SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2020] FAI 24

PER-B147-19

DETERMINATION

BY

SHERIFF PINO DI EMIDIO

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

into the death of

DARREN JOHNSTON

PERTH, 12 May 2020

The Sheriff, having considered all the evidence presented at the Inquiry, Determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act"):-

1. Darren Johnston, born 8 June 1982, died sometime during the prison lockdown period between 2030 hours on 18 September 2017 and 0710 hours on 19 September 2017 within cell number 320, in B Hall, level 3, HM Prison Perth.
2. In terms of section 26(2)(a) of the 2016 Act, the death occurred sometime during the prison lockdown period between 2030 hours on 18 September 2017 and 0710 hours on 19 September 2017 within cell number 320, in B Hall, level 3, HM Prison Perth.
3. In terms of section 26(2)(b) of the 2016 Act no accident took place.

4. In terms of section 26(2)(c) of the 2016 Act, the cause of his death was hanging.
5. In terms of section 26(2)(d) of the 2016 Act, there was no accident and therefore no finding requires to be made under the subsection.
6. In terms of section 26(2)(e) of the 2016 Act, there were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided.
7. In terms of section 26(2)(f) and (g) of the 2016 Act, there were no defects in any system of working which contributed to the death and there are no other facts which are relevant to the circumstances of the death.

NOTE

[1] This fatal accident inquiry into the death of Darren Johnston, ("the deceased"), who was born on 8 June 1982, was held on 14 January and 4 February 2020. The Crown was represented by Mrs Whyte, Procurator Fiscal Depute, Perth. Ms Gormley, solicitor, Edinburgh, appeared on behalf of Tayside Health Board ("THB"). Mr Fairweather, solicitor, Edinburgh appeared on behalf of the Scottish Prison Service ("SPS"). Mr Gillies, solicitor, Glasgow appeared on behalf of the Prison Officers Association for Scotland ("POAS").

[2] The deceased was a serving prisoner, having been sentenced on 2 August 2017 to consecutive sentences of 3 months and 60 days imprisonment at Dundee Sheriff Court. He was in legal custody at the time of his death. His earliest date of release would have been 16 October 2017. An inquiry required to be held in terms of section 2 of the 2016 Act. The procurator fiscal represented the public interest at the Inquiry which is an

inquisitorial process. It is not the purpose of the Inquiry to establish civil or criminal liability.

Procedural history

[3] A preliminary hearing took place on 9 July 2019. Further Preliminary Hearings occurred on 14 August, 16 September, 11 and 27 November and 18 December all 2019. The date for the Inquiry was fixed as 14 January 2020. The deceased's family were not represented at any stage.

[4] At the preliminary hearings, a number of points were identified in discussion which required some further investigation. I was concerned to seek to understand (a) the relevant facts relating to the deceased prior to his death and (b) how the prison scrutiny system relating to prevention of suicide had operated in relation to him. I decided I should hear some parole evidence from a number of witnesses and that not proceed only on the basis of the documents presented to the Court. The oral evidence was heard on 14 January and 4 February 2020. The Inquiry was concluded on the latter date.

Documentary material made available to the inquiry

[5] The following documents and other material were available by the time the Inquiry concluded.

1. The deceased's prison records.
2. His prison medical records.

3. The SPS Death in Custody Folder.
4. His NHS Records.
5. A book of photographs
6. Recordings of phone calls between the deceased and his girlfriend on 13 August and 22 August (two calls) 2017.
7. The post mortem report.
8. The SPS Standard Operating Procedure for Controlled Drug Confirmation Testing.
9. A record of the deceased's drug tests.
10. The SPS Management of an Offender at Risk ("MORS") Policy.
11. The Death in Prison Learning, Audit and Review ("DIPLAR") documentation relating to review by SPS staff only signed off by the SPS Chair on 22 May 2019.
12. DIPLAR Process Guidance.
13. Talk to Me: Prevention of Suicide in Prison Strategy, 2016-2021 (SPS production 3).
14. Talk to Me: Prevention of Suicide in Prison Strategy, 2016-2021 Guidance Document Parts 1 and 2 (SPS productions 4 and 5).
15. Local Adverse Event Review Report ("LAER") Report which followed a review on 21 December 2017. There were two versions of the LAER Report. An earlier version (Production 10) and a revised version which incorporated changes on pages 2 and 3 dated 11 November 2019.

16. Affidavits of witnesses Scott Faichney, Craig McCartney, Mary Hunt, Andrew Brown, Douglas Shepherd, Dr Fiona Cowden, Eleanor Morelli and Sheena Petrie.

Submissions

[6] The Crown submitted that the Court should make formal findings under section 26(2)(a) of the 2016 Act and that no recommendations were required. The solicitor for POAS also submitted that the Court should make formal findings only. The decision to remove the deceased from the SPS suicide prevention strategy was appropriate and there had been continuity of contact with clinically trained prison health staff after that. The solicitor for SPS made broadly similar submissions and emphasised that the evidence showed that the deceased was engaging with prison staff including nursing staff. It was difficult to see what could have been done to prevent the death. There was no indication the deceased would take his own life even to those members of staff and a prisoner who knew him quite well. The solicitor for THB adopted the Crown's submissions and went on to submit that the Court should make formal findings only. There were no reasonable precautions that THB staff could have taken to prevent the death and no defects contributed to the death. Under reference to MacPhail's Sheriff Court Practice (3rd ed. 2006) at paragraph 28.17 she politely cautioned me of the dangers of engaging in speculation. The decision of the Tayside Substance Misuse Service ("TSMS") to withdraw opiate replacement treatment ("ORT") medication in the form of methadone in the community was a properly justified one.

TSMS had no direct role while the deceased was in prison. The decision of TSMS did not prevent methadone being prescribed in prison. The evidence suggested that it was difficult to see what could have been done to prevent the death. There was no indication he would take his own life in the period prior to his death. Any suggestion that the decision to withdraw the prescription of methadone in the community might have been a factor in his death was speculative. This was a critically important point. There was no evidence supporting a causal link.

Summary of reasons for decision

Discovery of the death of Darren Johnston

[7] On the morning of 19 September 2017 the deceased was found dead within cell number 320, in B Hall, level 3, HM Prison Perth ("HMP Perth"). He had taken his own life. The cause of the deceased's death was established as hanging.

The SPS Talk to Me: Prevention of Suicide in Prison Strategy ("TTM")

[8] The TTM strategy is the main way in which SPS seeks to prevent suicide in its prisons. TTM is intended to care for those at risk of suicide by providing a person centred pathway based on the individual's needs, strengths and assets and by promoting a supportive environment where people in custody can ask for help. It is designed so that at any time anyone who is involved in the life of any particular prisoner can raise a concern which may activate measures to assist the prisoner who is causing concern. The TTM strategy is engaged if a prisoner is identified as being at risk of

suicide. Such identification can occur in a variety of ways beyond activation by a member of SPS staff or NHS staff within the prison. For instance, a message from the Court which has dealt with him may prompt engagement of TTM. Prisoners can self-refer or ask a member of staff to refer them.

[9] When a prisoner is subject to the TTM strategy there are regular reviews by way of case conference. A prisoner will be left on TTM if any one of the participants in a case conference, including the prisoner who is the subject of it, wishes it to continue in place. All prison officers are trained to look for cues and clues that may indicate cause for concern about contemplation of suicide or serious self-harm. Any prison officer who has a concern can initiate the TTM strategy. Each cell in the prison has a buzzer installed in it which can be pressed if a prisoner is in distress and wishes to seek assistance. A member of staff would then speak to the prisoner. The prisoner can also ask for access to the prison listener. The TTM training of staff is subject to re-iteration. Refresher training is provided so that staff members continue to be sensitised to the skills which assist to identify those who may at risk of suicide. There has to be a genuine reason for a prisoner to be on TTM. It is not appropriate to put a person on TTM if there is no cause to do so as that would overwhelm the system. If it is decided to place or keep a prisoner on TTM the strategy requires a review after no more than seven days. Some prisoners remain on TTM for periods up to 6 months. Once a decision is made to take a prisoner off TTM, he can be put back on it if reasons for re-engaging with TTM emerge.

Evidence of witnesses led at the Inquiry

[10] Oral evidence was led from Andrew Brown, Douglas Shepherd, Dr Fiona Cowden, Eleanor Morelli and Sheena Petrie.

Andrew Brown

[11] Mr Brown was a First Line Manager in SPS in August 2017. On 7 August 2017 he was in charge of B Hall. He took the chair at a case conference about the deceased. The others present were a Mental Health staff member and Douglas Shepherd, one of the residential prison officers from the flat (level) where the deceased's cell was situated. The deceased was a person who engaged with people he knew well. Mr Brown did not really know the deceased prior to the case conference. He found it difficult to communicate with him and the deceased did not speak freely to him. He was rather dour. He spoke more freely with the others who attended. Some prisoners are more open with nursing staff and Mr Brown had the impression that the deceased was in this category. The deceased stated that he was unhappy about being struck off methadone by TSMS. If he had had any concerns on 7 August 2017 the deceased would not have been removed from TTM. Mr Brown was a credible and reliable witness.

Douglas Shepherd

[12] Mr Shepherd was the prison officer who was present at the review meeting on 7 August 2017. He recalled the meeting. He confirmed he had been trained in the TTM strategy and was aware of the cues he should look for. If he had had any concerns on

7 August 2017 the deceased would not have been removed from TTM. The main concern expressed by the deceased at the case conference related to the stopping of medication (methadone) by the external health service, TSMS. Mr Shepherd was a credible and reliable witness.

Dr Fiona Cowden

[13] She is currently employed by NHS Tayside as a Consultant Psychiatrist in Addictions based at the Integrated Substance Misuse Service for the East Locality. She became a consultant in 2010 and took up her current post in Tayside in 2013. She was involved in the treatment of the deceased when the service was known under the TSMS banner. Her role involves prescribing in the community and the supervision of a team of pharmacy staff and nurse keyworkers. The service provides drop in clinics for people not open to the service. They also have duty clinics in the afternoon to assist those who may have had an unplanned liberation from Court. As regards ORT, buprenorphine causes less respiratory depression than methadone. She had not worked in prisons.

[14] The deceased had engaged with her service from about 2012. In 2014 when he was on methadone she had diagnosed that he was of low mood and had put him on anti-depressants. Her last contact with the deceased was on 2 May 2017 when she made the decision to reduce his methadone prescription gradually till it was withdrawn entirely. This was to reduce risk of a fatal overdose. This decision had been influenced by information she had about the nature and extent of the illegal drugs the deceased was accessing in the community. She explained to the deceased that she thought he was at

increased risk of overdose. She had no further direct contact with him after that date. She did not recall his case being discussed with her after that date. The main forum for discussion would have been at a multi-disciplinary team meetings.

[15] Once the deceased went to prison, he would not have been the responsibility of TSMS. She did not recollect any suggestion that the deceased should attend Addaction (a voluntary sector substance misuse service in Dundee) upon release and had no recollection of being informed of any suicidal ideation.

[16] The deceased's most substantial period at liberty in the months prior to his death was from 2 May 2017 to 29 June 2017. The TSMS records for this period did not contain any indication noted by the pharmacy staff who saw him daily or the nurse keyworker that the deceased was having thoughts of suicide. Nurse Petrie of the prison health care staff had not spoken with her direct in September 2017. She accepted that sometimes a different approach is taken by the health care staff in the prison.

[17] Dr Cowden was a credible witness. Dr Cowden did not answer some important questions put to her on more than one occasion. This was not impressive. In fairness, she clearly had a very substantial caseload. There seemed to be little scope for detailed consideration of someone who was in prison and not currently on her list. I was left with the impression that the system she operated did not really take account that individuals like the deceased might with regularity enter the prison system for short periods and then return to the community. There are obvious practical difficulties in ensuring consistency of care in such circumstances.

Nurse Eleanor Morelli

[18] Nurse Morelli was a Charge Nurse in the Mental Health Team at HMP Perth aged 29 when she gave evidence. She had been working at the prison for about two and a half years. She was a Staff Nurse in the Mental Health Team at the time of the death of the deceased. She has a degree in mental health nursing and prior to moving to the prison she had worked at Murray Royal Hospital, Perth, where she worked with people with severe and enduring metal illness, complex needs and challenging behaviours.

[19] She recalled the deceased. She confirmed that the deceased was put on the TTM strategy on 3 July 2017 during his second last period in custody. In her experience as a mental health nurse in the prison setting, there was significant focus on the risk of suicide when assessing a prisoner. Such assessment requires staff to pay careful attention to body language and past history in addition to what the prisoner is saying at interview.

[20] The deceased had later self-referred to the Mental Health team. That is why she saw him on 16 August 2017. She had not seen him after that. The self-referral was due to low mood and lifestyle challenges he was experiencing. She wished to ascertain if she should be offering the deceased more intervention. Following good professional practice, she discussed the deceased's case with a senior colleague. He was requesting prescribed medication but the requested drug was not appropriate for him. She discussed his level of verbal aggression in the meeting and also whether there was anything she could offer him. She would not have disclosed any of her discussions with the deceased to SPS staff unless thoughts of suicide were mentioned. She confirmed that

the discharge note for 16 August 2017 was accurate. She had noted his hostile presentation and misuse of illicit drugs in the prison as the reasons why he was not given a further appointment. She was a credible and reliable witness.

Nurse Sheena Petrie

[21] Nurse Petrie was a Senior Charge Nurse at the time of the death. She also had a counselling qualification. All discussions between her and the deceased were as a patient. They were confidential and not discussed with SPS staff. She was TTM trained and was alert to signs that a person might be contemplating suicide or self-harm. She was familiar with and had put people on the TTM strategy. Up to date NHS prescribing information was available to her so that current prescriptions can continue in the prison, if appropriate. The deceased was not withdrawn in his approach to her after she got to know him, though her experience was that he would try to manipulate professionals with whom he was in contact. When the deceased was serving his previous sentence in July 2017, he was on a reducing dose from TSMS. She was able to intervene so that when he was freed by the Court towards the end of the month she had ensured he was liberated with a degree of tolerance. When he returned to the prison in early August 2017, he was no longer on a prescription for methadone and he requested this. She thought he should be prescribed methadone to safeguard him from the risk of overdose upon release and the deceased was aware that this was her view.

[22] She spoke to a self-referral by the deceased on 7 August 2017. The issue was to see if the deceased wanted to attend any further groups to assist him with his drug

misuse in the prison. At the time this work was done by staff from the third sector. This function is now done within the NHS. The assessment was carried out on 15 August 2017 by Joy Kerr and a care plan agreed which was designed to get him stable and drug free prior to liberation. On 17 August 2017 the deceased again self-referred. On 5 September 2017 she saw him for his first clinical appointment in the health centre. This was a re-referral from the casework team back to the nursing team. He had tested positive for a drug he was not prescribed. At the time if ORT was prescribed prisoners got a choice of buprenorphine or methadone. All ORT medication is supervised. Methadone is a liquid (the deceased had requested it). At that time Buprenorphine was delivered sub-lingually. This has now changed. It is not easier to supervise one form of ORT or the other. On 5 September 2017 she was aware that the substance abuse caseworker had identified that the deceased had said he wanted to be back on methadone. She took him into her caseload as she knew him. In her experience, he was a complex individual who engaged better with people he already knew. She had no concerns about suicide or self-harm on that date. She decided she needed to know if TSMS would be prepared to resume prescribing methadone in the community if he was given a prescription in prison. She agreed to contact TSMS to seek their views.

[23] Her retrospective note of what occurred when they met on 13 September 2017 was written after the death of the deceased. The discussion was a follow up to his earlier appointment. She told the deceased that Dr Cowden's decision that he would not be prescribed methadone when released into the community had been confirmed. She expected that during the remainder of his time in the prison he would have further tests

and his drug diaries would be looked at in order to compare what he stated he was taking to the results of his urine samples. On 19 September 2017 she was one of the persons who attended the "Code Blue" when the deceased was found dead in his cell. She was upset when he died because she had known the deceased for a lot of years.

[24] She was a credible and reliable witness who had built up a professional relationship with the deceased and was concerned to maintain it in her interactions with him.

Affidavit evidence of other witnesses

[25] Prison Officer Scott Faichney. See the timeline below.

[26] Prison Officer Craig McCartney. See the timeline below.

[27] Prison Officer Mary Hunt. See the timeline below. Officer Hunt has 18 years' service in SPS. She knew the deceased quite well and spoke with him on most days when he was in prison. She had built up a good relationship with him over the years. She had completed the short term prisoners integrated care management ("STICM") paperwork with the deceased on 3 August 2017. This was the first time he had agreed to participate in this exercise and she thought this an encouraging sign. She saw him often in the month of August 2017 when he was on level 2 and spoke to him regularly. He had confided in her about a sense of loneliness but he had not mentioned his grievance about withdrawal of methadone by TSMS to her. He had denied suicidal thoughts. She saw rather less of him after he was moved to level 3 but they always spoke briefly when passing one another. She was one of the officers who attended when he was discovered

lifeless in his cell on 19 September 2017. I gave consideration to asking her to attend at court to give oral evidence. I was asked to refrain from doing so until I had heard the other witnesses as she was reported to be very upset at the prospect. After hearing the evidence of the other witnesses, I concluded that I could properly proceed on the basis of her Affidavit without requiring her attendance at Court. I found her evidence to be helpful.

Timeline of events relating to the deceased prior to his death in HMP Perth

[28] The following is a summary of the principal relevant events in this Inquiry.

1. In about January 2010 the deceased was prescribed methadone. Prescription of methadone is a form of ORT, that is, an intervention designed to treat substance misuse, not depression or suicidal ideation.
2. On about 9 June 2010 Tayside Drug Problems Service (the forerunner of TSMS) recorded that the deceased was illicitly injecting heroin putting himself at risk of overdose.
3. From about 22 June 2012 until about 29 June 2017, when not in custody, the deceased was prescribed methadone by TSMS from time to time.
4. In about October 2014 TSMS staff expressed concern to the deceased about his poor engagement and ongoing illicit drug use.
5. In about April, August and September 2016 the deceased's drugs diaries confirmed significant ongoing illicit drug use.

6. In about September 2016 he was on a high dose of methadone. Following a discussion at a TSMS multi-disciplinary team meeting, a plan was devised to continue to screen the deceased regularly. He was resistant to aspects of that plan.
7. On about 2 February 2017 there was a further TSMS multi-disciplinary team meeting at which it was noted that the deceased continued to use illicit drugs (including heroin) to the extent that it was feared he was at risk of cardiac arrest. He refused to comply with a request to have his heart rate monitored and missed a GP appointment. As a result, his prescription was reviewed and he was told that consideration would be given to stopping his methadone prescription as it could not safely continue if the use of illicit drugs (especially heroin) did not cease.
8. On about 2 May 2017 Dr Fiona Cowden of TSMS met with the deceased. At that time he was using alcohol to significant excess and also diazepam. Extreme concerns as to his risk of overdose were expressed to him. He displayed poor insight as to the risks attendant on his behaviour and said he did not intend to change his behaviour. Dr Cowden told him that his methadone prescription would be reduced over several weeks and then withdrawn. The prescription was reduced by 5mg per week so that it would be reduced to nil on 30 June 2017. He did not accept that his chaotic illicit drug usage increased his risk. Dr Cowden intended that he would be

reviewed after he no longer received methadone by prescription with a view to identifying other treatment options. He left the meeting in anger.

9. On about 29 June 2017 the deceased was admitted to HMP Perth. TSMS closed his case at that time. Reduction in his methadone prescription had taken place in line with the plan formulated on 2 May 2017.
10. He was liberated on 27 July 2017.
11. On about 1 August 2017 he was arrested and came into police custody.
12. On about 2 August 2017 he appeared in Dundee Sheriff Court on a number of charges. The Court imposed consecutive sentences of 3 months and 60 days imprisonment. His earliest date of release would have been 16 October 2017.
13. The prison health staff had access to the deceased's NHS health records and prescribing records. The normal procedure was that TSMS would be informed of an impending release of a former patient about one week before the date of release.
14. On about 2 August 2017 a nurse at Police Headquarters Dundee advised the prison healthcare service at HMP Perth that the deceased had received treatment for opiate withdrawal the previous day while in police custody. He had been bingeing on Heroin and Valium and he might pose a potential risk of deliberate self-harm or suicide. He had not divulged a formal plan but had stated "I will just wait till I'm in the jail, I've had enough."

15. On admission to HMP Perth on 2 August 2017, the deceased showed high levels of anxiety and he expressed similar sentiments to those recorded by the police. Following a reception risk assessment the deceased was placed on the TTM strategy on a regime of 15 minute observations. He was also the subject of a health care risk assessment by a staff nurse which concluded he was "at risk." It was specified that he should be provided with anti-ligature clothing. The deceased initially protested but agreed to this.
16. On about 3 August 2017 a pre-case conference health care assessment took place as part of the TTM strategy. The deceased was initially hostile due to having been in a safe cell overnight. He did not recall how he came to be in police custody. He stated that he had taken copious amounts of alcohol and 60 to 80 Valium a day prior to his arrest and he had been trying to get back into prison as his life was better there.
17. Later on 3 August 2017 a multi-agency case conference took place attended by the deceased and prison and mental health staff. He stated he was keen to settle in to the prison and had no current plans or intent of committing suicide. All agreed he should move to a normal cell but remain on the TTM strategy with observations reduced to hourly intervals.
18. At around 1330 hours the same day the deceased was examined by Dr Kay. He denied thoughts of suicide or self-harm. He was shaved and showered, maintained eye contact and spoke clearly and appropriately throughout.

19. Later on 3 August 2017 the deceased participated in the STICM strategy with Officer Mary Hunt. He insisted he was not suicidal but disclosed he was lonely due to having very little close family and no close friends.
20. Hourly observations of the deceased continued during 4, 5 and 6 August 2017. He was exercising, mixing with peers and appeared to be in good humour.
21. On about 7 August 2017 a further multi-agency case conference took place attended by the deceased and prison and mental health staff. The deceased was re-assessed as being at no apparent risk at that time. On that basis he was removed from the TTM strategy.
22. On about 7 August 2017 the deceased was told that his prescription for the antidepressant amitriptyline which had been provided in the community was being continued in the prison, subject to review in two months.
23. On 15 August 2017 a substance abuse consultation took place with Joy Kerr of a third sector organisation which worked in the prison. The deceased's goal was reported to be to access methadone prescribing and to stabilise prior to liberation on 16 October 2017.
24. On about 16 August 2017 a mental health assessment of the deceased was carried out by Nurse Morelli as a follow up due to the deceased having been on TTM upon admission to the prison. He strongly denied suicidal thoughts though he was of low mood. The meeting lasted about 20 minutes. They discussed possible nursing interventions but he was not receptive to this.

His daily routine was problematic due to his continuing illicit substance misuse. No further contact was thought to be required because he was unwilling to engage with the nursing team and also due to his illicit drug misuse. It was difficult to get a picture of his mental state due to these factors. Lowered mood and family bereavements were in the background. The deceased became hostile during the interview and stated it was a waste of time. No follow up was listed.

25. The telephone calls between the deceased and his girlfriend in August 2017 did not disclose anything that would indicate he was contemplating suicide.
26. On about 5 September 2017 the deceased's urine was screened and was positive for opiates and buprenorphine.
27. At the beginning of September 2017 due to a refurbishment, level 2 of B Hall was closed and the deceased was moved to cell 320 in level 3.
28. On about 5 September 2017 Nurse Petrie met with the deceased for clinical assessment. They discussed his desire to have his methadone prescription reinstated when he was liberated. He was aware this was a decision for TSMS. She undertook to contact TSMS to raise the issue with that service.
29. On about 5 September 2017 Nurse Petrie contacted TSMS seeking confirmation that they would continue with maintenance ORT prescription for the deceased when he was liberated.
30. On about 13 September 2017 Nurse Petrie was informed that TSMS had confirmed that following his release the deceased would not be prescribed

methadone. He was expected to seek help from Addaction which was a third sector service in the community. At her meeting with the deceased on 5 September 2017 she had assured him that she would update him when she had a response from TSMS. Though it was almost the end of her shift when she heard from TSMS, she went to his cell and spent about 10 minutes with him discussing the information received from TSMS. He was polite and they had a cordial chat. Their conversation ended with her saying "I am rooting for you" and he replied "I ken you are." Neither the content of their discussions nor his reactions caused her to think she should re-activate the TTM strategy.

31. The deceased was due to meet with Dr Elworthy, consultant in the Prison Health Care service, on 21 September 2017. He knew that one of the issues to be considered at that meeting was whether he would be commenced on methadone, though alternative treatment options would also have been considered.

32. On the evening of 18 September 2017 the deceased played pool during recreation time. He spoke with Prison Officers Craig McCartney and Scott Faichney. Mr McCartney and Mr Faichney had no concerns about his presentation. He also spoke at length with a newly arrived prisoner, Paul Stanton. Mr Stanton had known the deceased for about five years. He was aware that if he had concerns about the welfare of another prisoner he could pass them on to prison staff, medical staff or the prison chaplain. He had no

such cause for concern about the deceased's welfare that evening. At 2015 hours all prisoners were told to return to their cells. All cells were secured at 2030 hours after a numbers check.

33. At about 0705 hours on 19 September 2017 a routine numbers check took place which involved opening cell doors. On opening the deceased's cell the deceased was seen to be prone. A "code blue" alarm was raised. Health care staff attended immediately and attempted to assist him.

34. At about 0710 hours paramedic staff attended. The deceased was observed to have post mortem staining and rigor mortis. Life was pronounced extinct at 0720 hours.

35. The cause of the deceased's death was established as hanging. There were no suspicious circumstances.

The DIPLAR Process

[29] SPS carried out the DIPLAR review on 27 November 2017. Representatives of THB did not attend or otherwise participate in this review. The review report, which was signed only on behalf of SPS, stated that the deceased's removal from his methadone script in the community (by TSMS) had possibly been a contributory factor in his death.

The THB LAER review

[30] Various aspects of the timeline set above were noted in the review report. The conclusion of the LAER was that:

> "[at] the time the patient completed suicide, there was no immediate concern that the patient was at risk of suicide. He was noted to be active in the halls in the evening before the event, and there was nothing of note which gave concern."

Conclusion

[31] There was no natural contradictor in this Inquiry. All represented parties sought formal findings only. Although I caused a number of additional inquiries to be made, there was no evidential basis available to me to allow me to examine critically whether the suicide prevention protocols operated within the prison were adequate. The evidence did allow me to consider how the declared MORS policy and TTM strategy had operated in relation to the deceased during his last period of imprisonment. No evidence was led as to the availability of illicit drugs in the prison.

[32] The deceased had a long record of offending. He had become rather institutionalised. He found it hard to cope while at liberty in the community. He stated that he was willing to commit relatively minor offences which attracted short term prison sentences (due their persistent nature) but he was not prepared to commit more serious crimes that would have led to the imposition of longer spells in custody.

[33] If the deceased had remained on the TTM strategy on 7 August 2017, he would have been reviewed within seven days. It is unlikely he would have been on TTM for much longer because he did not give rise to significant relevant concerns while in the

prison in the succeeding weeks. I was satisfied that the decision to remove him from the TTM strategy on 7 August 2017 was made appropriately.

[34] The evidence of Nurses Petrie and Morelli was very valuable. He was seen on 5 September 2017 by Nurse Petrie who knew him quite well. She was contemplating putting him back on methadone at least at a dose which would have given him a degree of tolerance when he got back into the community. Nurse Petrie spoke to him again on 13 September 2017 when she told him that TSMS had confirmed its decision to stop prescription of methadone in the community. Following this encounter with the deceased, she did not think there was a problem that would trigger TTM. Her last comment to him had been supportive. Given her knowledge of him, it is difficult to see how anyone else would have been prompted to raise an alert that he was at risk of attempting to take his own life only a very few days later. I am satisfied that she would have taken action if she had noted anything that made it appropriate to return him to the TTM strategy. Similarly the evidence of Mr Faichney and Mr Stanton who were the last people to speak with him the evening before he died was that he did not give either of them cause for concern.

[35] The deceased presented complex problems for the health professionals who had to engage with him both when he was in prison and at liberty in the community. The Prison Nurses and TSMS approached the care of the deceased in ways that emphasised different aspects of his welfare in the months prior to his death. The prison mental health nursing staff were concerned that he should be released from prison with some level of tolerance and so they were prepared to consider prescribing him methadone.

The TSMS staff had taken him off methadone altogether because they were concerned about others risks (especially overdose) due to his chaotic consumption of other illicit substances including the injection of heroin. The evidence does not allow me to conclude that the firm refusal of any further prescription of methadone by TSMS had a direct link to the actions of the deceased that ended his life. I agree that it would be speculation to make a direct link between the decision to withdraw the prescription of methadone in the community and the deceased's decision to take his own life. I have no doubt that TSMS was dealing with challenging volumes of cases relating to those at liberty. Even with the enhanced presumption against short prison sentences, there remain cases where the criminal courts continue to have little option but to impose such sentences. The result is that regrettably persons like the deceased can find themselves in prison for relatively short periods with significant regularity though little direct predictability. The deceased may not be the only one to seek to engineer time in prison as it is less problematic than the outside world. The TSMS response to him was rather rigid once the decision to withdraw methadone had been made by Dr Cowden. Had the meeting scheduled for 21 September 2017 with the prison consultant Dr Elworthy taken place, it may be that further discussions between the prison health care authorities and TSMS might have occurred. It is not possible to say what would have emerged from any such discussion prior to his planned date of liberation.

[36] There are two aspects of the evidence that caused concern even though I have not thought it appropriate to make recommendations.

a) There was little documentation of the issues raised Nurse Petrie with TSMS in September 2017. The interested parties should consider whether there should be a greater degree of co-ordination between external NHS services like TSMS and the Prison health care staff. The record keeping of discussions of this kind should be improved.

b) It is regrettable that SPS and THB could not arrange that the DIPLAR review took place at a time when representatives of THB were available to participate in that review. Such absence should not be a regular feature of the process of review after a self-inflicted death in custody.

[37] I was satisfied that it was appropriate to make the findings stated above, having regard to the terms of the Joint Minute, the oral evidence of the witnesses who came to Court and the additional evidence presented in the affidavits and other documents. For the purposes of section 26 of the 2016 Act a precaution might realistically have resulted in the death, or any accident resulting in death, being avoided, if there was a real or lively possibility that it might have done so. I did not consider that any additional findings in my determination were required in terms of section 26(1)(a) or any recommendations in terms of section 26(1)(b) and (4) of the 2016 Act. On the evidence available to me, there were no reasonable precautions that could have been taken that might realistically prevent other deaths in similar circumstances.

[38] I offer once again my condolences to the family of the late Darren Johnston.