

D E T E R M I N A T I O N

by

SHERIFF NIGEL MURRAY PATON MORRISON, QC

in Inquiry into the circumstances of the death of

DANIEL THOMAS CREW

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

APPEARANCES

For the Crown: **Mr Macari, Procurator Fiscal Depute**

For the Crew Family: **Mrs Crew**

For the Scottish Prison Service: **Mrs Martin Brown, Solicitor, of Dundas & Wilson, Solicitors**

For the Prison Officers Association Scotland: **Mr Anderson, Solicitor, of Levy McRae, Solicitors**

EDINBURGH, 29 August 2007

[1] My determination is as follows.

Summary of findings

[2] Daniel Crew, who was 21 years old, was sentenced to two months' imprisonment at Selkirk Sheriff Court on 4 September 2006 for two offences of breach of the peace. Sadly, on 12 September 2006 he took his own life in prison.

[3] A fatal accident inquiry was held, and required to be held, by virtue of section 1(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

Place and time of death

[4] With respect to section 6(1)(a) of the 1976 Act, Daniel Crew, who was born on 16 January 1985, died between 1900 and 2100 hours on 12 September 2006 in cell 3.26, Hermiston House, HM Prison, Edinburgh.

Cause of death

[5] With respect to section 6(1)(b) of the 1976 Act, the cause of Daniel Crew's death was suspension by ligature.

Reasonable precautions

[6] With respect to section 6(1)(c) on the 1976 Act, there are no reasonable precautions whereby Daniel's death could have been prevented.

Defects in system of working

[7] With respect to section 6(1)(d) of the 1976 Act, there were no defects in any system of working which contributed to Daniel's death.

Other facts relevant to the circumstances of Daniel's death

[8] With respect to section 6(1)(e) of the 1976 Act, there were no other facts that had a bearing on Daniel's death.

Recommendations

[9] There are no recommendations for changes to practices or procedures which could have altered the course of events. The following matters, however, should be given consideration:-

- (1) Whether clarification is required about the use of the addiction assessment form in HM Prison, Edinburgh in relation to alcohol detoxification. (See paragraphs 61 and 62.)
- (2) Further training or instructions in relation to clear communications and use of codes in emergencies in HM Prison, Edinburgh. (See paragraphs 70 to 80.)
- (3) How the Scottish Court Service, in consultation with, for example, the Judiciary, Reliance and the Scottish Prison Service, might best ensure that

social enquiry, psychiatric and other medical reports tendered to the court at sentence are transmitted to the prison or detention centre when an offender is sentenced to a term of imprisonment. (See paragraphs 85 to 88.)

- (4) Whether procedures on admission in relation to establishing medical prescriptions require revision. (See paragraphs 96 and 97.)

Place, time and cause of death

[10] At about 1900 hours on 12 September 2006, Daniel Crew was making a telephone call to his girlfriend from Hermiston House in HM Prison, Edinburgh, known as Saughton Prison. This call is referred to in the second joint minute, and Crown production no. 26 is a transcript of that telephone conversation. Detective Inspector Thomson, then a detective sergeant in the Criminal Investigation Department of Lothian and Borders Police, subsequently observed CCTV footage which showed Daniel Crew making a telephone call at 18.59.

[11] At about 20.30 (according to the prison incident log in Crown production no. 21), a fellow prisoner entered Daniel's cell, no. 26 on level 3 in Hermiston House and found him hanging in his cell at the lavatory door. He called residential prison officer (RPO) Stephen Rooney for help. Mr Rooney said he heard that call at about 20.30. He found Daniel Crew lying on the floor in the cell doorway and tried to find signs of life. He shouted for staff for assistance. RPO Scott Thomson responded. He called for a nurse. RPO John Grieve also responded. He went to the cell, and then radioed the control room (ECR) for a nurse and an ambulance. He shouted to RPO Dunn at the officer's desk on level 3 to confirm that nurses and an ambulance were on their way. Mr Rooney and Mr Grieve carried out cardiopulmonary resuscitation (CPR) which they were trained to do. They did not find any sign of life. Within five minutes practitioner nurses Carol Brand and Claire Anderson arrived. Nurse Anderson thought that she received the call to attend at about 20.20. That is the time recorded by her in the SPS physical care records (Crown production no. 22). They

took over CPR in which they were trained. They arrived with Security Intelligence Manager, Edward Maley, who assisted. They found no signs of life. Nurse Anderson attached a defibrillator but could not use it because no heart rhythm was detected. They continued CPR until the paramedics arrived at the cell which was at 20.59 according to the prison incident log in Crown production no. 21. Paramedic Lesley Conway asked what had happened and was told that Daniel had been found hanging at about 20.25 and that no heart rhythm had been found. She found no heart rhythm and pronounced life extinct at 21.00 hours: see Crown production no. 29 (patient report form). An ECG was carried out at 21.10 which produced a flat line indicating no sign of life: see Crown production no. 28.

[12] Professor Gerhard Kernbach-Wighton, the Consultant Forensic Pathologist at Edinburgh University who carried out the post-mortem examination, gave evidence that death would have occurred within about 12 minutes. A ligature, he explained, compressed the arteries in the neck. After about 15 to 20 seconds the person becomes unconscious and unable to rescue himself. Complete occlusion occurs and it takes a couple of minutes to cause death. Irreversible brain death then occurs within five to ten minutes after that.

[13] Since no signs of life were ever detected by the prison officers who reached Daniel, or the nurses who reached him shortly after, which was at about 20.30, I think one can conclude that Daniel had died by 20.30. He was alive at 1900 hours when he was seen making a telephone call on the CCTV footage. He must therefore have taken his own life between 1900 hours and 2030 hours.

[14] Professor Kernbach-Wighton confirmed that death was by ligature. Daniel appeared to have used a strip of towel, which is seen in photographs 5 to 7 in Crown production no. 31. A prisoner is given two towels at a time for his use.

[15] It has not been possible to ascertain why Daniel took his own life. There seemed to have been some concern that CCTV footage showed someone entering his cell before he was found, but on investigation it transpired that a prisoner was visiting a cell next to Daniel's. I have read carefully the transcript of Daniel's telephone call to his girlfriend in Crown production no. 26, but nothing in it indicates that he felt he

had nothing to live for. He does describe the prison as a “shit-hole” with “a lot of junkies” and that it was “murder in here”. His girlfriend does not appear to be quite as enthusiastic about their relationship as he was. When he says he loves her she says “I know”. He asks if she will come up from Newcastle to see him in the Borders when he gets out if he sends money and she replies “definitely”; he asks if they are still going out with each other and she says “mmh”, then “yeah” when he asks again. He wondered if she was cheating on him, but she said “don’t be silly”. There was a particularly positive note to the conversation in that Daniel was discussing seeing his girlfriend at the end of his sentence.

[16] There was a suggestion that Daniel was being bullied. A prisoner came forward on 22 September 2006 claiming that he had heard prisoners shouting to Daniel about drugs and that he believed that Daniel had had drugs brought in to him on a visit. The credibility of this was brought into question because Daniel never had a visit during the eight days of his life in prison. None of the prison officers who gave evidence was aware during Daniel’s time in prison that he was being bullied. I think that it is unlikely that he was being bullied. There was evidence led about the anti-bullying strategy which the prison applied. That policy is described in the induction booklet handed to prisoners on admission. Crew production no. 10 is a copy of the induction booklet current at the time of Daniel’s admission and that policy is set out on page 24. That booklet explains about talking to someone if being bullied. Daniel did not mention any bullying and none was observed by staff.

Reasonable precautions

[17] I do not think that there are any reasonable precautions that could have been taken which were not taken whereby Daniel’s death might have been avoided.

Steps taken by the prison

[18] The steps taken by the Scottish Prison Service (SPS), and Saughton Prison in particular, to ensure a prisoner's wellbeing and to try to ascertain the prisoner's concerns and identify risks, are impressive.

[19] On arrival at the prison Daniel was interviewed by a prison officer. In accordance with the SPS Act 2 Care Suicide Risk Management Strategy (Crown production no. 10) a prison officer completed the first part of the reception risk assessment document (Crown production no 11). Among a number of answers to questions, Daniel answered that he was not feeling suicidal and that he did not feel that he might hurt himself. It was indicated that he showed no signs of anxiety. The prisoner officer identified no apparent risk. It was one of the duties of the prison officer to look for signs of and assess a risk of suicide or self-harm.

[20] Next, on admission, the prisoner sees a nurse. The nurse, Fiona Rose, completed the health care records nursing assessment form (Crown production no. 6, and health care risk assessment part of the risk assessment document (Crown production no. 11). It was part of the nurse's function to look for signs of and assess a risk of suicide or self-harm. Daniel indicated that he was on painkillers and sleeping tablets and had had psychiatric treatment; he had last taken drugs (Cocaine) two years ago and did not have a drink problem. He told nurse Rose that he did not feel suicidal and did not feel like hurting himself. She considered that he was slightly anxious, but presented no apparent risk at present. She indicated in her evidence that the length of the interview depended very much on the circumstances, but generally lasted about 15 minutes. She had no cause for concern about Daniel. The nurse then makes an entry in the SPS physical care records (Crown production no. 22). Nurse Rose recorded that Daniel "presents no particular medical issues at this time" and queried whether he was prescribed painkillers and sleeping tablets as he indicated. Daniel signed a form (Crown production no. 8) which is a consent sent to the general medical practitioner to release relevant medical information to the prison. For reasons of doctor-patient confidentiality, such a consent would be required.

[21] Next the prisoner has a one to one talk with a peer supporter, that is a prisoner who is a "meeter and greeter" at reception. That person is expected to pass on any

concerns to staff. It is thought that a prisoner might be more likely to be open with a fellow prisoner than with a prison officer.

[22] On admission a prisoner is given a copy of the induction booklet. The version current on Daniel's admission is in Crew production no. 10. Daniel appears to have been given a copy: see admissions data in Crown production no. 15. The booklet is revised at regular intervals and the current version is Crown production no. 17. The document provides information, among other things, about visits (page 8), the family contact development officer (page 9), the anti-bullying policy and the listener and Samaritan schemes. A listener, a prisoner, is on duty every day in the prison, one in the morning and one in the afternoon, to offer support to fellow prisoners to solve problems. They are trained by the Samaritans and offer confidentiality in line with Samaritan protocols.

[23] After passing through reception, on admission, a prisoner is allocated to a landing or level and a cell in Hermiston House. There is another peer supporter there, a "meeter and greeter", on each landing who speaks to the new prisoner. He also is expected to pass on any concerns to staff.

[24] Within 24 hours of admission the prisoner must be seen by one of the prison doctors who work as GPs in the prison. Daniel was seen the day after his arrival, on 5 September 2006, by Dr Vyas. Again the length of the assessment depends on the circumstances, but usually takes about 10 minutes. The doctor has access to the reception risk assessment (Crown production no. 11) and the nursing assessment (Crown production no. 6) completed at admission. The doctor records his notes in the SPS physical care records (Crown production no. 22). The prison doctor has also to assess the prisoner for risk of suicide or self-harm. Dr Vyas noted, among other things, that Daniel told him about a skull fracture in 2005, that he had constant headaches and had received psychiatric treatment for post-traumatic stress disorder (PTSD). Daniel said he was prescribed Amitriptyline (50 mg). He indicated that he did not have a drug problem, but he did have an alcohol problem, and was shaking. (This was contrary to what he had told the nurse on arrival when he indicated that he did not have a drink problem but had had a drug problem). Of course, by this time he would have had about 24 hours without access to alcohol. Dr Vyas prescribed

Chlordiazepoxide for alcohol detoxification; he also prescribed vitamin B (for the liver) and Thiamine (for the brain) as these were necessary supplements as part of detoxification for those with alcohol problems. The detoxification programme would be on a reducing dosage over 12 days so that the prisoner does not feel the lack of alcohol. Dr Vyas said he would have specifically asked Daniel if he felt suicidal or would do something like that. In the ACT reception risk assessment (Crown production no. 11) he wrote in the doctor risk assessment part “no problems” and ticked the “no apparent risk” box. Dr Vyas said in evidence that he had no concerns about suicide risk because Daniel had had post-traumatic stress disorder. If he had he would have referred Daniel to the mental health team and, if he had seen him later and he was having PTSD, he would also have referred him.

[25] Dr Vyas considered that there was no danger in prescribing Chlordiazepoxide to someone who had had a head injury. What Daniel was described was a therapeutic dose; it would cause no problems if taken by someone who did not have an alcohol problem. The dose was 10 mg as can be seen from the prescription sheet no. 1 in Crown production no. 25. There would be no problem in prescribing Amitriptyline as well even if it were not required.

[26] So far as Amitriptyline is concerned, Dr Vyas appears to have contacted Daniel’s GP, Dr Ross, and ascertained that 12 tablets of Amitriptyline (50 mg) were last issued to Daniel on 12 July 2006 and that no subsequent prescription had been issued. Dr Vyas did not consider that a further prescription was appropriate. This was apparent from a letter that Dr Vyas had written to the Health Centre Manager on 14 September 2006 being his report of his involvement with Daniel. Dr Briggs, however, another prison medical officer, said in evidence that he was asked on the afternoon of 5 September to contact the GP because it had not been done. He spoke to the receptionist who confirmed that Amitriptyline was issued on 12 July 2006 to Daniel and he marked the physical care records (Crown production no. 22) that a prescription should be continued. That prescription was for one a day. The nurses’ prescription sheet Crown production no. 25 indicates that Daniel was given two tablets on 6 September 2006 and seven on 8 September.

[27] Dr Briggs described Amitriptyline as primarily an anti-depressant but that Daniel's prescription was very low for depression. The drugs had other uses such as a sedative to help sleep or as a painkiller such as to reduce migraines. (One notes that Nurse Rose had recorded that Daniel told her that he was prescribed painkillers and sleeping tablets.) Dr Briggs thought that 50 mg was consistent with use to help sleep. In his opinion, if Daniel took a week's supply he would not come to any harm although he might become unwell. He confirmed that Amitriptyline and Chlordiazepoxide could be combined without risk. Professor Kernbach-Wighton also confirmed that there was no danger in prescribing these drugs together; and that they were not contributing factors to Daniel's death.

[28] Within 72 hours of admission a core screen document (Crown production no. 12) must be completed. In this document, completed on 6 September, Daniel did not disclose any problems; he did not want to discuss anything with a prison social worker. He did not say anything which caused concern that was noted. He did not mention that he had a problem with drugs or alcohol, but stated that he would like to stop smoking.

[29] Nurse Rose said that if she had been aware of the statement in the social enquiry report (in Crown production no. 20) that Dr Ross, Daniel's GP, felt that custody "would be very harmful to Mr Crew's mental well-being", that would have made her more inclined to look into Daniel's mental health background. On its own, however, the statement would not necessarily indicate to her that he should be put on ACT as a prisoner at risk. She might have referred Daniel to the mental health team to see how he was coping.

[30] In fact, as it happens, Daniel was seen by a mental health nurse, Norma Brown. She had 15 years' experience, was a registered mental nurse and a trained community psychiatric nurse. Apparently Mrs Crew had telephoned the prison, and spoken to a family contact development officer. Nurse Brown said that she received a request from Hall staff because Daniel's mother had called and was concerned at how he was coping in prison. Nurse Brown checked with Hall staff who said that Daniel seemed to be coping well given that he had never been in prison before. She interviewed Daniel privately in an office on level 3 in Hermiston House on 9 September for, she

thought, about 20 minutes. She recorded the interview in SPS mental health records (Crown production no. 23) and the fact that the interview had taken place was recorded in the physical care records (Crown production no. 22). She found Daniel to be bright and appropriate. He said he had been drinking to excess when at liberty. His mood appeared to be at a good level. He said he was coping quite well given that he had not been in prison before, and it was not as difficult as he had expected. He expressed no problems. In evidence Nurse Brown said that she asked him if he had any mental illness to which he replied “no”. If he had mentioned any, she would have contacted those concerned in his treatment. She said she asked him if he had had any contact with psychiatric services and he said that he had not. There was a contradiction in that she was aware of a reference to psychiatric treatment in the admission risk assessment and physical care records. So she asked him about the mental health treatment that he had had. He said that this was when he had received his head injury (in 2005). She saw no evidence of mental illness. It was not appropriate to put him on ACT. Nurse Brown said she would not put a person on ACT just because a person had had psychiatric treatment. From this, and from the evidence of Dr Sharp, the Consultant Psychiatrist at Huntlyburn House, Melrose, it is apparent that having psychiatric treatment does not necessarily mean that one has thoughts of self-harm or suicide.

[31] I asked Nurse Brown if she would be surprised to learn that Daniel did not mention that he had been interviewed by two psychiatrists within the last six weeks of his interview with her, that is on 27 July and 15 August. She said that she would have expected him to have mentioned it as a contact with psychiatric services. A prisoner, she said, might not mention it if he did not want them to know or if he was concerned what the consequences might be if he did mention it.

[32] Mrs Crew was concerned at the Inquiry that, on admission, Daniel exhibited factors which were indicative of self-harm or suicide which are mentioned in the Act 2 Care Strategy (Crown production no. 10). These were, she said, the first time in prison, mental health problems, unemployment, anxiety, headaches and sleep problems. The impression I got from Nurse Rose and Nurse Brown is that one had to look at the whole picture, not any particular factor. From their interviews with Daniel they could not see any cause for concern.

[33] Mrs Crew was critical of the fact that whereas the prison officer noted no anxiety, Nurse Rose noted that Daniel was slightly anxious. Nurse Rose did not seem to consider this a contradiction. She said sometimes a prisoner will say something different when speaking to a man than when speaking to a woman.

[34] On the information available to the prison, there does not seem to me to have been anything that should have led those who interviewed him, or the prison authorities, to conclude that Daniel was at risk.

[35] There was a query about the presence of alcohol in Daniel's post-mortem sample. Pauline Lax, the forensic toxicologist who analysed the sample, thought that alcohol would be produced in the blood as a result of post-mortem microbial production but was less likely to be so produced in urine. The alcohol present (7 mg in 100 ml) was very low and was more likely to have originated from the consumption of alcoholic drink. She thought it would have been taken less than a week before (ie taken while Daniel was in prison). Professor Kernbach-Wighton, on the other hand, said that the presence of a higher concentrate of alcohol was more likely to be found in urine rather than blood as a result of post-mortem microbial production. Pauline Lax said that she could not exclude the possibility that the alcohol in the urine was the result of post-mortem microbial production. In the light of that and Professor Kernbach-Wighton's evidence, I conclude that the very low concentration of alcohol in the urine sample was the result of post-mortem microbial production. It was not the result of Daniel having consumed alcohol in prison before his death.

Information from outside agencies at the time of Daniel Crew's admission to prison

[36] A social enquiry report had been requested by the court and was available when Daniel was sentenced on 4 September 2006 (in Crown production no. 20). This document included reference, under the heading "Drugs and Alcohol", that Daniel told the author of the report that he had not used illicit drugs for over two years; and he said he was a social drinker. It is recorded that he was recently assessed by Dr Sharp, the Consultant Psychiatrist, who advised Daniel to stop using alcohol, which advice his mother said he did not follow, and was drunk for five days before the

interview. Under the heading “Health”, there is reference to Daniel’s brain injury as the result of an assault to which he attributed his behaviour and that his GP considered that drugs and alcohol were the most likely cause of his difficulties. In relation to custody, under the heading “Sentencing Options”, is the reference to Dr Ross feeling that a custodial sentence would be very harmful to Daniel’s mental well-being.

[37] The author of the report, Lisa Grieve, was in training as a social worker at the time she wrote the report. She became a social worker in December 2006. She said, in evidence, that Daniel came to the social work office with his mother and Liddy Hall, a volunteer advocate with the Borders Independent Advocacy Service. Liddy Hall was with him during the interview. Miss Grieve said in evidence that Daniel was not easy to assess. He did not want to communicate, did not answer readily, or gave the shortest answer possible. Daniel mentioned the brain injury and that his behaviour was affected by it. He did not mention that he had psychiatric problems or treatment. He did not say anything about self-harm or suicide. Miss Grieve contacted his GP, Dr Ross, who told her about Daniel being assessed by Dr Sharp and that he was not receiving any psychiatric treatment and was told that he should stop taking drugs and alcohol. Miss Grieve did not contact Dr Sharp. Daniel denied to Miss Grieve that he had a problem with either drugs or alcohol. Miss Grieve could not remember exactly what Dr Ross said about custody being harmful to Daniel’s mental well-being. Dr Ross did not mention self-harm or suicide. Liddy Hall did not mention self-harm or suicide. Miss Grieve said that she came from that area of belief that prison was harmful to anybody and that she could have written that statement regardless of any psychiatric problem. Notwithstanding that statement, Miss Grieve had no concerns about the likely effect of custody on Daniel. If she had had a concern about self-harm or suicide she would have mentioned it explicitly in her report.

[38] After that interview Mrs Crew wanted to speak to Miss Grieve alone to which Daniel consented. Later Daniel withdrew his consent and became agitated, and the discussion was terminated. An interview with the parent of an offender over 18 would occur only if the offender consented, Miss Grieve said. Mrs Crew did not mention, according to Miss Grieve, self-harm or suicide. Mrs Crew put to Miss Grieve in cross-examination that she had told her about Daniel misusing his medication, an incident when he had cut his arms with a blade, an incident when he

refused medical help for an injured foot, and had shown her an image on the digital camera of Daniel having cut his face (a photograph which is in Crew production no. 9). Miss Grieve had no recollection of being told these things and had never seen the photograph before.

[39] Zoe Brydon, who was not a social worker, is a criminal justice officer who represented the social work department at court. She has been doing that work for 18 months. She was in Selkirk Sheriff Court on the day that Daniel was sentenced to imprisonment. She said that she would read all the social enquiry reports available on the day that she attended court and that she would mark any points to be raised with the offenders after sentence. When someone was given a custodial sentence she would ask them if they had any thoughts of self-harm or suicide and would look for clues in their behaviour. She said that she would look for signs such as the offender being withdrawn, making no eye contact, crying, being very upset, or even saying things such as “I can’t do it” or “I have to get out of here”. So far as observation was concerned, at that time she relied on what she had learned from watching her predecessor. In January 2007 she had had ASSIST training which gave one a better understanding to be able to recognise people who are suicidal and recognise those at risk.

[40] Miss Brydon said that if she had been aware of a sign of risk, or had any concerns about risk, or if anybody mentioned concerns such as a member of the family, the defence solicitor, police or the custody officers (Reliance) she would complete the SPS suicide risk identification court form (SPS production no. 2). If the form is completed it is given to Reliance and accompanies the offender to prison. She did not fill up the form and did not send it. She did not do so because she did not identify a risk. She could not remember Daniel, but said in evidence that if there had been an indication of suicidal or self-harm tendencies, she would have filled in the form. In not sending the form she would not have thought that there would have been a risk. She would have spoken to him because the social enquiry report mentioned mental health problems, that is the assessment by Dr Sharp and Dr Ross’s comment about Daniel’s mental well-being. Any conversation with Daniel would only have lasted a couple of minutes.

[41] If there were no indications of risk, but there was something in the social enquiry report or, for example, mention of self-harm some years before, it was Miss Brydon's practice to fax a letter to the prison. In this case she faxed a letter (Crown production no.32) at 16.41 on 4 September to the social work department at Saughton Prison stating that Daniel had some mental health problems due to a head injury. She waited until she had the confirmation of the transaction report. She did not usually seek confirmation of receipt by the social work department and did not do so on this occasion.

[42] It is apparent that neither the social worker who wrote the social enquiry report, nor the community justice worker in court, had any concerns or saw any signs of Daniel having thoughts of self-harm or suicide and they were not aware of any. I recognise that they were both relatively inexperienced; but it is also apparent that Daniel did not say anything to them that raised concerns.

[43] Dr Sharp, a Consultant Psychiatrist since 1995 and a psychiatrist for 20 years, is based at Huntlyburn House in Melrose. In his evidence he referred to the contacts Daniel had had with psychiatric services. In 2003 Daniel had been referred by his GP to the Borders Community Addiction Team (BCAT). He was discharged after failing to attend appointments. In 2004 he was referred to Huntlyburn in relation to substance abuse and apparently having been talked out of threatening to jump. He was not admitted. He appears to have been discharged with a referral for support in abstaining from drugs. The medical records in Crown production no. 27 indicate that he did not want to be admitted to Huntlyburn. The assessment was that his symptoms were probably due to his drug use. In June 2005 he was referred again to Huntlyburn after threatening to jump from a window; but was again not admitted. When first assessed on that occasion he denied suicidal thoughts. Dr Sharp said in evidence that Daniel had been drinking and was in a disturbed state at that time. A junior doctor concluded that his behaviour was related to intoxication. Dr Sharp saw him on 21 June 2005. His conclusion was that Daniel had no major mental illness but was troubled, emotionally immature, and a young man wrestling with drugs and alcohol. Daniel did not perceive he had a drugs or alcohol problem. According to Dr Sharp, his behaviour was disturbed when he took drugs and alcohol; he was at risk of self-harm if he continued with alcohol and drugs; he was not taking responsibility for his

behaviour and its consequences. He needed significant help with drugs and alcohol and should seek help from a drugs and alcohol service. Daniel became ambivalent about having a problem. Dr Sharp left it to Daniel to contact him about the options and that he would make the arrangements if he wished. Daniel did not get in touch.

[44] In July 2006 Daniel was referred again by his GP for psychiatric assessment after cutting his face (see the photographs in Crew production no. 9). This was the occasion that Liddy Hall described in evidence as very important to Daniel because he wanted help and treatment for his problems. When he was refused admission to Huntlyburn, she said that Daniel did not feel that anyone believed him about his condition, that that distressed him and that he felt what was the point.

[45] The truth of the matter appears to be rather different. Daniel was interviewed by Dr Mohamed Abou El-Alamein. Although Dr El-Alamein was the most junior psychiatrist with only four or five months' experience, his assessment of Daniel appears to be similar to that identified by all the other mental health professionals who had seen him previously. In the letter from the psychiatrist to Dr Ross on 1 August 2006 in Crown production no. 27 Dr El-Alamein described Daniel as not co-operative, denying any suicidal thoughts, and denying drinking alcohol and taking drugs. Dr Sharp did say in evidence that Dr El-Alamein was willing to offer admission to Daniel but that a senior psychiatrist had said no. The reason given in the letter of 1 August was Daniel's denial of problems with alcohol and drugs and denial of odd behaviour. He could not be admitted if he denied that he had a problem. Daniel and his mother were offered a meeting with Dr Sharp which they declined. Dr El-Alamein did himself discuss Daniel with Dr Sharp who thereafter arranged to see Daniel and did so on 15 August 2006.

[46] In his letter to Dr Ross of 16 August 2006 Dr Sharp indicated that Daniel was not interested in a referral to community agencies. He was told by Dr Sharp that he should abstain from alcohol to get his life in order. Dr Sharp, however, noted positive and encouraging signs: Daniel said he had not had a drink for two weeks, had been offered a job and was planning to move to Newcastle with his girlfriend.

[47] Dr Sharp was asked by Daniel's solicitor for a report for Daniel's sentencing diet on 4 September 2006. No psychiatric report appears to have been ordered by the court. In that report dated 31 August 2006 (in Crown production no. 27) Dr Sharp stated again that Daniel had difficulty accepting his responsibility, tended to minimise his alcohol and substance misuse, was not interested in a community referral and that he had to abstain from drink. Dr Sharp stated that Daniel had no psychotic symptoms.

[48] He had no psychiatric disposal to recommend. I do not know if this report was referred to by Daniel's solicitor in her submissions at the sentencing diet, or whether it was produced to the court; there is no evidence that it was. It may not have been because there was no psychiatric or other recommendation. Had it been, it would not have disclosed any risk of suicide or self-harm. Dr Sharp did not mention in it Daniel's previous threats of suicide or self-harm.

[49] Dr Sharp said in evidence that there was not a possibility of self-harm or suicide at that time; if he had thought that there was a serious possibility he would have mentioned it in his report to the defence solicitor. Daniel appeared to have plans for the future which was a positive sign. In his view Daniel's self-harm thoughts were related to his alcohol misuse (that is, they occurred when he was drunk) because after a few days (that is, when he was not drinking), they receded. In any event his self-harming was superficial. His disturbed behaviour was different from serious and persistent suicidal attempts. Daniel did not have a personality disorder. He would not have considered it necessary to contact the prison about risk because Daniel was like any other young man with similar problems.

[50] Dr Sharp considered that Daniel had to deal with his drug and alcohol problem before anything could be done about his underlying problems. It was very difficult to do anything when Daniel did not accept that there was a problem. It seems to me that those underlying problems were rather more social than psychiatric: Daniel was described by Dr Sharp as a troubled, unhappy young man struggling to find a role in life and sustain relationships.

[51] None of the mental health professionals who saw Daniel seemed to identify a suicide risk.

[52] Liddy Hall said that Daniel spoke to her about suicide from time to time and she had a fear about his suicidal tendencies. She wrote to Daniel's GP about him trying to harm himself and told Dr Sharp of her fears. Liddy Hall wrote a report for Daniel's solicitors (Crew production no. 1) for the court appearance on 4 September. She said she raised her concerns about suicide in this report. That report was primarily dealing with Daniel's head injury and the contact that Liddy Hall had with Maxine Kinnaird of the Headway Group. Daniel's lack of engagement could be due to his head injury, it was stated. Maxine Kinnaird was said to recommend assessment at somewhere like the Robert Ferguson Unit at the Royal Edinburgh Hospital. At the end of the last paragraph of the report Liddy Hall mentions that "Daniel has been in touch with health professionals but no clear path ahead which addresses his problems in relation to the safety of himself and others." She said in evidence that this was a reference to suicide risk. I do not think that that statement can be regarded as a clear, unambiguous or any reference to concerns about Daniel being at risk of self-harm or suicide. In any event, I do not know if this report was referred to or produced to the court on 4 September by the defence solicitor; there is no evidence that it was. Liddy Hall did say at one point in her evidence that if she had had concerns she would have contacted the prison. She did receive a telephone call from Daniel while he was in prison. He wanted her to contact his girlfriend. Though agitated, she said, he did tell her that he would be in prison for only a month and that he would be all right.

[53] Dr Sharp did recall Liddy Hall mentioning the Robert Ferguson Unit to him. He had worked at the Royal Edinburgh Hospital for nine years and he did not think that Daniel was in the category for referral. That unit was for people with severe brain damage.

[54] Mrs Crew was critical of the psychiatric report written by Dr Sharp for Daniel's solicitor because it did not mention instances of self-harm, his mother's concern about Daniel's suicide thoughts, his referral to the crisis team (when he was seen by Dr El-Alamein on 27 July 2006, following emergency contact from Dr Ross) or to the Headway Report about concerns of Daniel being a danger to himself. Had these points been made she said the sheriff might not have decided on a custodial sentence.

[55] As I have mentioned, it is not known that the sheriff was shown the psychiatric report obtained by the solicitor; and one was not sought by the court. Even if the report had made such references, one cannot know what the sheriff would have done. The evidence of Dr Sharp indicates that he would not have had concerns about current self-harm or suicidal risk; and I have mentioned why he did not say anything about it in his report to the solicitor. No one who assessed Daniel in the week before he died had any concerns.

[56] The only reference to Headway is in Liddy Hall's report for the defence solicitor (Crew production no. 1) and the comments recorded from Maxine Kinnaird in that report. Those do not mention concerns for Daniel's safety. I have already dealt with Liddy Hall's comment about Daniel's safety in her report in paragraph 52 above.

[57] Daniel was seen between 2004 and 2006 by a consultant neurologist, a psychologist and a number of psychiatrists. From the records in Crown production no. 27 and the evidence of Dr Sharp, Daniel appears to have denied suicidal ideation. The advice was that Daniel should make use of a referral to community drug or alcohol services, but he appears not to have wanted to take that up. A number of these professionals, including his GP, considered that Daniel was heading for a custodial sentence if he did not change his behaviour.

[58] Had the social enquiry report, Dr Sharp's report of 31 August 2006 and Liddy Hall's report of 4 September been available to the staff at the prison who assessed Daniel, those reports would not have disclosed anything that would have raised a concern about a risk of suicide or self-harm by Daniel. Furthermore, the social worker and Dr Sharp did not mention any concerns because there were none.

Defects in any system of working

[59] There were no defects in any system of working that I have been able to identify.

HM Prison, Edinburgh

[60] According to Mr Stuart Wright, the prison officer in charge of induction, a cell sharing risk assessment form (see Crown production no. 16) should have been completed on admission by the reception officer, the nurse and the Hall prison officer. The purpose of this is to identify whether a prisoner is at risk of harm or suicide to himself or of harm to others if on his own cell or if sharing a cell. There does not appear to have been one completed for Daniel; if it was, it was not produced. Daniel was in fact in a cell on his own. No risks to himself were identified on his admission. While this form should have been completed, there was no evidence that it not having been done contributed in any way to Daniel's death.

[61] There was a question raised as to whether an addiction assessment form (Crown production no. 7) should have been completed. It would be signed by the nurse. Nurse Rose said it would not be completed for someone given alcohol detoxification. The form itself, 1 notice, appears designed for drugs. Dr Vyas at one point thought it should have been completed, though at another seemed to suggest it was not required if just a straightforward detoxification drug programme was prescribed to combat the symptoms of alcohol withdrawal. There was no need to complete it for drugs because Daniel did not indicate he had a current drug problem. Where such a form is completed, the prisoner is referred to the addictions team. Associated with this form is the taking of a urine test. Dr Vyas seemed to think that this would always be done, but Nurse Rose thought it would only be done if a drug addiction were disclosed. Daniel did not disclose that he had a current drug addiction and was not being treated for one.

[62] Daniel told Dr Vyas on 5 September that he had an alcohol problem. Dr Vyas prescribed Chlordiazepoxide for detoxification. It was not apparent that Daniel required anything more than the prescribed detoxification drug regime. There was some confusion about whether the addiction assessment and the referral to the addictions team should be made when dealing with alcohol detoxification. It may depend on the degree of alcoholism. While there is nothing arising out of this which contributed to Daniel's death, the system might be looked into to see if there is

clarification required about when the procedure is to be used if at all in relation to alcohol.

[63] There is also a prisoner's supervision form (Crown production no. 13) to be completed at admission. This is not concerned with the risk of harm but with security. It is not clear if such a form was completed in respect of Daniel, as none was produced; though in the core screen document completed on 6 September (Crown production no. 12) it is recorded that Daniel's PSS level was "low" i.e. he required minimum supervision and restrictions. One imagines that this could not be recorded without an assessment document being completed. If this form had not been completed, the failure to do so did not contribute in any way to Daniel's death.

[64] In Crown production no. 11, the ACT reception risk assessment document, it is not possible to decipher the name of the prison officer who prepared the reception risk assessment. The printed name and signature are just squiggles. There will be occasions when it will be important to identify that person. While this failure did not contribute to Daniel's death, I think in future the name of the officer completing that part of the risk assessment document should be clearly legible.

[65] Mrs Crew was critical of the shortness of the interviews at admission by the nurse and the doctor. The length of time will depend on the circumstances, including the number of admissions to be seen. A prisoner is seen by two different members of staff separately and independently at admission (prison officer and a nurse) and by a third, a doctor, within 24 hours. He is also seen by two meeters and greeters, though I accept that these are not professionals there to assess risk. It has to be borne in mind that assessing risk is not something done only at admission. An ACT document can be raised at any time by any person working in the prison and in contact with a prisoner. All staff are trained with Act 2 Care Strategy, and within 24 hours of an ACT document being raised a case conference is held at which the prisoner is present. The strategy document (Crown production no. 10) points out that assessment on admission is a "one-off" snapshot and emphasises that it is vital for all staff to look for signs of risk throughout a prisoner's period of custody.

[66] I do not think that the prison can be criticised for the length of the interviews in the admission process.

[67] Mr Wright, the induction officer, formulated the induction course at Saughton Prison. It is for prisoners serving sentences from 30 days to life. On admission prisoners receive the induction booklet (Crown production no. 17 and Crew production no. 10). Prisoners are involved in its contents. It is a précis of the material covered on the induction course. Mr Wright tries to update the booklet quarterly. Prisoners also receive an invitation on the preceding Thursday or Friday of the start of the course, which is on a Monday, to attend the course. The induction course always starts on a Monday and lasts for five days. The course is presented by an induction officer and two prisoners; other members of staff also take part. It is compulsory to attend the start of the course. After that a prisoner can decline to attend. If he does so, he signs a disclaimer. Daniel signed a disclaimer on 11 September (Crown production no. 14) which was a Monday. This would have been the first day of the course that he attended, he having been admitted to the prison the previous Monday afternoon. When someone signs a disclaimer, the induction officer would try to encourage the prisoner to attend. He would also ask the meeter and greeter on the prisoner's level in the Hall to speak to him to try to persuade him again. It is not known if this happened in Daniel's case. Mr Wright was on leave at the time and had no dealings with Daniel.

[68] Mr Wright mentioned that the induction unit at Saughton Prison had been referred to as a centre of excellence in the October 2006 report by Her Majesty's Chief Inspector of Prisons, Dr Andrew McLellan. The prison was the most advanced in relation to induction of prisoners.

[69] Mrs Crew thought that attendance at the whole induction course should be compulsory. As was explained by the deputy governor, Christine McGeever, a prisoner who was made to attend a course that he did not want to attend could be disruptive, spoil it for others and would not get anything out of it for himself. For these reasons I do not think attendance at the whole induction course should be made compulsory.

Communications and emergency codes

[70] Mr Grieve said that, when he put out the call for a nurse and an ambulance, he used the term “code red”. He understood since that there were two unofficial codes “red” and “blue”, the former used when there was blood and the latter when there was a breathing problem. A number of members of staff who were called to the scene thought that the codes were unofficial. The deputy governor thought that these codes were official, the purpose of the different codes being to forewarn staff as to the type of emergency.

[71] It was apparent from all the witnesses from the prison that it made no difference which code was used. Both were treated as an emergency, and the nurses confirmed that they took the same equipment to the scene whichever code was used.

[72] Paramedic Lesley Conway said that she received an emergency call from ambulance control at 20.34 about a male prisoner with cut wrists. Crown production no. 30 contains a printout of the record of the emergency 999 call. It contains the statement in answer to the question “What’s the problem?” “MALE CUT HIS WRISTS”. It also mentions that the male was conscious and breathing, although a few lines later it is recorded that consciousness and breathing were unknown. The emergency appears to have been given an “amber” dispatch code by the ambulance service. Miss Conway indicated that she would not know whether the emergency was given a red (immediate response) or amber code. She was based, and was, at Livingston. Her ambulance must have been the nearest available ambulance to the prison at the time. She would answer the call as quickly as possible in any event. It usually took about 14 minutes to get to the prison. If the dispatch code was green they would not use flashing lights or siren.

[73] It may be, as the result of a code red being used, that confusion arose about the nature of the emergency in this case. A code red which suggests blood, would be more consistent with cut wrists than with use of a ligature.

[74] In this case it is clear that use of the term “code red” rather than “code blue” did not affect the response to the emergency in this case. Staff in the prison responded to

it immediately and the nurses arrived with the necessary equipment including oxygen and CPR equipment. The ambulance service and crew responded as quickly as they could.

[75] I can quite understand that prison staff would wish to use a code rather than call out the details of the emergency. It is quicker and avoids disquieting other prisoners. The use of “code red” rather than “code blue”, however, did not contribute to the death of Daniel.

[76] Mrs Crew said it should be possible to make a 999 call from all telephones in the prison and not to have to go through the control room. She said it would save time. There is also the issue of maintaining accuracy of information when more than one person is involved in passing on a message.

[77] It was not entirely clear whether it was possible to make an outside call from the officer’s desk on level 3. It is certainly not possible from every telephone. It does not necessarily follow that it would save time to make a 999 call from the officer’s desk. I can envisage circumstances where it would be quicker to ask the control room to do it, thus freeing up an officer for other duties. I can understand that the more people who are contacted to pass on a message, the more possibilities there are for the message to become garbled. There are other ways of ensuring that that does not occur. In this instance nothing done affected Daniel’s death.

[78] I can also envisage security problems if an outside call for an emergency could be made from any telephone. It would mean that all telephones could be accessible to prisoners as well.

[79] Mr Macari for the Crown, submitted that clear and accurate communication is essential and that there was a training issue to be considered. I agree.

[80] I think that if there are to be emergency codes, it should be clear to all prison staff what they are and when each is to be used. Consideration should be given to dealing with this and the issue of passing on accurate information in training or by some other means.

[81] There was some concern expressed by Miss Conway about the time it took to get to Daniel from the prison gates. She received the call at 20.34 (see Crown production no. 30 and the patient report form which she completed (Crown production no. 29)). According to her it took 14 minutes to get to the prison (which she did not record). She appeared to rely on the time it had taken on previous occasions to determine the time it took. That would take the time to 20.48. She noted the time she got to the patient as 20.55 (Crown production no. 29). Therefore, it took seven minutes to get to Daniel from the prison gates. She thought that the time it takes to get to a patient in the prison should be looked at. She was critical of the time it took to get the vehicle through the four gates of the prison entrance. She did not think there was a sense of emergency at the prison.

[82] The prison incident log (Crown production 21) in which times are derived, where possible, from CCTV or the gate/ECR log, indicates that the ambulance arrived at the prison at 20.55 and that paramedics reached the patient at 20.59.55. According to that log the time from the gate to the scene was therefore just under five minutes. Lesley Conway accepted that it could have been five minutes. One wonders whether the time she noted as the time at patient (20.55) was not in fact the time of arrival at the prison which she would have had time to record; although she said it was the time that she arrived at the patient. Nurse Rose said it would take about five minutes; Mr Rooney thought that that was quite quick because the scene was about the furthest from the gate one could get.

[83] The deputy governor said that the gate staff would look out for the ambulance so as to open the gate quickly. In fact Lesley Conway could not remember whether the gate was already half open when she arrived. One can understand that one gate has to be closed before the next is opened. The deputy governor was surprised that one officer had to walk from gates 3 and 4 (which had to be operated manually in order to open and close them) as Miss Conway said had happened. That may have been because there were not enough staff to deploy, said the deputy governor.

[84] I do not think that there was any critical time lapse in the ambulance crew getting to Daniel. The evidence suggests that it was about five minutes which was judged to be about right as the time it would take. If Daniel was found to have no signs of life

at 20.30 he would have been dead long before the ambulance arrived at the prison. Lesley Conway acknowledged that this was probably so.

Court reports

[85] Both Miss Grieve and Miss Brydon understood that the practice was that social enquiry reports accompanied prisoners to the prison. It appears that Daniel's social enquiry report did not accompany him to prison. The court warrant committing him to prison in Crown production no. 20 has the words "COPY SOCIAL ENQUIRY/COMMUNITY SERVICE/PSYCHIATRIC/MEDICAL REPORTS ATTACHED" crossed out by a line drawn through them. In joint minute no. 3 it is agreed that the clerk of court stated that she believed she would have attached the social enquiry report to the warrant but could not explain why those words were struck out of the warrant. I do not see how, or why, they would have been crossed out if the social enquiry report had been attached to the warrant.

[86] It was clear from prison staff, including the deputy governor, that reports are not always attached to the warrant. They provide useful information for the prison in dealing with and caring for a prisoner, not just in relation to information about risk of self-harm or suicide.

[87] The procurator fiscal suggested that the wording on the warrant should be amended so that it was clear whether a report had been "*prepared*". If the report was not attached, but it appeared that a report had been prepared, the prison could make enquiries to obtain it. Mrs Crew thought that all such reports should always be sent to the prison.

[88] I think the better course is to ensure that any social enquiry, medical or other report produced to the court for sentence accompanies the prisoner to the prison. There is not a statutory requirement for that to be done, but it is regarded as best practice. I think that the Scottish Court Service, in consultation at least with the Judiciary, Reliance and the Scottish Prison Service, might look into ensuring that such reports always reach the prison with the prisoner.

Daniel Crew

[89] Daniel was the youngest of four sons. He lived in the Borders. Growing up he loved football and was very interested in motor bikes and cars. Never academic, Mrs Crew said he saw his future as a mechanic and started a mechanic's course. He dropped out after a year. Like many teenagers, she said, Daniel chose a new circle of friends who had different standards and values and hence he got involved with drugs and alcohol and was unable to see how they were affecting him and his lifestyle. Liddy Hall helped him twice to obtain his own accommodation in Hawick with which he could not cope. He returned to living at home but there appeared to be friction at home because his parents were concerned about his drinking and abuse of drugs which he would not accept. It is clear that his parents were beside themselves in trying to get Daniel to see his problems and in trying to get help for him. By the time he was sent to prison on 4 September he had already 11 previous convictions mostly for breach of the peace. He did not make use of probation. He did not want to co-operate with social workers, the psychiatrists or make use of community addiction services. He was described by professionals with whom he came in contact as immature, not taking responsibility for his behaviour and its consequences, as confused, aggressive and threatening. He sometimes walked out of interviews when his mother contradicted his denials of his problems. Dr Sharp said that Daniel could be a sheepish likeable young man. Liddy Hall referred to his sensitive and caring side; but if something he wanted did not work he reacted badly. He would get into fights, being willing to take someone on.

[90] A picture emerged of a young man who not only did not want to take responsibility, but denied he had a problem and did not want to talk about it. His brother, Richard Crew, said that he would keep himself locked up, that is he would keep his thoughts to himself.

[91] In her submissions Mrs Crew said that his family failed him, the system failed him and the professionals failed him. I have not found any evidence that anybody failed him. Daniel could not have had a more supportive family; and I find no evidence of Daniel being failed by "the system" or by any of the professionals with whom he came in contact. Daniel was offered support and help by and from

psychiatrists and other health professionals. Sadly, I think Daniel failed himself by not taking responsibility.

[92] Mrs Crew considered that Daniel's profile, which she listed in her submissions, was one which, had it been known to the prison, would have alerted staff to treat him as at risk. The profile was: age range 18-24 high risk, history of drug and alcohol abuse, mental health problems, serious head injury, headaches and sleeping problems, unemployed, in prison for first time, self-harming, depression, anxiety, disbelieved by professionals, no hope, low self-esteem. There is no evidence that Daniel was disbelieved by professionals; he would not take their advice. The prison staff were not aware of the mental health problems, the self-harming and depression. As I have already mentioned, none of the four members of the prison staff who interviewed him saw signs of risk; the psychiatrists who assessed him saw no signs of risk; but some evidence for hope was noticed. No one who looked for signs of risk detected any.

Other factors relevant to the circumstances of Daniel's death

[93] None of the points with which I deal under this head had any bearing on Daniel's death. I consider it appropriate to mention them because they were raised.

Documents sent to the prison by fax

[94] Mrs Crew thought that any information sent to the prison by fax, such as the letter faxed by Zoe Brydon to the Social Work Department in the prison (see paragraph 41 above) should be confirmed by the recipient so that it was known not only that it had been sent but that it had been received. I think that that is probably a good idea: just because it is sent does not mean that it has been received.

Learning difficulties

[95] Mrs Crew considered that there was a failure to notice an indication of a learning difficulty or anxiety with Daniel because he put the wrong date on two forms. These were the consent to obtain medical information from his GP (Crown production no. 8) and an “in possession” medication document (Crew production no. 5). Anyone can put a wrong date down; and I think the month in the second document could in fact be a “9”. I have already dealt with the question of anxiety. I do not think the putting of the wrong date was an indication that Daniel was at risk or that he could not read the induction booklet.

Prescription and supervision of medicine in prison

[96] Mrs Crew was critical of the fact that Daniel could be prescribed Amitriptyline by Dr Briggs without him having seen the patient and when it had not been prescribed by his GP since 12 July 2006. Mrs Crew explained that it had not been prescribed since that date because Daniel had misused it. In fact the dosage was therapeutic and could not have harmed him; but it might have been otherwise.

[97] It appeared from the evidence that Dr Vyas decided not to prescribe it; although there is no record that he contacted the GP or did not prescribe it, whereas Dr Briggs said he was asked to contact the surgery because it had not been done. It may be because what was prescribed by Dr Briggs was not harmful, that he erred on the side of prescribing rather than not. Consideration should be given as to whether procedures in relation to establishing prescriptions on admission to prison require revision.

[98] Mrs Crew argued that all medicines in prison should be supervised. It was apparent that the Chlordiazepoxide was supervised in that Daniel had to go to the medical centre to take that medicine. The Amitriptyline and the vitamin B and Thiamine tablets were unsupervised, that is he was given the tablets in the Hall, and he could take them to his cell and take them when required. Dr Vyas said that there were spot checks made in relation to medicine that was unsupervised.

[99] As was pointed out by Mrs Martin Brown for the Scottish Prison Service, outside prison there are medicines that patients are allowed to take home to administer unsupervised. It may be, of course, that a prison is a rather different environment which may require more supervision than would be necessary outside prison. The vitamin B and Thiamine were vitamins. The Amitriptyline was a therapeutic dose which, if he had taken all seven pills, could not have done Daniel harm. I do not think, therefore, that it was necessary that the medicine should be supervised. I think it is perhaps going too far to say that all medication and vitamins should be supervised.

Staffing level in the prison

[100] Mrs Crew criticised the staffing level on level 3 in Hermiston House as being too low. There would be four or five officers on duty. There are 65 cells on the level with room for 80 prisoners. That means there would be one officer to 16 to 20 prisoners. There was no evidence that that was inadequate. There was no evidence that the number of staff on duty had any bearing on Daniel's death.

Whether the ambulance was delayed

[101] Mrs Crew said that the ambulance to be sent to the prison was stood down before the call was reclassified as an emergency. No one from the ambulance control gave evidence about Crown production no. 30. The paramedic, Lesley Conway, could not, as she did not usually see such a document. I think Mrs Crew has read too much into, or misunderstood a particular entry in, the transcript.

[102] The number of the emergency call in relation to Daniel, given when the call was received at 20.32.43, was "1673097". At 20.34.02 the transcript appears to list what the availability of ambulances was. There is no mention in that list of Lesley Conway's ambulance, the call sign of which on the first page is given as "LIV495". The entry at 20.34.14 "LIV495 Stood Down from Call: ROU 1673012" suggests to me that Lesley Conway's ambulance was stood down from or had finished a different

call. There is no entry before that indicating that Lesley Conway's ambulance was allocated to Daniel's emergency before the "stood down" entry. The ambulance could not be stood down from a call to which it had not yet been allocated. Lesley Conway's ambulance was allocated to the call at 20.34.15. That is also the time that Lesley Conway recorded in Crown Production no. 29 that she received the call. I suspect that "ROU" stands for routine and "1673012" is the number given to the call to which that entry relates which is not the same number as the call number given to the emergency call from the prison. There is no question of a delay in an ambulance being sent out to the emergency.

Other points raised

[103] Mrs Crew criticised the fact that medical staff did not appear to be available 24 hours a day in the prison. This is outwith the remit of the Inquiry, as Mrs Crew understood. Nursing staff were on duty when Daniel was found. There were two passing references to the availability of medical staff during the night. I do not know what the night arrangements are and they were not gone into during the Inquiry. I cannot possibly comment on this issue.

[104] Mrs Crew was surprised that some witnesses did not recall times, conversations and other facts. Mrs Crew would, of course, know a great deal about her son and his involvement with a number of people. Those who were dealing with Daniel would have a number of other individuals to deal with as well as Daniel. It would not be possible for everyone with whom Daniel came into contact to remember every detail in the way that Mrs Crew did.

[105] Mrs Crew was critical of the fact that after Nurse Brown had interviewed Daniel she received no call from the prison to say that her telephone call had been followed up and what the result was. She did mention in her submissions that she had had a telephone call at some point from a prison officer whose name she cannot remember who telephoned her with certain information. She informed him of her concerns that the family had had no message or request about a visit or for clothes for Daniel. He said he would take the time to deal with it. He subsequently telephoned again to

suggest a visit. Since those duties are the responsibility of the family contact development officer it may well be that it was such an officer who did in fact make contact with the family.

[106] Mrs Crew was also concerned that information was given to the press before formal identification of Daniel by members of the family. The deputy governor, Christine McGeever, said that this was dealt with by the press office at SPS Headquarters, and not by the prison and she was unable to give any explanation. The deputy governor did say that the press office was not informed until the police had advised that the next-of-kin had been informed of the death. While a deceased person must be identified, I do not think that it has to be by a member of the family.

[107] Mrs Crew complained that the family was overlooked in the days after Daniel's death. Mr and Mrs Crew were given two telephone numbers to contact and they had difficulty making contact. I can understand how the family might feel. Following such a tragedy there is a great deal for the prison staff and the police to do in making enquiries, and gathering and collating information. In the doing of that I can understand how the family might feel left out. I think sometimes there can be a reluctance to give out pieces of information as they become available until the whole picture is clear and the pieces of information can be confirmed. Were a family to be given a piece of information at an early stage which subsequently turned out to be wrong there would no doubt be criticism for the wrong information being disclosed. The deputy governor explained that after a death in prison, families are now referred to the Chaplaincy team in the prison.

[108] Mrs Crew was concerned that little information came to light about Daniel's last day in prison. It would not be possible, it seems to me, to record everything that every prisoner did in the course of each of his days in prison. Obviously certain events would be recorded such as attending a course, receiving a visit or making a telephone call which could subsequently be traced.

[109] There were graffiti in Daniel's cell. Graffiti in cells are common. I was informed that daily checks are carried out, and prisoners are encouraged to clean them off. If offensive, graffiti can be painted over. Richard Crew, one of Daniel's

brothers, wrote a letter to the procurator fiscal mentioning the graffiti on the walls in Daniel's cell and on his bedding. It is not known how much graffiti were present when Daniel was placed in the cell. There was no evidence that the graffiti affected Daniel's mental state.

[110] An envelope was found in Daniel's cell, but no letter. DI Thomson said that an envelope, or piece of paper, was found with the name 'Jen' and a telephone number written on it. He was given the envelope by Mrs Crew. Richard Crew said there was an envelope in the cell with the name and address of Daniel's girlfriend written on it. He took it and gave it to his mother. There was no letter in it. There was no evidence that a letter had been removed.

[111] Mrs Crew was critical of the fact that, as a party litigant, she was not able to obtain witness statements from the procurator fiscal, and the witness list which was produced gave her no clue as to the identify of the witnesses, what their roles were or what their evidence might be about. I do not know if the problem about witness statements may be regarded as similar to that in criminal cases in which such statements are given to defence solicitors, but not to accused persons representing themselves. In relation to the witness list most of the witnesses were just identified by name with an address being care of the prison. It might be possible to give more of a clue as to whether the individuals on the witness list were, for example, prison officers, persons who had dealings with the deceased or were involved in attempting to resuscitate him. These points were not gone into in the Inquiry, and there will be a number of issues to consider in relation to them. For those reasons I cannot make a recommendation, but they may bear some examination and consideration in the procurator fiscal's office.

Post-Inquiry letter

[112] Mr and Mrs Crew sent me a three page typed letter dated 15 August 2007 after the Inquiry. It is not always understood that a person cannot normally raise matters by letter after the proceedings in public have been concluded. Had any new issue been raised in their letter I would have had to consider whether to hear submissions

from all parties on that point. It is not necessary to do this. All the points raised in the letter except two were alluded to during the Inquiry and I have commented upon them. Mr and Mrs Crew's letter will be added to the court papers. The two additional points raised were these.

[113] Firstly, it had not been possible to contact one of Daniel's relatives before information had been passed on to the media and it was mentioned on radio and television. I do not think I can comment on this as it was not a matter with which the Inquiry is concerned. As a general rule I am not sure that it is possible to withhold information from the press until every family member has been informed.

[114] The other matter was the circumstances in which the family was refused legal aid. Again this is a matter with which the Inquiry was not concerned. The question of legal aid for the family of a deceased to be represented at a fatal accident inquiry is a matter to be taken up by a constituent with his or her Member of the Scottish Parliament.

WITNESSES
who gave evidence at the Inquiry
(in order of appearance)

Elizabeth (Liddy) Hall, volunteer advocate with Borders Independent Advisory Service.

John Grieve, Residential Prison Officer, HM Prison, Edinburgh.

Steven Rooney, Residential Prison Officer, HM Prison, Edinburgh.

Dr William Briggs, MB, ChB, MRCP, DRCOG, DCCH, Medical Officer, HM Prison, Edinburgh.

Edward Maley, Security Intelligence Officer, HM Prison, Edinburgh.

Claire Anderson, Admissions Advice, HM Prison, Edinburgh.

Lesley Conway, Ambulance Paramedic, Livingston Ambulance Station.

Christine McGeever, Deputy Governor, HM Prison, Edinburgh.

Dr Clifford Sharp, MB, ChB, MRCPsych, Consultant Psychologist, Huntlyburn House, Melrose.

Dr Rshanikant Vyas, MB, BS, Medical Officer, HM Prison, Edinburgh.

Pauline Lax, BSc, FRP, Forensic Scientist, Forensic Alliance Ltd.

Fiona Rose, Registered Nurse, HM Prison, Edinburgh.

Norma Brown, Mental Health Nurse, HM Prison, Edinburgh.

Stuart Wright, Induction Officer, HM Prison, Edinburgh.

Lisa Grieve, Social Worker, Scottish Borders Council.

Zoe Brydon, Criminal Justice Officer, Scottish Borders Council.

Professor Gerhard Kernbach-Wighton, MD, DRM, SFM, PhD, FGS, LegM, FRS Med, FFOSS, FGS TrafM, FGS, EtLM, Consultant Forensic Pathologist, University of Edinburgh.

Richard Crew, St Boswells.