 in particular was thorough and well documented in the deceased's medical records. It was a reasonable decision by healthcare staff to arrange an appointment with the visiting psychiatrist the week following the mental health assessment on 9 September 2020 given the absence of any acute indicators of increased risk of suicide – including the deceased repeatedly denying any thoughts of self-harm or suicide. Consequently, given the absence of any warning signs by the deceased, there was no reason for any staff involved in the care of the deceased to take any additional precautions. Dr Skilling states there was no indication that the deceased ought to have been placed on Talk To Me in the days prior to completing suicide.

[9] In addition to the first Joint Minute, I had the benefit of the parole evidence of Jenna Burns, the sister of the deceased. She had received a letter which she described as a "suicide note". She interpreted numerous religious references in the letter as suggesting her brother would "sacrifice himself". Her brother had told her previously that if he was returned to prison he would kill himself. Ms Burns further stated that on receiving this letter she had telephoned either Low Moss Prison or the police to warn them of the risk of her brother killing himself in custody. She was unable to provide details as to when the call had taken place or to whom.

[10] After a short adjournment the letter was produced and lodged in evidence with the agreement of all parties. A review of the letter confirmed its very religious content. Whilst the letter, in its terms, would no doubt give rise to concerns for the deceased's mental health, it did not contain any reference to the deceased planning to kill himself or as having any suicidal ideation. On the contrary, the letter contained a number of comments which suggested the opposite; with two references to speaking to his family in the future and to the time left on his sentence, amongst other things.

[11] Notwithstanding the terms of the letter, I agreed with Ms Buist's submission that Ms Burns' subjective assessment of it as a suicide note was justifiable given her circumstances. I agreed to adjourn the matter overnight for the Prison Service to make enquiries to ascertain if any such call from Ms Burns had been logged. On further examination of the circumstances surrounding the letter, I was advised that Ms Burns conceded she may very well have called the authorities after it was too late.

[12] After overnight enquires had been completed, a second joint minute of agreement was lodged in the following terms:

> 1. There is no record at HMP Low Moss of a telephone call coming into the prison expressly raising a suicide concern regarding JAMIE DAVID HAMILTON BURNS ("the deceased") on or around the time of his death on 13 September 2020. In addition, there is no record at HMP Low Moss of any suicide concern being expressly raised by a source outside the prison during the deceased's period in custody from 20 July 2020 to 13 September 2020.
>
> 2. If a call reached HMP Low Moss raising a suicide concern in relation to the deceased the Talk To Me process would have been initiated by the staff member receiving the phone call and a case conference would have been arranged for the deceased to have been assessed as either being at No Apparent Risk or At Risk of suicide.

SUBMISSIONS BY THE PARTIES

The Crown

[13] The Crown invited me to make the mandatory formal findings only, i.e. to determine when and where the death of Jamie David Hamilton Burns occurred, and the cause or causes of his death in terms of Sections 26(2)(a) and (c) of the 2016 Act. As there was no suggestion of any accident having taken place, Mr Ali advised he had no submissions in terms of Sections 26(2)(b) and (d). Mr Ali summarised the key points from the first Joint Minute of Agreement setting out

the history of Mr Burns' engagement with the prison mental health team and the Talk To Me programme. Following a deterioration in his mental health Mr Burns was placed on a Rule 95 (removal from association) on 10 September 2020 for his own wellbeing and he was scheduled to be seen by the visiting psychiatrist at the first available appointment; 14 September 2020. There was no evidence to suggest that Mr Burns was at risk of committing suicide or that other steps should have been taken. He further submitted that there was nothing from the evidence of Jenna Burns to change that assessment. I was referred to the report of Dr Skilling which concluded that the care and treatment given to Mr Burns in the prison was appropriate and no deficiencies had been identified. Accordingly the Crown also made no submissions in terms of Sections 26(2)(e) and (f). No submission was made under 26(2)(g) in respect of any other relevant facts.

Scottish Prison Service

[14] Mr Considine, on behalf of the Scottish Prison Service, also submitted that I make the mandatory formal findings only. I was invited to rely on the two joint minutes of agreement lodged in the inquiry, Dr Skilling's report and directed to the facts summarised in the Crown's submission. There was nothing in any of the evidence that would have indicated any warning signs of an intention to commit suicide. With regards to the evidence of Jenna Burns, the letter in question made no reference to committing suicide. The contents of that particular letter were consistent with Mr Burns' behaviour at the time and other letters found in his cell following his death. The timing of the letter to Jenna Burns was uncertain. There was also uncertainty as to when any purported phone call had taken place and to whom. Enquiries had been made and

the circumstances addressed in the second Joint Minute of Agreement. It was further submitted that I make no recommendations as per Section 26(4) of the 2016 Act.

Prison Officers' Association Scotland

[15] It was submitted by Mr Rogers, on behalf of the POAS, that I make the mandatory formal findings only. Again I was invited to rely upon the evidence contained within the two Joint Minutes of Agreement and in particular the contents of Dr Skilling's report. That report succinctly set out the numerous times that Mr Burns' mental health had given rise to concerns and the subsequent extensive involvement he had with the prison mental health team. This had been elevated to the point of engagement with clinical staff. Dr Skilling had concluded that Mr Burns had been treated appropriately. My attention was drawn to paragraphs 35 to 37 of the first Joint Minute of Agreement (set out above). The officers who had seen the deceased in the days before his death had advised there was nothing of concern to indicate a risk of suicide. None of the other parties in the inquiry had proffered any criticism of any prison officer. The invoking of Rule 95 by prison staff on 10 September 2020 was for care to be given to Mr Burns and he was being dealt with appropriately at that time. In conclusion, as per Dr Skilling's report, there had been no deficiencies in the deceased's care.

[16] In the context of Section 26(2)(e), Mr Rogers submitted that there would have to be a lively possibility of a reasonable precaution that might have prevented the Mr Burns' death before any such finding could be made in that regard. He submitted that there was no evidence to support any such assertion. The death of Mr Burns was a sudden and unpreventable incident. Whilst I was not referred to any authorities, Mr Rogers clearly had in mind the

reference to "lively possibility" in the Determination of Sheriff Kearney dated 17 January 1986 in the Death of James McAlpine:

> "In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one. The phrase 'might have been avoided' is a wide one. It means less than 'would, on the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."

This standard is also referenced in Carmichael on *Sudden Deaths and Fatal Accident Inquiries* (3rd Edn) at paragraph 5.75 on page 174, which provides, "…what is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution." I was invited to make no finding in terms of Section 26(2)(e).

[17] Similarly, Mr Rogers submitted that there had been no evidence of any defect in any system of working which had contributed to the death nor any further relevant circumstances. Accordingly, he submitted that I make no findings in respect of Sections 26(2)(f) and (g).

Next of Kin

[18] Ms Buist advised me that the deceased's next of kin took no issue with the time, location and cause of death. However, the next of kin and family of the deceased believed he ought to have been on 15 minute observations. It was submitted there may have been an indication of the risk of suicide from his deteriorating mental health; evidenced by a number of grandiose statements and the letter sent to the deceased's sister. I was referred to Production 11 lodged by the Crown; another letter written by

the deceased which was found in his cell after his death. This letter appears to have been written on 11 September 2020. At page 6 of that letter, the deceased erroneously made reference to his mother having died. There was no evidence as to how he had come to this erroneous conclusion. It was noted however that the deceased had spoken with his mother by phone that day on two occasions. It was suggested to me that the deceased's mental health was "potentially up and down".

[19] Notwithstanding these submissions as to the family's concerns, Ms Buist invited me to make the formal findings only and was explicit in stating that she was not suggesting the Scottish Prison Service should have done anything differently. It was conceded that any attempt by the deceased's sister to contact the relevant authorities may have taken place after the death had occurred. It was further conceded that even if the deceased had been on 15 minute observations it would likely have made no difference to the ultimate outcome.

[20] I allowed Mr Considine and Mr Rogers to respond briefly to the suggestion that the deceased should have been on 15 minute observations. I was advised that Rule 95 Removal from Association did not lead to such observations. For that to happen a prisoner would require to be on the Talk To Me Programme following an assessment that the prisoner was at risk of suicide. There was no evidence in this case to suggest such a risk. The deceased had requested to be placed on Rule 95. He seemed happier once that was done. There had been an improvement in his condition. The actions of the SPS and staff had been appropriate in all the circumstances.

CONCLUSIONS

[21] I accept the submissions made on behalf of all parties in respect of which findings should be made in this Inquiry; being the formal findings only in terms of section 26(2)(a) and (c). I am satisfied on the evidence before the Inquiry that there were no precautions which could reasonably have been taken to prevent the death of Mr Burns (section 26(2)(e)(i)). I accept the submission that there was no evidence to suggest the existing of a lively possibility that the death may have been avoided (section 26(2)(e)(ii)). There were no defects in any system of working, which contributed to his death (section 26(2)(f)). No submissions were made by any party that any accident had resulted in Mr Burns' death (section 26(2)(b) and (d)). Nor were any submissions made to indicate that any other facts relevant to the circumstances of Mr Burns' death fell to be included in my determination (section 26(2)(g)). No submissions were made that I should make any recommendations under section 26(1)(b).

[22] It is a sad fact that mental health issues are often, of themselves, not necessarily indicative of a risk of suicide. Whilst it was clear that Mr Burns was suffering from mental ill health, he had repeatedly denied any thoughts of suicide or self-harm. His presentation on 9 September 2020, shortly before his death, was encouraging. There were no indicators that he would take his own life. Appropriate steps and treatment were taken in the prison to address Mr Burns' health issues.

[23] With regards to the evidence of Ms Burns regarding a possible phone call to the prison, I was not satisfied that any such call had indeed been made. Ms Burns was clearly doing her utmost to recall the events of September 2020 as truthfully as she could. However, she had also been unwell at that time and her recollection was, at times, confused. Her level of distress in

giving her evidence was a clear indication of how upsetting the loss of her brother had been. None of this is to be taken as any criticism of Ms Burns. I was very grateful for the evidence she provided. Neither Ms Burns, nor anyone else in the family, should feel any guilt or blame in respect of the loss of Mr Burns.

[24] I am satisfied that in all the circumstances formal findings should be made in this case. I have set out those formal findings above

[25] In conclusion I wish to express my thanks for the assistance provided by all the parties into this enquiry and I offer my sincere condolences to the bereaved family of the late Mr Jamie David Hamilton Burns.