SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2025] FAI 42

FAL-B334-23

DETERMINATION

BY

SHERIFF PINO DI EMIDIO

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

into the death of

SARAH JANE RILEY

FALKIRK, 20 October 2025

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:

1. Sarah Jane Riley was born on 17 January 1990. Her death occurred sometime after 1715 hours on 11 January 2019 and before 0809 hours on 12 January 2019 in Cell 11 of the Separation and Reintegration Unit ("SRU") at HM Prison Perth, life being pronounced extinct at 0815 hours on 12 January 2019.

2. In terms of section 26(2)(b) of the 2016 Act no accident took place.

3. In terms of section 26(2)(c) of the 2016 Act, the cause of her death was by plastic bag asphyxia.

4. In terms of section 26(2)(d) of the 2016 Act, there was no accident and therefore no finding requires to be made under this subsection.

5. In terms of section 26(2)(e) of the 2016 Act, there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.

6. In terms of section 26(2)(f) of the 2016 Act, there was a defect in a system of working which contributed to the death. There was no system in place to allow for the formulations available in respect of Order for Lifelong Restriction ("OLR") prisoners regarding their risk to others to be reformulated to identify a prisoner's risk to themselves, although this could easily be done. Had this been done and communicated to the SRU staff working with the deceased they would have had a clearer understanding of what she was going through and the likely effect of the adverse Parole Board for Scotland ("PBS") that she received shortly before she was locked in her cell for the night on 11 January 2019. The deceased was a prisoner with complex needs, but the staff could have been given the available information about her complexities. With the benefit of the relevant knowledge the SRU staff would have identified that the PBS decision was likely to have a significant detrimental impact on Sarah such that should be placed on the Talk to Me ("TTM") suicide prevention strategy. Had that been done her death would have been avoided.

7. In terms of section 26(2)(g) of the 2016 Act, the following "other facts" are relevant to the circumstances of the death:

a. None of the staff in the SRU had knowledge of the deceased's OLR sentence and the impact of the recall on her.

b. There was a failure to deal promptly with the proposed transfer of the deceased to a prison in the female estate.

c. The deceased was removed from association upon arrival at Perth for the entire period up to her death.

d. There was no legal warrant for the first 18 days in which the deceased was removed from association. When authorisation was sought to keep the deceased removed from association the true state of facts as to the lack of legal warrant to keep her in the SRU was not disclosed to Scottish Prison Service ("SPS") HQ.

e. A personal officer was not appointed for the deceased who was a vulnerable prisoner despite a request by the prison psychologist.

f. Tayside Health Board ("THB") staff failed repeatedly to attend Transgender ("TSG"), OLR and other case conferences held in respect of the deceased.

g. There was delay by THB staff in commencing a mental health assessment of the deceased. The assessment commenced after 53 days and was not completed. The records were not preserved.

Recommendations

In terms of section 26(1)(b) the sheriff makes the following recommendations.

Dissemination of psychological formulation of OLR prisoners' risk to themselves

1. The Scottish Ministers and SPS should consider (a) establishing a system in respect of prisoners who have been sentenced to an OLR to allow for a psychological formulation focussed on the prisoner's risk to themselves, based on the information already available from the Risk Management Plan ("RMP"), to be prepared and shared with the prisoner's personal officer and other SPS and NHS staff working with the prisoner's personal officer on a regular basis; (b) providing training to SPS and NHS staff on the impact of OLR sentences on prisoners.

2. Training should be provided to SPS and NHS staff on OLR's and the impact of these sentences on prisoners.

Prompt consideration of whether a transfer should occur

3. The Scottish Ministers and SPS should consider (a) making a requirement that an urgent case conference should take place within 7 days of the arrival of a recalled prisoner who is within the scope of the current TSG policy to decide if the prisoner requires to be transferred to another prison; (b) specifying that the case conference should be chaired by a person of at least the rank of deputy governor; (c) the person chairing the case conference should be required to take action to secure that any decision as to transfer is actioned promptly; (d) the chair should within 7 days submit a report to

SPS HQ detailing the reason for the decision of the case conference; and (e) the report should be considered forthwith by the most senior person on duty at the time it is received at SPS HQ.

Review of decisions to remove OLR or TSG prisoners from association for safety reasons

4. Where an OLR or a TSG prisoner has been removed from association for more than 30 days for their safety, the Scottish Ministers and SPS should consider requiring that there should be an urgent high-level SPS HQ review at least at deputy governor level based on full reporting of the circumstances that has resulted in removal from association.

Disclosure to SPS HQ where a prisoner has been removed from association without legal warrant

5. Where a prison has removed a prisoner from association without the prison staff having initiated the Rule 95 process timeously, the Scottish Ministers and SPS should consider making a requirement that the local prison should disclose the fact that the prisoner has been held in segregation without legal warrant to SPS HQ forthwith, and provide an explanation for the failure to apply within the correct timescale.

Obligation to appoint a personal officer to an OLR or TSG prisoner

6. The Scottish Ministers and SPS should consider making a requirement that any request by a prison psychologist for the appointment of a personal officer to an OLR or TSG prisoner must be actioned within 7 days at deputy governor level.

Attendance at successive case conferences by NHS staff

7. The Scottish Ministers and SPS should consider making a requirement that: (a) a record should be kept of non-attendance by NHS staff at case conferences and the record monitored; and (b) if two successive case conferences are missed, this should trigger an obligation that a suitably experienced member of NHS staff must attend the next case conference.

Mental health assessment of OLR and TSG prisoners recalled from licence

8. The Scottish Ministers and SPS should consider making a requirement that when the need for a mental health assessment is identified on reception at prison or at a case conference or requested by a recently recalled OLR or TSG prisoner such an assessment should be commenced within 7 days.

Note

[1] This inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the "2016 Act"). This note comprises Introduction; Legal framework; Submissions; Findings in fact; and Analysis and Conclusions. The

reasons for the recommendations are discussed under Analysis and Conclusions. For ease of reference a table of abbreviations used has been added as an Appendix.

Preliminary observation

[2] Sarah Riley was a transgender woman. The findings in fact set out the history of Sarah's transition which commenced while she was in prison. Sarah had been living as a woman for a significant period prior to her death both in the male prison estate and on licence in the community. She had undergone treatment but did not have a Gender Recognition Certificate. She is referred to as "Sarah" in this determination as that is consistent with how she was known in the various public records relating to her in the last few years of her life.

Parties and representatives

[3] The Crown was represented by Ms I Davie KC AD from 2023. Scottish Ministers representing the Scottish Prison Service were represented by Mr P Reid KC instructed by Anderson Strathern. Tayside Health Board ("THB") was represented by Ms K Bennet, advocate and Ms Shippen, solicitor. The Scottish Prison Officers Association ("POAS") was represented by Mr D Adam, advocate. Ms Rachel McRae was represented by Mr A Gillies, solicitor advocate.

The history of this inquiry

[4] The progress of this inquiry has been delayed for several reasons. I have dealt with them in detail in notes that I added to many of the interlocutors I pronounced following the numerous preliminary hearings held when I was seeking to manage the case. I provide a brief summary here but the full story has been written elsewhere in the record of the inquiry proceedings so I will not repeat it here.

[5] The first major difficulty was that SPS did not co-operate appropriately with the inquiry process. It held extensive documents relating to Sarah who had been in various of its establishments over a long period of time. This inquiry was delayed by the failure of SPS to produce documents. The court had to exert considerable pressure to try to make progress. On 16 December 2020, following a continued preliminary hearing, I set out my concerns at length in a Note that a full explanation should be provided in advance of the next hearing.

[6] In about January 2021 Mr Reid, advocate, who was then first standing junior counsel to the Scottish Government, was instructed to represent them. That was a major benefit because he brought great expertise which aided progress. More documents were disclosed after he was instructed. Counsel advised the court that he had secured strong assurances from SPS that relevant documents had been appropriately disclosed. However, it later transpired that those assurances were rather worthless. The evidential segment of the inquiry was scheduled to take place online on ten consecutive court days commencing on 1 November 2021.

[7] It quickly became clear as witnesses were called to give evidence that the assurances given were not accurate and important witnesses were adamant that there was much more documentation. The result was that on 5 November 2021, I granted substantial parts of a Crown motion for commission and diligence to recover documents held by SPS after some adjustment in respect of on certain calls in a specification of documents. The process of recovery and intimation of additional documentation took many months.

[8] The delay that arose was not the fault of counsel who, I have no doubt, gave robust advice way and was evidently embarrassed by his clients' seemingly casual approach to its obligation. Eventually many more, though by no means all, relevant documents were disclosed.

[9] The Crown decided to reopen its investigation into whether criminal proceedings should be instituted arising from information in the new documentation. This process took many months. The court was advised that the police were instructed to carry out further inquiries. Eventually, the court was advised that Crown counsel had decided that no proceedings should be instituted either under statute or at common law. During this time, there was at least a possibility that some of the witnesses due to give evidence at the inquiry might face criminal prosecution. The renewed possibility of a criminal prosecution meant that there might be difficulties in getting as full an account as possible from some witnesses.

[10] The case continued to be reviewed regularly by the court at further remote hearings. I expressed concern on several occasions that the Crown required to improve

the quality of its representation because there was difficulty making progress due to several matters for which the Crown was responsible.

[11] The Crown sought to introduce a new expert report by a witness who had been instructed during its renewed criminal investigation. Unfortunately, this caused confusion and further delay. The report was not instructed for use in the inquiry. Its terms were not tailored to the issues to be considered by the inquiry and the author sought to apportion some blame on the PBS which had not been hitherto a party to the inquiry. The court required to order intimation on the PBS as a further potential interested party.

[12] These various matters took a substantial time to resolve. Ultimately Crown counsel decided not to prosecute any party. The PBS entered the process. Once the Crown instructed the advocate depute there was a step change. The Crown decided it did not wish to call the new expert or rely on his report. This enabled PBS to withdraw from the inquiry.

[13] When the inquiry resumed, the witness Barry Burns described how he was tasked with finding more missing documents in November 2021. Mr Burns is to be commended for his diligence when he carried out that search. As a result, documentation, including important TTM records, which had been stored incorrectly was found. This episode cast an unfavourable light on the record keeping standards at HM Prison Perth.

[14] The first phase of the inquiry had taken place online in November 2021. There was insufficient capacity at Perth Sheriff Court to accommodate all the parties in a

prolonged set of in person evidential hearings. As a result, after consultation with parties and the court administration it was determined that there were suitable facilities at Falkirk Sheriff Court. As a result, on 6 November 2023 I made an order transferring the inquiry to Falkirk. All in person hearings took place there using electronic copies of productions, thereby saving significant amounts of paper.

[15] It proved very difficult to secure time for evidential hearings when all involved in the inquiry were free to participate. Several witnesses had to be recalled to give further evidence in the light of the new material.

[16] When evidential hearings resumed in December 2023, they were conducted efficiently and according to plan until the final hour of the planned 8 days of hearings. On 7 June 2024, it was not possible to complete the evidence of the expert Mr Wheatley due to travel problems. The evidence of Mr Strachan could not be taken because of a technical problem with the sound equipment in the court room. After that, there were more problems in finding suitable dates due to the unavailability of counsel.

List of witnesses who gave oral evidence with dates when they did so

[17] All hearings in 2021 were conducted remotely by Webex.

Date	Witness
01.11.21	Tom McMurchie, Prison Inspector
01.11.21	Brian McKirdy, Prison Governor
01.11.21	George Stewart, Unit Manager
02.11.21	George Stewart continued
02.11.21	Mary Hunt, Prison Officer
02.11.21	Dr Naveel Saleemi, Prison Psychologist
03.11.21	Lesley McDowall, Senior SPS Official
03.11.21	Lorraine Roughan, Prison Deputy Governor
18.12.23	George Stewart Recalled
18.12.23	Brian McKirdy Recalled
19.12.23	Craig McKendry, CLT official
19.12.23	Barry Burns, SRU FLM
20.12.23	Anne Milne, Registered Primary Care Nurse, Perth Prison
20.12.23	Dr Naveel Saleemi Recalled
20.12.23	Michaela Cooper MH Nurse
26.03.24	Steven Keenan, U/M, formerly FLM, in Perth SRU
26.03.24	Dr Mark Wallace, Prison GP
26.03.24	Margaret McKay, Prison Social Worker
27.03.24	Vince Fletcher, SPS E & D Adviser
27.03.24	Dougald Lawson, Life Liaison Officer retired
14.05.24	Fraser Munro, former Governor
14.05.24	Rachel McRae, former Deputy Governor
15.05.24	James McKay, Drug and Alcohol Worker, Perth Prison
15.05.24	Dr Jo Brown, Consultant Psychiatrist, Royal Edinburgh Hospital
07.06.24	Philip Wheatley Retired Senior Prison Official, England and Wales [not completed]
06.09.24	Philip Wheatley – evidence completed online
20.11.24	Hearing on submissions

The witnesses who provided affidavits and whose evidence was agreed were:

a. Wendy Given (CP 41) Service Manager, Anchor House, Perth

b. Joy Michie (CP 39) Senior Practitioner in Criminal Justice Services, Perth and Kinross Council

c. Colin Spivey (CP 38) Chief Executive of the Parole Board of Scotland

d. Dr Morag Martindale (CP 45) Locum General Practitioner, NHS Tayside

e. Craig McKendry, (CP 40) Community Licence Team

f. Nick Lewis, (CP 42) Residential Prison Officer, SPS

g. Angela Cunningham, (CP 63) Service Manager for Justice Healthcare, NHS Tayside

h. Robert Strachan, (SPS Production 3) former Head of Strategy and Improvement for the SPS

Legal framework

[18] This inquiry was held in terms of section 1 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"). This was a mandatory inquiry in terms of sections 2(1), (4), and (5) of the 2016 Act as Sarah Riley was a prisoner in legal custody at the time of her death. The inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (SSI 103/2017) ("the 2017 FAI Rules").

Purpose of an FAI

[19] In terms of section 1(3) of the 2016 Act, the purpose of this inquiry is to establish the circumstances of Sarah Riley's death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The procurator fiscal represents the public interest in investigating, arranging, and conducting an inquiry. Fatal Accident Inquiries are an inquisitorial and not an adversarial process (Rule 2.2.(1) of the 2017 FAI Rules).

[20] It is not the purpose of the inquiry to establish civil or criminal liability. It is not for the inquiry to attribute fault, whether to individuals or institutions. However, as stated by Sheriff Collins KC in *Inquiry re Deaths of Katie Allan and William Brown* (Falkirk, 13 January 2025) [2025] FAI 6 (at para [19]):

> "If the evidence presented does establish that the deaths arose due to fault, whether because an individual did not do what they should have done under an existing system, or because the system was defective in requiring them to do what they did, then the determination of the inquiry should say so."

Section 26

[21] Section 26 of the 2016 Act sets out the matters to be covered in the determination. The sheriff's determination must be based on the evidence presented at the inquiry. In terms of section 26(2), the determination should set out findings on the following:

> "(a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) any precautions which—
> (i) could reasonably have been taken, and
> (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death,
> (g) any other facts which are relevant to the circumstances of the death."

[22] In terms of section 26(4), the matters covered can also include setting out such recommendations (if any) (although it is up to the sheriff's discretion whether to do so) in relation 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."

As the death was not the result of an accident, it is unnecessary to make any findings in terms of section 26(2)(b) and (d) of the Act.

[23] In terms of section 26(6) of the 2016 Act, the sheriff's determination is not admissible in evidence and may not be founded on in any judicial proceedings of any nature.

Section 26(2)(a) and (2)(c) – circumstances of the death

[24] As regards any findings in terms of sections 26(2)(a) and (c) as matters of fact, the sheriff simply need exercise a fact-finding function based on the evidence led at the inquiry. The standard of proof is on balance of probabilities.

Section 26(2)(e) – precautions

[25] As regards any finding in terms of section 26(2)(e) of the 2016 Act, the sheriff must conduct a judicial assessment alongside an exercise in fact finding. This assessment is one of, as noted by Sheriff Collins KC in *Allan and Brown* (at para [25]):

"a conditional counterfactual: if x had been done, might y not have occurred?"

[26] Sheriff Collins KC further stated the sheriff must consider the fact that "it is not every precaution which might conceivably have been taken that justifies a finding under section 26(2)(e)." He went on to outline four criteria that a precaution must satisfy to be included as a finding under section 26(2)(e) (at paras [28] – [29]):

> "(i) it must be a precaution which arises from and is supported by the evidence adduced at the inquiry and reasonable inferences drawn therefrom, not from the use of speculation or creative imagination on the part of the sheriff.
> '(ii) it must be a precaution that could reasonably have been taken, that is, it must have been available, suitable and practicable, even if not one that was required or indicated by guidance or practice at the time.
> '(iii) the precaution must be one which if taken might realistically have resulted in the death being avoided. Accordingly it is not necessary for the court to be satisfied that the precaution would necessarily have had this result, or even that it would probably have done so. What is required is rather a realistic possibility that the death might have been avoided, or put in other ways, an actual rather than a fanciful possibility, a real rather than a remote chance.
> '(iv) what has to be considered is whether the precaution might have avoided 'the' death, that is, the death which actually occurred. Accordingly, if otherwise justified, a finding under section 26(2)(e) should still be made even if the evidence indicates that had the deceased not died when and how they did, that they would or might well have died in another way in any event."

[27] In the recent decision in *Duncan, Petitioner* [2024] CSOH 114; 2025 SLT 47 the petitioner challenged certain conclusions of a sheriff in a Fatal Accident Inquiry under the 2016 Act. The petitioner submitted that the sheriff was disabled from making a finding in terms of section 26(2)(e) if more than one course of action was available (assuming that course of action is a precaution) which was reasonable. The Lord Ordinary, Lady Haldane, rejected that submission. As to what was the correct approach, she adopted a passage from the determination by Sheriff Braid, as he then was, in the case of *Marion Bellfield,* issued April 2011, at para [46] where he said:

> "It is therefore nothing to the point to inquire as to whether what was done was reasonable, and it seems to me to involve a *non sequitur* to hold that a precaution which was not taken can be held to have been reasonable only if what was done was not reasonable. To take that approach respectfully seems to me to apply the principles and language of negligence, which are irrelevant for the purposes of this inquiry. I do not see why it is not open to me to hold that, even though what was done was reasonable, other reasonable precautions might also have been taken which might have prevented the death"

[28] As Lady Haldane noted, the *Marion Bellfield* determination predated the passage of the 2016 Act. The language in section 26(2)(e) is slightly more expansive than that in the predecessor statutory provision but the analysis remains valid. I respectfully agree and adopt that analysis.

Section 26(2)(f) – defects in the system

[29] As regards any findings under section 26(2)(f), it is again simply an exercise of fact finding. The standard of proof being on the balance of probabilities. As Sheriff Collins KC stated in *Allan and Brown* (at para [30]):

> "A defect may consist in the absence of a proper system of working, not merely a defect in a system which already exists. A system may also be classified as defective not because of what it stipulates as a matter of form, but because those charged with operating it routinely fail to do so without effective correction or sanction."

Section 26(2)(g) – other relevant facts

[30] Section 26(2)(g) allows the sheriff formally to record matters which were relevant to the death but have no causal connection to the findings under sections 26(2)(e) or (f). It allows the sheriff to highlight reasonable precautions that could have been taken even if doing so would not have realistically prevented the death. It also allows the sheriff to highlight any defects, even if it was not established that any of these defects contributed to the death.

Exercise of hindsight

[31] The making of a determination in a FAI is an exercise founded on hindsight. In terms of section 26(3) of the 2016 Act, as far as identifying any precautions under section 26(2)(e) or defects under section 26(2)(f) are concerned, it does not matter whether it was foreseeable that the death or accident might have occurred if: (a) the precautions were not taken; or (b) as the case may be, as a result of the defects. As Sheriff Reith stated in *Inquiry re Death of Sharman Weir* (Glasgow, 23 January 2003):

> "a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death might have been avoided. The Sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of the death … The statutory provisions are widely drawn and are intended to permit retrospective consideration of matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the Inquiry. There is no question of the reasonableness of any precaution depending upon the foreseeability of risk."

The approach to the 2016 Act

[32] The Crown's submission, made in advance of the issue of Lady Haldane's decision in *Duncan, Petitioner*, was that Dr Brown's criticisms were appropriately classified as a defect in the system of working under section 26(2)(f). There was significant information available but SPS staff in the SRU were working operationally in a lacuna. Within the prison records there were 10 years of analysis of Sarah which contained much valuable information. As prison staff worked in silos, that information was used to assess the risk she posed but was not available to the staff dealing with her on a day-to-day basis in the SRU. As she put it, a large amount was being done about

Sarah but little with Sarah directly involved. The approach taken was to focus on what would have altered the outcome for Sarah.

[33] Senior counsel for the ministers referred to the then undecided judicial review in *Duncan, Petitioner*. As in that case, there was evidence of information, in recorded communications, which was not known at the time by the prison officers dealing with Sarah in the SRU.

[34] Having considered Lady Haldane's decision in *Duncan, Petitioner*, I concluded that the approach taken by the advocate depute in her submission remained valid. None of the other submissions suggested I should take a different approach to the legislation. For the reasons stated below I have proceeded on the basis that the information not known to the prison officers did not add much to what was known about Sarah's thoughts and feelings from the prison records.

[35] The advocate depute accepted that there were a number of matters relevant under section 26(2)(g) and I have made recommendations under this subsection.

Submissions of parties

[36] The parties provided detailed written submissions which have been fully considered. These were supplemented at a hearing where they were able to comment on each other's submissions. I have not provided a detailed account of the submissions. I have attempted to deal with them while setting out my own conclusions below. In this section I set out a summary of the main thrust of the submissions of the parties.

Crown submissions

[37] The Crown submissions, both written and oral, were of great assistance in this case. I have, by and large, followed the analysis of the Crown in the reasoning that follows though I may have gone a little further on some points of detail. I have tried to highlight where they occur. The main recommendation under section 26(2)(f) is closely based on the text proposed by the Crown.

Submissions for the Scottish Ministers

[38] Senior counsel for the Scottish Ministers submitted that the ministers had participated in the Inquiry to listen, learn and help. They had not sought to defend what had been done but had tried to furnish information. In my view, this last observation has been qualified by the very significant difficulties described above in getting proper disclosure. Those difficulties were due to the failure of SPS for which the ministers are responsible. While they were committed to listening, learning, and helping, they also required to challenge the evidence where appropriate.

[39] The prison rules left the discretion of the governor as to where to accommodate a prisoner mostly unfettered. The only restriction is in Rule 41 which provides that a health care professional may require a move in certain circumstances. As Sarah was living as a woman, under the rules in force at the time, although she could be on a male wing, she could not be placed in a dual occupancy cell.

[40] Senior counsel for the Scottish Ministers stated that it was their aim to come to the inquiry to listen. While SPS may have been, on the face of it, in listening mode

counsel firmly opposed every suggested innovation or suggestion that there was scope for improvement. The management of Sarah involved a consideration of and balancing of competing interests and rights. The inquiry should keep in mind that this remains a sensitive area which does not admit of a single answer.

[41] The Scottish Ministers relied heavily on the evidence of Dr Saleemi which was said to render several of the Crown's submissions untenable. In particular, the ministers took issue with the proposition that Sarah should have been on TTM at the time of her death. They also submitted that it was "plainly wrong" to suggests that Sarah had very little support in the SRU and her transfer was not well managed. All these matters are dealt with in the relevant sections below.

Other submissions

[42] The other parties confined their submissions to those matters that were most relevant to their interests. None of them suggested any more than formal findings were required.

[43] THB submitted that only formal findings were required. As regards the retrospective record completed posthumously of incomplete mental health assessment undertaken on 28 December 2018 it was submitted it was likely that it was completed by handwritten notes that were later destroyed rather than from memory. THB accepted that the assessment was delayed and should have commenced on 7 December 2018 but submitted that this was not a factor in Sarah's death. THB concurred in the Crown's

approach to section 26(2)(e) and adopted a neutral approach in respect of sections 26(2)(f) and (g).

[44] POAS's approach to this inquiry was very robust but focused on quite narrow issues relating to the admissibility of expert evidence on the operation of TTM. It attacked the admissibility of Mr Wheatley as an expert witness. I have dealt with the issue of admissibility in the section dealing with that matter below. I have also dealt with the submissions regarding TTM in the relevant section.

[45] On behalf of Ms McRae, it was submitted that section 26(2)(g) gave the court wide scope. Any suggestion that Ms McRae did not appear to have a particular sense of urgency was misplaced. Ms McRae had encountered significant difficulties when she returned from leave. No action had been taken to action a transfer while she was on leave. The approach to HMP Edinburgh was logical and reasonable having regard to Sarah's complex needs. After being rebuffed by Edinburgh, she had moved on to the next available option. She took all possible steps to accommodate Sarah's transfer at the earliest opportunity. Despite the unfortunate and unexpected obstacles, she was faced with. The court was invited to reject the evidence of the then Governor Mr Munro as to anticipated timescales for a transfer. The complexities of the case presented Ms McRae with a Gordian Knot. It was accepted that the Prisoner Management Authorisation Group ("PMAG") was designed to catch problems and highlight any ongoing issues at management level that could have cut the Gordian Knot. However, Ms McRae did not receive any information from any member of staff that related to any concerns about Sarah's mental health or that she was not content to wait within the SRU until a suitable

transfer could be arranged. There was no evidence of any perceived delay on the part of Ms McRae. No findings should be made under section 26(2)(g). No matters could be usefully addressed under section 26(4).

Agreement of evidence

[46] By the time the evidential hearings recommenced an additional party had been convened, the former Deputy Governor Rachel McRae. The parties to the resumed inquiry entered into three Minutes of Agreement. The first Minute of Agreement, number 86 of process was lodged at the hearing on 19 December 2023. The second Minute of Agreement, number 92 of process was lodged at the hearing on 7 June 2024. The third Minute of Agreement, number 93 of process was lodged at the hearing on 20 November 2024. All the professionals involved are to be commended for the effort made to reach substantial agreement on many matters. This reduced the extent of the oral evidence very considerably. The parties also produced an agreed timeline which has been of significant help. The use of a core bundle made the principal productions easily accessible in court once evidential hearings recommenced. All these collaborative actions by the representatives of parties were of great help to the court.

Findings in fact

[47] In the light of the evidence presented to the inquiry, I found the following facts to be admitted, agreed or proved. Where there was a conflict in the evidence of witnesses, it can be taken that I have accepted the evidence which is consistent with the

findings and rejected that which was not. The reasons for doing so are set out later in this determination.

1. Sarah Jane Riley was born on 17 January 1990.
2. On 12 January 2019, at the time of Sarah's death, she was an inmate at Perth Prison, 3 Edinburgh Road, Perth where she was the sole occupier of Cell 11, SRU.
3. On 21 December 2007 and 28 December 2007, Sarah appeared on petition at Perth Sheriff Court, was remanded in custody and accommodated at Perth Prison. On first arrival at Perth Prison, she was assessed as suicidal.
4. On 27 March 2008, Sarah pleaded guilty at a first diet. After hearing the narrative, the sheriff continued his remand and remitted the case to the High Court of Justiciary for sentence. On 12 May 2008, the court made a risk assessment order and sentence was further deferred until 8 December 2008.
5. On 8 December 2008 Sarah was sentenced at the High Court of Justiciary. An OLR was imposed. The punishment part was specified as 2 years 8 months detention (backdated to 21 December 2007). Whilst serving said sentence and awaiting a decision to release her on licence, Sarah was accommodated at YOI Polmont YOI, Cornton Vale Prison, Greenock Prison, Perth Prison and Castle Huntly Prison. The specified period of detention expired on 20 August 2010.
6. On 23 March 2011, a Parole Tribunal refused to release her on licence.

7. Sarah transferred to Perth Prison on 11 April 2011. As Sarah was an OLR prisoner, SPS made arrangements for preparation and maintenance of an RMP for her. The work on the RMP was carried out by staff within Perth Prison. In the ensuing years RMPs were prepared and submitted to the Risk Management Authority regularly.

8. On 21 August 2011, a Parole Tribunal refused to release her on licence.

9. On 7 January 2013, she was referred for mental health assessment as she was not sleeping and had asked to be referred.

10. On 19 April 2013, she was transferred to HMP Greenock (National Top End).

11. In 2013 and 2014, a number of mental health reviews disclosed significant fluctuations in her mood. She had a small number of home visits and carried out some external work assignments. There was a suggestion she had autistic traits though autism was not diagnosed.

12. On 20 August 2014, a Parole Tribunal refused to release her on licence.

13. On 17 November 2014, she transferred to Castle Huntly, an open estate prison.

14. Around February 2015, she declared her wish to live as a female and began living as a female in adult male open conditions. SPS recognised her protected status as a trans woman from 9 March 2015.

15. Further mental health assessments took place on 19 February and 2 April 2015.

16. On 26 June 2015, Sarah transferred to Cornton Vale Prison. She was accommodated in independent living units in this women's prison. She met Prison Officer McAinsh when incarcerated there.

17. The transfer to the female estate was not successful. Sarah encountered many difficulties with other prisoners.

18. On 31 July 2015, the prison authorities became aware that Sarah had suicidal ideation. She was placed in segregation under Rule 95 after this and remained in the SRU for the remainder of her time at Cornton Vale.

19. On 8 October 2015, she required medical treatment to suture an artery in her arm. She told medical staff she had cut herself in response to being told she was to return to the male estate.

20. On 22 October 2015, she required treatment for serious self-inflicted injuries to her neck and left forearm caused with a razor blade.

21. On 28 October 2015, Sarah was returned to Perth Prison after indicating she would live as a male.

22. On 3 November 2015, she was removed from the ACT suicide prevention regime then used by SPS.

23. At a mental health assessment on 13 November 2015, she expressed feelings of helplessness and anger that having been at the top end she was now back to the start.

24. On 25 November 2015, she expressed anger and upset at the way she had been treated at Cornton Vale. There had been recent incidents of self-harm.

She said she was being forced to stop the transition from male to female, and she would be kept in segregation for a long time because SPS did not know or understand where she is best placed.

25. Sarah's views about her treatment as a trans and OLR prisoner were documented by the prison authorities as far back November 2015. That included a very clear understanding that she was subjected to prolonged periods of removal from association.

26. On 27 November 2015, a Parole Tribunal refused to release her on licence.

27. In early December 2015, Sarah remained in distress. She stated clearly that she wanted to live as a woman, that she was being punished for being transgender and reported a sense of hopelessness and worthlessness. ACT 60/60 suicide prevention observations continued until 14 December 2015 when she was reported to be more positive.

28. On 24 March 2016, she stated that she wished to be referred to as Sarah.

29. On 3 May 2016, Sarah moved to mainstream conditions in C Hall Level 4 of Perth Prison.

30. The Risk Management Team at Perth carried out an assessment of Sarah using the International Personality Disorder Examination (IPDE) and Psychopathy Checklist Revised (PCL-R).

31. This work was completed in June 2016 when Sarah was 26 years old. It would not have been appropriate to carry out these assessments at a younger age.

32. The conclusion reached was that she met the diagnostic criteria for Paranoid Personality Disorder, Emotionally Unstable (Borderline Type) Personality Disorder and Anxious Personality Disorder. There were also features of dissocial and schizoid personality disorders [4.1.3]

33. The report submitted at that time recommended that she should be provided with psychological education about trauma and should receive support to process her own experiences.

34. Her risk assessment was updated to highlight the areas where she needed support. Specific recommendations were made regarding work that would benefit Sarah to manage the complexities of her own personality in the future.

35. Following referral to the Sandyford Clinic in 2016 it was concluded that Sarah met the diagnostic criteria for gender dysphoria.

36. Sarah was undergoing a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.

37. In line with guidance, she was started on hormone treatment after she had been living consistently as a woman for about 12 months.

38. In the June 2016 review of the risk assessment, it was noted that she had a profound sense of social exclusion, victimisation and social rejection.

39. On 19 December 2016, the Parole Tribunal refused to release her on licence.

40. In about August 2017 social workers began to assess whether Anchor House, Perth was a suitable facility for Sarah to spend periods of home leave.

41. On 19 September 2017, the Parole Tribunal refused to release her on licence.

42. Prior to her transfer to the open estate on about 31 October 2017, Mary Hunt was prison officer at Perth who became Sarah's personal officer. She built a relationship with Sarah within the prison that continued for a sustained period.

43. The role of a personal officer is a broad one. Its exact nature in any case will depend on the needs of the individual prisoner.

44. As Sarah was an OLR prisoner, her personal officer was required to contribute to a monthly risk management report which assessed the degree of risk Sarah posed to staff.

45. As her personal officer, Ms Hunt got to know Sarah well. As a result, Sarah opened up about her problems at this early stage of her incarceration in Perth.

46. Ms Hunt was aware from their discussions that Sarah felt strongly that the OLR was very unfair and that her predicament was very difficult.

47. At times Sarah referred to Ms Hunt's as her "prison mum". Other prison staff noticed that in this period prior to the move to the open estate Ms Hunt could get Sarah to focus.

48. On 31 October 2017, Sarah was transferred to Castle Huntly Prison.

49. In about October/November 2017, Sarah began to spend some periods of home leave at Anchor House.

50. In around January and February 2018, there were incidents in which Sarah did not have the expected amounts of prescribed medication in her possession. This caused staff to be suspicious.

51. As at February 2018, the psychological education work had not been fully completed due to concerns that there was no immediate access to NHS services to complete this.

52. On 13 March 2018, at a consultation, she disclosed she often thought of self-harm but did not do so as she knew she would be downgraded. She insisted she had taken the unaccounted drugs due to pain, but staff doubted this. As a result, a request for re-prescription was denied.

53. By June 2018, Sarah had had several extended periods of home leave at Anchor House. She was building relationships with the social workers there.

54. On 24 July 2018, the Parole Tribunal decided to direct her release by a majority.

55. On 26 July 2018, Sarah was released from HMP Castle Huntly to Anchor House on parole licence.

56. From Sarah's release from custody on licence on 26 July 2018 until her recall to prison on 6 November 2018, she resided at Anchor House, 47 Crieff Road, Perth.

57. On 10 October 2018, AB met Sarah who had moved into Anchor house. They became friends. After Sarah's recall to Perth Prison they kept in touch by means of letters, calls and visits.

58. In October 2018, there were several incidents that caused concern to the social workers at Anchor House. On 18 and 19 October 2018 they had meetings with Sarah to discuss their concerns and how she might formulate strategies to lessen the risk of further incidents.

59. On 22 October 2018, a Throughcare Licence Breach Report ("TCLBR") was submitted to PBS.

60. On 24 October 2018 the PBS issued a formal warning to Sarah stating any further breaches were likely to lead to revocation of her licence.

61. The PBS received a further TCLBR advising that Sarah had self-reported alcohol consumption to her supervising officer.

62. On 31 October 2018 she did not attend a meeting with her community addictions worker but provided a sample to her supervising officer that tested positive for cannabis and methadone.

63. On 1 November 2018 she failed to attend a meeting with her supervising officer.

64. On 5 November 2018, her supervising officer submitted a further TCLBR to the PBS reporting further breaches of licence conditions.

65. These related to concerns reported by staff at Anchor House in relation to further alcohol use and an aggressive altercation during the weekend of 3 and 4 November 2018.

66. During the time she was residing at Anchor House, Sarah spoke regularly about the OLR and stated she would end her life if she was recalled to prison.

Sarah's Recall and admission to Perth Prison

67. On 5 November 2018, the Parole Board, following consideration of the latest TCLBR, revoked Sarah's licence and this was communicated to the Scottish Ministers Community Licence Team (CLT).

68. Officials in CLT made a call to check that Perth Prison would accept Sarah and decided to specify the institution to which Sarah should be taken following arrest was Perth Prison. The decision to specify Perth was intimated by email to the Police Service of Scotland, Perth Prison and Perth & Kinross Social Work.

69. On 6 November 2018, officers of the Police Service of Scotland traced Sarah at 1000 hours. They then arrested her and transported her to Perth Prison where she arrived at 1030 hours.

70. As part of the standard admissions process, all prisoners are assessed by a reception officer and a nurse under the TTM strategy. TTM is a multi-agencies suicide prevention policy. The role of the reception officer

is to book in a prisoner and carry out an initial interview before the prisoner meets with nursing staff.

71. On 6 November 2018 at 1030 hours, Sarah was seen by Reception Officer Grant Peletier. Officer Peletier entered the standard descriptive details of Sarah onto the system. He carried out an assessment under TTM, noted that Sarah had "good communication, no thoughts of suicide or self-harm at this time and presents well" and assessed her as "No Apparent Risk".

72. Between around 1100 and 1215 hours on 6 November 2018, Sarah was assessed by Nurse Pauline Ogilvie. During that assessment Sarah was asked several questions about her physical and mental health, which was recorded on the prison medical records system VISION, which was operated by Tayside Health Board.

73. Sarah confirmed, amongst other things, that she had been drinking alcohol and smoking cannabis daily. She had alcohol dependence syndrome. Fast score 8 (indicative of problematic alcohol use) was recorded, and because of this score, Sarah was prescribed a chlordiazepoxide detoxification programme.

74. Sarah had a history of psychiatric disorder and a history of depression. She reported her mood as currently low. She was prescribed sertraline (an anti-depressant).

75. She had self-harm wounds to her stomach that appeared superficial and clean though inflicted in the last few days.

76. Sarah reported a long history of self-harm but that she felt safe within prison and denied any thoughts of self-harm or suicide at the time of assessment.

77. As regards her experience since liberation on licence she reported having negative experiences communicating with others. There had been an historical attempt of suicide approximately 5 years earlier. She denied any current thoughts of suicide. She reported that she regularly had suicidal thoughts but no plans to act on these thoughts.

78. Sarah presented with good eye contact, was relaxed in manner, and chatted at ease during assessment process.

79. Every person admitted to Perth Prison at the time of Sarah's admission was asked to provide a sample of urine, which was dip tested by nursing staff and will detect methadone, opiates, benzos, buprenorphine, cocaine and cannabis.

80. On 6 November 2018, Sarah provided a sample of urine during her healthcare risk assessment. That sample showed the presence of cannabis.

81. After the standard admissions process had been carried out on 6 November 2018, Sarah was taken to the SRU where she was allocated Cell 2.

82. On 22 November 2018, she was relocated to Cell 11 where she remained until her death.

The Suicide Prevention Strategy in place at the time of Sarah's death

83. All members of staff who encounter prisoners (including NHS staff) are trained on TTM. If any member of staff has a concern about a prisoner, they can complete a "concern form". This initiates the TTM process, and a case conference takes place.

84. At the TTM case conference, a group of multi-disciplinary trained individuals assess the prisoner. Account is taken of the prisoner's presentation, conduct and relevant medical history (eg previous self-harm attempts). If the prisoner is assessed as "At Risk", an appropriate care plan is put in place (eg observations/anti-ligature cell). If deemed as "No Apparent Risk", no action is taken.

85. In December 2019, the TTM process was revised to include a requirement to risk assessments being undertaken following receipt of adverse parole decisions.

Visits, letters and calls after Sarah's recall

86. She discussed her sense of distress and helplessness about her OLR and trans status with both her mother and a close friend in several telephone conversations that were recorded after her recall to Perth.

87. The content of the recordings was not available to the prison authorities until after Sarah died.

The Rule 95 process for removal from association

88. Although Sarah was lawfully imprisoned in Perth Prison, she was kept in the SRU without legal authorisation for a period of about 18 days, from 6 to 24 November 2018.

89. On 24 November 2018 the governor of Perth Prison made an order under Rule 95 of the *Prisons and Young Offenders (Scotland) Rules* 2011 (SSI 331/2011) ("the 2011 Prisons Rules") removing Sarah from association.

90. On 27 November 2018, a Rule 95 CC was held. Sarah stated that a hospital admission may have been more appropriate following her recall and that prison did not support her needs. Mr Coupe, the Unit Manager ("UM") who chaired the case conference agreed that she would benefit from mental health input and confirmed that a referral had been submitted in her case. Sarah was informed that a Rule 95(11) application would be made to SPS HQ.

91. The Rule 95(11) application was presented without disclosure to SPS HQ that Sarah had been held in the SRU since 6 November 2018. The application was approved without inquiry by SPS HQ.

92. On 27 December 2018 a further Rule 95 case conference was held chaired by the UM George Stewart. He noted that Sarah had expressed no interest in being transferred to Polmont Prison. He hoped that with Sarah's co-operation that the transfer issue could be resolved as soon as possible and

he understood the impact that remaining in the SRU was having on Sarah's mental health.

93. Following the Rule 95 case conference an application under Rule 95(12) for renewal of the existing Rule 95 order was presented to and approved without inquiry by SPS HQ.

94. If a fourth Rule 95 case conference required to be held, it had to be chaired by a deputy governor.

The effect of the delayed commencement of the Rule 95 process in Sarah's case

95. SPS HQ required to keep the use of segregation under review. The case of any prisoner who had been held in segregation for a period of 3 months required to be considered at a national meeting of prison deputy governors known as PMAG.

96. SPS HQ calculated the commencement of the 3-month period by reference to the date of authorisation of an application for removal from association under Rule 95. Sarah's case required to be referred to the regular meeting of PMAG if Rule 95 remained in place for 3 months.

97. As approval of the first Rule 95 application for Sarah was dated 27 November 2018, this had the consequential effect that in Sarah's case SPS HQ proceeded on the basis that the 3-month period started 21 days after she was first placed in the SRU.

OLR implications of the recall – risk management processes

98. As an OLR prisoner Sarah was subject to extensive risk management processes.

99. An RMP required to be prepared for each OLR prisoner which focussed on the risk that prisoner posed to other people.

100. A large amount of information about Sarah's psychological formulation was available within Perth Prison. This had been accumulated in the time since had come into the prison estate as an OLR prisoner. This information was used only for the purposes of the preparation and updating of the RMP.

101. In November 2018, there were about seven OLR prisoners at Perth. There was little experience of them being released on licence and then recalled.

102. As result of the recall, Dr Naveel Saleemi, Psychiatrist at Perth Prison required to update the RMP. This was a complex task carried out by the risk management team under Dr Saleemi.

103. The updating of the RMP would not be completed before Sarah's case was considered by a Parole Tribunal.

104. On 5 December 2018 by email Dr Saleemi asked SRU staff to complete behavioural observation sheets dealing with Sarah's presence in the SRU for the purpose of assisting the updating of the RMP.

105. The sheets identified behaviours to be monitored which were drawn from the existing RMP.

106. On 12 December 2018, there was a recall Integrated Case Management (ICM) meeting relating to Sarah.

The failure to appoint a personal officer

107. On 28 November 2018, Dr Saleemi requested that a personal officer be appointed for Sarah. He suggested that Prison Officer Mary Hunt be appointed as personal officer as she had had an established therapeutic relationship with Sarah.

108. No action was taken by the prison authorities to appoint a personal officer to Sarah in the period between her recall and her death.

The nature of the psychological information held on Sarah

109. Sarah was a complex prisoner. The failures that led to her recall would have prompted feelings of rejection and abandonment.

110. The plan to move Sarah to the female estate would have reinforced her sense of self and her identity that it would also involve an increase in anxiety and fear of rejection.

111. The SPS staff working regularly with Sarah after her recall had little or no awareness of the psychological formulation held in prison records.

The operation of the TSG policy following Sarah's recall to Perth

112. During the period when Sarah was recalled to Perth Prison till the date of her death, the SPS's Gender Identity and Gender Reassignment Policy dated March 2014 applied to her. (Crown production 11).

113. The SPS TSG policy specified that the first TSG case conference should take place within 24 hours of the prisoner's arrival at the receiving prison.

114. A TSG case conference to consider Sarah's case was convened on 12 November 2018.

115. Vince Fletcher was the Equality and Diversity Manager at SPS HQ. This was an advisory role which covered trans prisoners across the whole prison estate.

116. Mr Fletcher attended first TSG case conference at Perth. The others in attendance were Sarah, Mr Stewart the UM for SRU, Brogan Currie the C Hall UM and Barry Burns the SRU First Line Manager ("FLM").

117. Mr Fletcher was concerned that Sarah had been returned to Perth as she living in the community as a woman for some time. In his view, the policy required she should have been placed in the female estate.

118. Sarah expressed some concern about moving to a female prison due to the problems she experienced when she was placed in Cornton Vale. She stated she felt safe in Perth as it was familiar, and staff knew her well.

119. Mr Fletcher discussed the options within the female estate. He undertook to investigate the options for transfer to the female estate and to contact

Scottish Transgender Alliance. STA had received late notification and could not provide a representative to attend the TSG case conference.

120. The SPS staff in attendance agreed that there should be an application under Rule 95 to authorise Sarah's removal from association for her protection as a trans woman. Despite this no action to progress an application was taken until 24 November 2018.

121. Following the TSG case conference, as he was leaving Perth Prison, Mr Fletcher met the Governor, Fraser Munro, in the prison car park and discussed Sarah's case with him. Mr Munro stated he wished to seek legal advice from SPS HQ about Sarah's case.

122. Mr Fletcher had no doubt that the then current SPS TSG Policy required that Sarah should be transferred to the female estate. In follow up correspondence, Mr Fletcher made his view clear to the Deputy Governor Ms McRae. He expected that the transfer to happen within a few weeks.

123. Following the TSG case conference, the officials at Perth proceeded on the basis that Sarah would be transferred. The main responsibility for identification of a suitable prison for the transfer lay with Ms McRae.

The attempt to transfer Sarah to Edinburgh Prison

124. Around 12 December 2018, following a formal meeting at SPS HQ, Ms McRae discussed Sarah's proposed transfer with Natalie Beale, then the

Deputy Governor of Edinburgh Prison. Ms Beale refused to take Sarah as she said there were already too many TSG prisoners in Edinburgh.

125. Ms McRae had not expected Ms Beale to refuse to agree to a transfer. She discussed Sarah's case with the Governor, Fraser Munro. He refused to get involved at that stage.

126. Mr Munro was aware that if Sarah remained in the SRU at Perth Prison under Rule 95 the 3-month rule would have required her case to be considered at a national meeting at SPS HQ. He would have been willing to intervene to try to secure a transfer shortly before the expiry of that period to avoid the need for formal scrutiny by officials at HQ.

The attempt to arrange for transfer of Sarah to Polmont Prison

127. A further TSG case conference was held on 20 December 2018. Mr Stewart chaired as UM. Also in attendance were Barry Burns FLM in the SRU and two officers from Blair House, Polmont Prison. They were Mr R McAinsh, UM and Mr P Humphries, FLM. Sarah was also present. Vincent Fletcher was not in attendance.

128. The sole topic for discussion was a proposed transfer to Polmont. Sarah refused to go to Polmont due to previous adverse experiences there. Mr McAinsh knew her from Cornton Vale. He agreed to come back in January to attempt to get agreement for the transfer as Sarah did not appear to be in the frame of mind to discuss a transfer.

129. Sarah told Mr Stewart after the TSG case conference on 20 December 2018 that Mr McAinsh was the reason she refused to go to Polmont due to her earlier experiences at Cornton Vale.

130. Mr Stewart reported on the TSG case conference to the Deputy Governor, Ms McRae. At this stage the only plan for transfer still under consideration was to try again with Mr McAinsh to get Sarah to agree to transfer to Polmont.

The visit to Ninewells Hospital

131. On 21 December 2018 Sarah was taken to Ninewells Hospital, Dundee for outpatient treatment by a dermatology nurse. During that appointment Sarah told the nurse that no one was listening to her, she felt isolated and was having thoughts of taking an overdose.

132. The dermatology nurse reported this to the health centre staff at Perth Prison while Sarah was in transit back there. She thought that Sarah was "emotionally unbalanced".

133. Sarah was placed on TTM on arrival at the prison.

134. The following day 22 December 2018, a "multi-disciplinary" case conference was convened. It was attended by Mr Stewart, the SRU UM, Barry Burns the SRU FLM and three other prison officers. The THB mental health team were not available. Sarah was removed from TTM.

Attempted mental health assessment of Sarah

135. On 12 November 2018, at the TSG case conference, Sarah made a request for a mental health assessment. No action appears to have been taken in response to this request.

136. A meeting to commence a mental health assessment was originally scheduled for 7 December 2018 but was rescheduled due to unspecified operational reasons.

137. On 28 December 2018, Charge Nurse Michaela Cooper commenced, but did not complete, a mental health assessment with Sarah. She spent about an hour with Sarah. She made notes at the time.

138. Nurse Cooper failed to input her contemporaneous notes into the VISION health record system. No risks were identified regarding suicide by Nurse Cooper.

139. After Sarah' s death, the Head of Nursing identified that Nurse Cooper had failed to record patient presentation and the level of risk.

140. On 16 January 2019, Nurse Cooper completed the mental health assessment record relating to the assessment on 28 December 2018 on the VISION system either from recollection or her handwritten notes.

141. Nurse Cooper destroyed her handwritten notes at an unknown date.

142. The plan, as retrospectively reported by Nurse Cooper, was to review healthcare records given Sarah's previous contact with mental health services and review in 2-3 weeks' time to offer space to talk as a supportive

intervention and finish assessment. This is set out in Crown production 25, pages 1088 to 1091.

Other medical inter-actions

143. On 4 January 2019, Sarah was seen by the prison doctor Dr Mark Wallace during his weekly round. Sarah reported that her mood "could be improved" but denied suicidal ideation. Her anti-depressant medication was increased after this meeting.

The effect of removing Sarah from association

144. The prison based social worker Margaret McKay visited Sarah three times in the period she was in the SRU. She noted variations in her mood between visits and that the deprivation of association had an isolating effect. She thought that Sarah would have benefitted by remaining in Perth.

145. The Drug and Alcohol Worker James McKay visited Sarah four times in the period she was in the SRU. He noted variations in her mood and that it was lower shortly prior to her death.

146. In her dealings with prison staff and THB staff during the period she was kept in the SRU Sarah expressed her sense of grievance about the long-term impact of the OLR sentence on her.

147. Sarah's prolonged stay in the SRU led to a deepening of her sense of isolation.

148. The regime provided to Sarah within the SRU at Perth was not reasonable as it did not provide her with the support and guidance she required.

The Parole Board hearing and its aftermath

149. On 8 January 2019, Sarah attended a PBS Order of Lifelong Restriction Tribunal hearing within Perth Prison. She was represented by a solicitor. Dougal Lawson, Lifelong Liaison Officer (LLO) was also present during the hearing.

150. There was no practical route to being released on licence again from Perth other than by way of a progression to the open estate usually at Castle Huntley.

151. Staff within Perth knew that there was no prospect that Sarah would be released on licence as a direct result of this hearing. Without an updated RMP, it would be virtually for the PBS to make any decision to release Sarah on licence in the short term.

152. Between 8 and 9 January 2019, staff within Perth Prison received an email and attachment. This was the Parole Board's decision letter to refuse to release Sarah on licence and specifying that there would be a further review in 12 months (Crown production number 4).

153. Sarah was anxious about the result of the PBS tribunal as she waited to learn of the outcome.

154. Margaret McKay, prison social worker visited Sarah on 11 January 2019. Sarah was anxious and frustrated about the result of the PBS Tribunal which she expected imminently.

155. When she left Sarah's cell, Ms McKay wished to speak to one of the officers in the SRU about Sarah's concern about the pending PBS decision. The officers were dealing with an incident involving another prisoner so she could not speak to them.

156. She went back to her office and tried to call them, but no one replied.

157. After Ms McKay had left SRU, in the afternoon of 11 January 2019, the PBS notification came through the internal mail system in a plain envelope which contained a printed off copy of the Parole Board's decision letter intimating that she would remain in closed prison conditions for at least 12 months.

158. Residential Officer Steven Keenan delivered the envelope to Sarah in the course of that afternoon.

159. At around 1700 hours on 11 January 2019, Sarah selected some books and was then secured within her cell for the evening at approximately 1715 hours. She had a short conversation with Mr Keenan in which she told him that the PBS had refused to release her on licence. His interaction with her did not cause him concern about her welfare.

160. On 12 January 2019, during morning checks, officers in the SRU found Sarah unresponsive in her cell at around 0809 hours. Her life was pronounced extinct at 0815 hours on 12 January 2019.

161. On 12 January 2019, at 1400 hours, Sarah's cell was searched. The following items were recovered by officers of the Police Service of Scotland.

Next to window

Empty blister packs for prescription medication in the name of Sarah.

Codeine phosphate 30mg would have contained 28 tablets. There were no tablets remaining.

Sertraline 50mg tablets would have contained 12 tablets. There were four tablets remaining.

On shelving unit next to bed

Plastic bag containing medication in name of deceased as follows:

Sumatriptan 50mg tablets would have contained 6 tablets with 5 remaining, Codeine 30mg tablets would have contained 28 tablets with 6 remaining, Estradiol 2mg tablets - all 14 tablets present, Sertraline 50mg tablets would have contained 7 tablets with 2 remaining, Thiamine 100mg tablets, would have contained 84 tablets with 10 remaining, Sertraline 100mg, would have contained 6 tablets with 5 remaining, Fexofenadine·120mg tablets, would have contained 14 tablets with 7 remaining, Gabapentin 300mg, would have contained 20 tablets with

3 remaining and 600mg capsules would have contained 21 tablets with 2 remaining.

On floor

Empty prescription medication bags in the name of deceased (relating to Sertraline 50 mg tablets, Estradiol 2mg tablets, Gabapentin 300 and 600mg tablets, multivitamin tablets and Fexofenadine tablets) all dated November or December 2018.

162. A toxicological analysis of samples of Sarah's blood and urine, which were taken on 15 January 2019 during the post mortem examination disclosed that Sertraline, Gabapentin, Codeine and morphine were present in Sarah's blood. Codeine and morphine were present in Sarah's urine. Morphine is the active metabolite of Codeine.

163. The post mortem examination report relating to Sarah and contains the findings of examination is Crown production 2. Sarah's cause of death was established as plastic bag asphyxia.

164. The toxicological analysis revealed a therapeutic level of Sertraline (prescribed antidepressant). The level of Gabapentin detected represented a potentially toxic level. Codeine was detected at a potentially fatal level. The presence of small amounts of morphine was explained as a metabolite

of Codeine. Codeine and Gabapentin toxicity may have represented a potential event in the absence of plastic bag asphyxia.

165. The rapidity of death in most cases of such asphyxia made the contribution of drug toxicity of lesser significance. In view of the history, circumstances and other negative findings, death was attributed to plastic bag asphyxia.

Communications with persons outside the prison

166. During the period from 6 November 2018 and 11 January 2019, Sarah wrote letters to a friend she met whilst residing at Anchor House, Perth, in which she expressed her distress at the circumstances in which she had been recalled to prison.

167. On 11 December 2018 in a recorded telephone call Sarah talked about wanting to die in an external phone call.

168. On 5 January 2019 Sarah in a recorded telephone call talked about wanting to die in an external phone call.

169. The content of these calls only became known to prison staff after her death.

Local Adverse Event Review (LAER)

170. The LAER report dated 19 January 2019 concluded that the appropriate level of THB care had been provided and that Sarah's death could not have been predicted or avoided.

Death in Prison Learning Audit & Review (DIPLAR)

171. The DIPLAR report noted that Sarah was quite volatile in terms of her emotions. Her mood could fluctuate daily and there was no way to predict her behaviour. It also noted difficulties in trying to move her to the female estate. It recommended that the process for delivery and communication of parole decision letters should be reviewed. Consideration should be given to identifying when a reception risk assessment should be completed following a parole hearing.

Later developments

172. Following experience in two cases where suicide was completed by a prisoner after receipt of an adverse PBS decision, the guidance was changed to require a risk assessment to be completed by a member of reception staff after a parole hearing and upon receipt and communication of an adverse parole decision.

173. In 2023 the HM Inspectorate of Prisons in Scotland published its report "A Thematic Review of Segregation in Scottish Prisons.". This review report highlighted several concerns about the overuse of segregation in Scottish prisons with prisoners spending detrimentally long periods there, limited human contact and SRUs being used as places of safety for prisoners who are mentally unwell. It noted that relationships between SRU staff and

prisoners were generally positive but that there was a need for better staff training due to a lack of relevant expertise to provide therapeutic and psycho-social interventions.

174. In around February 2024, SPS published its new policy for the Management of Transgender People in Custody. In around February 2024 SPS also published operational guidance designed to support the policy for the Management of Transgender People in Custody.

175. If Sarah had been recalled to prison at a time when the 2024 policy and supporting operational guidance were in force, it is likely that the application of the new policy would have resulted in Sarah being sent to a male prison.

Analysis and conclusions

Issues

[48] During the preparatory hearings for the inquiry, there was discussion of the issues that would have to be addressed. On 9 November 2023 the parties lodged an agreed Consolidated List of Issues for the inquiry in process. That list was of assistance as a case management tool. I have reproduced the questions posed verbatim in this paragraph . I have found it convenient to further sub-divide some of the questions in the analysis that follows. I have noted the conclusions reached on each issue in the relevant parts.

(i) Whether the recall paperwork issued by the Community Licencing Team should have specified the committal establishment as Perth Prison.

Whether the Community Licencing Team ought to have had in place a policy for issuing recall papers to a transgender person.

Whether in absence of such a policy, they ought to be bound by the terms of the SPS Transgender policy.

These questions are dealt with in the section headed "The recall of Sarah to prison".

(ii) Whether the decision to accommodate the late Ms Riley in the SRU between 6 November 2018 and the date of her death caused or contributed to her death.

This question is dealt with mainly in the section headed "Sarah's removal to the SRU and her death there" but also in other sections.

(iii) Whether the Suicide Prevention Strategy (Talk to Me) was appropriately utilised and sufficient to manage the risk of Ms Riley completing suicide.

This question is dealt with in the section headed "The operation of TTM"

(iv) Whether the supply of Gabapentin available to Sarah was appropriately prescribed and safely dispensed.

Whether the clinical decision to provide 7 days of medication should have been reviewed following the Parole Board decision not to direct release.

These questions are dealt with mainly under the heading "Attempt to carry out a mental health assessment".

(v) Whether the decision of the Parole Board to refuse release and set a review in 12 months should have generated a reception risk assessment or other assessment.

This question has been superseded by changes in SPS procedures that require such an assessment when a decision to refuse release is communicated to a prisoner.

(vi) In addition, the court requires to fully consider the cause or causes of the circumstances resulting in the death, any reasonable precautions which might realistically have prevented the death and any defects in the system of working which may have contributed to the death of said Sarah Jane Riley.

All these matters are considered in the following sections of this determination, and my conclusions are set out below.

The POAS objection to Philip Wheatley being treated as an expert witness

[49] Mr Wheatley's evidence was led under reservation. Written notice of the objection as to the admissibility of his evidence was given by the POAS. The submission was that as Mr Wheatley had not been a prison officer in a Scottish Prison, he was not qualified to express an expert opinion on the work of prison officers. Mr Wheatley has no direct experience with the SPS Act 2 Care strategy, nor the TTM strategy. Necessary expertise can be obtained from "time served" but a long time served in a profession, or occasional exposure or study, do not equate to expertise on that profession. Thus, a

skilled witness should only be admitted where they have direct, practical experience of the matters addressed.

[50] Mr Wheatley's level of knowledge and experience were also criticised because he had last worked in the English and Welsh system as a prison officer in 1970, and as a prison governor in 1990. Prison operations across the United Kingdom have changed significantly since then. It was asserted this meant he was not qualified to express an expert opinion in this inquiry.

[51] Rule 4.1(1) of the 2017 FAI Rules provides: "Any rule of law or enactment that prevents evidence being led on grounds of inadmissibility does not apply in an inquiry." On the face of this rule provides a complete answer to the objection. However, in deference to the full written and oral submission made to the court, I have dealt with the objection on its merits.

[52] In *Kennedy* v *Cordia LLP* 2016 SC (UKSC) 59, the Supreme Court observed that it is for the court to decide whether expert evidence is needed when the admissibility of that evidence is challenged (at para [45]). The court set out the four criteria that must be satisfied for such evidence to be admissible are (at para [44]):

> "(i) whether the proposed skilled evidence will assist the court in its task;
> (ii) whether the witness has the necessary knowledge and experience;
> (iii) whether the witness is impartial in his or her presentation and assessment of the evidence; and (iv) whether there is a reliable body of knowledge or experience to underpin the expert's evidence."

Most relevant to the current objection is the second criterion: "whether the witness has the necessary knowledge and experience". Elaborating on this criterion, the Supreme Court stated that (at para [50]):

> "The skilled witness must demonstrate to the court that he or she has relevant knowledge and experience to give either factual evidence, which is not based exclusively on personal observation or sensation, or opinion evidence. Where the skilled witness establishes such knowledge and experience, he or she can draw on the general body of knowledge and understanding of the relevant expertise (*Myers and ors v R,* para 63)."

To demonstrate relevant knowledge and expertise, the Supreme Court stated that an expert witness must (at para [42]):

> "[S]et out his or her qualifications, by training and experience, to give expert evidence and also say from where he or she has obtained information, if it is not based on his or her own observations and experience."

[53] I consider that Mr Wheatley fulfilled these requirements. The evidence was necessary to assist the court to understand the issues. His experience was appropriate. The objection that he has not worked in the Scottish Prison Service was misconceived in so far as it was based on the idea that an appropriately qualified expert whose experience has been gained in another prison system cannot help the court when it seeks to understand the issues that surrounded the death of Sarah Riley. He had in the past worked with in the Scottish system as a consultant and has acted as an expert in other Fatal Accident Inquiries. He was very well placed to comment on the management of prisons and the quality of suicide prevention strategies. He spoke to similar issues in the English system. He had been involved in the adaptation of the Scottish Act 2 Care strategy in England. That was a prime example of how one system can benefit from borrowing advances made in another similar system. His significant experience of the Scottish system was set out in his report.

[54] Counsel for the POAS argued strongly that Mr Wheatley was not qualified to give expert evidence on the role of a prison officer especially regarding TTM due to a lack of direct practical experience. He had only been a prison officer in England and that was many years ago. Reference was made to *De Sena* v *Notaro* [2020] EWHC 1031 (Ch) and *R* v *Brecani* [2021] 1 WLR 5851. I reject this submission. Mr Wheatley was very well qualified by virtue of his knowledge and experience of the running of prisons across a wide range of roles. He was extremely well placed to assist the court in this inquiry. He was not disqualified from expressing a view about the operation of TTM because he had not himself had to operate it. He demonstrated a clear understanding of what the strategy required. The nature of his knowledge and experience was very different from the limited exposure to an area of work which troubled the court in *De Notaro*. While I have not made recommendations under section 26(2)(e) I consider that this submission was misconceived.

[55] The objection to the admissibility of the expert evidence given by Mr Wheatley is rejected. This leaves the question of the evaluation of his evidence which is discussed later.

[56] Since the hearing on submissions, the report in the case of *McGregor* v *Chief Constable of Scotland* 2025 SLT 335; [2024] CSOH 109 has been published. The case concerns a claim for damages based on an allegation that a police standard prosecution report submitted to the Crown has been deliberately false and misleading. A similar ground of objection to that taken by the POAS was raised by the defender in this case. The court rejected that objection after a review of his knowledge and experience (see

para [101]). I considered whether I should invite additional submissions on this point and concluded that fairness did not require that I should do so.

General assessment of Mr Wheatley's expert evidence

[57] I have explained how I have treated his expert evidence in the relevant chapters dealing with the issues on which he gave evidence below, but I provide a general assessment here. The Crown, having led him as an expert submitted that some care required to be taken when assessing some aspects of his evidence. These will be discussed below.

[58] The Scottish Ministers submitted that Mr Wheatley's evidence should be treated with caution. He was said to have very limited direct operational experience and none in a Scottish prison. Such experience that he had long pre-dated general awareness of TSG issues and their management in a custodial environment. He was said not to be qualified to comment properly on the introduction of TTM. He was said to be dogmatic and at various points beyond of the scope of his expertise.

[59] Adopting a cautious approach, I consider that the criticism of Mr Wheatley was not well founded. I concluded that Mr Wheatley had extensive expertise which was very relevant to the issues in this inquiry. He had some experience of an operational type in dealing with suicide prevention. He was qualified to talk about suicide prevention policies. He took a pragmatic and fair-minded approach taking full account of the issues faced by those working within a busy local prison like Perth, both at operational and management levels. He was correct when he suggested that SPS

management had to make decisions in a situation like that presented by Sarah's proposed transfer. It was important to seek Sarah's views but there needed to be action to complete a move to another prison.

[60] Mr Wheatley accepted that if there was now greater flexibility that was an improvement in the system. He was not saying that the SRU might never be the right place at any point in time for a prisoner like Sarah. Mr Wheatley was balanced in his approach and commended SPS for steps subsequently taken to place prisoners on TTM when a PBS rejection letter is received. This change in TTM reflected proper learning from this incident, as well as another similar one that took place around the same time.

General assessment of the evidence of Dr Jo Brown, Consultant Psychiatrist

[61] The Scottish Ministers submitted that although her evidence would have been of assistance to the inquiry, it was retrospective and detached from what would have been the realities at the time. Her view that Sarah should have been on TTM was described as "retrospective desktop view" and of no evidentiary value. She was said to have been evasive when pressed on the issue. This criticism is not well founded. I concluded that her view about TTM was based on a careful consideration of the information placed before her informed by her knowledge and practical experience.

[62] She was a good witness who had relevant and recent experience of working in the prison environment. There were two main themes to her approach that were of considerable assistance.

[63] First, the significance of the nature of psychological formulation and the use to which it might be put. The preparation of a psychological formulation provides a short statement derived from the medical records that can be shared more widely.

[64] Second, Dr Brown explained that the prison records contained a great deal of information about Sarah's complex psychological state. As Sarah was very young when the OLR was imposed, it was several years before prison staff carried out a full mental health assessment which diagnosed personality disorders. The records contain much information her detailing Sarah's patterns of behaviour and responses as noted by the professionals who interacted with her. As a result, Dr Brown's report provided a detailed analysis of Sarah's state of mind over the entire period of her incarceration and how she coped with the difficulties she encountered in relationships and interactions with others.

[65] The prison records also contained considerable information about Sarah's life prior to coming into the prison system. These disclosed that she had experienced feelings of being ignored, rejected or abandoned which had given rise to intense feelings of shame. This, in turn, had led to dramatic behaviours. Dr Brown interpreted her early disruptive behaviours as being suggestive of trying to find a way to be heard. I note in passing that some of them were so extreme that they attracted a heavy criminal sanction of the OLR.

[66] Sarah found her voice initially as a gay man and then as a trans woman. Dr Brown noted that she responded in a positive way when provided with support and one-to-one engagement and clear structure. She had accessed support from many

different agencies and built positive relationships with those working with her. Dr Brown saw this development as a big shift in her time within the prison estate. The difficulties she experienced when in the female estate in 2015 led her to choose to deny her won identity as Sarah to return to a place of safety in the male prison estate at Perth.

[67] Dr Brown considered it was apparent that there was a build-up of perceived experiences in the period from Sarah's arrival at Perth on 6 November 2018 to the date of her death. These experiences prompted a variety of feelings which included shame (her failure to comply with licence conditions and the recall to prison), rejection (the decision of the prison to pursue a transfer to the female estate), disgust (the ongoing presence of the OLR). Aside from these matters, Dr Brown also noted that there was an issue about possible disclosure of childhood sexual abuse that prompted feelings of disgust, shame and of being ignored.

[68] Dr Brown concluded that there was limited and poor information sharing around factors that increased a person's risk of self-harm and suicide. Greater sharing of information about the extent of risk of suicide would have been an appropriate step to take because it would have added context to why TTM was an appropriate step to take at the time when the news of rejection by PBS was given to Sarah.

[69] When she reviewed the telephone records Dr Brown identified three areas that were causing Sarah considerable anxiety. They were the upcoming PBS Tribunal, the OLR and her prison experience, including the recall and the proposed transfer to the women's estate.

[70] I turn from these more general observations regarding the expert evidence to discuss the main substantive issues on which evidence was led in this inquiry.

The recall of Sarah to prison

[71] Record keeping around the important decision to specify a prison of recall was very poor which meant that there was little documentary evidence available to the inquiry as to the issues that drove the decision to direct recall to Perth.

[72] Craig McKendry was the CLT official who spoke to the process for designating a jail to send a recalled person. All his evidence was hearsay as it was his colleague Andrew Large dealt with Sarah's case. In normal circumstances, the system is to send to nearest prison.

[73] Mr Lawson worked as a Life and Liaison Officer at Perth. He also helped with PBS hearings and had some meetings. Mr Large spoke with Dougald Lawson at the prison, and they agreed that Perth would take Sarah if it was specified as the committal establishment.

[74] Mr McKendry and Mr Lawson were both generally credible and reliable, but they had little of value to add. As he did not give evidence I cannot say whether Mr Large at CLT was aware of or had regard to the TSG policy at the time of the discussion with Mr Lawson. The Crown correctly submitted that the TSG policy then in place did not prescribe that a TSG prisoner be accommodated in a prison which accorded with their lived gender. However, the TSG policy was in place and ought to have been considered. If the TSG policy had been considered, Perth may not have been

specified as the committal establishment. Any decision to depart from the policy by specifying a male prison would have had to be justified.

[75] The recall of a complex prisoner like Sarah at short notice presented serious issues for SPS. The failure of CLT to take account of the SPS TSG policy may not have been of much significance if the prison authorities had taken prompt action after Sarah arrived to make a decision that did take account of the TSG policy. On this occasion, the CLT decision was significant because it left Sarah in a prison that was not equipped to deal with her complex needs and did not want her there.

[76] The process of determining the prison of recall has changed since Sarah's recall. The staff member at CLT requires to contact SPS about the recall of any TSG prisoner. The determination of the prison of recall will be guided by SPS.

[77] Any such decision is likely to be made against a background of some urgency due to the need to arrest the person who is being recalled. It is not practical to require that there be detailed and measured consideration of the policy at the point of recall. It follows that a decision to specify a prison is unlikely to be made in such a way that takes account of all relevant considerations affecting the placement of the prisoner in the longer term.

[78] The change in the recall process is an improvement in that there is some recognition of the needs of the individual who is being recalled under reference to a relevant policy. The change does not remove the need for prompt further consideration of the ultimate location for the prisoner once the element of urgency has been removed and the prisoner has been returned to a prison as directed. Given the change in the

recall process the second question posed under paragraph (i) of the Consolidated List of Issues is no longer a live one.

[79] The Scottish Ministers produced the new TSG policy and its accompanying operational guidance. A supporting affidavit from Robert Strachan provided some further explanation. It is likely that had the new policy applied at the time Sarah would have been admitted to the male estate and managed out of association in the SRU until a case conference within 72 hours.

[80] The third question posed under paragraph (i) of the Consolidated List of Issues is no longer live because the TSG policy has changed but some comment is appropriate. The failure to take account of the policy at a point where there may be a serious degree of urgency to get the person who has been recalled back into the prison estate is understandable. An effective process to determine where the recalled prisoner is best accommodated following recall where a relevant policy is in force should involve officials with sufficient levels of seniority to make an informed decision promptly. I have made a recommendation to seek to avoid a reoccurrence of what happened in this case.

Sarah's removal to the SRU and her death there

[81] Several prison officers and others working in Perth gave evidence about Sarah's time in the SRU.

[82] When Sarah was recalled to Perth Prison, Barry Burns was one of three FLMs in the SRU. He had not previously known Sarah during the earlier period she spent in

Perth, but he built a good relationship with Sarah in her time in the SRU. He cannot be faulted for the actions he took within the scope of his training and knowledge of her. He did the best he could with a prisoner who was removed from association without having misbehaved in the prison. Others with more senior roles such as the governor, deputy governor and the UM had greater responsibility for her continued placement there. The training he received was basic and gave him no real guidance as to how to deal with a complex prisoner like Sarah. He did the best he could having regard to his experience and his limited training. More sophisticated training and the provision of relevant available information might have helped him have greater insight into Sarah's needs.

[83] Steven Keenan had advanced to become a UM when he gave evidence. He was a residential officer in the SRU in 2018/19. He spoke to Sarah's time there. He accepted that did not know much about OLR prisoners back in 2018-19, though he had more experience now in his promoted role. He was generally credible and reliable though I did not accept his evidence as to the extent of the involvement of Mary Hunt. I have explained my reasons below in the section dealing with the failure to appoint a personal officer for Sarah.

[84] Margaret McKay was a prison based social worker. She was credible and reliable. She had met Sarah three times. She explained that if all went well and the risk assessments were positive, following recall from licence to a closed prison it would take at least 6 months to a year to progress to the open estate. She described Sarah as having

both low moods and more positive times in the SRU. She thought that being deprived of association in the halls had an isolating effect on Sarah. I have accepted that evidence.

[85] She had visited Sarah on 11 January 2019, ie, the day she got the PBS letter. She did not know the PBS rejection letter was coming that day, but she was aware that Sarah was anxious about it. When she left Sarah's cell, she wanted to speak to one of the officers in the SRU about the pending PBS decision. They were dealing with an incident so she could not speak to them. She went back to her office and tried to call them, but no one replied. Though no fault attaches to Ms McKay, it is unfortunate that she did not get an opportunity to discuss Sarah's concerns with SRU staff that day. Given the way in which TTM was operated it is unlikely that Sarah would have been placed on TTM as a result.

[86] James McKay visited Sarah in the SRU on several occasions in his capacity as a drug and alcohol worker within Perth. He was credible and reliable. He had visited Sarah on four occasions in the SRU, including shortly prior to her death. Her mood had been variable between visits. He noted that it was lower than on the previous occasion on 12 December 2018. He was very familiar with TTM and would have activated it if he had thought he should do so on any of these visits. He was focussed on drug and alcohol harm reduction. He had no awareness of Sarah's complex psychological diagnosis.

[87] As regards paragraph (v) of the Consolidated List of Issues, SPS changed its policy following the death. It was correct to do so.

The effects of prolonged periods spent in segregation

[88] The problem of suicide risk is complex. SPS sought to achieve a balance between adequate surveillance and the imposition of such an oppressive regime that it causes more harm to those it seeks to protect.

[89] The period Sarah would spend in the SRU was prolonged without an end in sight so long as there was no realistic prospect of transfer. This was not due to any misconduct by Sarah. No mechanism existed to trigger a more intense focus on Sarah that had regard to the following three factors: (a) her diagnosis; (b) her status as an OLR prisoner and (c) her status as a TSG prisoner. All three factors fed into the need to move her from Perth Prison without undue delay. Attempts to transfer her were ineffective. There was no plan other than to wait and see if Sarah was more disposed to the proposal that she transfer to Polmont a few weeks after she had expressed strong opposition to that proposal for reasons based on her prior adverse experience in the female estate.

[90] The only option apparently being pursued after 21 December 2018 was to hope that if Sarah was left out of association in the SRU for a few more weeks it might make her more amenable to the only transfer proposal on the table. I have accepted Mr Wheatley's evidence as to the detrimental effect of such a prolonged period of segregation. I have made a recommendation directed to avoiding a repeat of prolonged periods in segregation without review in similar circumstances.

Problems with the Rule 95 process for authorisation for removal of Sarah from association

[91] Rule 95 of the 2011 Prisons Rules provides for removal of a prisoner from association. The SRU is the place where prisoners are place when so removed. The following parts are relevant for present purposes:

> "(1) Subject to paragraph (2), the Governor may order in writing that a prisoner must be removed from association with other prisoners, either generally or to prevent participation in a prescribed activity or activities.
>
> '(2) An order under paragraph (1) may only be made where the Governor is satisfied that removal from association is appropriate for one of the following purposes—
> (a) maintaining good order or discipline;
> (b) protecting the interests of any prisoner;
> (c) ensuring the safety of other persons.
>
> '(5) An order under paragraph (1) cannot last for more than 72 hours from the time it is made unless an extension has been authorised by the Scottish Ministers in writing in accordance with paragraphs (11) and (12).
>
> '(11) The Scottish Minsters may—
> (a) on the application of the Governor prior to the expiry of an order made under paragraph (1); and
> (b) where they are satisfied that it is necessary for one of the purposes in paragraph (2),
> grant an extension to an order made under paragraph (1), in writing, for a period of no more than one month, to be calculated in accordance with paragraph (13).
>
> '(12) The Scottish Ministers may—
> (a) on the application of the Governor made prior to the expiry of any extension granted under paragraph (4) or this paragraph; and
> (b) where they are satisfied that it is necessary for one of the purposes in paragraph (2),
> grant any number of further extensions to an order made under paragraph (1), in writing, for successive periods of no more than one month, …"

[92] On 24 November 2018 the governor made an order under Rule 95(1) for Sarah to be removed from association. It was a matter of agreement that although Sarah was in the SRU at Perth from 6 November 2018, there was a period from 6 November to 24 November 2018 where there was no authorisation under Rule 95. While Sarah was in lawful custody following her recall to prison, despite a suggestion to the contrary by senior counsel for the ministers at an early stage in the evidence, it was accepted by the ministers that there was no legal warrant for her segregation in the SRU for this whole period.

[93] The evidence disclosed that the Rule 95 process was not operated in line with the legislative requirements following Sarah's arrival at Perth. Mr George Stewart was a UM at Perth. He was involved in several of the case conferences held in Sarah's case. In particular, the TSG case conference on 12 November 2018, the Rule 95 case conferences on 24 November 2018 and 27 December 2018 and the TTM case conference on 22 December 2018.

[94] The first TSG case conference did not take place within the timescale envisaged in the policy then in force. Although the need for a Rule 95 application was recorded, no application under Rule 95(11) was made to SPS HQ for a further 12 days. As a result, there was no legal warrant for Sarah's segregation for a total of 18 days.

Scrutiny of Rule 95 applications by SPS HQ

[95] In about November 2018, Brian McKirdy was based at the SPS Headquarters Operations Directorate. When he gave evidence in November 2021, he was the governor

at Inverness Prison. When he was recalled in December 2023 he had moved to the post of governor at Grampian Prison. In about November 2018, he dealt with about 20 Rule 95 applications a week from prisons around Scotland. When scrutinising applications, he looked for proper reasoning and would reject some requests. He explained that his job at the time was to provide scrutiny from the centre but not to run the prison. That was the job of the local governor. On 27 November 2018 Mr McKirdy approved the continued removal of Sarah from association in the SRU at Perth under Rule 95(11). Mr McKirdy accepted he was not made aware of the true start date of Sarah's accommodation in the SRU.

[96] When Mr McKirdy was recalled, he was at pains to point out that any use of discretionary powers to remove a prisoner from association was a matter for the governor of the local prison and not the concern of SPS HQ. He explained that the abbreviation "RRMC" referred to prisoner refusing to return to mainstream conditions. There was no evidence presented to this inquiry to suggest that Sarah refused to return to mainstream conditions after her recall.

[97] When the UM Mr Stewart was asked to explain why Sarah's removal from association in the SRU from 6 November 2018 was not actioned under Rule 95 he said his understanding was that she was subject to RRMC which allowed detention for 14 days without Rule 95 being operated. Senior counsel for the ministers intervened to suggest that these were questions for the deputy governor. He appeared to signal that the inquiry would hear in due course that Sarah had been placed in the SRU with proper authority despite the lack of use of Rule 95. As the inquiry progressed the ministers did

not press the point that there was some other form of authority for her removal without operation of Rule 95.

[98] No proper or tenable explanation for the failure to apply within the time limits envisaged by Rule 95 was ever given in the evidence to this inquiry. There was no mechanism to identify to officials like Mr McKirdy in the Operations Directorate at HQ that the application was being made at the point of first removal to SRU. The role of SPS HQ was to check that the Rule 95(11) and (12) process had been followed formally.

[99] Similar problems arose when an application for authority to be renewed under Rule 95(12) was made. When she gave evidence on 3 November 2021, Lorraine Roughan was a deputy governor at Barlinnie Prison. On 27 December 2018, she was based at SPS HQ. She was responsible for authorising the application from Perth Prison to extend segregation for a further month under Rule 95(12). She proceeded on the basis that segregation had commenced on 27 November 2018. She was not told that Sarah had been in the SRU from 6 November 2018. The Rule 95 application that Ms Roughan considered did disclose the decision to put Sarah on TTM from 21 to 22 December 2018.

[100] When she was asked about the gaps in the information sent to her, her position was that it would not have made any difference to her role as representing the Scottish Ministers. It was open to her as a senior official at SPS HQ to phone prison to find out more, but she did not see the need to do so in this case.

[101] The Rule 95(12) renewal application process was deficient in that the true extent of Sarah's time in the SRU was not disclosed to SPS HQ by Perth. A further relevant

consideration was also omitted, that is, the reasons for the failure of the attempt to get Sarah to agree to be transferred to Polmont.

[102] The level of scrutiny by SPS HQ was superficial and inadequate. The system did not provide safeguards to ensure that relevant information was supplied to the HQ officials charged with granting approval for removal from association. The true state of affairs should have been disclosed by staff who prepared the Rule 95 applications at Perth to SPS HQ on both occasions. The process did not put officials at SPS HQ in a position to exercise any serious review function. Further, Mr McKirdy and Ms Roughan did not demonstrate any sense of curiosity about the background to the applications they received in relation to this unusual prisoner.

Consequences of the Rule 95 process

[103] This was not simply a matter of form. There was a serious practical consequence for Sarah due to the failure to disclose that she had been in the SRU unlawfully from 6 to 24 November 2018. SPS HQ only commenced the calculation of the 3-month period before Sarah's individual case would be considered at national level at the PMAG meeting from the date when her detention in the SRU was authorised. Sarah suffered a double disadvantage. Not only was she removed from association without legal warrant for 18 days, but that period was omitted from calculation of the 3-month period before which her case would get greater scrutiny. As will be seen, the potential consideration of Sarah's case at PMAG was treated as a matter of significance by the governor.

Sarah as a complex prisoner

[104] Dr Brown reported that following Sarah's referral to the Sandyford Clinic a gradual approach was taken to her transition. In line with guidance, she was started on hormone treatment after she had been living consistently as a woman for about 12 months. This occurred whilst in the male prison estate and may reflect the enduring therapeutic relationships she had established with the staff at Perth. The prison records disclosed that Sarah understood from an early stage in her transition journey that SPS was not properly equipped to deal with a person with her range of issues and serving an indeterminate sentence.

[105] Dr Brown provided a detailed analysis of the Sarah's state of mind when she was recalled to prison. Sarah's fear and anxiety arising from her earlier experiences was articulated in appropriate settings after her recall. Dr Brown considered that it was unclear whether these articulations were heard and responded to. She also noted the extent of Sarah's honesty with her supervising officers in the community as regards her behaviour.

[106] I concluded from the evidence is that she did articulate her fears and concerns within the prison after recall, but that little weight was accorded to them. Especially as regards their relevance to the attempts to transfer her, they were ignored. The response of the responsible staff at Perth to her objection to Mr McAinsh was to decide to try again next month. No consideration seems to have been given to whether there might be good reason for her objection to transfer to Polmont.

[107] Dr Brown thought that the failure to recognise her chosen gender at the stage of recall may have had an effect on her mental health as it could be expected to reinforce feelings of rejection and dismissal. This is a consideration that might have suggested an early decision about transfer was necessary. However, those charged with dealing with the transfer did not have this degree of detailed information about Sarah even though it existed in detail within prison records.

[108] Dr Brown considered that the PBS decision to recall her would have had a significant effect on Sarah's mental health at the time of her death though this will have been more complex that it might initially appear. With her complex history of trauma and personality disorders that decision would have emphasised to her that she had failed in several respects. These included her return to the community, her relationship with her mother and a new relationship she had established in the community. These failures would prompt feelings of rejection and abandonment.

[109] Sarah would have been aware that the plan to move her to the female estate would happen. That move was a complex matter for her. While it would reinforce her sense of self and her identity that it would also involve an increase in anxiety and fear of rejection. The PBS decision would also have emphasised the ongoing implications of the OLR thereby reinforcing feelings of shame and disgust with herself. I have accepted Dr Brown's conclusions on these matters.

The effect of Sarah's psychological diagnoses

[110] The diagnoses of personality disorders occurred when Sarah was 26 years old. These diagnoses provided an opportunity to focus on how to support her to manage the distress she experienced and recognise patterns of behaviour. This was another area where Sarah could be offered support, even though the extent of support within prison may be limited.

[111] Dr Brown's view was that the personality disorder diagnoses were significant not only for Sarah as an individual but also for those working with her. There was no evidence that, aside from Dr Saleemi, any other SPS staff would be confident in working with persons with personality disorder diagnoses.

[112] Although staff were asked to collect information about Sarah on behalf of Dr Saleemi to assist him in updating the RMP, they were given no insight into why it was being collected. The intention appears to have been that the information collected would be used at the next RM Team meeting which was due to take place on a three-month cycle. There was no suggestion that any changes in behaviours noted in the observation sheets might be of significance for those dealing with Sarah day to day in the SRU. There was no clear escalation plan.

[113] Dr Brown reported that there were some excellent formulations in the management plans of Sarah prepared by different professionals. She noted a reference to SPS staff receiving support from the prison psychologist who prepared the June 2016 report which has a detailed formulation. There was no suggestion in the evidence that

the provision of support of this kind should be provided to SPS staff after her recall in 2018.

[114] The various minutes of case conferences held after Sarah was recalled to Perth do not contain any indications that the discussion was to any appreciable extent informed by the known psychological formulation.

Risk assessment information relating to OLR prisoners

[115] All OLR prisoners have an RMP. Dr Naveel Saleemi was a forensic psychologist working within Perth Prison. He had responsibility for the preparation of an updated RMP for Sarah on her return. He had known Sarah over a long time. Sarah had undergone significant change since she had last been in incarcerated in Perth Prison. She had lived in the open estate and then gained experience of living in the community for some months. When she was recalled, she was further on in her journey of transition than she had been when he had last dealt with her.

[116] The time scales for the preparation of Dr Saleemi's updated RMP were such that it would not be available for the PBS hearing. Without it, the PBS was unlikely to take a decision to change her status. Within the prison, most of the staff members involved with Sarah knew that this vital part of the ongoing risk management assessment process would not be completed prior to the PBS hearing.

[117] Dr Saleemi's behavioural observation sheets did not contain confidential information, but the trained observer could work out from it the sorts of matters that the person who prepared it thought might cause concern. Dr Brown considered that the

provision of the observation sheets to SRU staff indicated an understanding of Sarah and of the need to support staff. There is no evidence that of any attempt to explain to SRU staff the significance of the issues identified for observation on the sheets.

[118] The list of behaviours to be noted appeared to be taken from an earlier RMP. The sheets were not updated to take account of the isolated environment in which Sarah was being held. They did not focus on the problems associated with being socially isolated within the SRU. There was no clear route provided to staff who were asked to monitor her of how to escalate or report concerns between RMT meetings. No consideration seems to have been given as to how the information being collected might inform decisions relating to Sarah within the prison other than in the context of the need to update the RMP. Staff were not given a clear means of understanding where they might need to act if there were concerns about Sarah's behaviour. There was no evidence of how helpful the SRU staff found them or whether they were shared outside the SRU team.

[119] When recalled Dr Saleemi thought the SRU was good for Sarah because it would help her to cope by reducing her interactions with others, but he accepted that it would increase her isolation as well. Dr Saleemi had few concerns about Sarah spending prolonged periods in the SRU. He would only be concerned if it stretched into a period of years. Though he was not directly challenged on this point (there being no direct contradictor as the family were not represented), I did not accept his evidence on this point in so far as it was at odds with that of Dr Brown, Mr Wheatley and the prison social worker Margaret McKay. Dr Saleemi's approach was informed by an assumption

that prolonged confinement to SRU was not problematic. Consideration was not given to whether such confinement was itself potentially harmful and required some form of observation to allow action to be taken if it was seen that it was harmful.

[120] Ms McRae, former deputy governor at Perth accepted she did not know much about Sarah. The focus of the RMP preparation process was to seek to satisfy the Risk Management Authority of the risk posed by the prisoner to others. She accepted that the focus was not on Sarah's needs as an OLR prisoner. The processes followed regarding the preparation of the RMP would not have highlighted Sarah's difficulties to her. She was being told by the UM that Sarah was content in the SRU. She did not have information that suggested to her that Sarah was particularly vulnerable. I did not accept this part of Ms McRae's evidence. It must have been obvious to her that Sarah was a complex prisoner with many problems. The information available to Ms McRae about Sarah's vulnerabilities was limited. This may account in part for her lack of concern about her.

The role of Mary Hunt as personal officer to Sarah before 2018

[121] Mary Hunt was a very experienced prison officer and a credible and reliable witness. She had been Sarah's personal officer at an earlier stage of her incarceration in Perth. Her first contact was as a shadow personal officer well before the transition began.

[122] When Sarah returned from Cornton Vale in 2015 she was in a sorry state. The move to the female estate had gone very badly. Ms Hunt continued to have regular

contact with Sarah once she returned to Perth. Eventually Sarah made sufficient progress with the result that she moved to the open estate at Castle Huntley. Although her official role had come to an end, Ms Hunt went to see her there a couple of times.

Mary Hunt's interactions with Sarah after she was recalled to Perth in 2018

[123] She went to see Sarah in the SRU a short time after her return to Perth in November 2018. Her impression was that Sarah had matured a great deal. She discussed the future with her. Sarah was aware that she was unlikely to be released soon. Ms Hunt encouraged her to think positively about working towards a future release on licence. She could get herself back to a position where the PBS would again decide to release her into the community.

[124] In the period from 6 November 2018 to 11 January 2019, Ms Hunt recalled went to see Sarah about three or four times in the SRU. Steven Keenan said in his evidence that Ms Hunt had visited regularly while Sarah was in the SRU. That was not the evidence of Ms Hunt herself. I had no reason to doubt that Ms Hunt's more precise personal recollection was accurate. Therefore, I have preferred her evidence of the number of visits she paid to Sarah to that of Mr Keenan.

[125] The last of Ms Hunt's visits was just before the PBS hearing. She had not observed anything that caused her to think that she should activate TTM. She explained that she was good at getting Sarah to be "realistic". In January 2019 a realistic assessment was that Sarah would be at least 6-12 months in the closed prison estate before there was any prospect of moving to the open estate. Sarah understood this.

[126] These informal visits demonstrate Ms Hunt's kindness and concern for a vulnerable prisoner. They reflect well on SPS in the sense that they were evidence of an ethos that allowed a member of front-line staff going well beyond the strict confines of her duties. If Ms Hunt had seen cause for concern of the kind that would require her to trigger TTM in line with her training, she would have taken the appropriate action. However, that does not justify the conclusion that she, in effect, acted as an unofficial or informal personal officer. That role brought responsibilities within the prison system.

[127] As she did in her dealings with others in the prison, Sarah made clear to Ms Hunt the depth of her feelings about the predicament caused by the imposition of an OLR on someone so young.

Failure to appoint a personal officer for Sarah after her recall to Perth

[128] Dr Saleemi requested that Prison Officer Mary Hunt should be given the role of personal officer for Sarah at a meeting on 28 November 2018, but he did not have the power to make that happen. SPS took no action in response to his request. It is regrettable that Sarah was not provided with the support of a personal officer. Not only did Dr Saleemi make this specific request, but the need to appoint a personal officer was noted at more than one case conference.

[129] Ms McRae's evidence was that she had not been aware at the time that a personal officer was not appointed to Sarah. That had been an oversight.

[130] The Scottish Ministers submitted that Dr Saleemi was not concerned by the "formal absence" of a personal officer because of the role Mary Hunt was playing. In

practice Mary Hunt was performing the role and with her support Sarah was in an analogous position to a prisoner who is transferred to the SRU from the wing. The idea that very little was provided by way of support was said to be "completely unfounded".

[131] I have not accepted these submissions for the reasons provided here and elsewhere in this determination. Ms Hunt had many other duties within other parts of the prison including acting as personal officer for prisoners in the hall in which she was based. It was not feasible for her to take on the role. She was not based in the SRU. There was no indication given that she saw herself as performing that role. Her visits reflected no more than care and concern for Sarah on a personal level. No explanation was provided for the failure to appoint a personal officer to Sarah. Neither Mr Munro nor Ms McRae were aware of this failure at the time. They regarded it as a matter for the UM.

[132] If it was not possible to move Sarah out of the SRU, Mr Wheatley thought at the very least a personal officer should have been appointed to her. This was a significant failure to provide necessary support and engagement that should have been in place. This is especially so given that she was kept in segregation for a prolonged period. I have accepted this criticism. The failure to provide a personal officer meant that an important source of support and of information about potential triggers and developing crises were not there.

[133] Mr Wheatley also noted that Perth was not set up to deal with someone with complex needs like Sarah as it was a local prison. A personal officer was very important in that setting. Sarah required to be managed in a setting that was geared up to support

her complex needs. The limitations of TTM with its emphasis on restriction rather than support meant that it did not contribute to keeping her safe.

[134] I have accepted Mr Wheatley's evidence on this point and have made a recommendation that reflects this.

Attempt to carry out a mental health assessment

[135] Sarah was recorded as repeatedly expressing her concerns about the need for a mental health assessment. As at the date of the first Rule 95 case conference she had been in the SRU for 22 days, 18 of them without any lawful authorisation. The UM chairing the case conference agreed she should have a mental health referral.

[136] An initial meeting to commence the assessment was scheduled for 7 December 2018 but cancelled. The assessment process did not commence until 28 December 2018. There was some obscurity about the chronology of the referral process. It may have been made because of the discussion at the Rule 95 case conference. The DIPLAR suggested that the initial appointment on 7 December was because of a routine referral by the reception nurse, presumably on 6 November 2018, ie not by the UM at the Rule 95 case conference on 28 November 2018. The issue of the need for a mental health assessment had also been raised at the TSG case conference.

[137] Former Psychiatric Nurse Michaela Cooper began a mental health assessment of Sarah on 28 December 2018. She understood that Sarah had self-referred for assessment a second time. The assessment had been rescheduled from 7 December 2018.

Ms Cooper did not know whether the second referral happened before or after Sarah

was put on TTM on 21 December 2018. The documentation vouching the referral could not be put to her as it does not appear to have been found, so the court could not take account of what it said or when it was written. It is a cause of some concern that the chronology was to a degree unclear from the records. It is perhaps of greater concern that no such assessment commenced until Sarah had been in the SRU for 52 days. There is no suggestion that the delay was in any way the responsibility of Nurse Cooper.

[138] There were further evidential problems associated with the work done on the partial assessment on 28 December 2018. Nurse Cooper made handwritten notes during her meeting with Sarah in the SRU, but these had been destroyed. Notes of such meetings required to be entered into the VISION system. Nurse Cooper failed to transcribe her handwritten notes onto the VISION system at the time so that an electronic version of the contemporaneous note was not available. Nurse Cooper's recollection when giving evidence was very poor. She could not recall whether the notes had been destroyed before or after Sarah's death. THB submitted that it was likely that the handwritten notes were destroyed after they had been used to input information to the VISION system. I am unable to make a finding on this point having regard to the unsatisfactory state of the evidence of Nurse Cooper.

[139] Although the full assessment was not completed before Sarah's death, it is regrettable that so little reliable evidence was available in relation to this important meeting. I concluded that Nurse Cooper's evidence was unsatisfactory as a whole and especially on this matter.

[140] There was no explanation by THB or any other party for the delays in dealing with a complete mental health assessment for Sarah. Decisions about whether Sarah should have been provided with potentially fatal quantities of prescription drugs within her cell could not be informed by an up-to-date mental health assessment. Given the extent of the information available within prison and NHS records about Sarah's complex issues, it is a matter of regret that the clear and urgent need for such an assessment was not given appropriate priority. I have made a recommendation on this matter.

[141] As regards the first question posed at paragraph (iv) of the Consolidated List of Issues, in the absence of a full mental health assessment, despite the need for such an assessment to be carried out having been identified repeatedly at case conferences, and having been requested by Sarah herself, it is not possible to say that the supply of gabapentin was appropriately prescribed. With the benefit of hindsight, it was not safely dispensed.

[142] As regards the second question posed at paragraph (iv) of the Consolidated List of Issues, I consider that given Sarah's complex needs the clinical decision to provide 7 days of medication should have been reviewed following the PBS decision not to direct release of Sarah. If a full mental health assessment had been completed timeously it would have assisted any review process.

Failures to attend case conferences

[143] It is concerning that there were no THB staff attended the TSG case conferences and the second Rule 95 case conference in December. The result was that these important case conferences were not truly multi-disciplinary.

[144] The position of THB at the inquiry was that these were all optional requirements. While it is understandable that there cannot be full attendance at every such meeting, the board seemed to adopt a complacent approach to this persistent failure. There was no evidence to suggest that either within the prison staff or THB there was any concern at this persistent failure of THB staff to be in attendance. There did not appear to be any concern that this meant that THB had no input to these important processes for a complex prisoner like Sarah. Aside from pressure of other work, no specific explanation as put forward for this persistent failure.

The operation of the TSG policy in Sarah's case

[145] Several witnesses gave evidence on this issue.

[146] Tom McMurchie was a very experienced witness who was serving in the prison inspectorate by the time he gave evidence. He provided mainly historical context in that he dealt with Sarah when she was in Perth Prison in about 2015. He had been involved in the actions taken when it became clear she wished to transition. He spoke to the attempts to operate the TSG policy and the some of the issues that had arisen in Sarah's case that were not really addressed by the policy. He also spoke to the need for Sarah to make progress to the open estate to be considered for release on licence.

[147] He was keen to emphasise the openness of SPS to what was involved to help Sarah with her desire to transition. He had knowledge of the numbers of OLR prisoners in the SPS estate. At the time she was recalled to Perth, there were 3 housed at Perth out of a population about 600. The main concentrations were at Edinburgh (40+) and Polmont (about 74). This evidence fits with that of Mr Wheatley that as a local prison Perth was not really set up to deal with a prisoner with needs as complex as Sarah. He was credible and reliable though he was not involved in the central events with which this inquiry is concerned.

[148] Mr Stewart explained that Sarah told him after the TSG case conference on 20 December 2018 that Mr McAinsh was the reason she refused to go to Polmont due to her earlier experience at Cornton Vale. This did not feature in the minute of the meeting. Despite this, the only plan seemed to be to get Sarah to agree to go to Polmont. There appears to have been no attempt to consider whether there was a sound basis for her objection.

[149] Mr Stewart was recalled on 18 December 2023. He was clear that all staff at Perth Prison the governor down wanted Sarah to be moved to another prison. She was a unique prisoner in Perth. There was no training to assist him as UM to deal with a prisoner who presented such complex needs.

[150] Mr Stewart was not an impressive witness. Although he was one of the UMs on rotation within the SRU, there were some important tasks that were his responsibility, at least in the first instance, that were not properly attended to. He was present at the TSG

case conference on 12 November 2018 when it was noted that a Rule 95 application was required. This was already 6 days late, but no action was taken for a further 12 days.

[151] Vincent Fletcher's equality and diversity role within SPS had national reach but, with due respect to him, he was a relatively low-level officer (at band E) for such an important job. He took a quite prescriptive approach at the first TSG case conference and stated that Sarah had to go to the female estate because the policy said that she should. Mr Fletcher held a very rigid view of the SPS's responsibilities under the Equality Act 2010 Act. He does not appear to have considered whether the policy should be departed from in this very unusual case where there was a previous history of Sarah living in the hall at Perth as a woman.

[152] Mr Fletcher knew many of the senior people within SPS very well. On 12 November 2018, he discussed Sarah's case with Mr Munro the governor of Perth when they met in the car park. On 13 November 2018, he wrote to the head of operations. He was trying to get a transfer expedited but this did not happen. He gave the impression he liked to work in the interstices of the organisation and perhaps on occasion he had more influence than others at his grade. Mr Fletcher was well intentioned. He thought the transfer process should move quickly. He tried to smooth the process. However, he did not have sufficient influence to affect decision making at the deputy governor level which exercised initial control of the prison transfer process.

[153] Mr Fletcher's involvement did not detract from the responsibility of those higher up the chain of command at governor and deputy governor level. The SPS is a

hierarchical organisation. All those who gave evidence who worked within it were very clear as to their relative places in the hierarchy, including Mr Fletcher.

[154] Margaret McKay, the prison-based social worker who met Sarah several times in the SRU thought that the best thing would be for Sarah to stay in Perth. She was close to family, had links in the community and was known to the local social workers. No one higher in the prison hierarchy seems to have been aware of her view. The only course pursued was to seek a transfer.

Attempts to transfer Sarah to the female estate

[155] Mr Stewart's evidence was that on her return from leave, the deputy governor Ms McRae took the lead in trying to effect a transfer. He understood there were conversations going on about a potential transfer at deputy governor level. Polmont was the preferred option. Edinburgh also was approached but by December 2018, Edinburgh was off the table. So far as he was concerned the TSG policy required a move to the female prison estate.

[156] The Deputy Governor Ms McRae was on leave when Sarah was recalled to Perth. She only returned on 21 November 2018 when Mr Stewart briefed her. She received the TSG case conference minutes around 26 November 2018. She understood that the plan was to seek a transfer to Edinburgh. She consulted with the governor, and they agreed there was no need for a further TSG case conference at that stage. She did not envisage any problems with the proposed move.

[157] Her expectation had been that a transfer to Edinburgh could be arranged in a week to 2 weeks. The only practical difficulty might be the need for the psychologists to look at the RMP. She was taken aback by the outright refusal by Natalie Beale when she broached the subject after a regular monthly PMAG meeting. That was when she realised that it was necessary to look elsewhere.

[158] She was aware that Mr McAinsh had attended the TSG case conference on 20 December 2018 and that it had not gone well. Mr Stewart told her he would try again to persuade Sarah to go to Polmont. He was good at persuading people, so she was content for him to try again. In the meantime, she took some modest steps to explore other less palatable options for transfer to prisons that were further away. All that happened after 20 December 2018 was that Ms McRae concurred in Mr Stewart's plan to try to persuade Sarah to take a different view and agree to go to Polmont. Ms McRae did not inquire into the reason for Sarah's refusal. There was no reasonable basis to think she would change her mind in a few weeks' time.

[159] Ms McRae had little awareness of the multiple failings of the prison processes in Sarah's case. She thought that Sarah had been given more consideration than other prisoners and they had tried to enlist her support. Despite this, she does not appear to have explored why Sarah did not wish to go to Cornton Vale. She accepted that Mr Stewart should try again without question. At the point when Edinburgh refused to take Sarah, Perth had no option but to leave her in the SRU. This was unsatisfactory for a number of reasons.

[160] Following the first TSG case conference, the governor sought legal advice about the TSG status of Sarah from the SPS HQ legal team. The ministers withheld the content of that legal advice from the inquiry. They were quite entitled to do that, and I do not speculate about how that advice may have affected the decisions made by those who gave evidence to the Inquiry about Sarah following her recall to Perth. There was no suggestion that the plan to transfer Sarah to the female estate was affected by the legal advice tendered to the governor. Serious consideration does not appear to have been given by senior staff to whether Sarah should remain at Perth and be integrated into mainstream in the way that had occurred before she moved to the open estate in 2017. It should be acknowledged that when she was recalled Sarah was further on her journey of transition than she had been when previously in Perth.

[161] Mr Wheatley's view was that the discussion as to transfer should have taken place at the level of deputy governor at a much greater level of detail. The result of the approach taken was that there was no account taken as to what was the position of the ground at Edinburgh. The proposal for transfer was simply rejected out of hand.

[162] When challenged in cross-examination, Mr Wheatley insisted that his was a nuanced position. He had not sought to criticise the SPS TSG policy then in place but proceeded on the basis it was there. His criticism was that by leaving her in the SRU at Perth for a prolonged period there was a failure to provide support and engagement.

[163] Mr Wheatley did not criticise SPS for following the TSG policy then in force. It was important to follow such a policy when it was there. This was a difficult area in which to get the right policy.

Decision making about a transfer

[164] SPS was not prepared for the return to custody of a prisoner with the complex needs of Sarah. Yet she was well known to SPS staff at Perth, and it was foreseeable that there was a likelihood she might be recalled at any time given the stringent licence conditions imposed on her release. Mr Wheatley considered that those conditions were probably close to impossible for her to comply with given the location where she would be required to reside on release.

[165] Both her status as an OLR prisoner and as a transgender woman in the community were matters that SPS required to deal with by policies and processes within the management of prisoners. This was despite the success that had been achieved in accommodating Sarah in the men's estate, both closed and open, prior to her release on licence.

[166] Once Sarah was taken to Perth following recall, no urgency was displayed. There was no means for action to be taken on a short time frame. Mr Fletcher, the person who coordinated Trans policy was well motivated but quite junior in rank in the service and thus had limited scope to influence decision-making by more senior officials in the service.

[167] Fraser Munro, the former governor of Perth Prison had retired from SPS by the time he gave evidence on 14 May 2024. Ms McRae was on leave when Sarah arrived at the prison following her recall. He was concerned about the case as it was unusual and difficult. He was copied into correspondence because it was a difficult case, and his

deputy was on leave. He ensured that Sarah was removed from association and located in the SRU for her protection though he failed to ensure that Rule 95 process was initiated.

[168] Mr Munro's recollection of the case after that was rather patchy. He did recall that Mr Fletcher was uncomfortable that Sarah was being kept in the SRU, but he concluded that this was necessary for her safety. Mr Munro explained that there were two policies in play as regards Sarah, that is, those relating to OLR prisoners and TSG prisoners. He did not have the power to order a transfer. This required the agreement of the receiving prison.

[169] There needed to be a decision to seek a transfer made at a TSG case conference and the permission of the RMA for a transfer to the receiving prison. Mr Munro expected a negotiation to take place at whatever level. He was surprised when Edinburgh refused to take Sarah. He did not escalate the question of transfer. He could have spoken to others at the monthly meeting of governors chaired by the SPS director of operations but did not do so. The PMAG was a deputy governor level group which only convened once a month, but a case only qualified to go there after 3 months if a transfer had not successfully taken place.

[170] Mr Munro anticipated that the transfer would be done within the 3-month window. He expected he would have been kept informed. He wished to make sure that decisions were legally sound by liaising with the SPS legal team at HQ. As a result, he was not directly involved but he had strategic oversight over her case. He had no

explanation for the failure to trigger a Rule 95 application process upon the return of Sarah to Perth. This should have been done by the UM.

[171] In cross-examination by senior counsel for the Scottish Ministers, Mr Munro confirmed that OLR prisoners required to be managed in accordance with an approved RMP as a matter of law. He was treating the proposed transfer as an operational matter and the OLR aspect was just another complexity in the case. He did not expect his deputy to go to the governor of another prison behind his back. He did not recall the case being discussed with him by Ms McRae on about 26 November 2018 and, to that limited extent, contradicted her assertion that she asked him to intervene. I prefer Ms McRae's evidence that she did ask Mr Munro to intervene to try to expedite the transfer and he refused.

[172] Mr Munro was being kept updated. His expectation was that the transfer of this unique prisoner would take place within about a month but crucially he declined to do anything to cause it to occur when this did not happen. I have accepted these parts of his evidence. The contrast with the position taken by Dr Saleemi at the inquiry is notable in that Mr Munro does not seem to have contemplated that Sarah might remain in the SRU for a prolonged period as this would provide stability for her.

[173] Some other aspects of Mr Munro's evidence were problematic. At times, his recollection was very poor. He was not aware of the failure to activate Rule 95 until a week before he gave evidence to the inquiry. He was also not aware of the failure to appoint a personal officer. He would have approached the governor of Edinburgh Prison closer to the 3-month time limit for the case to be considered by PMAG. He was

concerned to ensure that he adhered to general SPS processes without specific consideration for the circumstances of this unusual case.

[174] Mr Munro and Ms McRae worked within the operational guidelines set for them. Despite Mr Munro's assertion in evidence that prison had to work for every prisoner, the complex set of difficulties that Sarah presented does not seem to have caused him to consider whether her case might merit more prompt and decisive action.

[175] I am satisfied that before the stage where SPS HQ had to be involved was reached, Mr Munro would have made a serious effort to find a suitable location for Sarah. Until the 3-month PMAG limit was approaching, he was not prepared to support the deputy governor in her attempts to find a suitable transfer place for Sarah. In Sarah's case, that was too late. It is nothing to the point to suggest that she might still have experienced problems had she been transferred more quickly. The issue of how she was to be managed following her return to prison was not addressed for a prolonged period other than by keeping her removed from association. She was kept in the SRU for want of any better short-term option.

[176] Ms McRae was surprised that other colleagues at her grade in other prisons would not help. The only action she took in response was to ask Mr Munro if he wished to get involved. His refusal meant nothing further of significance would happen for several weeks into 2019 until the PMAG process required HQ scrutiny of Sarah's case.

[177] The result was uncertainty at a time of great stress for Sarah. She had come to the realisation that her OLR status probably meant that it was going to be very difficult for her to progress to the open estate for a long time and that a prolonged successful

release into the community was likely to be very difficult to achieve. She expressed that realisation openly to staff as well as in more private communications.

[178] The Scottish Ministers submitted that finding an appropriate and sustainable long-term solution for Sarah was not easy. That task was being properly undertaken and could and should not be rushed. Drawing on Dr Saleemi's evidence they submitted that it would only be appropriate to move Sarah to alternative accommodation once it was clear that Sarah would be held in custody for the medium to long term.

[179] It is indisputable that finding an appropriate and sustainable long-term solution for Sarah was not easy. Apart from that, I did not accept these submissions. The view Dr Saleemi stated in evidence that Sarah would benefit from a period of stabilisation in segregation does not appear to have been communicated to Mr Munro and Ms McRae. There was no realistic prospect that Sarah would be released on licence again after the PBS hearing set for 8 January 2019. Mr Munro and Ms McRae worked on the basis that a transfer should take place in line with the views of Mr Fletcher about the requirements of the TSG policy. If Edinburgh Prison had agreed to take her the transfer would almost certainly have gone ahead in December. That is what Ms McRae expected to happen until she was rebuffed.

[180] While I have expressed some criticism of both Mr Munro and Ms McRae, they did both attempt to apply the TSG policy then in place. The submission for the Scottish Ministers does not appear to support the approach they took. Mr Munro was concerned to ensure that a transfer was legally appropriate. There was no suggestion in evidence that the SPS legal people advised him the proposed transfer to the female estate should

not happen. The ministers have focussed on the evidence of Dr Saleemi to the inquiry. There was no evidence to suggest that at the material time Dr Saleemi told either of them that a transfer should be either delayed or not pursued to allow Sarah to have a period of stabilisation in segregation till well into 2019. Dr Saleemi's evidence on this point was problematic when compared with other evidence in the case. I did not regard it as "largely uncontradicted" and I did not accept it.

[181] The 3-month period envisaged by the PMAG process before there might be intervention by SPS HQ was far too long for such a complex case. Without the co-operation of Mr Munro to seek to accelerate matters, Ms McRae was stuck with that process. No such co-operation was forthcoming. If the PMAG process had specified a shorter time scale, Mr Munro and Ms McRae would have adhered to it.

[182] I have accepted Mr Wheatley's critical analysis of the way the prison dealt with Sarah. To borrow the very apt phrase used by the advocate depute, Sarah was kept in a holding pattern once it was decided she was to be transferred to another prison. The problem with that was that there was a serious failure of support and engagement while a prolonged and unfocused transfer process achieved very little, if anything at all.

[183] I have accepted Mr Wheatley's criticism that the culture was not one in which SPS HQ would intervene in a proposed transfer quickly. There was a process of brokering of prisoner transfers. A director of operations at SPS HQ could have instructed Edinburgh Prison to take her but the process and culture did not allow this to be considered at PMAG until the 3-month period expired. The process took too long for a prisoner with Sarah's considerable vulnerabilities. The result was that the decision to

accept the recall of Sarah to a local male prison could only be changed with difficulty even though it was viewed as problematic and inappropriate by many of those working with her. The failure to have any senior management involvement was a serious problem. I have made a recommendation focused on this issue.

The operation of TTM

[184] The operation of the TTM suicide prevention strategy was the subject of a considerable amount of evidence in this inquiry. The only occasion during the period she was back in Perth that Sarah was placed on TTM was due to concerns expressed by an external healthcare professional who saw her for a relatively short time during a visit to Ninewells for medical treatment on 21 December 2018. She was removed from TTM the next day.

[185] Lesley McDowall, a senior official in SPS, devised the TTM suicide prevention strategy. She gave evidence as to the points of differences from the earlier Act2Care scheme. The idea was to get away from the old system that was perceived as a form of punishment. There was a more individual element to the updated scheme designed to ensure that there would be more individual assessment of each prisoner. The intention was to reduce the use of actions such as removal to safe cells, the requirement to wear safer clothing and the extent of regular observations within cells. All prisoners had to be given proper awareness of the TTM strategy as they were each a potential source for reports that might lead to a decision to put a person on TTM.

[186] Dr Saleemi accepted that, like many other experienced prisoners with knowledge of how TTM worked, Sarah often hid her true feelings when interacting with staff who were TTM trained. As a result, there might not be cues and clues for staff to pick up when considering whether to put her on TTM. I consider this applied especially to staff who were not given available information about her formulation and the impact of the OLR sentence.

[187] Mr Wheatley's criticism of the adequacy of TTM as a suicide strategy involved tracing its origin back to the predecessor scheme Act2Care. He described its positive influence on the development of the equivalent suicide strategy in England and Wales. He was critical of the changes made to the Act2Care strategy when it evolved into TTM. In his view, it was inferior to the earlier scheme. Those who devised the changes were well intentioned, but it resulted in a more superficial approach to the problems of complex prisoners. As a suicide prevention policy, TTM focussed on those who were identified as actively suicidal. As a result, it missed a lot. I have accepted this criticism of the TTM strategy.

[188] Mr Wheatley thought Sarah needed to be somewhere where she could be looked after properly. Perth was not set up to do that. Mr Wheatley observed that outside prisons people with a comparable range of mental health issues would not have been removed from association and placed in segregation. Mr Wheatley accepted that the kind of support and engagement he thought necessary could have been provided without use of TTM. A more sensitive suicide prevention strategy might have brought focus on to the very serious problems Sarah was experiencing at the time.

[189] For the reasons set out by the Crown, the state of the evidence led does not allow me to make recommendations in relation to TTM. However, there is a basis for concluding that the TTM strategy was inadequate to meet the serious risk of suicide that existed in Sarah's case having regard to substantial amount of information the prison held about her. Dr Brown referred to Sarah's long history of self-harming behaviours and suicidal thoughts and intent. These patterns of behaviour and responses made it likely that Sarah would consider suicide as a definite plan.

[190] Placing prisoners on TTM will normally involve frequent observation of them. Some of the cross-examination for the Scottish Ministers was about the feasibility of very frequent observations of prisoners put on TTM. Difficulty in establishing exact intervals between observations does not detract from the force of the criticism made. They do not provide an argument for no observation in cases of concern where the use of a suicide prevention strategy is appropriate.

[191] One obvious moment when the availability of this information as to formulation might have been helpful was when she received the written notification of the PBS decision that Sarah was to remain in prison for at least a further 12 months. The staff in the SRU did not have the advantage of this information. I consider that Dr Brown was correct to suggest that this was a missed opportunity. It is impossible to say whether if the prison social worker had managed to speak with a staff member on the afternoon of 11 January 2019, this might have caused TTM to be triggered. She was obviously concerned for Sarah. SRU staff would have had a different perspective with more relevant information about Sarah.

[192] The POAS submitted that it could not be said that there was a "lively possibility" that the provision of a formulation would have caused Mr Burns or Mr Keenan to act differently. The submission seemed to be predicated on the evidence as to the discussion between Mr Keenan and Sarah on the evening before she died and her observed demeanour before being locked in her cell. This submission does not take account of the insight that would be provided to the prison officers working in a similar situation by the provision of the formulation. The submission seemed to deny, without justification, the notion that POAS members are capable of being trained even when such training has the potential to assist them to have some insight into what may be triggering for vulnerable prisoners under their care. I reject it.

[193] As regards paragraph (iii) of the Consolidated List of Issues, TTM was not a sufficient strategy to manage the risk of Sarah completing suicide. The strategy was utilised appropriately based on the limited training and information about Sarah provided to SPS and THB staff.

[194] The TTM strategy was not sufficiently sophisticated to deal with a prisoner like Sarah whose needs were complex. Although I am unable to reach a definitive conclusion that she should have been put on TTM on other occasions, there were a number potential missed opportunities in the period between Sarah's recall and her death where the lack of information available to staff who interacted with her may have contributed to a failure trigger the only available strategy, TTM.

[195] The advocate depute submitted that, with hindsight, it could be seen that there was a build up of stresses in Sarah's life in the period leading up to her death. She drew

attention to Sarah's recorded phone conversations. The reality was that those prison staff who made decisions about TTM were dealing with time-limited circumstances and did not know about the calls.

[196] I consider, with respect, that the advocate depute gave too much weight to the content of the telephone conversations. Prison staff who interacted with Sarah knew very well her sense of grievance and hopelessness due to the implications of the OLR sentence because she had articulated it to them. Sarah's views and grievances about both her OLR and trans status within the prison were well known to staff who dealt with her. She had told them that she thought it was impossible to comply fully with the licence conditions. There was an abundance of information recorded within the prison records that left no reasonable doubt as to the detrimental effect of her prolonged isolation in the context of being recalled as an OLR (and TSG) prisoner. The staff did not have the information about the psychological formulation that would have allowed them to understand the extent to which she was a risk to herself. That information was not made available to them.

Treatment of expert evidence re TTM

[197] One other matter merits separate discussion. The Crown submitted that there was some tension that could not be resolved between the expert evidence of Mr Wheatley and of Dr Brown as to the number of occasions that they each thought Sarah should have been put on TTM. As they could not both be right, where there was conflict, the Crown submitted that the evidence of Dr Brown should be preferred. She

could speak to when the triggering of TTM might have made a difference. Where commenting on the question of what would have made a difference to Sarah, Dr Brown was better placed.

[198] Dr Brown's conclusion was there were a number of missed opportunities when putting Sarah on TTM might have made a difference, but she concluded that there was no point at which she could say Sarah ought to have been on TTM and that would have made a difference to the outcome.

[199] Mr Wheatley's evidence was to an extent similar. He thought there were a number of missed opportunities, but he maintained his position that Sarah should have been put on TTM in circumstances where Dr Brown was not able to reach the same conclusion. Even though the advocate depute sought to persuade me that I should reject this part of Mr Wheatley's evidence, she submitted that this did not detract from the force of the criticism made by Mr Wheatley as the deficiencies in TTM strategy as an adequate approach to the management of a prisoner as complex as Sarah. I agree with that submission.

[200] As a Forensic Psychiatrist Dr Brown had experience of the up-to-date operation of TTM. She looked at the missed opportunities to place Sarah on TTM within the prison. On balance, she could not be satisfied that that Sarah should have been placed on TTM on any other than the single occasion that occurred after her recall. On 21 December 2018 when Sarah was taken for treatment at Ninewells Hospital, she let her guard down when she spoke with the treating nurse. As a result, she was put on TTM

on her return to the prison. Very experienced people did the subsequent case conference the next day and removed her from TTM straight away.

[201] I prefer Dr Brown's evidence that, apart from the day before her death, she could not identify specific missed opportunities to place Sarah on TTM. This does not mean that TTM was an adequate suicide prevention strategy. The circumstances leading up to Sarah's death demonstrate the inadequacy of the only suicide prevention strategy that was available to SPS staff who were not provided with available information about Sarah's complex needs.

The section 26(2)(f) recommendation

[202] This section deals with the Crown's proposed recommendation which was based on Dr Brown's evidence. There was sufficient information about Sarah held in the SPS and THB record systems to allow staff to be provided with a greater understanding of her risk of suicide, even though she did not disclose her intent directly to SPS and/or THB staff. Effective dissemination of that information for the purpose of allowing staff who had contact with Sarah to be better informed as to the extent of risk of suicide did not happen within staff groups and between staff groups.

[203] The Scottish Ministers submitted that the recommendation proposed by the Crown under section 26(2)(f) was not necessary nor supported by the evidence. Draft guidance was under development and the sharing of information would be considered as part of that. For the reasons stated here I did not accept that submission.

[204] The factual findings show significant lack of communication within the prison. The governor and deputy governor worked towards a transfer even if the time scales were slower than they expected. Meanwhile, based on Dr Saleemi's evidence, he was content for Sarah to remain in the SRU as it provided stability. He does not seem to have told Mr Munro and Ms McRae this. Sharing information presents challenges within prisons. Nevertheless, I have concluded that the Crown's proposed recommendation was necessary and appropriate. The findings made from the evidence support it. The information as to formulation that is the subject of the recommendation under section 26(2)(f) was already held in prison records. If it had been available to SRU staff, it would have assisted them in their dealing with Sarah throughout her time in the SRU . This might have led them to operate TTM at the stage of delivery of the PBS letter. They would have been better informed as to its potential effect on her. The acceptance of Dr Brown's conclusion on this point did not undermine the overall importance of Mr Wheatley's evidence on the inadequacy of TTM.

Post death reviews

LAER

[205] The prescription drugs that were found in Sarah's cell are listed in the findings. The toxicology evidence established that she had taken potentially fatal amounts of those drugs though that was not the cause of death. While there was limited focus on this aspect in this Inquiry, it is a matter of concern that such amounts of drugs had been accumulated in the cell of a prisoner who had Sarah's level of complex needs. The

prison GP increased the level of anti-depressant medication on 4 January 2019. Once again, SPS and medical staff working with her did not have the benefit of relevant information about her that was held only for the restricted purposes of the RMP.

DIPLAR

[206] SPS did change its practice following this death and at least one other so that, as envisaged in the DIPLAR recommendation, there was a change in practice to allow for risk assessment on communication of an adverse parole decision. This was an obvious and necessary action. I have not made any related recommendation because relevant action has been taken. Beyond this, the DIPLAR picked up on important aspects of the circumstances leading up to Sarah's death, no critical thought seems to have been applied to try to work out how the death might have been avoided. It noted there was no way to predict her behaviour. The difficulty in getting a move to the female estate was noted. For the reasons given above, in fact, there was a great deal of information available to the prison authorities that pointed to the predictability of her demise.

Summary conclusions

[207] The nomination of Perth as the committal establishment upon the recall of Sarah meant that those who had to deal with her there were faced, without any notice, with difficult and sensitive decisions which involved the need to balance competing rights and interests. Perth was not equipped to deal with the sudden arrival of a prisoner who presented three serious sets of issues. She was an OLR prisoner of long standing just

recalled, she had multiple personality disorder diagnoses, and she was a transgender woman. Sarah's case had to be negotiated around the various rules (Rule 95), policies (TG) and strategies (TTM) that had to be applied.

[208] The initial solution chosen was to remove her from association by placing her in the SRU. After some delay, the TSG policy was considered and the conclusion reached that Sarah should be transferred to the female estate. The authorities at Perth had very little influence over transfers which led to further delay. Her other problems were neglected in the meantime. I have thought carefully but have refrained from reaching a conclusion that the multiple failures which occurred here had a cumulative effect that allows me to make a causative finding under section 26(2)(e). This case is an example of the inappropriate use of segregation for a prolonged period in circumstances where the prisoner had not acted in a manner that merited removal from association.

[209] Once the prison authorities decided that Sarah had to be transferred elsewhere in line with the TSG policy, progress was slow. Meanwhile Sarah had to be accommodated within the SRU. This was not well managed. The defective processes described in this determination regarding delays in arranging case conferences, persistent failures to attend case conferences when they took place, delays in mental health assessment, failures to operate Rule 95 at the correct time and the failure to appoint a personal officer to Sarah were all avoidable.

[210] Having regard to the findings in fact and reasoning above I have made the statutory findings and recommendations set out at the outset of this determination.

Final observations

[211] It is a matter of regret that serious problems arose because substantial numbers of documents relating to Sarah were not produced when they should have been. Crown counsel thought there was sufficient cause for concern that a police investigation was instructed into the failure to produce prison records. Although it is not strictly a statutory recommendation, I think it is appropriate to recommend that SPS should put in place a system for ensuring that steps are taken forthwith to secure all records, in whichever medium they may be held, relating to a prisoner who has died while within its estate.

[212] Those representing the Crown went to considerable efforts to keep Sarah's mother and sister regularly updated. I was informed that the advocate depute took time to explain her approach to the case to them on several occasions. However, the inquiry would have benefitted from separate representation for the next of kin. This is not a criticism of the advocate depute whose involvement transformed this inquiry but a concern as to the unbalanced nature of the process in the absence of such representation. While the court of its own accord followed up on numerous lines of questioning during the evidence, this was not an adequate substitute for legal representation that can carry out its own investigations.

[213] I wish to repeat the thanks I expressed in court to the instructing agents for their input, agreement of evidence and collaborative working. Their contribution kept oral evidence within reasonable limits once the inquiry resumed. On resumption counsel led the oral evidence very efficiently and adhered closely to the time limits identified at case

management. To borrow the expression of senior counsel for the ministers, they cut their cloth to ensure this happened. It was unfortunate that due to reasons beyond anyone's direct control, it proved impossible to lead evidence with any degree of continuity due to the non-availability of counsel. This made completion of the determination more difficult.

The family members who attended the inquiry hearings

[214] Sarah's mother and sister attended virtually all the online and the in-person evidential hearings in this case. Senior counsel for the Scottish Ministers described as humbling the dignity and composure shown by Sarah's mother and sister during their attendance at these proceedings. I agree wholeheartedly with that observation and reiterate the expression of my condolences to them.

Appendix

Glossary

CC – case conference

CLT – Community Licence Team

DIPLAR - Death in Prison Learning Audit & Review

FLM – First Line Manager

LAER - Local Adverse Event Review

PBS – Parole Board for Scotland

PMAG - Prisoner Management Authorisation Group

POAS – Prison Officers Association Scotland

SPS – Scottish Prison Service

SRU – Segregation and Reintegration Unit

TCLBR – Throughcare licence breach report

THB – Tayside Health Board

TSG - Transgender

UM – Unit Manager