2010FAI 5

DETERMINATION

by

James Peterkin Scott, Advocate,
Sheriff
in
The Sheriffdom of Lothian and Borders
at
Edinburgh

Following an Inquiry held at Edinburgh
under
Sections 1(1)(b) and 3 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976,
on
The Twenty-third and Twenty-fourth days of November, Two Thousand and Nine
into
the Death of
Stephen Robert Thomas Cobb

EDINBURGH, 19th January 2010

The Sheriff, having considered all the evidence adduced, **DETERMINES** in terms of the **Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, section 6(1):**

(a) that the late Stephen Robert Thomas Cobb, born 4th May 1984, who resided at 21 Forthill Terrace, Jedburgh, died in Ward 118, Intensive Care Unit, Edinburgh Royal Infirmary, at about 0705 hours on 2nd May 2008 as a result of hanging himself by a bed sheet from an upper bunk in a cell at level 3, Hermiston Hall, Saughton Prison, 33 Stenhouse Road, Edinburgh, at approximately 1050 hours on the 30th April 2008;

(b) that the cause of death was suspension by ligature;

(c) that there were no reasonable precautions whereby the death might have been avoided;

(d) that there were no defects in any system of working which contributed to the death; and

(e) that the following facts are relevant to the circumstances of the death:

(i) when a prisoner is assessed under the 'Act 2 Care' system as being at risk of self harm or suicide at a time when he is outwith the hall in which he is resident, the person making the assessment should immediately (and prior to informing the prisoner's hall manager) inform the prison officer in charge of escorting the prisoner of the assessment, the reasons therefor, and the immediate care plan;

(ii) in such a case, the identities of both the prison officer in charge of the escort and the hall manager, and the times at which they were informed of the assessment, the reasons therefore, and the immediate care plan should be recorded contemporaneously in the prisoner's 'Act to Care' book;

(iii) in such a case, the prison officer in charge of the escort should ensure that the prisoner does not leave the location at which the assessment has been made until the prisoner's 'Act 2 Care' book has been handed to him;

(iv) in such a case, on the prisoner's return to the hall in which he is resident, the time of the prisoner's arrival in the hall, the simultaneous arrival of the prisoner's 'Act 2 Care' book and the identity of the escorting prison officer should be recorded in the prisoner's 'Act to Care' book by the desk officer in the hall; and

(v) The 'Act 2 Care' book should be amended to allow for the foregoing records to be kept in a separate section to be used when a prisoner who is then outwith the hall in which he is resident is assessed as being at risk of self harm or suicide.

NOTE

The Scottish Prison Service (hereinafter 'SPS') has put in place formal and informal arrangements to prevent prisoners from committing suicide or harming themselves. The principal, formal system of assessment and care of prisoners deemed to be at risk of suicide or self harm is called 'Act 2 Care.' The late Stephen Robert Thomas Cobb was remanded to Saughton Prison, Edinburgh, on the evening of 29th April 2008. On the morning of 30th April 2008 he was assessed under the 'Act 2 Care' system as being at low risk of suicide or self harm. About an hour later he was found to have hanged himself in his cell. The primary issue in this inquiry was whether there were any defects in the 'Act 2 Care' system that contributed to the death. My conclusion is that although there was no defect in the system, on this occasion there was a failure to operate the system as intended. While I am satisfied that the failure did not contribute to the death in this case, I have made recommendations with a view to preventing such a failure in future.

Unusually, Miss Rollo, for the Crown, and Mr. Chaffey, for SPS, lodged a joint minute in which the following facts were agreed:

(i) the deceased's personal particulars and date of death;

(ii) the identification of the deceased in life and death;

(iii) the findings and conclusion in the post mortem dissection report (Production 2); and

(iv) the cause of death (suspension by ligature).

Members of the deceased Mr. Cobb's family were present, but not represented, during the inquiry.

(1) The SPS System of Care

(a) The 'Act 2 Care' System

When a prisoner is assessed as being at risk of suicide or self-harm, the person making the assessment initiates standard 'Act 2 Care' procedures for the prisoner's care by raising an 'Act 2 Care' document relating to the prisoner. An outline of the 'Act 2 Care' system for management of suicide risk is contained in a flowchart within the 'Act 2 Care' document.[1]

[1] in this case, Crown production 5

If a case conference cannot be held immediately, an 'immediate care plan' is devised pending the holding of a first case conference within 24 hours of the raising of the 'Act 2 Care' document. The immediate care plan is an interim plan, in force pending a case conference.
Prisoners assessed as 'high risk' are put in 'anti-ligature' cells. Such cells are designed to prevent people from hanging themselves.
'Low risk' prisoners are put in a safe environment, i.e. a cell near to the officers' gallery.[2]

The system has been devised in such a way that the manager of the prisoner's location or hall is intended to play a central role in the implementation, dissemination and supervision of the immediate care plan.

In practice[3], in the case of a prisoner "assessed as low risk":

> (i) first of all, as soon as possible the person who made the assessment should inform the hall manager of the area in which the prisoner is located, __ normally by telephone; and
> (ii) if the prisoner is placed 'on Act' outwith the hall, the 'Act 2 Care' book relating to the prisoner should come to the hall along with the prisoner. If such a prisoner returns to the hall without the 'Act 2 Care' book, the hall manager should contact the person who placed the prisoner 'on Act' and tell that person that he wants the book as soon as possible.

The hall manager should always be contactable. He carries a radio. Main control (the Electronic Control Room in the prison) would inform him by radio that he has a call and that he has to get in contact with someone. The Electronic Control Room is manned 24 hours per day.
The person putting a prisoner 'on Act' should telephone the hall manager first. If the hall manager cannot be contacted, as a matter of common sense the next best step is to telephone the desk officer in the hall. The hall manager passes on information about prisoners 'on Act' verbally to the prison officers in the hall. Also the 'Act 2 Care' book goes to the prisoner's flat. Therefore the officer in charge of the flat is aware that the prisoner is 'on Act' and how often the prisoner should be seen. At the end of each shift the 'Act 2 Care' book is filled out and signed off by the hall manager. At the end of each shift the desk officer in the hall passes information about the prisoner to the incoming desk officer. The incoming desk officer passes on the information verbally to the other incoming officers in the hall. The 'Act book' is available at the desk to be read by all the incoming officers.
All staff members receive training in the 'Act 2 Care' system, including yearly refresher training.

(b) **Listeners**
The prisoners also operate a system of 'listeners', i.e. prisoners who attempt to help other prisoners who may have problems. As the witness John Miller Hutchison put it, "These guys will sit and listen for hours on end. If they think that there's a problem they can get instant access." He added, "They're very trusted. They can walk throughout the whole jail, so they've got a high position of trust as well." Prisoners are made aware of the 'listeners' system on the first night in custody.[4]
(c) **The Peer System**

---

[2] testimony of Dr Vyas
[3] testimony of Peter McPherson
[4] ibid.

In Saughton prison there is a 'peer' system, sanctioned by the prison governor, in terms of which more experienced prisoners help the less experienced. The prisoners who operate the 'peer' system go out of their way to help others.[5]

(d) **Pass-men**

Pass-men clean the cells and serve meals. They also try to help incoming prisoners, for example by giving them tea and tobacco. If they "spot a problem, they'll flag it up with a P.O."[6]

(2) The Relevant Facts

(a) Mr. Cobb's Mental Health History & Background

In February 2008 Mr. Cobb had been in Saughton prison, serving a sentence of about one year's imprisonment. At the time of his admission he was very depressed, his depression being linked to alcohol and drug abuse. He had been placed on suicide watch. His mother's death occurred some months before his own death. He was very much affected by his mother's death and felt very guilty about having been in prison when she died.

For about 30 months prior to his death he had been in a relationship with Aimee Louise Jones. Miss Jones was asked if the relationship had been going well prior to Mr. Cobb's remand. She replied, "Yes and no. We were adjusting to him coming out of prison."

On 29th April 2008 Mr. Cobb was remanded to Saughton prison on a charge of attempted murder.

(b) Chronological Outline of Relevant Events

The following outline of events emerges from the testimony of the witnesses.[7]

29th April 2008

At 1652 on 29th April 2008, at reception in Saughton Prison, PO Mark Shaw assessed Mr. Cobb as 'no apparent risk'.[8]

At reception a practitioner nurse, Lynn Muriel Carswell, also assessed Mr. Cobb. She had no concerns about his being a suicide risk.

30th April 2008

At about 0845 Dr Rashmi Vyas assessed Mr. Cobb as 'no apparent risk.'

Thereafter Mary Stuart Clancy, a registered mental health nurse, spent about 15 minutes in assessing Mr. Cobb at the prison health centre, which is situated outwith the hall in which Mr. Cobb was resident. In so doing she observed, *inter alia*, self-inflicted cuts one of his arms. The cuts appeared to be a few days old. From her assessment as a whole she concluded that although he was not a suicide risk, he was vulnerable and at risk of further self harm. She raised an 'Act 2 Care' book in respect of Mr. Cobb and assessed

---

[5] testimony of John Miller Hutchison

[6] ibid.

[7] See '(c) The Witnesses' below, p. 6 to 17

[8] 'Act 2 Care' Reception Risk Assessment, p. 3

him as "low risk." Her immediate care plan for Mr. Cobb included observations at a maximum of 30 minutes. No razors were to be permitted. She 'informed Mr. Cobb of the outcome' of her assessment at 0945.[9]
It should be noted that Nurse Clancy accepted that Mr. Cobb's 'Act 2 Care' book did not go with him to the hall. She deponed that,

> "I gave [Mr. Cobb's] book to a prison officer, 'Here's his documentation', and I phoned the hall and said [Mr. Cobb] had been put on Act and a 30-minute observation."

She did not know if Mr. Cobb was still there when she handed the book to the prison officer. There was a large group of prisoners, which is the norm. She knew the officer to whom she handed the book only as 'Les.' She did not know the name of the prison officer to whom she spoke by phone.
The witness was asked about the time which elapsed between last seeing Mr. Cobb and making a phone call to the hall. She replied,

> "Probably a considerable amount of time. Probably about an hour or so, __ when I'd seen that group of prisoners, when that group was being taken over by the prison officers. So far as I was aware [Mr. Cobb] was safe."

By about 1000 Mr. Cobb had returned to the Hermiston Hall from the health centre. At about that time PO James Cumming saw Mr. Cobb in Hermiston hall, talking to the pass-man, John Miller Hutchison. PO Cumming put Mr. Cobb in his cell and spoke to him, promising to arrange a phone call and 'wages' for him.
Thereafter John Hutchison told PO Cumming that Mr. Cobb had been "talking shite." PO Cumming returned to Mr. Cobb's cell and spoke to him. His assessment was that Mr. Cobb was not a suicide risk. He left Mr. Cobb in his cell at about 1005.

At times estimated by PO Gavin Murray variously as "1005, 1010 or 1020" Nurse Clancy telephoned PO Murray, the desk officer on duty in Hermiston Hall, and told him that she had placed Mr. Cobb 'on low risk'. She told him that she thought he was acting odd, but she did not think that he would do himself any harm.

"3 to 5 minutes later," or "shortly after 1030: 1035, something like that," or a minimum of 15 minutes and a maximum of 30 minutes after Nurse Clancy's phone call,[10] or about 1040,[11] Mr. Cobb's 'Act 2 Care' book arrived in the hall. PO Cumming took Mr. Cobb's 'Act 2 Care' book from PO 'Les' Brown, who had brought it to the hall. On this issue I prefer the testimony of PO Cumming. Therefore my conclusion is that about 1040 PO Cumming first learned that Mr. Cobb was 'on Act' and assessed as 'low risk'.

About 1045 or 1050 PO Cumming went to Mr. Cobb's cell and found that he had used a bed sheet to hang himself from the rail of an upper bunk.

(c) **The Witnesses**

[9] Production 5: 'Act 2 Care' document, p. 3
[10] all PO Gavin Murray's estimates
[11] PO Cumming's testimony

Aimee Louise Jones (25) unemployed, 25 Forthill Terrace, Jedburgh.
She had been in a relationship with the deceased, Stephen Cobb, for about 2 ½ years prior to his death. He had been in prison for part of that time. At the time of his death he was on remand, charged with attempted murder. He was very upset.
Previously he had served about a year in prison, during which time his mother had died (some months before his own death). He was very much affected by his mother's death. He felt guilty about being in prison when his mother died.
Asked if the relationship between Mr. Cobb and the witness had been going well prior to his remand, she replied, "Yes and no. We were adjusting to him coming out of prison."

On the evening of his remand [29th April 2008] Mr. Cobb contacted her by telephone. He was upset. He was keen to know what was going on outside. He felt that he had let people down. He was keen to arrange a visit by her, to receive money and to contact his lawyer. This was her last contact with Mr. Cobb.

Later that day Miss Jones received a phone call from an employee of Reliance, the court escort company, who told her that he was concerned about Mr. Cobb: he said that he had seen Mr. Cobb receive previous sentences, but he had never seen him react as he did on being remanded. He cried like a baby. He was heartbroken.

Mark Shaw (37) prison officer, 11 years service (all in Saughton).
On 29th April 2008 he was reception officer when Mr. Cobb arrived at reception in Saughton Prison.
One of his duties was to carry out a suicide risk assessment on prisoners arriving at reception, using an 'Act 2 Care' Reception Risk Assessment document. He noted the time of Mr. Cobb's admission as 1647 hours. In section 1 of the form he noted that Mr. Cobb had been 'subject to ACT' during a previous period in custody. Thereafter the witness completed section 2 of the form ('Assessment of behaviour, attitude and risk') by asking the questions set out in the form, recording whether Mr. Cobb's replies were positive or negative, and noting whether or not he appeared to the witness to be displaying any of the features listed therein.
PO Shaw's final assessment (recorded at 1652) was 'NO APPARENT RISK'.

Lynn Muriel Carswell (52) LLB, Dip LP, is a legal researcher, but on 29th April 2008 she was 'practitioner' nurse in the SPS at Saughton Prison. She holds a diploma in nursing, having qualified at Napier University in 2000. Having been employed previously in geriatric nursing, she worked in the prison from 2005, and at reception for three years as at April 2008.
On 29th April 2008 she was on duty at reception when Mr. Cobb was admitted to the prison.

At reception she completed a nursing assessment form relating to Mr. Cobb. She had admitted Mr. Cobb to the prison in 2008. She told him that looked better than the last time she had seen him. He had put on a little bit of weight. She knew that he had drink and drug problems, therefore it was good that he had put on weight.
He "had been accompanied from court by a mental health alert. The first thing I did was speak to him about how he felt." He told her that, "In court he's said things which might make his father believe he'd self-harm, but he had no intention of doing so."
He asked not to be put in a suicide cell, saying that "last time" he had been put in one and it had made his mental health worse.

He was making good eye contact; he had a good, open posture; he looked quite relaxed; there were no signs of alcohol withdrawal and he was not sweating or shaking.
He said that he had been using heroin, Valium and Dihydrocodeine, but he did not want to detox.

He wanted to get to his cell, have a cup of tea and a cigarette, and get some sleep.
Miss Carswell's opinion was that this seemed to be best.

To her, he did not seem to be like someone with suicidal intent. "He was clear that he did not intend to harm himself." She asked him if he had suicidal tendencies. He said that he had such tendencies in the past, but that pretending to his father to be suicidal before court had been "a wind-up." She believed him because of his presentation. He was very open. He said that his mental health became worse if somebody "dug into it in detail." She knew that he had had mental health problems in the past, but at the time of her assessment "he presented as quite together." She had no concerns about his being a suicide risk. If she had been concerned she would have assessed him as 'high risk'.

Mr. Cobb was taken to his cell. That was the last that Miss Carswell saw of him.

In cross-examination Miss Carswell deponed that she was aware of the nature of the problems that Mr. Cobb had previously: in February 2008 he had been very depressed (his depression being linked to his use of drink and drugs) and had been placed on suicide watch.
She had received some training in relation to depression.

Dr. Rashmi Vyas (64) MB, ChB, qualified as a doctor in 1973. He was a general practitioner. He retired in 2002 and became a full-time medical officer in the SPS in the same year. He worked in various prisons. He has worked at Saughton for five years. He takes care of all admissions and makes sure that newly admitted prisoners get their medication. Also he is involved in the daily care of prisoners at clinics. He sees all prisoners on the first day after their admission. He examines them physically, prescribes medication, and retains their medication. He also assesses their mental well-being and decides whether or not they are at risk. He has knowledge of the prisoners' mental health backgrounds. He sits down with the prisoner, creates a rapport, and asks the reason for his incarceration. He asks, "Do you have suicidal thoughts or intentions of self-harm?" If the prisoner says, "No", he looks at them and notes, e.g., whether they look at the floor or at his face. After the doctor's assessment, a nurse sees prisoners.

On 30th April 2008 Dr Vyas assessed Mr. Cobb. The whole assessment process took about ten minutes, with the mental health assessment taking up the first four or five minutes. In the 'Act 2 care' document under 'Doctor Risk Assessment' Dr Vyas wrote, 'No suicidal thoughts or intention of self harm.' He ticked the box beside the printed words, 'No Apparent Risk.' Dr Rashmi noted the time as '8.45'. He deponed that, "I didn't feel that he was at all suicidal at that stage. He did mention that he had a bit of depression, but he was fine now."

In cross-examination he deponed that he had carried out, "Lots and lots… thousands" of risk assessments. Asked if he had placed anybody at risk, he replied that he had.

His attention was drawn to the **'Immediate Care Plan'** at page three of the 'Act 2 care' document[12] which had been completed by Nurse M Clancy. The form is partly printed and partly completed by hand. The date and time of commencement of the assessment, and the duration of the interview, have not been noted.
Under *'Concerns (Cues and Clues)'* Nurse Clancy noted:

> 'Previous self harm and suicide attempts. Denies any desire at present to self harm/end his life. Tearful during interview. Very worried about the impact this will have on his family __ he feels isolated from them.'

Under *'Precipitating Factors' (Events and Triggers)'* she noted:

> 'Recent charges of attempted murder. Stephen is voicing that he feels he can never get out of the offending cycle. Recent self harm attempt.'

Dr Vyas deponed that 'Precipitating Factors' meant, "Has anything happened to him from the time he came in?"

The following is printed below the 'Precipitating Factors' section:

> 'The First Case Conference should now be immediately convened. However, if it is not possible to hold the First Case Conference now, the following Immediate Care Plan must be agreed and enforced until it is convened.
> **Immediate Care Plan:** Record the agreed decisions and the reasons why, ensuring that the above information is taken into account. (If there is disagreement between those involved in the Regime Decisions, you must ensure a safe environment is provided, and also ensure your decisions do not isolate/alienate the Prisoner as a result.)'

Dr Vyas deponed that those present at the first case conference would be:

- the nurse in the ward;
- a doctor;
- the senior officer of the wing; and
- one or two other prison officers there.

The case conference must be held within 24 hours.

Below instructions relating to the Immediate Care Plan, Nurse Clancy made the following notes:
Under *'Regime' and 'Level of Support'* she noted:

> 'Low'.

Under *'Decision'* she noted:

> 'Low risk'.

She made no note under the word, *'Reason'*.
Opposite *'Maximum Contact Interval'* she noted:

> '30 min observation'.

Opposite *'Phone Access'* she noted:

> 'Requests phone call to family. Please arrange for this.'

Nothing is noted opposite 'Items of Clothing Not Permitted'.
Opposite *'Any Items Not Permitted'* Nurse Clancy noted:

> 'Razors'.

Nurse Clancy noted that the prisoner had been informed of the outcome of the assessment at 0945 on 30th April 2008.

---

[12] Production 5

Dr Vyas deponed that prisoners assessed as 'high risk' would be put in an 'anti-ligature' cell. Such cells are designed to prevent people from hanging themselves.
'Low risk' prisoners are put in a safe environment, i.e. a cell near to the officers' gallery.
On the basis of the immediate care plan, an assessment is made of items (such as sharp objects) to be removed from the cell. The immediate care plan is an interim plan, in force pending a case conference.
Dr Vyas opined that the 'Act 2 care' policy is fairly well established and works very well.

In answer to my questions Dr Vyas said that he was aware that Mr. Cobb had suffered from depression and that he had tried to commit suicide. "I asked did he have a history of depression and he was feeling much better." Referring to medical notes, Dr Vyas deponed that on 30th April 2008 Mr. Cobb "…said there is no history of depression presently, though there had been depression in the past. He confirmed that he had excess alcohol in the past few weeks, prior to coming to the prison." He said that he had access to Mr. Cobb's medical records. Asked if he read them, he replied, "I would have glanced at them, just to keep me aware of it. But there was no need for me to go very deeply into that."

By 'own cell', Dr Vyas meant a cell occupied by the prisoner alone.

He deponed that "Quite a few" of the thousands of prisoners assessed by him may have had histories of depression, or of being on suicide watch. In assessing Mr. Cobb, Dr Vyas took into account Mr. Cobb's history of depression and having been on suicide watch.

John Miller Hutchison (52) is unemployed and gave his address as c/o Lothian and Borders Police. On the 30th of April 2008 was serving a sentence in Saughton Prison. At that time he had served about one year. He was a 'pass-man' in the 'overnight hall', Hermiston 3, north wing, in which prisoners were accommodated during their first night in prison. On the following morning they were assigned to another hall.

Pass-men cleaned the cells and served meals. Mr. Hutchison deponed that pass-men try to help incoming prisoners, for example by giving them tea and tobacco. If they "spot a problem, they'll flag it up with a P.O."

On 30th April 2008 he became concerned about a young fellow called Stephen (Mr. Cobb). Some time before lunch (he thought between 1000 and 1100, although he was not sure) he had just settled down for tea and a cigarette when Mr. Cobb sat down and asked him if there was "any chance of a snout." They talked for about ten minutes. Mr. Cobb said that he "had not long been released and was back in" for "fighting with his father-in-law." He also said:

> "But I don't know if I can handle it, __ another couple of years in here. I'm thinking of doing myself in."
> "I don't know if I can handle this, __ daein' more time."

Mr. Hutchison told him that he would be all right.
The fiscal asked Mr. Hutchison, "Did you have any genuine concerns for him when he made that comment. Did you believe him?" He replied, "No' really. No."

A prison officer, "Wee Billy" (P.O. William Cumming), came along to put Mr. Cobb in his allocated cell. Mr. Hutchison asked the P.O. for permission to pass tobacco and cigarette paper under the cell door to Mr. Cobb, which permission was granted.

P.O. Cumming placed Mr. Cobb in the cell. Seconds later, Mr. Hutchison said to P.O. Cumming "The boy did say he might hurt hissel'." Mr. Hutchison deponed that, "Often you get it and it's a false alarm. I know the boy was upset at being in jail. I didnae really think there was anything wrong, but I told him anyway. I didnae think it was genuine, but I though I'd better."
P.O. Cumming went to Mr. Cobb's cell immediately, intending to speak to Mr. Cobb. Mr. Hutchison deponed that, "I know Billy spent some time with him." About half an hour later P.O. Cumming returned to Mr. Cobb's cell and shouted "Alarm!" All the prisoners were locked up.

Mr. Hutchison was asked for his best estimate of the time that passed between P.O. Cumming leaving Mr. Cobb's cell and the alarm going off. He replied, "Half an hour, maybe more. That's a guess. We're not really taking much notice. You're just going about your business.

In Saughton prison there is a 'peer' system, in terms of which more experienced prisoners help the less experienced. Mr. Hutchison believed that the system is sanctioned by the prison governor. One of his friends, Jamie ("a lifer") is a peer worker. They go out of their way to help others.

Moreover the prisoners themselves operate a system of 'listeners', __ prisoners who attempt to help other prisoners who may have problems. As Mr. Hutchison put it, "These guys will sit and listen for hours on end. If they think that there's a problem they can get instant access." He added, "They're very trusted. They can walk throughout the whole jail, so they've got a high position of trust as well." Prisoners are made aware of the 'listeners' system on the first night in custody.

Mary Stuart Clancy (41) is a community care assistant. She gave her address as c/o Lothian and Borders Police. She is a Registered Mental Health Nurse, having qualified in 1992 after three years of mental health training. She worked in the community with people who suffered from dementia. She also worked in general practitioners' surgeries with patients suffering from mild to moderate anxiety and from mild to moderate depression. She has substantial experience of dealing with people who are suffering from clinical depression.
Having worked in mental health nursing for about 15 years she began to work in Saughton prison in January 2008. She was employed there as a 'practitioner nurse', not as a mental health nurse. She was concerned with holistic health needs, __ mainly physical care and needs. The purpose of her assessment of prisoners was to find out if the prisoner required referral to other services. She considered mental heal, addiction, blood-borne viruses, height, weight and blood pressure. If a mental health issue arose she would refer it on.

On 30th April 2008 Nurse Clancy assisted in the assessment of Mr. Cobb, who had already been seen by Dr Vyas (that day) and Nurse Carswell (on the previous evening). Normally such an assessment takes about five minutes. Mr. Cobb's assessment took about 15 minutes.

When he came into the room his eye contact was not good. As she was taking his blood pressure she saw and touched cuts on his arm. The cut were self-inflicted. He said that he had not made the cuts in prison. The cuts were scabbed over and appeared to be a

few days old. She told him that she was worried about whether he wanted to hurt himself or end his life.
He told her that:

- he did not want to be in prison;
- he was fed up with coming in and out of prison;
- his family did not know that he was there;
- his mum had died the year before; and
- he had received help outside prison from 'cruise', bereavement specialists.

His eye contact was better. He was quite tearful, which Nurse Clancy felt that this was appropriate because he was talking about his mother at the time.

She told him that:

- she would speak to officers with a view to allowing him to speak to his family;
- she was concerned that he would hurt himself or end his life;
- she was going to "put him on Act."

She was concerned about his having lost his mother and about the fact that his family was not close by.

Although she had told him twice that she was concerned that he might hurt himself or end his life, he denied having such intentions. She believed him. By this time his eye contact was good and he said that he wanted to accept some help. They had quite a good rapport and he had calmed down by the time he was leaving the room.

Nurse Clancy's final assessment was that he was vulnerable. He had a stressful time when he was in prison previously, but he had coping strategies and family support. With assessment, he could get treatment if required. She wanted to "put him on Act at low risk" so that he had support from officers and 'listeners'. At that stage she did not consider that he was a suicide risk. Had she assessed him as a suicide risk she would have asked that he be put in an anti-ligature cell.

She was asked, "At low risk of what?" She replied, "He's a vulnerable person. His mental health's deteriorating. He may have been at risk of further self-harm. I think I asked for no razors to be allowed. And he's checked every 30 minutes." The intervals at which the prisoner is checked can be reviewed.

I asked what checking involved. She replied that officers in the hall would speak to the prisoner, __ specifically about self-harm and suicide. She thought that in order to do so they entered the cell.

She deponed that the checking interval for 'high risk' prisoners is 15 minutes.

She made the handwritten entries under 'Immediate Care Plan' on page 3 of the 'Act 2 Care Document' in Production 5 after Mr. Cobb had left the room in which the assessment had taken place.

She deponed that the effect of Mr. Cobb "being put on low risk" is that officers in the hall are made aware and put him on a computer. The hall manager is informed and they start the process of checking.
I noted the following questions by the procurator fiscal and answers by the witness.

Q. "The 'Act book' is the only record of [Mr. Cobb] being on Act?"

A. "Yes, __ or until I telephone."
Q. "Therefore intimation is by telephone or receipt of the book?"
A. "Yes. Either way."
Q. "How does the hall manager receive the book?"
A. "The officer I'd give it to would give it to him, or I'd telephone him and say, 'I've put this prisoner on Act and a prison officer is coming over with documentation.'"
Q. "The prison officer who returns [the prisoner] to the cell will be the one with the Act book?"
A. "Yes."
Q. "Or, alternatively, you phone?"
A. "Yes."

The witness agreed that in Mr. Cobb's case the book did not go with him to the hall. She deponed that, "I gave [Mr. Cobb's] book to a prison officer, 'Here's his documentation', and I phoned the hall and said {Mr. Cobb] had been put on Act and a 30-minute observation." She did not know if Mr. Cobb was still there when she handed the book to the prison officer. There was a large group of prisoners, which is the norm. She knew the officer to whom she handed the book only as 'Les.' She did not know the name of the prison officer to whom she spoke by phone.

The witness was asked about the time which elapsed between last seeing Mr. Cobb and making a phone call to the hall. She replied, "Probably a considerable amount of time. Probably about an hour or so, __ when I'd seen that group of prisoners, when that group was being taken over by the prison officers. So far as I was aware [Mr. Cobb] was safe." Later the following exchange took place:
Q. "Your phone call was up to an hour after [Mr. Cobb] left your company?"
A. "Yes. Prisoners were on their way over and wouldn't have arrived yet."
Q. "So your phone call would have arrived *[sic]* prior to the prisoners?"
A. "Yes."

She thought that Mr. Cobb was the only prisoner to be put 'on Act' that morning and that only one 'Act' book would have been handed over. She saw about 15 prisoners in one group that morning. After assessment they go to two holding rooms. Other (non-nursing) facilities (e.g., 'Phoenix Futures', concerning Phoenix House drug rehabilitation centres) are available to prisoners after assessment and before returning to the hall.

William James Cumming (37) is a prison officer with nine years' service, all in Saughton Prison. Some prisoners refer to him as "Billy". He is a 'residential' officer, which involves working in a hall and, *inter alia*, meeting the needs of prisoners, their daily welfare and their work.

On the 30th of April 2008 he was working as a residential officer on level 3 of Hermiston Hall, the 'first night in custody' wing. There were about 20 to 25 inmates in the hall on that date. He was on early shift, which begins at 0715. He became aware that Mr. Cobb, whom he knew "from previous times", was in custody there. PO Cumming described Mr. Cobb as a chatty person who never caused any problems.
On the morning of 30th April 2008 PO Cumming spoke to Mr. Cobb, who seemed to be fine. He told Mr. Cobb that he had to go to the doctor. Mr. Cobb said that he did not want to go. PO Cumming told Mr. Cobb that he thought that everyone had to go to the doctor, but he would check with his manager and, if it was compulsory, he personally would take him. PO Cumming checked with his manager, who told him that in view of

the prison authorities' duty of care, Mr. Cobb must be seen by the doctor. Mr. Cobb had a cigarette. He and PO Cumming talked about the Borders and about rugby. Thereafter PO Cumming took Mr. Cobb (alone) to see the prison doctor, 'dropping him off' (he thought) about 0830. Other prisoners had already gone.

PO Cumming next saw Mr. Cobb back in the hall round about 0945/1000. Mr. Cobb was sitting with the pass-man, 'Hutchie' (John Miller Hutchison). They were chatting. Mr. Cobb seemed fine and PO Cumming had no concerns about him.

Mr. Cobb asked to make a phone call. PO Cumming told him that he was busy just then, but not to worry: he would arrange for a phone call. He also told him that he would "get his wages". So that he could carry on with his duties, PO Cumming put Mr. Cobb in his cell and locked the door. He deponed that Mr. Cobb "was fine. I had no concerns."

'Hutchie' asked PO Cumming if he had a minute. Referring to Mr. Cobb, he told PO Cumming, "He's talking shite. You better have a word with him."

PO coming went to Mr. Cobb's cell and asked him if he was OK. He said that he was. PO Cumming said, "The pass-man's a bit concerned about you." Mr. Cobb replied, "No." Asked by PO Cumming if he had any problems, he replied, "No."
PO Cumming said, "You're not going to hurt yourself Stephen?" He replied, "No."
PO Cumming deponed that he was "...looking for body language. He seemed straight up, looking me in the eye. He had good body posture, good eye contact."

He left Mr. Cobb in his cell at about 1005. He did not think that Mr. Cobb was at risk of hanging himself. He was quite calm. There was no stress in his face. At that time PO Cumming did not know that he was "on Act."

When a prisoner is "put on Act" this is made clear to the prison officers on the wing. PO Cumming would expect the "Act book" to come back with the prisoner, and to be told that the prisoner was "on Act" by whoever brought the "Act book" to the wing. He assumed that it was possible for a prisoner "on Act" to return from the medical centre without his "Act book" if someone forgot the book. Prisoners come back in dribs and drabs. The prisoners who did not want to speak to the Phoenix House addiction people came back early to the hall.

A prisoner would know that he had been put "on Act." He is told that he will be looked after and the procedures are explained to them. "So it's not a shock if somebody's observing them." The prisoner would see the "Act book" in the prison officer's hand.

At about 1040 PO Cumming learned that Mr. Cob was 'on Act" and assessed as 'low risk' when PO 'Les' Brown handed Mr. Cobb's 'Act 2 Care' documents to PO Cumming.[13]

PO Cumming went to the hall landing and asked the officer on duty there if the nurse had phoned. The officer said, "She's just off the phone." He went to the office there and tried to phone the nurse, intending to chat to her about Mr. Cobb, but there was no reply. He came out of the office, talked to prisoners, put them in cells, and then went to see Mr. Cobb. The time was probably about 1050, or just before 1050.

[13] Production 5

When he was asked what he found in Mr. Cobb's, PO Cumming became very distressed. He deponed that he opened the door of Mr. Cobb's cell and said, "Right, Stephen. I'll get your phone call." He continued, "I thought he was sitting and I noticed the ligature. I screamed' 'Staff! Staff! Staff!' I went back in and lifted him. His head was [???]. Andy Brown helped me. He worked on the knot as I was holding him." He held Mr. Cobb up. "Other staff helped cut him down. I placed [Mr. Cobb] on the floor and placed a mouth guard in his mouth. I checked for pulse and breathing. Andy Brown and I started C.P.R." They continued with C.P.R. until medical staff arrived.

Mr. Cobb was the sole occupant of the cell.

Asked if any changes were necessary to improve the system of work, PO Cumming replied, "No' really. No. We tried our hardest."

In cross-examination PO Cumming was asked if he would have done anything differently if he had the immediate care plan in front of him. He replied that he would have carried out observations on the prisoner. He had seen Mr. Cobb at about 1005. He next saw him at about 1045. There was, a gap of about 45 minutes.

Where checks on a prisoner every 30 minutes have been ordered, they are usually carried out at intervals of around 20 or 25 minutes, around the clock. An officer enters the cell and speaks to the prisoner, asks if he wants a shower, and assesses how he is feeling. At night the cell door is not opened. The cell light is switched on from outside the cell and the officer looks at the prisoner through a sliding hatch.

The 30-minute observation period is part of an interim assessment until a case conference is held. Those attending the case conference are the prisoner, the hall manager, a nurse and a gallery officer.

An officer cannot extend the 3-minute period. He can assess the prisoner as 'high risk' and put him in an 'anti-ligature' cell and in 'anti-ligature' clothing.

Anyone putting a prisoner 'on Act' should tell the hall manager and officers immediately. That is clear in the training. Therefore the nurse should have informed the hall and the escort officers straight away the Mr. Cob was 'on Act.'

Andrew John Brown (45) is a prison officer with 21 years' service, 6 years of which he has served in Saughton Prison. Nurse Clancy and PO Cumming also refer to him as 'Les' Brown.
On 30th April 2008 he was on duty in Houston Hall when he heard PO Cumming's emergency call. He ran to Mr. Cobb's cell and assisted other officers. Mr. Cobb had tried to hang himself.
On a unit in the cell PO Brown found a letter[14] apparently written by Mr. Cobb and addressed 'To Aimee.' It reads:

> 'Well I fucked up again Im thinking it might be better if I just do my self in I cant life with out you I love you and all I want is to be with you but I do these stupid things and with my mum dieing it's really fucked with my head and to top it all

[14] Production 7

off I was haert brocken about you sleeping with that cunt and I dont blam you for it I blame my self I think Im losing the plot. Babe I need help'

PO Brown notified the governor about the letter.

Gavin Murray (35) is a prison officer with 11 years' service, having served eight years at Shotts Prison and three years at Saughton Prison.

On the morning of 30th April 2008 he was on duty at the 'desk area' of Hermiston Hall. After breakfast, at about 0730, he saw Mr. Cobb and other prisoners being taken from the hall to the prison health centre. He remained at the desk in the hall all morning, where he was available to receive telephone calls. If a phone call came in it would be answered.

About 1000 Mr. Cobb returned to the hall. PO Murray received a telephone call concerning Mr. Cobb after Mr. Cob had returned to the hall. About two or three minutes after that telephone call, the 'Act 2 Care' book concerning Mr. Cobb arrived in the hall. He estimated that he received the phone call at 1005, 1010 or 1020. He estimated the minimum gap between Mr. Cobb returning to the hall and receipt of the phone call as 15 minutes, the maximum gap as 30 minutes.

The 'Act 2 Care' book arrived in the hall "shortly after 1030: 1035, something like that." PO 'Les' Brown brought it into the hall. PO Cumming took the book from PO Brown "pretty much in front of" PO Murray, who was at the desk.
PO Murray was asked how PO Cumming reacted. He replied, "He wasn't aware that [Mr. Cobb] had been placed on low risk. He asked what this was about. I had just received the phone call three to five minutes before." Nurse Clancy had told him that Mr. Cobb had been "placed on low risk." "I said I'd received the phone call." While officers Cumming, Brown and Murray were conversing, Mr. Cobb was in his cell, which was about 30 feet from the desk, on the same level.
Asked if Nurse Clancy had given any reason for Mr. Cobb being 'on low risk', he replied, "She thought he was acting odd. But she didn't think he would do himself any harm."
PO Murray deponed that the person putting a prisoner 'on Act' should notify the hall manager. The 'Act 2 Care' book should arrive in the hall along with the prisoner.

He continued, "PO Cumming went down into the section. I know he found him [Mr. Cobb] at 1050." He could be precise about the time because of the nature of the incident. He logged it at the time. PO Cumming shouted for staff assistance. He and PO Brown ran to the cell. PO Cumming was supporting Mr. Cobb's weight. Mr. Cobb was hanging from a bed sheet, which had been used as a ligature. One end of the bed sheet had been secured to the top rail of the upper bunk bed.
Later in his testimony he made it clear that Mr. Cobb had been hanging by his neck, with the bed sheet round his neck.
PO Brown tried to undo the knot in the bed sheet and get Mr. Cobb down. It was quite tight. PO Murray left the cell to get scissors from a 'crash pack'. By the time he returned to the cell, Mr. Cobb was on the floor and other prison officers were "working on him."

Mr. Cobb was removed from the cell in a wheelchair. PO Murray believed that Mr. Cobb had an oxygen mask on, but he was not sure.

Asked if there were any problems with the 'Act 2 Care' system, PO Murray replied "No' really." He was not sure about what else might be 'tweaked' to make it better.

He deponed the health centre is in a separate building from the hall. He was unsure of the number of prisoners who went from the hall to the health centre that morning, but it could have been 15 or 16.

Peter McPherson (49) is acting unit manager at Saughton Prison. He has worked in the Scottish Prison Service for 24 years, beginning his career as a prison officer. He has worked in every department in the prison.

On the morning of 30th April 2008 he was 'hall manager' in Hermiston Hall. Also on duty were two prison officers in the hall and a third prison officer manning the desk on level 3. The desk officer controls the movements from that flat, keeps computer records, ensures that paperwork is correct, etc.

The hall manager is probably the most important person in the 'Act 2 Care' system. He talks to the prisoner and tells staff why the prisoner is 'on Act 2 Care'. Also, he makes sure that staff:

- follow procedures;
- fill out the proper documentation; and
- "sign it off at the end of every shift"

The hall manager is responsible for updating the computer record.

Mr. McPherson deponed that once a prisoner had been "assessed as low risk"

a. first of all, as soon as possible the person who made the assessment should inform the hall manager of the area in which the prisoner is located, __ normally by telephone; and

b. if the prisoner is placed 'on Act' outwith the hall, the 'Act 2 Care' book relating to the prisoner should come to the hall along with the prisoner. If such a prisoner returns to the hall without the 'Act 2 Care' book, the hall manager should contact the person who placed the prisoner 'on Act' and tell that person that he wants the book as soon as possible.

When informed of the assessment by telephone, the hall manager would ask the person who made the assessment why the prisoner had been placed 'on Act' and what the care plan was. Therefore, provided that the information was passed by telephone, the hall manager would know what was required without being in physical possession of the 'Act 2 Care' book.

The hall manager should always be contactable. He carries a radio. Main control (the Electronic Control Room) would inform him by radio that he has a call and that he has to get in contact with someone. The Electronic Control Room is manned 24 hours per day.

The person putting a prisoner 'on Act' should telephone the hall manager first. If the hall manager cannot be contacted, as a matter of common sense the next best step is to telephone the desk officer in the hall.

The hall manager passes on information about prisoners 'on Act' verbally to the prison officers in the hall. Also the 'Act 2 Care' book goes to the prisoner's flat. Therefore the officer in charge of the flat is aware that the prisoner is 'on Act' and how often the

prisoner should be seen. At the end of each shift the 'Act 2 Care' book is filled out and signed off by the hall manager. At the end of each shift the desk officer passes information about the prisoner to the incoming desk officer. The incoming desk officer passes on the information verbally to the other incoming officers. The 'Act book' is available at the desk to be read by all the incoming officers.

There are three shifts. At night only one officer is on duty in the hall. No record is kept of the time of each visit to the cell of a prisoner 'on Act'. At the end of each shift the officer responsible writes general observation in the 'Act 2 Care' book.

He did not receive a call about Mr. Cobb being placed 'on Act'.

Asked if he had any suggestions as to how the system of work could be improved so that a prisoner could not return to the hall without his 'Act 2 Care' book, Mr. McPherson said, "We have training, including training for nurses. I would suggest that it's re-emphasized in 'e-learning' training that there is a need to inform the hall manager in charge of the area that any prisoner has been placed 'on Act'."
The requirement to inform the hall manager forms part of a multitude of issues in training. Mr. McPherson recommended that training should emphasise the necessity of contacting the hall manager first, and urgently, in cases such as Mr. Cobb's.

'E-learning' takes about an hour on a computer. There is a test at the end and (the trainee) must get 70% to pass, otherwise (the trainee) must re-sit the test. That includes all staff.

As part of yearly refresher training Mr. McPherson also gives classroom training, "...making sure that the staff have done 'e-learning' and are up to speed. Then we look at specifics: how often should the prisoner be observed? __ high risk, low risk, etc. It takes about one and a half hours. A lot of it is debate between myself and (the trainees)."

(4) Conclusions

My clear impression from the evidence was that SPS is not only alive to the difficulties of identifying and caring for vulnerable prisoners, but is also genuinely concerned for their care.

Further, on the evidence before me I am satisfied that if it is operated as intended, the 'Act 2 Care' system is likely to be effective in achieving its key aims, including:

> 'To assume a shared responsibility for the care of those at risk of self harm or suicide.'
> and
> 'to identify and offer assistance in advance, during and after a crisis.'

Training in the system is given to all staff and refresher training is undertaken annually.

Moreover, my impression of the individuals who gave evidence at the inquiry was that they are genuinely responsible and caring people. In particular I was favourably impressed by Nurse Clancy, PO Cumming and Mr. McPherson, the acting unit manager.

- Before Nurse Clancy's assessment, a prison officer, another nurse and a doctor had assessed Mr. Cobb. Nurse Clancy was the only one who identified Mr. Cobb

as being at risk of self harm. Her nursing assessment lasted for 15 minutes, rather than the normal 5 minutes. On the whole of the information in her possession, including Mr. Cobb's history, her assessment cannot be faulted. The contrary was not suggested.

- PO Cumming was obviously an experienced, sensible, caring individual. He had gone out of his way to help Mr. Cobb on the morning after his remand. Upon being told what Mr. Cobb had said to the pass man, and before he knew of Nurse Clancy's assessment, PO Cumming went to Mr. Cobb's cell spoke to him and assessed the situation informally. His assessment was that Mr. Cobb whom he knew from his previous incarceration) was not at risk. That assessment was not criticised before me.
- Mr. McPherson began his career as a prison officer. He was a compelling witness who inspired confidence. He and impressed me as a sensible, intelligent man with a thorough knowledge of prison administration and prisoner care, including the 'Act 2 Care' system.

The 'Act 2 Care' document serves several functions: it gives guidance to those who use the system; parts may be used as an aide memoire; parts may be used in assessing the prisoner's continuing needs and in planning for his care; and parts provide for keeping a record of actions taken, etc.

My impression is that the document was designed to meet the needs of a prisoner who is assessed as at risk in the hall in which he is resident. In a hall, information concerning an assessment may be disseminated quickly and easily. But where a prisoner is 'put on Act' when he is away from his hall, there is a requirement to intimate the assessment to the prisoner's hall immediately, in order that the immediate care plan can be implemented as an interim measure. Such intimation depends (a) on the person who made the assessment informing the prisoner's hall manager immediately; and (b) the 'Act 2 Care book and the prisoner being returned to the prisoner's hall simultaneously. In my opinion that is a sound system, provided that it is operated as intended.

With the benefit of hindsight, it is now clear that there is scope for human error leading to the prisoner returning to his hall before the 'Act 2 Care' book arrives there, and before intimation has been given to the hall manager, as happened in this case. But in my opinion the human error in this case did not contribute to the death. Mr. Cobb returned to the hall at about 1000. Thereafter the pass man alerted PO Cumming to a possible problem and (before becoming aware of the Nurse Clancy's assessment) PO Cumming went to Mr. Cobb's cell and spoke to him. Having concluded that Mr. Cobb was not suicidal, PO Cumming left the cell at about 1005. He next saw him at about 1045 or 1050, a gap of about 40 or 45 minutes. In fact, PO Cumming's assessment may well have been correct at the time it was made. Nobody, including Nurse Clancy, assessed Mr. Cobb as being at risk of suicide. Moreover, a person suffering from clinical depression may be plunged into suicidal despair in an instant, for no discernable, rational reason. Nothing in the evidence before me suggested that had Mr. Cobb been checked at 1030 and seemed to be all right, he could not have hung himself by 1045 or 1050. As Mr. Chaffey pointed out, no evidence was led as to the time which would have been taken for Mr. Cobb to injure himself fatally by hanging.

Mr. Chaffey founded on the fact that Mr. Cobb did not tell anyone of his intention to commit suicide. He also founds on the opinion of Sheriff Principal Sir Stephen Young in an inquiry into the death of Scott Currie to the effect that notwithstanding the fact of

his imprisonment, a prisoner remains an autonomous human being. With all due respect, I do not find the notion of autonomy to be helpful in the context of the case before me. I infer from the circumstances as a whole, from Mr. Cobb's history of depression and from his suicide, that in his cell he suffered an acute episode of clinical depression which caused him to take his own life. It seems to me that in such a situation a man is no more autonomous in any meaningful sense than a man who is suffering from, e.g., dementia or an acute malarial attack: such a person is completely overwhelmed by his condition. This is recognised implicitly in the 'Act 2 Care' system. In attempting to identify prisoners who may be at risk of self harm or suicide, personnel are trained not to rely on verbal assurances by the prisoner, but to look for objective, non-verbal clues as to the prisoner's true mental condition (e.g. lack of eye contact).

Although I am not satisfied that the failure to comply with the system in this case contributed to Mr. Cobb's death, it is possible that such a failure could contribute to a death in future. In my opinion such a failure might be prevented by amending the 'Act 2 Care' procedure and book. In my view it would be appropriate to amend the amend the 'Act 2 Care' book in order that:

(i) when a prisoner is assessed under the 'Act 2 Care' system as being at risk of self harm or suicide at a time when he is outwith the hall in which he is resident, the person making the assessment should immediately (and prior to informing the prisoner's hall manager) inform the prison officer in charge of escorting the prisoner of the assessment, the reasons therefore, and the immediate care plan;

(ii) in such a case, the identities of both the prison officer in charge of the escort and the hall manager, and the times at which they were informed of the assessment, the reasons therefore, and the immediate care plan should be recorded contemporaneously in the prisoner's 'Act to Care' book;

(iii) in such a case, the prison officer in charge of the escort should ensure that the prisoner does not leave the location at which the assessment has been made until the prisoner's 'Act 2 Care' book has been handed to him;

(iv) in such a case, on the prisoner's return to the hall in which he is resident, the time of the prisoner's arrival in the hall, the simultaneous arrival of the prisoner's 'Act 2 Care' book and the identity of the escorting prison officer should be recorded in the prisoner's 'Act to Care' book by the desk officer in the hall; and

(v) The 'Act 2 Care' book should be amended to allow for the foregoing records to be kept in a separate section, to be used when a prisoner who is then outwith his hall is assessed as being at risk of self harm or suicide.

J.P. Scott

APPENDIX (A)

SUBMISSIONS

For the Crown

I would respectfully ask your Lordship to consider that the following facts are established in terms of s.6 (l)(a) and (b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

That the deceased Stephen Robert Thomas Cobb of 21 Forthill Terrace, Jedburgh born on the 4th of May 1984 died at 0705 on the 2nd of May 2008 at ward 118, the Intensive Care Unit of Edinburgh Royal Infirmary from an incident which occurred at approximately 1050 hours on the 30th April 2008 at level 3, Hermiston House, Saughton Prison, 33 Stenhouse Road, Edinburgh.
and
That the cause of death was suspension by a ligature

I do not propose to make any submissions in respect of s.6(1) (c) and (d) of the said Act.

I would ask your Lordship in respect of s.6(l)(e) of the said Act to take cognizance of the following factors.

That Stephen Cobb was a young man with a history of alcohol addition and who used both legal and illegal drugs, that he had an extensive history of self harm and depression and had on a number of occasions attempted to take his own life, that he had previously and recently whilst in prison been "placed on Act" as at high risk of taking his own life and had drawn to the attention of prison staff that he was suffering a number of personal problems, also set out in his suicide note to his partner Aimee Louise Jones relating to the loss of his mother, his and Miss Jones' relationship and that he felt trapped in an offending cycle which had resulted in him being incarcerated again.

I would however ask that this be set against the background that a clear a system of work existed in Saughton Prison in relation to the physical and mental health of inmates. Mr. Cobb had clearly in the first twenty four hours within prison been seen and assessed by three health care professionals and two trained prison officers, all with extensive experience, who had also as well as carrying out the assessment procedure specifically asked the deceased did he intend to self harm and/or take his own life and received a negative response, which they believed. It has been said that had Mr. Cobb been assessed as at a high risk of suicide different steps would have been taken to care for him however it was the opinion of the five persons who assessed him that he did not meet the test.

It is further clear that in the context of a busy prison on this occasion the procedure as spoken to in relation to prisoners deemed to be at risk has not been followed in so far as the transfer of information between staff dealing with the said prisoner has not been done immediately and there has been a delay as a result of human error. The intervention of others within this time frame however means that Mr. Cobb was effectively "checked" by staff within the timescale envisaged had the process worked as described, i.e. 30 minute checks. The assessment would, if properly enforced, have allowed for Mr. Cobb to be alone in his cell for thirty minutes without interference.
I would invite your Lordship to consider that the facts have been established in terms of s.6 of the said Act and to consider your determination.

For the Scottish Prison Service

1. <u>Overview</u>

The legal framework of the Inquiry is entirely straightforward. The Inquiry takes place under the framework provided by the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. The purpose of the Inquiry is defined in Section 6(1) of the Act which is in the following terms:

> "At the conclusion of the evidence and any submissions thereon or as soon as possible thereafter, the Sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction-
>
> (a) where and when the death and any accident resulting in death took place;
> (b) the cause or causes of such death and any accident resulting in the death;
> (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
> (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
> (e) any other facts which are relevant to the circumstances of the death."

In my submission, as far as SPS is concerned, we have heard no evidence during this Inquiry which would justify anything other than formal findings under the 1976 Act, namely:

- date;
- time;
- place; and
- cause of death.

We have heard no evidence of any reasonable precautions whereby the death might have been avoided; no evidence of any system of working which contributed to the death; and there are no other facts which are relevant to the circumstances of the death as far as SPS is concerned.

2. <u>Section 6(1)</u>

Section 6 (1) (a) of the 1976 Act deals with when and where the death took place.

• Date

This can be taken from the post mortem report (Crown Production 2) which is a matter of agreement in the joint minute. It indicates that Stephen Cobb died on 2 May 2008.

• Place

Again, this can be taken from the post mortem report (Crown Production 2) which is a matter of agreement. It indicates the place of death as Ward 118, Intensive Care Unit, Edinburgh Royal Infirmary.

• Time

Again, this can be taken from the post mortem report (Crown Production 2) which is a matter of agreement. It indicates the time of death as 07:05 hours.

Section 6 (1) (b) deals with the cause of death.

• Cause

This can be taken from the post mortem report (Crown Production 2) which is a matter of agreement in the joint minute. It indicates death was recorded as being the result of (1a) suspension by ligature.

Section 6 (1) (c) deals with the reasonable precautions, if any, whereby the death might have been avoided. There are two aspects to this subsection - the precaution must not only be reasonable, but it must also be shown that it might have avoided the death.

- **Reasonable Precautions**

In my submission we have heard no evidence of any reasonable precautions on the part of SPS staff which might have avoided Stephen Cobb's death. I appreciate that your Lordship may take the view that, with hindsight, the ACT 2 Care documents should have been completed and sent with Stephen Cobb back to the hall in the prison and that Prison Officer Cumming should have been informed earlier. However, it is my submission that this should not result in a finding under subsection (c).

It is my submission that there has been no evidence led that had the ACT 2 Care document been completed on time and the prison officers been informed earlier, Stephen Cobb's death might have been avoided after Prison Officer Cumming spoke to Stephen Cobb in his cell at 10:05.

Stephen Cobb was admitted to HMP Edinburgh on 29 April 2008 and attempted to take his own life within the prison on 30 April 2008. During the short period he was under the prison's care, Stephen Cobb had four individual assessments of his risk of self-harm and suicide by four different members of SPS staff. He was also asked if he intended to harm himself by Prison Officer Cumming at 10:05 on 30 April 2008. At no point did Stephen Cobb inform anyone he intended on committing suicide, or that he had suicidal thoughts.

Although I do not seek to criticise Mrs. Clancy, evidence has been led by an experienced SPS Unit Manager, Peter Macpherson, which indicates that she did not take all of the steps she was required to carry out under the ACT 2 Care policy. The Unit Manager confirmed that the SPS member of staff who places an individual prisoner on ACT 2 Care must call the manager of the area where the prisoner is held to inform them that an ACT 2 Care book has been raised. The book should also be completed and passed to a prison officer to ensure it goes with the prisoner back to the hall. Mrs. Clancy did not call the Hall Manager after placing Stephen Cobb on ACT 2 Care after she had assessed him as "at risk". Mrs. Clancy did not make a telephone call to the hall to inform them she had put Stephen Cobb on ACT 2 Care until 1 hour after her assessment, at around 10:40.

Notwithstanding this delay in my submission there has been no evidence led that carrying out half-hourly observations would have prevented Stephen Cobb's death. There has also been no evidence led about the length of time it took Stephen Cobb to attempt to take his own life.

Any reasonable precaution must be one 'whereby the death....might have been avoided'. As Carmichael says in 'Sudden Deaths and Fatal Accident Inquiries', 3rd edition, 2005, page 174: 'Certainty that the...death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a "probability" but a real or lively possibility that the death might have been avoided...'. In my submission there has been no evidence led that had there been no delay in notifying Prison Officer Cumming there was a real or lively possibility that the death of Stephen Cobb could have been avoided.

In my submission Stephen Cobb did not disclose his intentions to any member of SPS staff who assessed him during 29 to 30 April 2008. All of the SPS witnesses involved correctly applied their ACT 2 Care training to assess any non-verbal indicators and indicated that Stephen Cobb did not present a risk of suicide. In my submission there was no reasonable precaution that any member of SPS staff could have taken that might have prevented the death and I would resist a finding under section 6 (1) (c).

Section 6(1)(d) deals with the defect, if any, in any system of working which contributed to the death. Again, there are two aspects to this subsection. The system must be shown to be defective and that must have contributed to the death.

- **System of Working**

In my submission, there has been no evidence led that the system of working at HMP Edinburgh contributed to Stephen Cobb's death in any way. Peter Macpherson gave clear evidence on how the ACT 2 Care policy should be applied at HMP Edinburgh and what is expected from staff.

In my submission we have heard no evidence that the ACT 2 Care policy itself or the system of working at HMP Edinburgh is defective. By contrast, we have heard that ACT 2 Care is a robust and well regarded system; that all SPS staff have been trained in it; and that they are fully aware of how the policy ought to work in practice.

In my submission there may have been a delay in informing the hall that Stephen Cobb had been placed on ACT 2 Care, but this was not due to a defect in the system of working.

I would submit that Mrs. Clancy was a competent experienced nurse dealing with a number of prisoners and I do not seek to criticise her individually, as under the pressure of time and workload individuals do not always fully comply with policies. Notwithstanding this, my submission is that the delay in notifying the Hall Manager and Prisoner Officer Cumming was caused by Mrs. Clancy and was not due to a defect in the system of working and I would resist any finding under section 6(1)(d) in relation to SPS.

Section 6 (1) (e) deals with any other facts which are relevant to the circumstances of the death.

- **Facts Relevant to Circumstances of Death**

Whilst I appreciate that there may be issues which My Lord may wish to comment upon, as far as those comments relate to SPS, in my submission, any such comments should be contained in the Notes section of the determination and no findings should be made under Section 6 (1) (e) in relation to SPS. This is because there were no issues raised in relation to SPS policy and procedures which can properly be said to be relevant to the circumstances of the death.

3. <u>Conclusion</u>

I would refer your Lordship to the Scott Currie Inquiry where Sheriff Principal Sir Stephen Young QC highlights in his determination (Notes page 34, para 26) that society as a whole has a duty to take all reasonable care of prisoners and in particular, prisoners who are for one reason or another vulnerable and/or at risk of suicide or self harm. SPS quite rightly set very high standards for staff to aspire to in caring for such prisoners.

Sheriff Principal Sir Stephen Young QC stressed (page 35, para 28) that in concentrating so much on the duty of SPS staff to take all reasonable care to prevent the suicide of a prisoner there may be a danger of losing sight of the fundamental point that, notwithstanding the fact of his imprisonment, a prisoner remains an autonomous human being and retains ultimate responsibility (within the constraints of the prison system) to take care for his own life.

Stephen Cobb died because he acted upon his suicidal ideation when the opportunity presented itself. Exactly why will forever remain uncertain. However, in my submission we have heard no evidence of any reasonable precautions whereby the death might have been avoided; no evidence of any system of working which contributed to the death; and there are no other facts which are relevant to the circumstances of the death as far as SPS are concerned.