SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2025] FAI 33

EDI-B1674-24

DETERMINATION

BY

SUMMARY SHERIFF PETER McCORMACK

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

into the deaths of

FRANCIS PETER MCCARTHY

and

JOHN HAY ANGUS

Edinburgh, 26 August 2025

DETERMINATION

The summary sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

When and where the deaths occurred

1. In terms of section 26(2)(a) of the Act, Francis Peter McCarthy (born 5 February 1961) died on 12 April 2020, aged 59 years old. He died in Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF, having been transferred there from HM Prison Low Moss, 190 Crosshill Road, Glasgow, G64 2QB where he was in legal custody.

2. In terms of section 26(2)(a) of the Act, John Hay Angus (born 2 August 1953) died on 9 April 2020, aged 66 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road, Edinburgh, EH16 4SA, having been transferred there from HM Prison Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN where he was in legal custody.

When and where any accidents resulting in the deaths occurred

3. In terms of section 26(2)(b) of the Act, there was no accident that resulted in either death.

The cause or causes of the deaths

4. In terms of section 26(2)(c) of the Act, the cause of death of Francis Peter McCarthy was presumed COVID-19 disease with chronic obstructive pulmonary disease.

5. In terms of section 26(2)(c) of the Act, the cause of death of John Hay Angus was: 1a complications of COVID-19 infection; 2 left hip fracture following an apparent fall, diabetes mellitus, cerebrovascular and peripheral vascular disease, hypertension.

The cause or causes of any accidents resulting in the deaths

6. In terms of section 26(2)(d) of the Act, there was no accident that resulted in either death.

Precautions

7. In terms of section 26(2)(e) of the Act, there were no precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in either death being avoided. There was no accident that resulted in either death.

System of working

8. In terms of section 26(2)(f) of the Act, there were no defects in any system which contributed to either death. There was no accident that resulted in either death.

Other facts relevant to the circumstances of the deaths

9. In terms of section 26(2)(g), there are no other facts which are relevant to the circumstances of either death.

RECOMMENDATIONS

10. No recommendations are made in terms of section 26(1)(b) of the Act as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] A fatal accident inquiry was held at Edinburgh Sheriff Court on 18 August 2025 into the deaths of Francis Peter McCarthy and John Hay Angus. Preliminary hearings took place on 14 January, 26 March and 3 June 2025.

[2] Three parties were represented at the inquiry. Mr Hill, procurator fiscal depute, appeared for the Crown. Miss Thornton, solicitor, appeared for the Scottish Ministers as representing the Scottish Prison Service ("the SPS"). Mr Stewart, solicitor, appeared for both Greater Glasgow and Clyde Health Board and Lothian Health Board ("the Health Boards"). I was advised that the next of kin of Mr McCarthy were content to be advised by the Crown as to proceedings and did not wish to participate directly. I was advised that the next of kin of Mr Angus did not wish to be involved in the inquiry in any way.

[3] For the purposes of the inquiry parties tendered a signed joint minute of agreement which covered all the evidence, including witness statements, expert reports and other productions which required to be placed before the court. Due to the comprehensive nature of the joint minute, no parole evidence was led.

[4] I was grateful to parties for lodging written submissions in advance. The solicitors for the SPS and the Health Boards had the advantage of seeing the submissions for the Crown in advance.

[5] The SPS and the Health Boards invited me only to make substantive determinations in respect of section 26(2)(a) and (c). The Crown invited me also to make determinations under section 26(2)(g) in respect of "other facts relevant to the

circumstances of the deaths" and to make recommendations under section 26(4) of the Act, all in addition to determinations under section 26(2)(a) and (c).

[6] For reasons which I will explain I was only prepared to make determinations under section 26(2)(a) and (c). I did not consider the material founded upon by the Crown for the proposed additional determinations and recommendations to be relevant to the circumstances of the deaths. I will, however, refer informally to those matters for whatever assistance they might give to the various Health Boards in Scotland which provide healthcare to persons in custody.

The legal framework

[7] This inquiry was held under section 1 of the Act. It was a mandatory inquiry in terms of section 2(4)(a) of the Act as both Mr McCarthy and Mr Angus were in legal custody at the time of their death. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (SSI 2017 No 103).

[8] In terms of section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths in similar circumstances. Section 26 requires the sheriff to make a determination which in terms of section 26(2), is to set out factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These are (a) when and where the death occurred; (b) when and where any accident resulting in the death occurred; (c) the cause or causes of the death; (d) the cause or causes of any accident resulting in the death; (e) any precautions which could

reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided; (f) any defect in any system of working which contributed to the death or to the accident; and (g) any other facts which are relevant to the circumstances of the death. In terms of sections 26(1)(b) and 26(4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances. The procurator fiscal depute represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The determination must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish criminal or civil liability.

Summary

Overview

[9] Francis Peter McCarthy (born 5 February 1961) died on 12 April 2020, aged 59 years old. He died in Glasgow Royal Infirmary, 84 Castle Street, Glasgow, G4 0SF, having been transferred there from HM Prison Low Moss, 190 Crosshill Road, Glasgow, G64 2QB where he was in legal custody.

[10] John Hay Angus (born 2 August 1953) died on 9 April 2020, aged 66 years old. He died in the Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith

Road, Edinburgh, EH16 4SA, having been transferred there from HM Prison Edinburgh, 33 Stenhouse Road, Edinburgh, EH11 3LN where he was in legal custody.

Provision of healthcare in Scottish Prisons

[11] On 1 November 2011, responsibility for the provision of healthcare to prisoners was transferred from the Scottish Prison Service to the NHS (under the Health Board Provision of Healthcare in Prisons (Scotland) Directions 2011). Since then each individual regional NHS Health Board has been responsible for the delivery of healthcare services within prisons in Scotland which fall within their geographical ambit for the provision of medical care.

DIPLAR

[12] A Death in Prison Learning, Audit, and Review ("DIPLAR") is a process for reviewing deaths in custody. This type of review is completed after the death of any person in prison custody in Scotland and provides a system for SPS (or a private prison operator) and the applicable NHS Board to record any learning and identify actions following a death.

Mr McCarthy - Imprisonment

[13] On 28 February 1985 at the High Court of Justiciary at Paisley, Mr McCarthy was convicted of murder and sentenced to life imprisonment. He remained in custody until 9 December 2002 when he was released on life licence. On 8 December 2009 he was

recalled to custody and was convicted of assault to injury (domestic) on 10 March 2010. Mr McCarthy was again released on life licence on 22 August 2017 but was recalled to custody on 22 November 2017 for breaching his licence conditions.

[14] Mr McCarthy was transferred to HMP Low Moss on 15 March 2018 where he was an inmate at the time of his death. He ordinarily resided within Clyde Hall, Level 3, Cell 1.

Mr McCarthy - Medical care and treatment

[15] Mr McCarthy was diagnosed with chronic obstructive pulmonary disease ("COPD"). He also had a history of intravenous drug use.

[16] On 27 March 2020, Nurse Kerry McCormack discussed shielding with Mr McCarthy within Clyde Hall and provided him with a shielding information leaflet. A record of this interaction was recorded in his Vision records (Crown Production 3, Page 1).

[17] It is recorded within the DIPLAR (Crown Production 5, Page 2, section 5) that Mr McCarthy was given the opportunity to shield but chose not to. There is no record of Mr McCarthy choosing not to shield either within his Vision records (Crown Production 3) or within any of the statements provided by nursing staff.

[18] On 8 April 2020, a prison officer requested that nursing staff attend Mr McCarthy's cell as he was complaining of shortness of breath. Nurse Ros O'Sullivan attended and assessed Mr McCarthy. Oxygen saturation, pulse and temperature were measured and recorded. Respiratory rate and blood pressure were not recorded and no

NEWS score was calculated (see below for an explanation of "NEWS"). Mr McCarthy stated that he felt no different to usual in terms of his breathing and that he always has a cough and that there was no change in his condition. (Crown Production 39.12) Nurse O'Sullivan noted that no symptoms of COVID-19 were present and that there was no need for isolation. Nurse O'Sullivan was not aware if Mr McCarthy had been identified as being a close COVID contact with another prisoner or if he had been advised to self-isolate.

[19] The National Early Warning Score (NEWS) is a tool used to standardise the assessment of acute illness severity in patients. It records six parameters as a basis for a scoring system. The parameters being respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness or new confusion. A score is allocated to each element with the magnitude of the score reflecting how extreme the parameter varies from the normal. A more detailed explanation of NEWS is contained in Crown Production 31, paragraph 3.5.

[20] On 10 April 2020, a prison officer requested that nursing staff attend Mr McCarthy's cell as he was feeling unwell and that they had concerns regarding his breathing. Charge Nurse Andrew McTaggart attended and assessed Mr McCarthy. Nurse McTaggart noted that Mr McCarthy was neither laboured in his breathing nor experiencing any breathing issues when conversing and was experiencing some leg discomfort. No physical assessment took place, no clinical observations were taken and no NEWS score was calculated. Nurse McTaggart was not aware that Mr McCarthy had

been advised to shield. Nurse McTaggart stated that he did not observe any COVID-19 symptoms. (Crown Production 39.1).

[21] On 11 April 2020, a prison officer requested that nursing staff attend Mr McCarthy's cell as he was feeling unwell and experiencing shortness of breath. Nurse Megan Fitzpatrick attended and assessed Mr McCarthy. Clinical observations were taken. No NEWS score was calculated but Nurse Fitzpatrick discussed Mr McCarthy's condition with Nurse Kerry McCormick who advised that an ambulance was requested and that oxygen be provided immediately. Nurse Megan Fitzpatrick believed that Mr McCarthy had been advised to shield as a result of his COPD and being high risk. (Crown Production 39.10).

[22] On 11 April 2020, at around 1930 hours, Mr McCarthy was conveyed by ambulance to the Emergency Department at Glasgow Royal Infirmary. Mr McCarthy returned a negative COVID result but a chest X-ray was clinically suggestive of COVID-19. Mr McCarthy was reviewed by a specialist registrar and two consultants and was treated with Continuous Positive Airway Pressure. A decision was made not to transfer him to the Intensive Care Unit.

[23] On 11 April 2020, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was discussed with Mr McCarthy and completed by doctors who did not deem that CPR would be successful given Mr McCarthy's condition and history of COPD.

Mr McCarthy - Death

[24] Mr McCarthy died on 12 April 2020 at 2325 hours within Glasgow Royal Infirmary. Life was pronounced extinct by Doctor Robert Sykes.

[25] A view and grant post-mortem examination was carried out on 17 April 2020 at the Queen Elizabeth University Hospital, Glasgow by pathologist Marjorie Turner. The cause of death was noted as 1a Presumed COVID-19 disease with chronic obstructive pulmonary disease. (Crown Production 1).

[26] A view and grant post-mortem is a non-invasive examination of a deceased's body, carried out by a pathologist alongside a review of his medical history and circumstances of death.

[27] A DIPLAR was conducted on 7 July 2020 in respect of Mr McCarthy's death. (Crown Production 5). No relevant learning points or actions were identified in terms of the care and treatment of Mr McCarthy.

[28] No Significant Adverse Event Review ("SAER") was held in respect of Mr McCarthy's death.

Mr Angus - Imprisonment

[29] On 12 December 2011 Mr Angus was made subject to an order of lifelong restriction following convictions for indecent assault and breach of a sexual offence prevention order. He was initially detained within HMP Edinburgh before being transferred to HMP Barlinnie on 14 June 2017. Mr Angus remained in HMP Barlinnie until 12 July 2019 when he was transferred back to HMP Edinburgh.

[30] Mr Angus was an inmate at HMP Edinburgh at the time of his death. He ordinarily resided within Hermiston Hall, Level 2, Cell 40.

Mr Angus - Medical care and treatment

[31] Mr Angus suffered from multiple medical conditions including Type 1 diabetes mellitus, peripheral vascular disease, hypertension and coeliac. He suffered a stroke in 2018 which adversely affected his mobility and ability to undertake certain tasks for himself.

[32] Sharlyn Taylor, healthcare manager for HMP Lothian Prisons stated that, to her knowledge, Mr Angus was not advised to shield. (Crown Production 39.27).

[33] It is recorded within the DIPLAR (Crown Production 12, Page 4, section 4) that over 90 people in custody had received shielding letters from NHS healthcare, and that Mr Angus chose not to shield. There is no record of Mr Angus choosing not to shield either within his Vision records (Crown Production 8) or within any of the statements provided by nursing staff.

[34] On 17 January 2020, Mr Angus fell whilst in the shower. Mr Angus was assessed by Nurse Angela Swinton. Mr Angus described the circumstances of the fall, denied any head injury and had no significant areas of pain or bruising. No clinical observations were recorded, no post fall protocol was conducted, no falls risk assessment was carried out and no falls prevention and management care plan was initiated.

[35] On 18 January 2020, Mr Angus was assessed by Nurse Allen Beatson after complaining of a stiff hip. He was referred to Accident and Emergency for an X-ray which showed no sign of bony injury.

[36] On 2 March 2020, Mr Angus was assessed by Doctor Cameron Gracie complaining of shortness of breath. He was referred for an X-ray which was conducted on 10 March 2020 and showed no significant changes from his most recent chest X-ray.

[37] On 16 March 2020, Mr Angus reported to Nurse Greig Temple that he had fallen at 0130 hours in the morning and had slightly injured his right arm. There is no record of a post fall protocol being conducted, no falls risk assessment was carried out and no falls prevention and management care plan was initiated.

[38] On 3 April 2020, Mr Angus was seen by Nurse Angela Swinton to have a dressing changed. At this time Mr Angus complained of pain under his arms around the rib area and reported that he fell the previous week whilst in his cell when getting up to go to the toilet. He was advised that due to continued falls he would benefit from carers supervising him when showering. There is no record that a falls risk assessment was carried out and no falls prevention and management care plan was initiated.

[39] On 5 April 2020, nursing staff were requesting to assess Mr Angus in his cell as it was reported that he had a consistent cough since the previous day. Mr Angus was isolated in his cell pending assessment. Nurse Elaine McAdam assessed Mr Angus and found that he had no cough or temperature at that time. Oxygen saturation levels were recorded at 88%. No other clinical observations were recorded at the time and a NEWS

score was not calculated. Nurse McAdam concluded that Mr Angus had no symptoms of COVID-19 and was not for Rule 41.

[40] In her statement to the police (Crown Production 39.18), Nurse McAdam stated that due to Mr Angus' low oxygen saturation levels a follow up appointment was to be made at the advanced nurse practitioner clinic to ascertain if he was suffering from COPD. There is no record of a referral or reference within Mr Angus' Vision records. (Crown Production 8).

[41] On 7 April 2020, a retrospective entry was made into Mr Angus' Vision records (Crown Production 8) by Nurse Mikaele Corsie. Nurse Corsie details assisting Nurse McAdam's assessment of Mr Angus and notes observations taken. The date of entry was after Mr Angus was taken to hospital and the date of assessment is incorrectly noted as 4 April 2020.

[42] On 7 April 2020 at 0800 hours, prison officers found Mr Angus in his cell and noted that he had fallen, injuring his left hip. Nurses Natalie Coyne, Shelley Jones and Elaine McAdam attended. It was noted that his left leg was shorter than his right, indicative of a hip fracture. Mr Angus was struggling to breathe and his oxygen saturation levels were 72%, he was unable to maintain his own oxygen levels without high flow oxygen and he was using his accessory muscles to breathe.

[43] An ambulance was requested and Mr Angus was conveyed to the Accident and Emergency department of the Royal Infirmary of Edinburgh. Mr Angus tested positive for COVID-19 by way of throat swab on admission and a DNACPR form was completed by medical staff within the Accident and Emergency department.

[44] Hospital records note that Mr Angus presented as frail, had a fever and had features of severe respiratory distress. He was assessed on the Glasgow Coma Scale with a score of 15. Mr Angus was treated with high flow oxygen but following assessment was deemed not suitable for surgery or admission to the Intensive Care Unit. On 8 April 2020 the decision was made to move Mr Angus to palliative care where he received morphine and midazolam.

Mr Angus - Death

[45] On 9 April 2020 at 1550 hours within Ward 205 of the Royal Infirmary of Edinburgh, Mr Angus died. Life was pronounced extinct by Doctor Sarah Galloway.

[46] A view and grant external post-mortem examination was carried out by pathologist Robert Ainsworth on 16 April 2020 within Edinburgh City Mortuary. The cause of death was noted as: 1a) complications of COVID-19 infection and (2) left hip fracture following an apparent fall, diabetes mellitus, cerebrovascular and peripheral vascular disease, hypertension.

[47] A DIPLAR was conducted on 6 July 2020 (Crown Production 12). Learning points and lessons learned were noted under section 8 of that report.

[48] A SAER was carried out into the death of Mr Angus between 31 August 2021 and 5 January 2022. (Crown Production 13). The SAER identified three lessons learned: (i) the nursing team needs to be aware of NEWS as the protocol was not followed in respect of Mr Angus; (ii) there needs to be a better ability to document medical issues;

and (iii) PPE recommendations need to be followed by all staff throughout the pandemic.

Management of COVID-19 in HMP Low Moss and HMP Edinburgh

[49] Between 16 March 2020 and 11 April 2020, there was one confirmed positive COVID-19 case and 24 cases symptomatic of COVID within HMP Low Moss, Clyde Hall. (Crown Production 35) All positive or symptomatic cases were isolated and Mr McCarthy was not identified as being a close contact with any of the aforementioned cases.

[50] There were no COVID outbreaks in HMP Low Moss, Clyde Hall, either before or immediately following Mr McCarthy's admission to hospital. The source of Mr McCarthy's COVID is unknown.

[51] The first COVID symptomatic case recorded in HMP Edinburgh was on 24 March 2020. Between 24 March 2020 and 7 April 2020, there were five cases symptomatic of COVID within HMP Edinburgh, Hermiston Hall. Mr Angus was the first positive COVID case recorded in HMP Edinburgh.

[52] The cellmate of Mr Angus was a passman whose duties allowed him greater freedom to associate with other inmates and areas within Hermiston Hall. The cellmate did not acquire COVID or develop COVID symptoms in the period immediately after the admission of Mr Angus to hospital.

[53] There were no COVID outbreaks in HMP Edinburgh, Hermiston Hall, either before or immediately following the admission of Mr Angus to hospital. The source of his COVID is unknown.

Falls guidance policies

[54] In 2020, NHS Lothian had in place falls guidance polices for hospital settings, care home settings and primary care settings. There was no corresponding policy or procedure for prison settings.

[55] Crown expert witness Julie Bowmaker Gibson is an expert in nursing practice. In her report dated 20 February 2024 regarding the case of Mr Angus (Crown Production 33) she recommended in section 5 of that report, *inter alia*, that a falls prevention and management policy and procedure should be developed for use within the prison environment. Mrs Bowmaker Gibson has consulted with the NHS lead regarding the creation of such a policy and, having reviewed NHS Production 1, "NHS Lothian Standard Operating Procedure for the Prevention and Management of Falls in NHS Lothian Prisons" dated 30 July 2025, she regards it as adequate and appropriate.

Criticisms of nursing procedure in the cases of Mr McCarthy and Mr Angus

[56] Mrs Bowmaker Gibson also produced a report regarding the case of Mr McCarthy, dated 11 September 2023 (Crown Production 31). In her two reports,

Mrs Bowmaker Gibson noted *inter alia* the following criticisms with corresponding recommendations:

- a failure to use the assessment tool NEWS2 (the updated version of NEWS);
- a lack of annual training for nursing staff on NEWS2;
- incomplete documenting of assessment, care planning, evaluation and review of care;
- lack of documenting of refusals by patients to engage in care;
- consideration should be given to making prisoners' medical records available to nursing staff in the prison halls;
- the DIPLAR process should include consideration of medical records to include clinical aspects of care in the findings.

Causation of deaths

[57] Expert medical reports both dated 30 August 2024 were available from Professor Patrick Nee, consultant in Emergency Medicine and Critical Care Medicine: first regarding Mr McCarthy (Crown Production 32); and secondly regarding Mr Angus (Crown Production 34). Professor Nee had the two reports from Mrs Bowmaker Gibson available to him.

[58] In the case of Mr McCarthy, Professor Nee was supportive of his not being referred to hospital on 8 or 10 April 2020. Had he been so referred he would likely have been discharged. Present treatments for COVID-19 were not available in April 2020.

Any criticisms made of the nursing care had no effect on the outcome. Mr McCarthy would in any event not have survived his COVID-19 infection.

[59] In the case of Mr Angus, according to Professor Nee he would also have failed to survive even if he had been admitted to hospital at an earlier stage. In any event, had he been referred to hospital on 5 April 2020 he would not have been admitted, given his vital signs were essentially normal at that time. Present treatments for COVID-19 were not available in April 2020. Any criticisms made of the nursing care had no effect on the outcome. Mr Angus would in any event not have survived his COVID-19 infection.

Submissions

[60] It was accepted by the Crown that any failings in nursing procedure and (in the case of Mr Angus) the lack of a falls policy for prisoners did not contribute to the deaths of Mr McCarthy and Mr Angus. Nevertheless it was submitted that these factors were "relevant" as "other facts relevant to the circumstances of the deaths" and the corresponding recommendations of Mrs Bowmaker Gibson were relevant for the purposes of recommendations under section 26(1)(b) of the Act.

[61] For the SPS it was submitted that only findings under sections 26(2)(a) and (c) should be made.

[62] For the Health Boards it was also submitted that only findings under sections 26(2)(a) and (c) should be made. It was accepted that, based on the comments of Mrs Bowmaker Gibson, the expert witness on nursing practice, that certain elements fell short of best practice. These shortcomings, however, did not in any way cause or

contribute towards the deaths of either Mr McCarthy or Mr Angus. In the case of Lothian Health Board, there is now a falls policy in place as of 30 July 2025 (NHS Production 1). Since 2020, annual NEWS2 training is delivered in both Health Boards. As regards record keeping, both Health Boards now undertake regular audit checks of employee standards. As the COVID pandemic progressed, information about shielding status of prisoners was recorded in medical records.

Discussion and conclusions

[63] Mr McCarthy and Mr Angus were 59 and 66 years old respectively at the time of their deaths. Each became infected with COVID-19 during in the early stage of the nationwide pandemic, and succumbed to the disease despite prompt transfer to hospital.

[64] I accept the expert evidence of Professor Patrick Nee that neither of them would have survived, regardless of any criticisms of nursing practice. The lack of a falls policy in the case of Mr Angus was not relevant to his failure to survive.

[65] It was accepted by the Crown that any such failures did not cause or contribute to the deaths. I was not persuaded by the Crown that such failures could nevertheless be "relevant" so as to entitle or otherwise make it appropriate for me to make the additional findings or recommendations as sought by the Crown. If the failures did not cause or contribute to the deaths then they are merely incidental.

[66] It seemed to me that in a sense the Crown's informal position was that there was analysis of value to be taken from Mrs Bowmaker Gibson's reports. That may be so,

but in so far as the analysis concerns matters which have no causal link to the outcomes, it does not justify the making of the formal findings or recommendations sought in this process.

Other observation or comment

[67] It was not clear whether other Health Boards in Scotland have a falls policy for prisoners at all, or, if they do have such policies, how they compare with the Lothian policy (NHS Production 1). As discussed with parties' representatives, I am content informally to suggest to interested parties such as Health Boards that they may wish to have regard to the Lothian policy, with a view either to acquiring an equivalent policy or to considering the adequacy of such policies that they already have. Similarly, Health Boards may wish to consider the other comments made by Mrs Bowmaker Gibson in this case with a view to assessing whether her comments about nursing practice might apply to their own nursing staff.