SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2023] FAI 17

GLW-B830-21

DETERMINATION

BY

SHERIFF GERARD CONSIDINE

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

into the death of

STEPHEN MASSON

Glasgow, 20 March 2023

The Sheriff, having considered the joint minute of agreement, the evidence and the submission of parties, Determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") that:

In terms of section 26(2)(a) of the Act (where and when the death occurred)

Stephen Masson died between approximately 1330 hours and 1605 hours on 6 December 2018 within HM Prison Barlinnie, Glasgow.

In terms of section 26(2)(b) of the Act (when and where any accident resulting in the death occurred)

Mr Masson's death did not result from any accident.

In terms of section 26(2)(c) of the Act (the cause or causes of death)

The cause of death of Stephen Masson was:

1a Hanging.

In terms of section 26(2)(d) of the Act (the cause or causes of any accident resulting in the death)

Stephen Masson's death did not result from any accident.

In terms of section 26(2)(e) of the Act (the taking of precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided)

There were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided.

In terms of section 26(2)(f) of the Act (defects in any system of working which contributed to the death or any accident resulting in the death)

There was a defect in the system of working to ensure the provision of prescribed medication.

In terms of section 26(2)(g) of the Act (any other facts relevant to the circumstances of the death)

There are no other factors relevant to the circumstances of the death.

Recommendations

The sheriff having considered the information presented at the Inquiry, in terms of section 26(1)(b) of the Act, in having regard to matters mentioned in section 26(4) of the Act recommends that:

(1) A note of all ongoing prescriptions currently prescribed to a patient should be registered with the NHS regardless of the prescriber to allow healthcare professionals immediate access to details of a patient's medication.

(2) A clear and robust system should be put in place to ensure that all prescription medication is provided without delay to a prisoner once confirmation is received and a system should be in place before the end of each day where confirmation is awaited to confirm if a reply has been received to ensure that a prisoner is receiving the correct medication.

Sheriff

NOTE:

Introduction

[1] This Inquiry was held into the death of Stephen Masson who was discovered around 1555 hours on 6 December 2018 to be on his knees in his cell, facing away from the door. Upon a prison officer opening the door, he observed that Mr Masson had a ligature around his neck which was attached to his bunkbed. The ligature was made from bedding. A code blue alert was raised and medical staff attended immediately however there was no sign of life. Life was

pronounced extinct at 1605 hours on 6 December 2018 at HM Prison, Barlinnie. The death of Mr Masson was reported to the procurator fiscal and, after a number of preliminary hearings, the Inquiry took place over five days of evidence (10 and 11 August 2022 and 8, 9 and 11 November 2022) and submissions were made on 5 January 2023.

[2] The parties were represented as follows:

(i) Mr Hill, procurator fiscal depute, represented the Crown;

(ii) Mr Smith, solicitor, represented the Scottish Prison Service (hereinafter referred to as "SPS");

(iii) Mr Paterson, advocate and Ms Paton, solicitor for NHS Greater Glasgow and Clyde;

(iv) Ms Railton, solicitor, and Mr Varney, solicitor for the Chief Constable, Police Scotland;

(v) Mr Gallagher, solicitor, represented the family of Mr Masson;

(vi) Mr Rodgers, solicitor, represented the Scottish Prison Officers' Association;

[3] The representatives had agreed a significant amount of evidence in a joint minute of agreement which ran to 24 paragraphs that resulted in the need for oral evidence to be reduced. I heard oral evidence from the following witnesses:

(i) Catriona Allan, police custody nurse;

(ii) Gary McKenzie, police inspector;

(iii) Richard Palmer, retired prison officer involved in the admission assessment on 4 December 2018;

(iv) Laura Connolly, nurse involved in the admission assessment at HM Prison, Barlinnie;

(v) Deborah Byrne, nurse involved in the admission assessment at HM Prison, Barlinnie;

(vi) Dr Suchitra Senthil, a doctor who assessed Mr Masson on 5 December 2018;

(vii) Martin McGrory, prison officer who spoke with Mr Masson on 6 December 2018;

(viii) Dr Michael O'Keefe, Crown medical expert;

(ix) Mr Philip Wheatley, prison expert led by the Crown;

(x) Siobhan Taylor, SPS policy manager for national suicide prevention;

(xi) Dr John Callender, consultant psychiatrist led by Greater Glasgow Health Board as a medical expert.

In addition I had evidence by affidavit from Nicole McRobbie, an addictions nurse who assessed Mr Masson on 5 December 2018.

Legal Framework

[4] This Inquiry was held in terms of section 1 of the 2016 Act. Mr Masson died in legal custody, and, therefore, the Inquiry was a mandatory Inquiry held in terms of section 2 of the 2016 Act. The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules 2017) (hereinafter "the 2017 rules") and was an inquisitorial process. The Crown represented the public interest. The purpose of the Inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Masson and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the Inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an Inquiry is not restricted. Information May be presented to an Inquiry in any

manner and the court is entitled to reach conclusions based on that information (see rule 4.1 of the 2017 rules).

[5] Section 26 of the 2016 Act sets out what must be determined by the Inquiry. Section 26 of the 2016 Act is in the following terms:

> "**26 The sheriff's determination**
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
>
> > (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> > (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1) (a) are—
>
> > (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,
> > (g) any other facts which are relevant to the circumstances of the death.
>
> (3) For the purposes of subsection (2) (e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—
>
> > (a) if the precautions were not taken, or
> > (b) as the case May be, as a result of the defects.

(4) The matters referred to in subsection (1) (b) are—

(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1) (b) May (but need not) be addressed to—

(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and May not be founded on, in any judicial proceedings of any nature."

[6] I will set out a summary of the evidence laid before me. I will break the evidence into the chapter of Mr Masson's time in police custody and thereafter in relation to his time on remand at HM Prison, Barlinnie. Thereafter I will set out the expert evidence. I will then set out a summary of the submissions made by the various parties and will explain, with reference to the evidence before the Inquiry, the conclusions I have reached and explain the recommendations that I consider to be appropriate.

Mr Masson's time in police custody

[7] On 30 November 2018 at around 2215 hours, police officers attended at Waterloo Street, Glasgow in response to reports of an intoxicated male. The officers attended and spoke with Stephen Masson who became abusive towards them, punched one of them in the groin area and he was subsequently arrested and conveyed to hospital before being assessed as being fit for

detention in police custody. Mr Masson was conveyed to Govan Police Office and processed into police custody at around 2340 hours on 30 November 2018. He refused to answer any questions in respect of the Police Scotland vulnerability assessment. As a result he was placed in the high risk category and placed under constant observations via CCTV which was observed by a dedicated police officer. He remained in the high risk care plan until 1725 hours on 1 December 2018. At around 1710 hours on that date he engaged with police staff and completed the Police Scotland vulnerability assessment. During this assessment he stated that he had a drug dependency and was prescribed 70ml of methadone daily.

[8] On 1 December 2018 at around 1015 hours, police custody nurse Katrina Allan was advised that Mr Masson had vomited in his cell. She attended at around 1115 hours and carried out an assessment which was noted on the NHS computer system. Mr Masson was said to be alert and orientated to time, place and person and was able to answer all questions put to him and confirmed that he was a daily drinker and prescribed 70 ml of methadone daily. He appeared to be sweating, tremulous and had been vomiting but was not experiencing hallucinations. Nurse Allan noted that he suffered regularly from severe alcohol withdrawal with a history of seizure activity. He was administered with 20 mg of Diazepam and 3 mg of Prochlorperazine for nausea and vomiting. He was marked for further review in 4 hours. This assessment was placed in the Police Scotland custody record.

[9] Nurse Allan gave evidence that nurses can prescribe and administer certain medications to people in custody however methadone is not one of the drugs that they can prescribe. The process regarding methadone was that they would inform the police sergeant and then attempts would be made to collect the detainee’s methadone at which time the nurses can administer.

[10] Mr Masson was next assessed by Nurses Allan and Pamela Dounan at 1740 on 1 December 2018 where he was administered 20 mg of Diazepam and 60 mg of Dihydrocodeine in respect of his drink and drug withdrawal symptoms. He continued to be assessed, cared for and treated by nursing staff regularly throughout his period in police custody and continued to be treated for opiate withdrawal by administration of 60 mg of Dihydrocodeine. Mr Masson was marked for regular review by nursing staff and notes were recorded into the police station medical notes. The standard of care and treatment afforded to Mr Masson by nursing staff whilst in police custody was to a high standard.

[11] Following the disclosure to Nurse Allan regarding his methadone prescription, on 1 December 2018 police officers made an attempt to obtain the methadone from a pharmacy. This information was contained in police station medical notes. A further unsuccessful attempt was made to obtain Mr Masson's methadone on 3 December 2018 and was recorded in Crown production 4, the Police Scotland custody records, by Police Support Officer Derek Clydesdale. The entry did not detail what officers attempted to obtain the methadone or which pharmacy they attended or what time they attended. Notwithstanding the fact that the record keeping could have been better, it is clear that this did not affect the standard of care afforded to Mr Masson by the police.

[12] A personal escort record (PER) was completed by the police and passed to G4S staff on 4 December 2018 for the purpose of Mr Masson appearing at court. It was noted on Mr Masson's PER that he suffers from drug and alcohol issues, that he is an alcoholic, Valium dependent and suffers from withdrawals. Mr Masson appeared at Glasgow Sheriff Court on 4 December 2018

where he pled not guilty and was remanded in custody with trial diet assigned for 4 January 2019. He was thereafter taken to HM Prison, Barlinnie.

Mr Masson's time on remand from 4 December 2018 until 6 December 2018

[13] Mr Masson was transported from Glasgow Sheriff Court on 4 December 2018 to HM Prison, Barlinnie. The PER form was passed to SPS staff upon his arrival at HM Prison, Barlinnie at around 1752 hours. Upon arrival at HM Prison, Barlinnie Mr Masson was processed through the admissions area. He was assessed by a prison officer Richard Palmer who has now retired. He worked for SPS for 17 years and spent his entire time at HM Prison, Barlinnie. Mr Palmer worked on reception duty for around 7 years immediately leading up to his retirement. He had met Mr Masson in the past during previous prison sentences. Mr Palmer carried out the Reception Risk Assessment (RRA) dated 4 December 2018 which is part of the Talk to Me (TTM) prevention of suicide in prison strategy. Mr Palmer confirmed that he did not fill in parts 1 and 2 of the Mr Masson's RRA and stated that this would have been done by a fellow officer at the front desk prior to Mr Masson's meeting with Mr Palmer. The partially completed RRA would then have been handed to Mr Palmer when he was ready to begin his assessment. The PER would be attached to the partially completed RRA when it was provided to him. He would read the PER prior to carrying out his assessment. The colleague who completed parts 1 and 2 has no details recorded. Mr Palmer could not recall who that colleague was. Part of that section includes the PR2 record, which is the prisoner record database. This would detail the prisoner's previous addresses and discipline reports, and any prior involvement with TTM. He could not now remember if he had read those records in respect of Mr Masson. He confirmed his

normal practice would have been to check the PR2 although on this occasion his colleague May have completed parts 1, 2 and 3 which would mean that Mr Palmer was unaware of a previous suicide attempt in August 2018 when Mr Masson had his methadone prescription withdrawn. It has to be borne in mind that Mr Palmer was giving evidence in August 2022 about an assessment carried out in December 2018.

[14] Mr Palmer confirmed that he could see from the form before him that Mr Masson had a previous harming episode on 8 August 2018 which he took to mean that there were concerns at that time. Mr Palmer completed part 4 of the form which is headed "Assessment of Behaviour, Attitude and Risk". A set of questions then follow where the officer will ask the prisoner if they have any concerns at the time of the assessment regarding any of the following points – "Is this your first time in custody?; Was your sentence/ remand unexpected?; Do you foresee any relationship/family contact or visit issues? Do you have any other concerns at this time (nature of offence, length of sentence)? Do you feel suicidal?". The officer then completed the following section to summarise his responses. When Mr Palmer assessed Mr Masson he concluded that Mr Masson had no thoughts of suicide or self-harm. He then completed the section "comment on individual's presentation throughout discussions considering eye contact, mood, anxiety or anger (list not exhaustive)". Mr Palmer recorded that Mr Masson had told him he was suffering from drug withdrawal and noted that he communicated well and had no concern. He assessed Mr Masson as at no apparent risk and duly passed him onto the nurses for a healthcare assessment in terms of the RRA protocol. He confirmed that the admissions area would have been busier than normal due to it being a bank holiday Tuesday and that no additional staff would have been laid on to assist processing the prisoners. The assessment was no longer than

23 minutes. Mr Palmer could not recall exploring Mr Masson's drug withdrawal as that would be a healthcare issue. It was fairly common to deal with prisoners suffering from drug withdrawal and this confirmed the information which was contained on the PER. In Mr Palmer's view drug withdrawal was a matter to be dealt with by the healthcare professionals. He confirmed that he received training on TTM and received refresher training once a year although he did not know what was meant by the term "Protective Factors" and he confirmed that he generally would not have explored mental health or background issues with a prisoner to identify risks. He would not have had access to intelligence information at that stage nor would he ever have access to any medical records.

[15] Following upon Mr Masson's assessment by Mr Palmer, he was assessed by two nurses, namely Laura Connolly and Deborah Byrne. Both nurses gave evidence that it was a joint assessment with Nurse Connolly asking the questions in completing the healthcare risk assessment and Nurse Byrne completing the medical records. Both nurses had received training on the TTM protocol and stated that everyone within the prison does. Both were aware of how a person presents when suffering from withdrawal symptoms. Mr Masson was asked questions in the course of his assessment and observations were taken. Both nurses were satisfied by Mr Masson's answers and presentation and they concluded he was not currently suffering from withdrawal symptoms and that he was not at risk in terms of the TTM policy. Both nurses were aware that Mr Masson had a suicide attempt in August 2018. Nurse Connolly confirmed the typical signs of drug withdrawal and that the physical signs of withdrawal are difficult to mask and had Mr Masson displayed any such symptoms they would have been noted on the records. Nurse Connolly gave evidence about part 6 of the RRA which she completed on 4 December 2018

where she detailed Mr Masson's previous hanging attempt in August 2018, adding that he said that he was unsure why he did it and could not remember doing it. Nurse Deborah Byrne could not recall if the details surrounding the August attempt were provided by Mr Masson himself or if they were only taken from his records. The August incident had been flagged by a prisoner officer on the RRA and they would have looked that incident up on their records system. She added that the August attempted suicide would not constitute an alarm bell in itself. Self-harm is common in a custodial setting and they assess each individual as they find them. She indicated that at the RRA the assessment is based on how the prisoner presents at that time and not how they presented five months previously and in their assessment they look at the whole picture. The nurses look out for cues and clues such as poor eye contact, agitation. Both nurses stated they would have no hesitation in placing someone on TTM if they felt it appropriate and they have, in the past, come across situations where a prisoner has not been truthful during the RRA and in that scenario they would place them on TTM. Nurse Connelly considered TTM better than its predecessor given its flexibility.

[16] Dr Suchitra Senthil saw Mr Masson at 0903 hours on 5 December 2018. She assessed Mr Masson as part of the admissions process where a new prisoner is required to be assessed by a GP within 24 hours of their admission. She gave evidence that her assessment took place after Nurse Stewart's assessment. She explained that she assessed Mr Masson for risk factors including whether he had any signs of withdrawal symptoms and observed his behaviours and attitude. She had been trained in the TTM protocol. She explained how she would carry out a mental health assessment. This included establishing a rapport with the patient, asking how the patient was, assessing how comfortable they were, monitoring their speech and its content and asking

directly about mental health. She documented that Mr Masson had good eye contact and slow speech. She considered that he was conversing normally and he co-operated with the assessment. At the time of her assessment she did not consider Mr Masson to be on TTM and based on her observations she did not consider that he was at risk. She could see no signs of withdrawal. She recorded that Mr Masson had told her that he had last had Valium, heroin and methadone two days beforehand. At that point she did not have access to prison records to ascertain whether that information was accurate or not which it. She also recorded that Mr Masson was smelling of alcohol but could not recall if she acted on this.

[17] Dr Senthil explained that she followed the opiate withdrawal protocol and prescribed Dihydrocodeine and Diazepam to alleviate any withdrawal symptoms until his methadone prescription was confirmed. This prescription was being used as a stop gap until the methadone prescription was confirmed. Dr Senthil was aware that the prison was awaiting confirmation of the methadone prescription from an outside prescriber. She thought it was important to recommence Mr Masson on methadone as quickly as possible and as soon as she received confirmation of that prescription she would have prescribed him methadone, albeit at a reduced rate of 30/40 ml of methadone once it was clarified that he had received his last dose on 29 November 2018. Dr Senthil never received confirmation of the existence of the prescription. She could have prescribed methadone immediately had she been made aware of the prescription. She did not believe that Mr Masson was at risk and she did not place him on TTM.

[18] On 21 May 2019 Dr Senthil provided the police with a statement about her dealings with Mr Masson. Within that statement it was noted "Because of what he told me, he was already on Talk to Me, a protocol for someone of concern. Usually if someone is on this, the prisoner will be

on 15 minute observations and the mental health team would come and speak to him." In evidence Dr Senthil stated that during the assessment she did not believe that Mr Masson was on TTM. At the time that she was to give a statement to the police, she was working in HM Prison, Barlinnie and was told by a nurse that she would have to go to the health centre to get paperwork as she was going to be asked for a statement. This had not been arranged in advance. She confirmed that she had signed every page of the statement. On 23 May 2019 she sent an email to the police indicating that she wished to make an amendment to her statement that she gave on 21 May 2019 to clarify that Stephen Masson was not put on TTM during the admission process of 5 December 2018.

[19] On 5 December 2018 Stephen Masson was assessed by addictions nurse Nicole Stewart who provided evidence to the Inquiry by affidavit. She did not know the precise time that she saw Mr Masson. She discussed his drug use and obtained blood and urine samples and assessed his physical and mental health. She was of the view that he presented well, was happy to be back in prison, was not suffering from withdrawal and denied any thoughts of suicide. She was aware of his previous suicide attempt but did not discuss it with him and did not check the circumstances of the suicide attempt because there is not a computer in every assessment room. She advised that Mr Masson knew the process for obtaining methadone and that confirmation had to be received before it was prescribed. She had recorded Mr Masson's last dose of methadone being 3 December 2018 and that he had last taken heroin and Diazepam on 2 December 2018. This information must have come from Stephen Masson and was incorrect.

[20] At 0832 hours on 5 December 2018, Margaret Millen, in her role as administrative assistant, sent an email to Hunter Street Homeless Addictions Team requesting confirmation of

Mr Masson's methadone prescription. At 1025 hours that day, Enrico Quaradeghini, in his role as Senior Addictions Worker at Hunter Street Homeless Addictions Team, replied to Ms Millen's email providing confirmation of the methadone prescription. In her statement to the police, Margaret Millen stated that there should be a hard copy of the reply within the prison medical records, but there is none. Confirmation of the prescription does not appear to have been brought to Dr Senthil's attention.

[21] Between 4 and 6 December 2018 Mr Masson was allocated to D Hall, which is a hall mainly designed for new prisoners coming into the prison. At some time between 1300 and 1330 hours on 6 December 2018, Martin McGrory, a prison officer, received an intercom call from Mr Masson who was enquiring about when he would receive his methadone. Officer McGrory checked with the health centre but was advised that Mr Masson was not on the list to receive any methadone that day. After around 20 to 30 minutes Mr Masson again used the intercom enquiring about his methadone and was advised by Mr McGrory that he was not on the nurse's list for medication that day. Officer McGrory was trained in TTM and stated that he had no reason to believe that Mr Masson was at any risk. He was not aware of the incident from August 2018, but even if he had been, he would still have told Mr Masson he was not on the methadone list that day.

[22] At around 1555 hours Mr McGrory was conducting visual checks on prisoners when he observed Mr Masson to be on his knees within his cell facing away from the door. Upon opening the door he saw that Mr Masson had a ligature round his neck and attached to his bunkbed. He raised a code blue for assistance and other prisoner officers and medical staff attended. They cut

the ligature from Mr Masson's neck but noted there was no sign of life. Life was pronounced extinct at 1605 hours.

Expert evidence

Police Inspector Gary McKenzie

[23] This officer gave evidence as an expert on police custody procedures and had prepared a report in relation to this Inquiry which he adopted. He confirmed that initially the vulnerability questions (Crown production 4 pages 62-66) were not answered by Mr Masson on processing due to his demeanour and intoxication. As a consequence he was assessed as high risk and placed on CCTV observations. The vulnerability assessment was answered later that day and Mr Masson's condition was monitored and continually reviewed. Detail on the records system did not accurately reflect the known risks referring only to demeanour and behaviour. The information on Mr Masson's previous depression, drug and alcohol addiction and withdrawal was not noted but was available for those assessing him. He was referred to the health hub. While it might be good practice for these risks to be noted on the records system they had no impact on the action taken and the referral showed that the information was acted upon. Mr Masson was seen several times by medical staff whilst in police custody and was treated for alcohol and drug withdrawals. He described the process for obtaining methadone whilst in police custody. He advised that the police generally have to identify the pharmacy which is provided by the prisoner and then the police complete a Force Form 5:30:20 authorising the collection on their behalf by Police Scotland. It appears that attempts were made by the police to collect the methadone prescription on two occasions. The details of the officers dispatched and where they were dispatched to was not

noted. The lack of note had no bearing on what had occurred. Police Inspector McKenzie thought it in everyone's interests for a prisoner to receive their methadone prescription, if possible, whilst in police custody. When methadone cannot be obtained the patient will be referred to healthcare who can dispense an alternative.

[24] Police Inspector McKenzie gave evidence about the PER. He confirmed that this notes all known risks whilst in custody and the transfer of custody to third parties transferring the prisoner to court. The purpose of the form is to inform G4S of any issues with the prisoner and thereafter to inform the Scottish Prison Service of any issues should the prisoner be transferred there following court. In his opinion an electronic system would be better as it would allow more space to input relevant information and it would be available to the receiving party such as the prison in advance of the arrival of the prisoner. The carbon paper copy form is somewhat outdated and an electronic version would allow for the flow of information between the relevant agencies to be improved. Longer term audit and security of information purposes would also be improved. In this case the officers completing the PER assessed Mr Masson and the section on suicide/self-harm/bereavement was not ticked. That would indicate that Mr Masson was not considered at risk of these particular factors at the time the form was completed. It was noted on the PER that Mr Masson was suffering from withdrawals.

Philip Wheatley

[25] Mr Wheatley provided the court with two reports, namely Crown productions 17 and 18 which he adopted. He is currently working as a consultant on prison matters. He had significant experience within the prison service in England and was involved in developing suicide policy in

the English prison system. Whilst he accepted that he had exposure to medical issues he was not a medical expert. He gave evidence that at the time that he was involved in the English & Welsh prison service when they were looking to improve their own suicide policy that they reviewed the Act 2 Care system which was in place at the time in Scotland and they decided to lift and adopt that policy because they were so impressed with it. He was surprised that the system was changed in Scotland to TTM and he believed the old policy to be better in many respects. Under Act 2 Care prisoners could be assessed as being high risk or low risk and he believed that the removal of the low risk category resulted in staff concentrating on prisoners who are at immediate risk of suicide. In his view those who May have issues that could possibly lead to self-harm or suicide are no longer captured by the policy. He was of the view that this was evidenced by the staff who assessed Mr Masson when he re-entered custody in December 2018. He felt that significant weight was given to his presentation at that time and little consideration was given to his history or any other factors. No consideration was given to the similarities that May have existed between Mr Masson's state presenting in December 2018 when compared with his recent suicide attempt in August 2018. As a consequence of the current TTM policy he was of the view that the previous attempt of suicide was not explored in any detail. He also gave evidence that sometimes prisoners, who are aware of the policy, actively try to avoid engaging in it due to it being seen as a punishment. He said that the continued use of safe cells in Scotland was a contributing factor to that thinking. The previous policy, which is currently in use in England & Wales, focuses on prisoners' issues and it actively tries to engage them to identify and resolve issues before they escalate. He made various criticisms of the TTM system. As an example, he suggested that TTM omits key factors like the raised risk of suicide of those in prison

for the first time, and suggested that it did not stress the need to identify those who are anxious. In cross-examination he was directed to part 4 of the RRA (SPS production 3/12) which specifically requires officers to ask the question whether that was the person's first time in custody and also to comment on the prisoner's presentation throughout discussions including eye contact, mood, anxiety and anger. He confirmed that he had never worked in practice with the TTM policy. He was of the view that had Mr Masson's assessment taken place under the Act 2 Care system, as opposed to TTM, it was more likely that he would have been assessed as "at risk" and accordingly an appropriate care plan could have been put in place and the death avoided. Mr Wheatley was critical of the prescription of Dihydrocodeine (DHC) although ultimately stated he would defer to medical experts. He understood the prescription was being used as a detoxification from methadone (whereas the medical evidence was that this was only an interim measure until the methadone prescription was confirmed). He was critical of the fact that two different prison officers completed Mr Masson's RRA on 4 December 2018, although he confirmed that any issue over drug withdrawals was a matter for health care staff and not prison staff. Whilst he agreed that providing staff with as much information as possible carrying out the initial assessment is preferable, at the same time if too much information is provided it will not help the decision-making process. He was critical of the continued use of safe cells in Scottish prisons which he felt were overused in HM Prison, Barlinnie. He reviewed the TTM paperwork regarding the suicide attempt in August 2018 and, whilst there were different explanations given by Mr Masson for that attempt on his own life, he had explained at one point that he could not bear the pain from the methadone withdrawals. In his view, there was no detailed record in the TTM assessment to understand the earlier suicide attempt. In his view Stephen Masson was an

obviously vulnerable prisoner. A denial of being suicidal does not guarantee the prisoner will not commit suicide. He thought that due to the continued use of safe cells that May be a reason why someone might deny being suicidal. He drew parallels to the fact that the suicide took place when he was not receiving methadone. He was of the view that someone such as Mr Masson who had major problems with alcohol and drug addiction along with a recent attempt on his life whilst withdrawing from methadone, all increased his risk of suicide. He was of the view that too much weight was placed on the denial of being suicidal and not enough weight attached to the other known risk factors.

Dr Michael O'Keefe

[26] Dr O'Keefe is an independent forensic physician who prepared two reports for the Crown, namely Crown productions 19 and 22, which he adopted and supplemented with oral evidence. He gave evidence about the symptoms of methadone withdrawal which typically start to appear approximately 24 to 36 hours after last taking the drug and the duration of withdrawal varies from person to person. It could last anywhere from 2 to 3 weeks up to 6 months. He was of the view that even if Mr Masson was not displaying outward signs of drug withdrawal that did not mean he was not suffering from withdrawal. He gave various examples of the signs of withdrawal. He confirmed that substitute drugs could lessen withdrawal and reduce distress. There are numerous factors that can aggravate withdrawal, including the general state of health, whether dependent on other drugs and mental state. He considered that Mr Masson received a high standard of care within police custody. He confirmed that the sooner a prescription is resumed the better, regardless of whether the person is in custody, especially if they May have

been on methadone for many years as there May be severe psychological and physical dependency. Many patients cannot do without their methadone. Accordingly, as soon as confirmation of a prescription is available it should be prescribed at the earliest opportunity. He reviewed the TTM risk assessment upon entry at Barlinnie where Mr Masson was assessed as no apparent risk. He considered that any prisoner with a history of drug and alcohol dependence, who has a diagnosed psychiatric history of anxiety and depression, a documented history of previous recent suicide attempt by self-harming whilst in prison, who was suffering drug withdrawal symptoms, should be classified as a high risk vulnerable detainee. That assessment was carried out based on paperwork which he had reviewed. He thought the TTM assessment in December 2018 should have looked at the specifics of the August 2018 incident in assessing whether Mr Masson was at risk or not. His evidence was that it was vital that a thorough investigation of the earlier incident should have taken place in the December 2018 admission assessment. He accepted that to carry out an assessment you would have to consider the patient in front of the person at that time as opposed to basing it on previous incidents. It was important to find out how he was functioning at the time of the assessment but previous incidents should form part of the assessment in order to come to a sound, reasonable judgement. As far as the delay in prescribing methadone after confirmation was received at 1025 hours on 5 December 2018, he was of the view that this could have been a factor and that Mr Masson could have been more frustrated due to the delay in being provided his medication. Mr Masson asked for his methadone and May have been familiar with the process. He May have been expecting the drug so that could have been a precipitating factor in his ultimate decision to hang himself. He confirmed he would defer to the expertise of a consultant psychiatrist in this area. Under cross-

examination Dr O'Keefe accepted that he was not qualified to provide expert testimony in nursing assessments. A key component of his report in evidence had been that Mr Masson was suffering from drug withdrawal symptoms, which none of the clinicians assessing Mr Masson in the prison had identified. Ultimately he conceded that there was nothing from the assessments to suggest that Mr Masson was suffering withdrawal and he accepted he was not in a position to second guess the assessments or clinical judgment of those who actually met with Mr Masson. His report had been based on papers provided and his understanding of the position at that time. He had not heard the evidence of the clinicians and was unfamiliar with one of the terms used within the records which related to an electronic record of prescribing.

Siobhan Taylor

[27] Ms Taylor is the policy lead in national suicide prevention strategy in Scottish Prison Service. She has worked operationally with TTM since its inception and has been involved in reviewing the policy. She previously also was involved working with Act 2 Care before implementing TTM and was involved in the review of Act 2 Care policy. She explained the various agencies who were involved in reviewing that strategy including expert mental health persons from the NHS and organisations such the Samaritans. The TTM strategy, guidance (part 1) and guidance (part 2 – revised December 2019) were all provided to the court and referenced. The TTM strategy introduced a concern form which sets out the procedure to follow on receipt of information that a person in custody is distressed. She explained how anyone can fill out a concern form for a prisoner. It can be from someone outwith the establishment highlighting a concern or it can be social work, family, the prisoner or any other source. Where self-harm is

identified as a method for coping or release it May not be appropriate to place the individual on the suicide prevention strategy. The individual May be better supported through referrals to appropriate services such as the mental health team for counselling. This process allows for recording of concerns and appropriate action or referrals May include the initiation of being placed on TTM but the system allows for flexibility which was not available under the previous system. She explained how TTM was no longer going to use the high or low risk assessment from Act 2 Care and that the assessment is now at risk or no apparent risk. The reason for that is that it was difficult to decide if the risk was high or low. People tended to default by going for high risk which then meant people were relocated to safe cells. Now if they are simply assessed as Maybe at risk then this allows staff to take a more personal view and explore any suicidal thoughts as well as a safety plan. It is a more flexible way for keeping them safe and to deal with what is causing the prisoner distress. Nowadays if a prisoner is placed in a safer cell then the unit manager must review the position within seventy-two hours. She went through the assessment process and care. Care would not focus exclusively on crisis. They tried to deal with concerns at a lower level and encourage prisoners to tell them even minor or trivial things. She gave examples such as where a prisoner May have no money and be distressed about being unable to make a phone call or when a visitor did not attend a visit and that May cause distress. They have attempted to design a supportive environment and regime and encourage people to raise any concerns. They will try to resolve any issues causing distress or upset but that does not automatically require a referral to TTM. She gave evidence about the training that every member of staff receives. In respect of the use of safer cells she explained that these should only be used in exceptional circumstances and specific reasons have to be identified and reviewed in order that

the prisoner is returned to the mainstream population as quickly as possible. The current TTM policy recognises the potentially negative effect that safe cells can have although on occasion they are necessary. She explained the prevention of suicide in prison means everyone coming into custody is assessed. If someone is placed on TTM that there would be a case conference to examine the reasons for that and to explain the review process to the prisoner. She explained the cues and clues that staff are taught to look for to include the verbal signs and non-verbal signs. A person saying they are not suicidal does not necessarily mean they will not be placed on TTM. She thought the RRA May be completed by two officers in certain circumstances such as where there was a large influx of prisoners. It May be more efficient to have some of the factual information completed prior to the assessment. For example, parts 1 and 2 could be completed when it was known that an existing prisoner was returning from court later that day but she would expect the officer carrying out the assessment to familiarise themselves with the information which was completed by the first officer and take account of the PER and the prisoner's PR2 record. She confirmed that in terms of the current review of TTM will consider making it clearer where certain parts were completed by different officers. There is currently a review of TTM taking place as they are constantly trying to review and improve the system. In cross-examination she confirmed that if someone had a number of issues, but was not thought to be at immediate risk of suicide, then a concern form could be used. A prisoner could be placed on the TTM strategy whether they were at immediate risk or not. She confirmed that the Death In Prison Learning, Audit & Review (DIPLAR) is the joint SPS and NHS process for reviewing all deaths in custody and provides a system for recording any learning and identifying actions. The purpose of TTM is not simply to identify those at risk of suicide and not only to look at crisis but

to have early intervention. The policy is not weighted towards those most at risk. That was never the intention of the policy nor had they ever had that feedback. She confirmed that they would not have a system which would automatically place someone on TTM because of an attempt on their own life some months earlier. Suicidal ideation four months beforehand would not necessarily mean they were suicidal at that time. It was appropriate in her view to assess the prisoner at the time of their entry into the prison.

Dr John Callender

[28] Dr Callender is a consultant psychiatrist and had the role of associate medical director for NHS Grampian Mental Health Services. Part of that role was to review all critical incidents that occurred in their service, most commonly death by suicide. He established their critical incident review procedure and retained lead responsibility for it until 2014. A substantial proportion of those deaths occurred in patients whose main problem was abuse of alcohol and/or drugs. He had the benefit of not only having access to the paperwork but he was provided with a note of the evidence from witnesses at the Inquiry. He prepared a report which he adopted in evidence. In his opinion the assessment of suicide risk in the course of Mr Masson's final admission to HM Prison Barlinnie was thorough and conscientious. It is possible that delay in administration of methadone made some contribution to his decision to end his life. However this was only one of a range of factors that could have predisposed to, and precipitated his suicide. It is unlikely that this delay was either the sole, or a major factor in the creation of this tragic outcome. He had no criticisms to offer in relation to the assessment and treatment of Mr Masson in the course of that admission to the prison. He could find no fault with the assessment and care offered following

his admission, or of the judgements formed by the clinicians who assessed him. Mr Masson was assessed by several experienced clinicians, all of whom knew him from previous admissions. Their findings in relation to suicide risk were consistent with each other and he did not believe that Mr Masson's suicide could have been predicted or prevented. He felt it was too simplistic to think that because he had no methadone prescribed in August 2018 that the same circumstances precipitated the actions several months later because there were significant differences between the two treatments he was receiving. In his assessment by the medical practitioners, they explained how they carried out the assessment to establish rapport, assessing speech and asking about his mental health, and seeing that he was co-operating. In the August 2018 suicide attempt he had been removed from his methadone prescription for two days and had received no replacement prescription to alleviate withdrawal symptoms. In December 2018 he was prescribed Dihydrocodeine. Dr O'Keefe stated that the doses prescribed were appropriate with the guidelines and that the risk arising from withdrawal would be mitigated. At the time of death, he was six days into withdrawal, and seven missed doses of methadone was unlikely, in his view, to be a significant factor in his suicide. Also in relation to the August 2018 incident, Mr Masson gave a variety of explanations. He does not appear to have shown any signs of withdrawal in Barlinnie in December 2018. In his ultimate suicide, it is not possible to say what the significant factors were as there can be many number of factors. When commenting on Dr O'Keefe's evidence, he was of the view that the diagnosed psychiatric history of anxiety and depression is less certain. Mr Masson had a mental health assessment in August 2015 at which point a consultant psychiatrist said that at that moment his presentation did not suggest a depressive illness although there was some anxiety which appears to be part of his personality

make up. No psychiatric treatment was proposed and no follow-up offered. He was of the view that it was a non-specific condition. He conceded that in the course of being examined by the nurses, when he was swearing and said to be abusive, repeatedly stating he was not suicidal, that could possibly be an indicator of withdrawal or at least could be a contributor to that behaviour. Whilst Mr Masson gave three different explanations for the August 2018 attempt on his own life, Dr Callender would give the most credence to the methadone withdrawal. In summary, he was of the view it is impossible to know with any certainty what led to Mr Masson's final act. It is possible that delay in administration of methadone played some role, but there were other possible precipitating factors such as the effects of withdrawing from alcohol and benzodiazepines. There are longer term factors which might have contributed to his death. He was a chronic alcoholic and drug abuser. He was said to have been homeless. He had poor self-care and under nutrition which would have taken a growing toll on his physical and mental health and there could have been a degree of cognitive impairment from traumatic brain injuries, vitamin deficiencies and the impact of alcohol on the brain.

Submissions

[29] The Crown submitted there were defects in the systems of working which contributed to the death of Mr Masson. The withdrawal from and non-prescription of methadone was a factor in in his suicide. He raised the provision of methadone in police custody, with the prison and medical staff and in his final interactions with the prison officer. Several witnesses stressed the importance of administering prescribed medication, in this case methadone, at the earliest opportunity. Dr Callender stated the reason for somebody getting back on their prescription was

to stabilise the situation. There had been a recent suicide attempt. Dr Callender accepted it is possible that the delay in administration of methadone May have made some contribution to the decision to end his life. He also stated that there is an obvious similarity between Mr Masson's attempted hanging in August 2018 and the lethal hanging four months later in that both occurred at times when he was in prison and had not been receiving his usual dose of methadone although Dr Callender also pointed out relevant differences. Accordingly it is possible the non-prescription of methadone was a factor along with other factors. The Crown pointed out the only two serious attempts he made on his own life were when methadone had been withdrawn from him. As far as the August 2018 attempted suicide was concerned, although he provided several explanations why he did what he did, the most likely one accepted by Dr Callender was the explanation that he was trying to kill himself because he could not deal with the pain of withdrawing from methadone. In those circumstances it was submitted I should accept the evidence of Dr O'Keefe, who believed Mr Masson should have been recognised as a vulnerable prisoner and classified as at risk and placed under special observations until such times as his methadone prescription was provided.

[30] The Crown submitted that the assessment carried out by Mr Palmer was inadequate, not only in how it was carried out, but also the process that was followed. By splitting the assessment between two different officers, the opportunity to identify that Mr Masson was at risk was compromised. Had Mr Palmer carried out the entirety of the assessment form he would have placed him on TTM. In particular the Crown submitted that the operation of the TTM policy was primarily concerned with whether the individual is at immediate risk of suicide rather than whether he was someone at risk. He also submitted that Dr Senthil believed that Mr Masson was

already on TTM. By staff failing to place him on TTM, this was a precaution that could reasonably have avoided his death.

[31] The Crown submitted there were defects in the system of working in that there was no failsafe system in place relating to the prescription confirmation process. The process seems to be that administrative staff would print out the prescription confirmation and place the form in a drawer which would then be checked by addiction nurses. There appeared to be no system that legislates for the hard copy form being misplaced or going missing. Dr Senthil gave evidence she did not receive the confirmation. Some 29 hours passed between confirmation arriving and the death of Mr Masson. Had a system been in place where he was provided with opiate replacement, the death May have been avoided and accordingly the defect in the system contributed to the death.

[32] The Crown submitted that the removal of the low risk category on the TTM assessment resulted in staff concentrating on prisoners who are at immediate risk of suicide and that those who have issues that May lead to self-harm or suicide are no longer captured by the policy. In their submission, significant weight was given to Mr Masson's presentation at the time of the assessment and very little or no consideration or review was carried out regarding his history or other factors. As a result no-one explored the recent suicide attempt in August 2018. In the circumstances, the Crown invited recommendations that a system is introduced for the prescription confirmation process to ensure that no confirmation is left unattended for a reasonable period of time; that consideration is given to amending the TTM policy to reintroduce low and high risk categories; the practice of pre-populating the admission assessment form is stopped and that the same officer who reviews the paperwork should be the person who carries

out the assessment; and finally, further training is provided to all staff to ensure that more weight is attached to prisoners' history and other risk factors as opposed to how they present at the time.

Submissions on behalf of the Chief Constable, Police Service of Scotland

[33] It was submitted that, in general terms, findings require a causal connection to the death to be established and it is generally accepted that the expression "might have been avoided" envisages not a "probability" but a real or live possibility the death might have been avoided by the reasonable precaution. It was submitted there were no precautions that could reasonably have been taken by the Chief Constable of the Police Service of Scotland. There was no criticism made of the Police Service of Scotland in respect of their treatment of Mr Masson other than that certain records might have been better kept, but these had no bearing on his ultimate death. I was accordingly invited to make no recommendations relative to the Chief Constable.

Submissions on behalf of Scottish Prison Service

[34] It was submitted that the assessments of Mr Masson in HM Prison, Barlinnie were consistent, thorough, reasonable and appropriate. It was submitted that ultimately Dr O'Keefe accepted that Mr Masson had been subject to a more thorough examination than he originally thought from what appeared on the documents. That was supported by Dr Callender who could see no fault with the assessment or care offered and did not believe Mr Masson's suicide could have been predicted or prevented. As far as Mr Palmer's involvement was concerned, notwithstanding the partial completion by another officer, when he came to complete parts 4 and 5 he would have had access to the completed parts 1 – 3 of the RRA, to the PER and to

Mr Masson's PR2 record. His recollections at the Inquiry were several years after completing the form. As far as there was any criticism of the TTM policy, it was made by someone with no first-hand experience of the policy and that the policy does deal with those at moderate risk or in distress and that there is a concern form process. It was submitted that the evidence from Ms Taylor was that a prisoner who would have been assessed as low risk under Act 2 Care would be likely still to be assessed as at risk under TTM. There was no reasonable basis to conclude that Mr Masson was more likely to have been assessed at risk had the assessment been under the old system rather than TTM. There was no evidence to suggest any causal link between the issues mentioned by Mr Wheatley and the death. The use of safer cells had no causal link in this case and in any event safer cells are only used in exceptional circumstances. In the circumstances they sought no findings other than formal findings.

Submissions on behalf of the Prison Officers' Association Scotland

[35] It was submitted that when looking at whether any precautions could reasonably have been taken there must be a real or live possibility that the death might have been avoided by the reasonable precaution. Causation has a role and there must be a causal link with the death. It was submitted that the Inquiry heard no evidence which May suggest there existed a live possibility that Mr Masson's death May have been avoided. None of the witnesses involved in his care within the prison identified any sign of drug withdrawal. When placing someone on TTM that must be a reasonable step to take and it should only be done if merited by the situation. Mr Masson was assessed by Officer Palmer and thereafter Nurses Connolly and Byrne he was then assessed the following day by Dr Senthil and gave no cause for concern. It was said it would

be difficult to justify placing Mr Masson on TTM based on the assessments carried out. Staff indicated they would not hesitate to instigate TTM if they felt it appropriate but he simply did not present as somebody at risk. Even if he had been placed on TTM on 4 December 2018, there is nothing to suggest he would have remained on it by the point he committed suicide on 6 December as there were no identifiable risks. It was suggested that the system of working in respect of the assessment for TTM did not contribute to the death. Every member of staff had been trained on TTM. It was submitted that the reception process had not been shown to be defective and accordingly they sought only formal findings.

Submissions on behalf of NHS Greater Glasgow & Clyde

[36] In so far as medical personnel are concerned, Mr Masson was assessed by Nurses Laura Connolly and Deborah Byrne, Dr Suchitra Senthil and Nurse Nicole McRobbie and none of them regarded Mr Masson as being at risk of suicide. They all gave evidence of how they carried out the assessment and they saw no signs of withdrawal. Mr Masson did not give cause for concern and he was not considered to be suffering from opiate withdrawal. Criticism was made of witness Philip Wheatley who gave evidence on medical matters that were outwith his expertise. Dr O'Keefe conceded the assessments carried out were reasonable and that he was not in a position to second guess the assessments. It was submitted that it cannot be said that placing Mr Masson on TTM would have constituted a reasonable precaution. Even if he had been placed on TTM there was no evidence that these measures would have been continued and it was submitted the court cannot conclude that it might have avoided Mr Masson's death. In respect of the provision of methadone, it was agreed that confirmation was received of the methadone

prescription at 1025 hours on 5th December 2018 and that there should have been a hard copy of the reply forwarded to Dr Senthil. She was never advised of this and the court can draw the inference that the prescription confirmation was not brought to her attention. Dr Callender's evidence was commended, in particular, where it came into conflict with other evidence. It was submitted that any delay that existed was not a significant or decisive factor that led to Mr Masson's death but was "of no more than marginal significance". His death could not have been predicted or prevented. There were significant differences between the August 2018 and December 2018 incidents, in particular the replacement opiate replacement therapy prescribed in the December 2018 events which ultimately Dr O'Keefe accepted were appropriate. In all of the circumstances it was submitted that it was not possible to say what the significant or decisive factors were which precipitated Mr Masson's suicide in December 2018.

Submissions on behalf of next of kin, Emma Masson

[37] It was submitted on behalf of the family that there were precautions that could reasonably have been taken and had they been taken Mr Masson's death would have been avoided. He had serious long-term addiction issues to both alcohol and drugs and had a history of self-harm, in particular the incident from 5 August 2018. Although he had given other explanations he had stated that he wanted his pain to stop as he was experiencing withdrawal from methadone and he expressed anger at being taken off his methadone by the prison doctor. During his time in police custody he did not receive his methadone but was prescribed Dihydrocodeine. Upon his attendance at HM Prison, Barlinnie on 4 December 2018 it was noted by Prison Officer Richard Palmer that Mr Masson was suffering drug withdrawal. When Mr Masson had the nursing

assessment with Nurses Connolly and Byrne he was asked about his methadone and was told by Nurse Connolly that processes had to be gone through first. On 6 December 2018 when he spoke with Officer Martin McGrory, he was asking about his methadone prescription and in the second call was told that he would not be receiving methadone that day. Confirmation of his methadone prescription had been available for more than 27 hours. It was submitted on behalf of the family that any prisoner who had a history of drug and alcohol dependency, who is homeless and has a history of deliberate self-harm and suffering from drug withdrawal should be classified high risk and should automatically be placed on TTM. They were critical of the delay in prescribing methadone after confirmation had been received. It was submitted that had Mr Masson been placed on TTM and/or provided with his methadone then this might realistically have resulted in Mr Masson's death being avoided. It was submitted that there was a defect in the system of work by failing to prescribe methadone after receiving confirmation of his prescription and that this delay contributed to his decision to take his own life.

Conclusion

[38] The first issue for me to determine was whether the fact that Mr Masson was not receiving his prescribed methadone had any causal link to his death. Several witnesses stressed the importance of administering medication, in this case methadone, at the earliest opportunity. Dr Callender stated the reason for somebody getting back on their prescription was to stabilise the situation. I accepted evidence from Dr O'Keefe about the length of time withdrawal from methadone can last. The prescription of Dihydrocodeine might alleviate the symptoms. I accepted Dr Callender's evidence in full. Dr Callender accepted it is possible that the delay in

administration of methadone made some contribution to the decision to end his life. In his opinion it was unlikely to be the significant or decisive factor. However, it has to be recognised that most, if not all of the other suicide risk factors were ordinarily present for Mr Masson. There is an obvious similarity between Mr Masson's attempted hanging in August 2018 and the lethal hanging four months later in that both occurred at times when he was in prison and had not been receiving his usual dose of methadone. There were differences between the two incidents, in particular the prescription of Dihydrocodeine in December 2018. I accepted Dr O'Keefe's evidence that there May be severe psychological and physical dependency if methadone is not provided over a prolonged period, especially if someone such as Mr Masson has been prescribed it for many years. The only two serious attempts on his life by Mr Masson took place when he was not receiving his methadone prescription. As far as the August 2018 attempted suicide was concerned, although he provided several explanations why he did what he did, the most plausible explanation was that he was trying to kill himself because he could not deal with the pain of withdrawing from methadone. Mr Masson asked for his methadone at the police station, when he first arrived at Barlinnie and repeatedly requested his methadone on the day of his death. I accept there were other factors which will have been involved in his decision making process but I do not consider that the non-prescription of methadone played no role in his decision making process to end his life. Accordingly, on a balance of probabilities, the non-prescription of methadone was a contributory factor in Mr Masson's decision to end his life along with other factors.

[39] Confirmation of the prescription was not available on the NHS system. Nurse Connelly completed the opiate substitute confirmation form on 4th December 2018 in order that the

prescriber would be asked for confirmation the following morning by the addictions team. That form (Crown Production 9 page 235) is from the Health Centre, HM Prison Barlinnie. It is headed as follows –

" Methadone, Subutex, Suboxone, Naltrexone Confirmation Form

URGENT – SAME DAY REPLY REQUIRED"

The form was signed by Mr Masson. The urgency of the confirmation is obvious from the form heading. At 0832 on 5th December 2018 the request for confirmation of Mr Masson's prescription was emailed to Hunter Street Homeless Addictions Team and a response was received that morning at 1025 hours providing confirmation of the prescription. Ordinarily that confirmation would be printed out by administrative staff and given to an addictions nurse for checking before being provided to the doctor to provide the prescription. In this case it is not clear at what stage of the process the system broke down but the confirmation was never provided to Dr Senthil, who would have provided the prescription immediately had she been aware of the confirmation. Confirmation of his methadone prescription had been available for almost 30 hours prior to Mr Masson being discovered hanging in his cell. There was no system in place to confirm whether the confirmation had been received or passed to the relevant personnel. This is despite the form specifying the urgency of the confirmation. It is clear there should have been a robust system in place before the end of each day to ensure that confirmation had been received and that a prescription was in place and medication being received by the patient. There does not appear to be a system in place to deal with a hard copy piece of paper being misplaced. The system did not include forwarding the email confirmation of the prescription to all interested parties such as the addictions nurse and the prison doctor. In my view, had such a system of checking the

prescription for methadone on the day of the request for confirmation been in place, then Mr Masson would have been provided with his methadone prescription and this might realistically have resulted in Mr Masson's death being avoided.

[40] It was clear from various sources that it is important that patients of the NHS should receive their prescription drugs as soon as possible for reasons already set out. It is clear on at least two occasions when Mr Masson was in police custody that police officers were dispatched to try to obtain confirmation of his prescription. Had they done so he would have received methadone. It appears to me that resources are being used up trying to obtain confirmation of prescriptions because the NHS do not have access to them. There does not appear to be any good reason why any organisation or body prescribing medication to their patients or clients should not register medication that is prescribed with the NHS and similarly register when a prescription is stopped. Had such a system been in place then NHS staff in both the police station and prison would have had immediate access to that information and would have been able to continue the prescription immediately. In the circumstances I recommend that such a system should be developed in order that patients have immediate access to the medication they require. Currently NHS staff May be unable to obtain confirmation because prescribing agencies May be closed due to time of day or holiday periods. Developing such a system would be in the best interests of the patient and accordingly I recommend such a system should be put in place.

[41] There were various issues raised in respect of the Talk To Me assessments and the policy itself. I will deal firstly with the assessment of Mr Masson by Richard Palmer. Mr Palmer was giving evidence in August 2022 about an assessment for Talk To Me he carried out in December 2018. He had been working on reception for around 7 years. These Talk To Me assessments are

carried out on everyone entering the prison. Unsurprisingly, after this length of time his memory of the assessment was vague. In respect of the Reception Risk Assessment he confirmed that he had not completed Parts 1 and 2 of the form. He could not recall who had completed those sections. He stated this would have been completed by a fellow officer at the front desk and then handed to him to carry out the Talk To Me assessment. His normal process would be to consult both the Prisoner Escort Record (PER) and the Prisoner Record Database (PR2). The latter would detail previous involvement with discipline reports and prior involvement with Talk To Me. He could not remember specifically reading these nor the terms of the conversation for the assessment. Mr Masson appears to have been processed at the front desk at 1832 hours on 4th December 2018 and the assessment by Mr Palmer concluded at 1855 hours. Contained within the PR2 (page 181 of the productions) was the entry relating to the incident on 6th August 2018 which set out that Mr Masson was found unresponsive in his cell with a ligature round his neck. The PR2 did not record any reason for that attempted suicide. Mr Palmer could not recall this document. Certainly on the Talk To Me assessment document there was reference to this previous incident in August 2018. Although Mr Palmer conceded that if he had known that the incident in August 2018 had been associated with withdrawal from methadone and that in December 2018 he had not received methadone he May have reached a different conclusion in his assessment. However, the only way he could have known that information would have been if Mr Masson had volunteered it as that information was not contained in the PR2 and Mr Palmer did not have access to Talk To Me documents from August 2018. Mr Masson did not disclose that the August 2018 attempt on his life was linked to the non-provision of methadone during his nursing assessment immediately after Mr Palmer's assessment. From the assessment paperwork

that was completed he summarised the interview as "custody unexpected, no thoughts suicide/ self-harm". He therefore must have spoken to him regarding those matters. On commenting on his presentation he noted "suffering drug withdrawal otherwise communicated well. No concern".

[42] That assessment was supported by Nurse Connelly who completed the following page of the Talk To Me document under the "Healthcare Risk Assessment". Her notes were contemporaneous with the assessment of 4th December 2018. The first part of the section she completed related to an assessment of behaviour, attitude and risk. The section continued:-

> "As part of the assessment the nurse should consider if the individual has any current or previous mental health issues including treatment and psychological support. The health care professional should determine if the individual has previously attempted suicide or self-harm or if they currently have any thoughts of suicide or self-harm".

She noted on the form:-

> "Depression and anxiety diagnosed by psychiatrist years ago. Attempted hanging in August 2018. States unsure why and reports can't remember doing it. Strongly denies any thoughts of self-harm or suicide at this time."

In the section where she had to comment on his "presentation throughout discussions considering eye contact, mood, anxiety or anger (list not exhaustive)" she recorded

> "Conversing well. Good eye contact maintained. Denies any thoughts of self-harm and suicide at this time."

[43] In the circumstances I am satisfied that Mr Palmer carried out a proper assessment under Talk To Me. His findings were consistent with all of the other assessments carried out on Mr Masson. I consider that it should be made clear in training that the person who carries out the assessment must have read the PR2 and PER as there May be important information contained within these documents to allow a proper assessment to take place. I consider that the assessment

documentation makes it clear that staff are looking for more than just an immediate risk of suicide. I do not find any causal link between the assessment by Mr Palmer and the death of Mr Masson.

[44] In respect of his initial Talk to Me assessment and medical assessments on 4th and 5th December 2018 Mr Masson was seen by four medical practitioners. Nurses Connolly and Byrne assessed him on his initial reception to the prison. The following day he was seen by Nurse Stewart and then by Dr Senthil. All four assessed that there was no cause for concern at the time he was seen by them. None of them regarded Mr Masson as being at risk of suicide. I did not find that Dr Senthil thought Mr Masson was on Talk To Me at the time of her assessment but rather that at the time she gave her statement she erroneously stated he was subject to Talk To Me. That statement was given several months after her assessment and she quickly corrected that error. I accepted her explanation that she had not expected to have to give a statement on the subject on the day she was asked to do so. I found all of the assessments consistent, thorough and appropriate. Dr Callender could see no fault with the assessments carried out by the medical staff and I accepted that evidence. There was no identifiable reason to consider placing him on Talk To Me at the time of those assessments. None of the medical practitioners considered that he was suffering opiate withdrawal. In those circumstances I have no criticism of the medical assessments carried out and do not consider in light of those that placing Mr Masson on Talk To Me would have been a reasonable precaution.

[45] Criticism was made of the change of policy from Act 2 Care to Talk To Me by Mr Wheatley. He believed the current policy was primarily concerned with whether the individual is at immediate risk of suicide rather than whether he was someone at risk. It was suggested that

the removal of the low risk category from that which applied to Act 2 Care assessment resulted in staff concentrating on prisoners who are at immediate risk of suicide and that those who have issues that May lead to self-harm or suicide are no longer captured by the policy. The Crown submitted that significant weight was given to Mr Masson's presentation at the assessments and very little or no consideration or review was carried out regarding his personal history or other factors and as a result no-one explored the recent suicide attempt in August 2018. In my view that is not borne out by the Talk To Me assessments nor the paperwork lodged in respect of Talk To Me policy. It is clear that Mr Masson was asked about his suicide attempt from August 2018 and gave an explanation regarding that incident. He May not have been entirely forthright about the reasons behind that but staff can only proceed on the information provided. On the basis of Mr Masson's presentation at the assessments and the information provided to the staff by him I can see no reason to find that staff erred in failing to find him at risk because he had attempted suicide on an earlier occasion months prior to his assessment.

[46] Miss Taylor gave evidence about the reasons for changing the Act 2 Care policy to Talk To Me. The review took the views of prisoners and prison governors along with thirty two multi-disciplinary experts ranging from the Associate Medical Director for mental health, the head of the Government's Mental Health Improvement Unit, NHS providers and agencies such as the Samaritans, Families Outside and Breathing Space. A full review is currently ongoing as five years have passed since it was first implemented with a view to ascertain if improvements can be made. As far as Talk To Me operates in practice, I accepted Ms Taylor's evidence that caring for those most at risk does not focus exclusively on crisis. One of the main changes introduced by the new policy was the Concern Form process. This is completed when a prisoner May be in distress

or if there are concerns about a prisoner's mental health, behaviour or risk. The information can come from anywhere including family and outside agencies. This results in a multi-disciplinary meeting to assess and address the problem. It does not automatically result in a prisoner being placed on Talk To Me but that is an option along with providing assistance from other support networks such as mental health professionals or addiction workers. The current system was designed to allow more flexibility within the process. I accepted the evidence that the concern form allows for those not at immediate risk of suicide to be referred to the Talk To Me programme without being at immediate risk of suicide.

[47] The Crown submitted that consideration should be given to amending the Talk To Me policy to reintroduce low and high risk categories and further training should be provided to ensure that more weight is attached to prisoners' history and other risk factors as opposed to how they present at the time. I do not accept that such reform is either necessary or appropriate. As far as there was criticism of the Talk To Me policy, it was made by someone with no first-hand experience of the policy, who thought that the policy does deal with those at moderate risk or in distress. However, the evidence from Ms Taylor was that a prisoner who would have been assessed as low risk under Act 2 Care would be likely still to be assessed as at risk under Talk To Me. There was no reasonable basis to conclude that Mr Masson was more likely to have been assessed as at risk had the assessment been under the old system rather than Talk To Me. I was never provided with a copy of Act to Care policy, but it appears to me that Talk To Me takes account of those at any sort of risk rather than trying to assess the level of risk. There was no evidence to suggest any causal link between the issues mentioned by Mr Wheatley and the death. He was critical of the level of use of safer cells. I had no figures to compare the use of safer cells at

HM Prison Barlinnie with any other prison and I am therefore unable to comment on the level of use of safer cells in 2018 nor indeed more recently. There was no causal link between the use of safer cells in HM Prison Barlinnie and the death of Mr Masson.

[48] It was submitted by the family that any prisoner who had a history of drug and alcohol dependency, who was homeless and had a history of deliberate self-harm and suffering from drug withdrawal should be classified high risk and should automatically be placed on Talk To Me. I can understand, with the benefit of hindsight, why the family would wish such a finding in particular as they will still be grieving. In respect of the previous suicide attempt in August 2018, different explanations were given by Mr Masson for that attempt. Whilst I can conclude on a balance of probabilities on the evidence what I consider the most likely reason behind that attempt at suicide that was not an assessment open to staff at the time. An explanation was given to those assessing him in December 2018. Dr Callender's evidence, which I accepted, was that it was impossible to determine the specific trigger for his suicide in retrospect. Nurses Byrne, Connelly, McRobbie and Dr Senthil confirmed that a previous suicide attempt was one of a number of factors that would be taken into account when assessing an individual under Talk To Me. Dr Callender concluded that there was no fault with the assessments carried out and he did not believe that Mr Masson's suicide could have been predicted or prevented. Mr Masson was not showing any physical signs of drug withdrawal at the time of his assessments which May well have been due to the prescription of Dihydrocodeine alleviating some of the physical symptoms of withdrawal. It is speculation to consider what would have happened in the assessments if he had been showing such signs of withdrawal at the time of the assessments. The factual position from those assessing him was that he was not displaying such signs and I accept

that evidence. Many prisoners suffer from challenges mentioned such as homelessness and addiction issues. To automatically place everyone on Talk To Me with those issues without assessment would, in my view, mean that the system would fail those with the greatest need as a significant increase in numbers of prisoners being placed on Talk To Me would over-stretch the resources available. In my view the most appropriate way for the system to operate is to assess every prisoner entering the prison to ascertain whether they are at risk rather than have criteria which would place them automatically on the Talk To Me programme regardless of their presentation.

[49] In the circumstances I make the following recommendations –

(1) A note of all ongoing prescriptions currently prescribed to a patient should be registered with the NHS regardless of the prescriber to allow healthcare professionals immediate access to details of a patient's medication.

(2) A clear and robust system should be put in place to ensure that all prescription medication is provided without delay to a prisoner once confirmation is received and a system should be in place before the end of each day where confirmation is awaited to confirm if a reply has been received to ensure that a prisoner is receiving the correct medication.

[50] Mr Masson's sister Emma Masson was present throughout the inquiry and I wish to formally express my condolences to her and all of her extended family and friends of Stephen Masson. I similarly take this opportunity on behalf of all those who participated in the inquiry to pass on their condolences for the loss of Stephen Masson.

Addendum

The Police Service of Scotland, Scottish Prison Service, local health boards and prisoner transport providers should consider the development of an electronic personal escort record and jointly review the contents and layout of the PER to show full and accurate information about an individual in custody. It has to be recognised that this played no part in the death of Stephen Masson but it appears to me that it could improve the information sharing between the various agencies. In this case Mr Masson provided inaccurate information about his last drug use and period of time since his last prescription. The health care staff in the prison did not have access to details of treatment he received in the police station nor did they know how long he had been in the police station. An electronic PER, as suggested by Inspector Gary McKenzie, would allow a much easier transfer of information. It would allow access to medical information from the police station. It May allow prison staff to see the risk factors identified by the police in their initial risk assessment and provide further information to the prison staff carrying out the initial assessment of the prisoner upon entry to the prison. It May assist in the prompt prescription of medication by the prison authorities. In those circumstances I thought it prudent to raise whether such a system might assist the relevant authorities in dealing with individuals in custody.